The Intersection of PASRR & Dementia

Today’s Presenters:

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Today's Goals

Identify	Requirements set forth in the CMS regulations for PASRR.
Consider	Dementia : Evaluation and Treatments
Discuss	The concept of primacy and complexities of differentiation from other conditions.
Promote	Best practices for interpreting a dementia diagnosis within the context of PASRR.
Draw	Conclusions about your State's practices and how to reduce risk in PASRR.

Dementia and PASRR

Use of Person Centered Language

Our own use of Person Centered language is an example of modeling and helps promote other's use of appropriate, inclusive, and non-stigmatizing language.

Say This	Not That
• Dementia • Alzheimer's disease and other forms of dementia • A form of dementia • A type of dementia • Symptoms of dementia	• Dementing illness • Demented • Affliction • Senile dementia • Senility • "Going on a Journey" etc.

Say This	Not That
• A person/people with dementia • A person/people living with dementia • A person/people with a diagnosis of dementia	• Victim • Sufferer • Demented person • Afflicted • "Not all there" • "Losing their mind"

42 CFR: 483.102 (Applicability and definitions)

An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on (i) Diagnosis, (ii) Level of impairment and (iii) Recent treatment (i.e., duration)

- This mental disorder is-
  - (A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder, somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability; but…
  - (B) **Not a primary diagnosis of dementia**, including Alzheimer's disease or a related disorder or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A)…

Dementia is now categorized as neurocognitive disorder.

January 25, 2018

Can states refer to the DSM 5 in their operations guidelines related to PASRR, or do they need to incorporate the CFR reference to the DSM lll?

- Given the important role PASRR plays in helping NFs develop individualized plans of care, **CMS understands there would be sound policy reasons for state mental health and intellectual disability authorities to use the updated version of the DSM when writing PASRR procedures**. States that choose to use the more current DSM in their PASRR operational guidance will not risk being out of compliance for that reason.

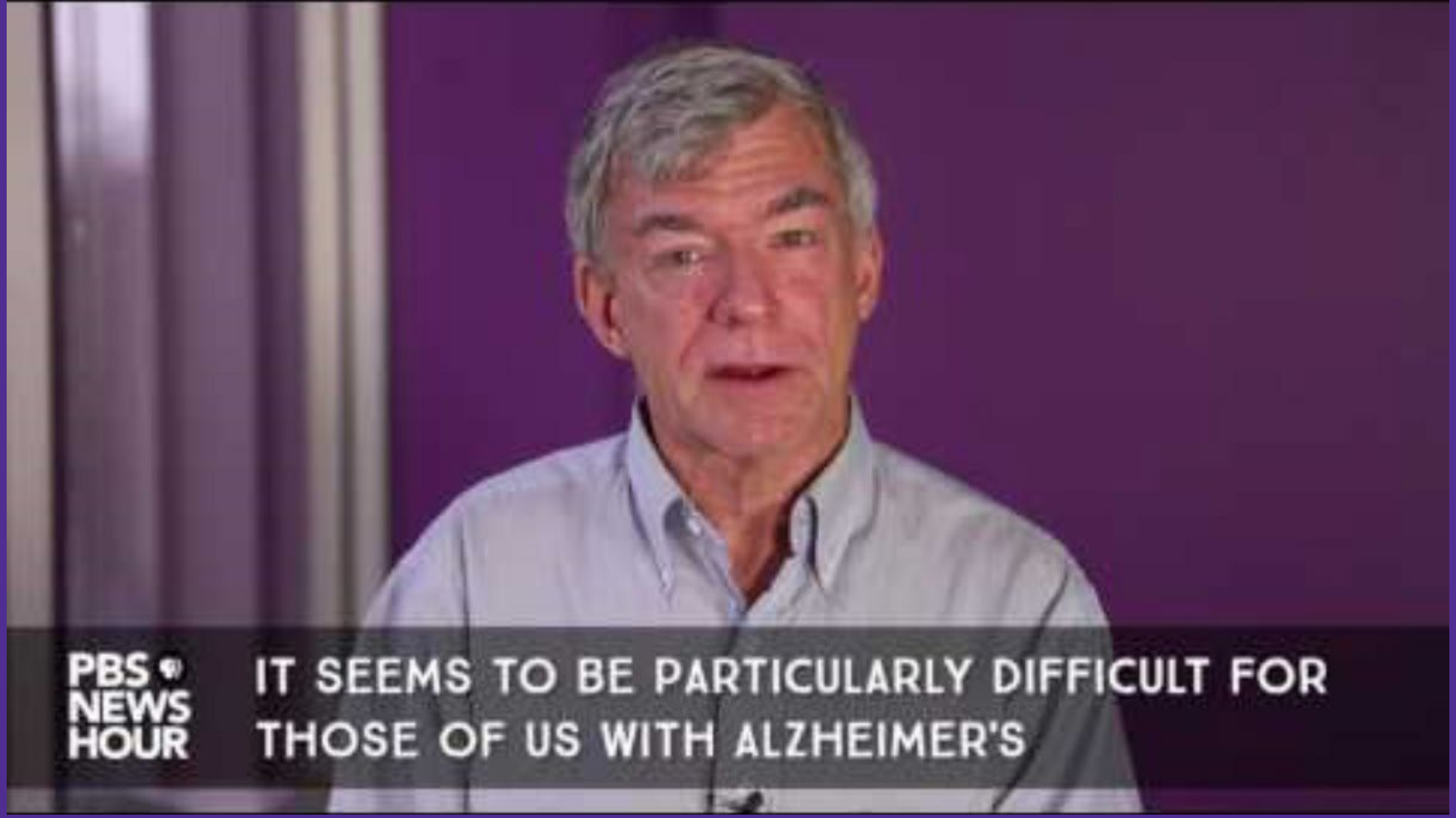
Halting a LII Evaluation

§ 483.128 PASARR evaluation criteria.

(a) through (i)…

(m) The evaluation may be terminated if the evaluator finds at any time during the evaluation that the individual being evaluated—

- **(1)** Does not have MI or IID; or
- **(2)** Has—
  - (i) A primary diagnosis of dementia (including Alzheimer's Disease or a related disorder); or
  - (ii) A non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness and does not have a diagnosis of IID or a related condition.



PBS News Hour:

This is what Alzheimer's looks like. It looks like me

What is the History and Current Definition of Dementia

1952–1968

DSM-I & II:

Etiology-driven, vague use of dementia. Used the phrase organic brain syndromes.

1980

DSM-III:

Symptom-based, formalized Dementia as a category.

1994

DSM-IV:

More precise criteria for Dementia. Functional impact emphasized.

2013

DSM-5

Mild/Major Neurocognitive Disorder(Dementia).

Neurocognitive Disorders in DSM 5: Major vs Mild

(Dementia) Major:

- Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains based on concern of the individual, a knowledgeable informant or the clinician and preferably documented by standardized neuropsychological testing or other quantified clinical assessment.
- The cognitive deficits interfere with independence in everyday activities.

Mild:

- Evidence of moderate cognitive decline from a previous level of performance in one or more cognitive domains based on concern of the individual, a knowledgeable informant or the clinician and preferably documented by standardized neuropsychological testing or other quantified clinical assessment.
- The cognitive deficits do not interfere with independence in everyday activities.

Key Points Regarding Major Neurocognitive Disorders: Cognition and ADLs

- Major NCD/Dementia is a multifactorial process that is always associated with cognitive decline and impaired functioning.
- There are many cognitive screening tests. (MMSE, MOCA, BIMS) Neuropsych testing is gold standard.
- As the disease progresses there will be gradual dysfunction and loss of individual autonomies
- Besides decline in memory or other cognitive domains, the criteria for the diagnosis of Major NCD requires impact/decline in functional status.
- Assessments for functional ability fall into two levels:

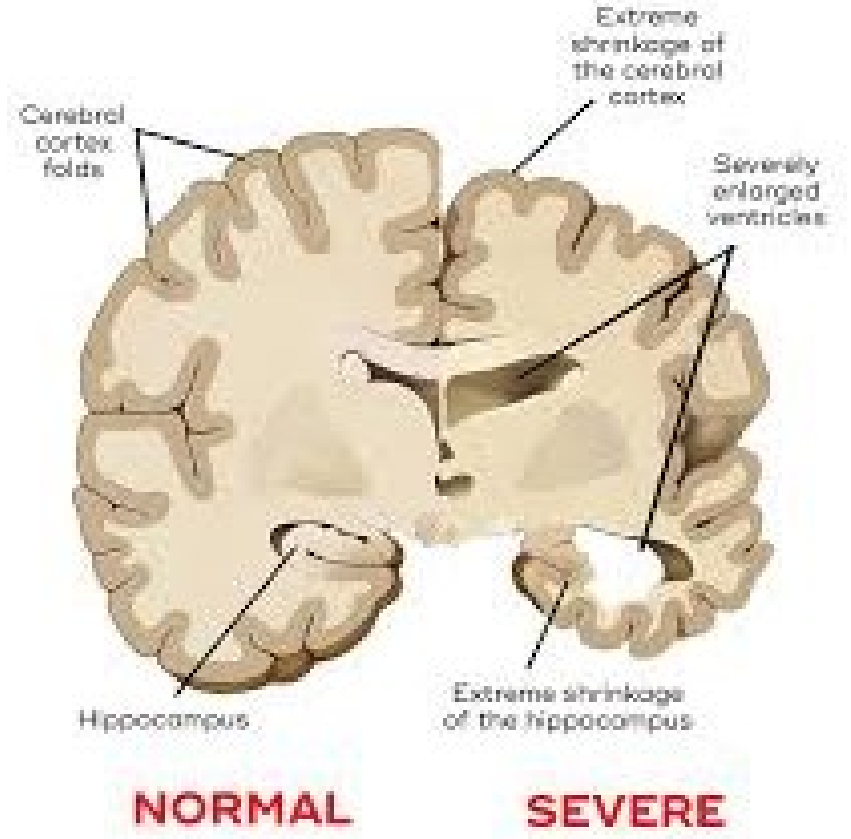
IADLs	Transportation, shopping, preparing meals, managing households, finances, medication management, communication devices
ADLs	Mobility, toileting/bathing, continence, hygiene, dressing and feeding

Source: Dementia Neuropsychology 2020 April-June;14 (2):93-102

IADLs and Major Neurocognitive Disorders

- Instrumental Activities of Daily Living (IADLs) are usually affected before Basic Activities of Daily Living (ADLs).
- IADLS require higher level cognitive functions such as executive function.
- Executive function refers this set of higher-level cognitive skills that help a person plan, organize, initiate, monitor, and adapt behavior to achieve goals. (The brain's CEO)

How is Dementia Diagnosed?



Medical assessment for dementia generally includes:

1. Medical history: Obtain medical history from individual and someone who know them well such as a family member or caregiver
2. Physical exam. Perform a physical exam
3. Administer cognitive screening tests. Consider functional screening for activities of daily living.
4. Refer to specialist if early onset symptoms, severe behavioral disturbances or unclear diagnosis.

Tests Used to Assist in Diagnosing Dementia

Screening tools and/or neuropsych testing

Laboratory testing

Brain Scans

Psychiatric evaluation

Genetic tests

maximus

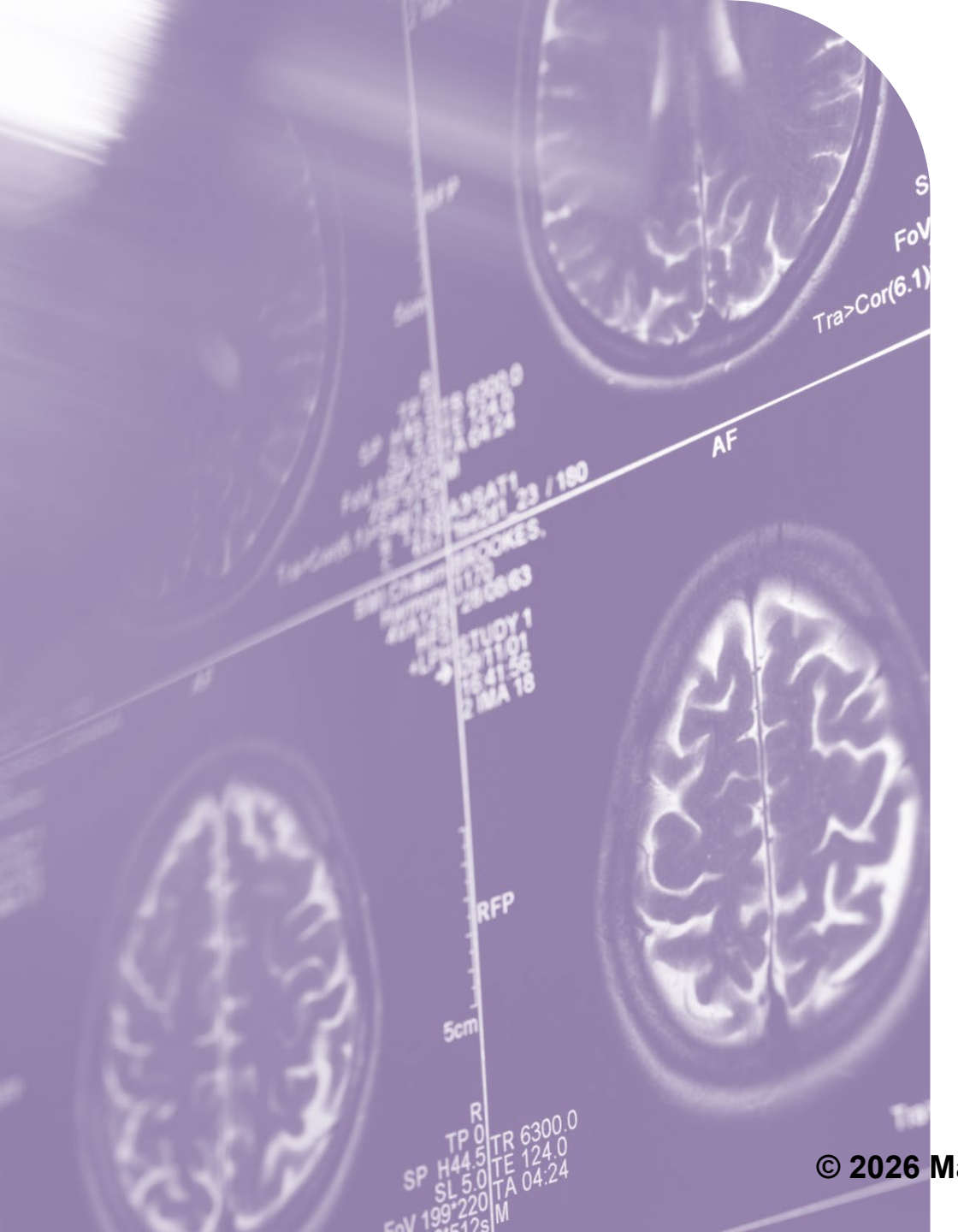
Where Do We Find Assistance in Determining Dementia for PASRR Purposes

Documentation of skills/abilities and evaluation tools giving insight into the diagnosis and progression can be found in these records:

- Nursing notes
- Progress notes
- H&P
- MDS (Minimum Data Set)

Things to look for include:

- Orientation. Self, place, time and situation.
- Behavior. Wandering, agitation, hallucinations and delusions
- Support needs. Skills and abilities decline.



What are the Types of Neurocognitive Disorders DSM 5 (Mild/Major)

Many types of NCD, including:

- **Alzheimer's disease—most common and our focus today**
- Dementia with Lewy Bodies
- Vascular examples CVA
- Frontotemporal Dementia

DSM 5 Major NCD (Dementia) due to Alzheimer's Disease

Insidious onset and gradual progression of impairment in one or more cognitive domains

Probable Alzheimer's disease is diagnosed if either of the following are present: (otherwise ***possible***)

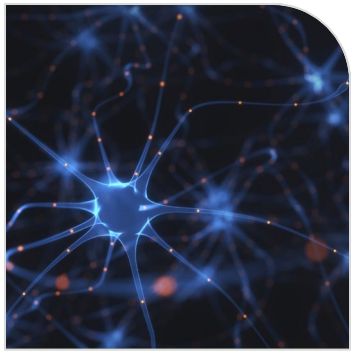
A. There is evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing.

B. All three of the following are present:
   1. Clear evidence of decline in memory and leaning and at least one other cognitive domain based on detailed history or serial neuropsychological testing,
   2. Steadily progression gradual decline in cognition without extended plateaus, and
   3. No evidence of mixed etiology

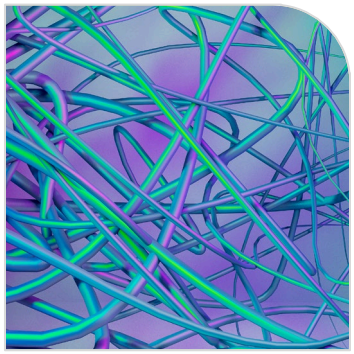
How is Biochemistry involved in Alzheimer's Dementia

There are several chemical neurotransmitters active in the brain; each has a fairly specific group of actions. Associated neurologic syndromes may be related to a deficit or overabundance of a particular neurotransmitter.

The neurotransmitter that features most prominently in AD is acetylcholine. Dysfunction and reduction of nicotinic acetylcholine receptors is linked to adverse cognitive and neurodegenerative effects



NMDA is a glutamate receptor. Overactivity can lead to excitotoxicity aiding in the formation of amyloid plaques.



The presence of neurofibrillary tangles and amyloid plaques are the structural hallmarks of AD. Beta-amyloid and tau are two proteins involved in the formation of these abnormal structures. A form of tau, A68, is the major component of these tangles. We are not certain about causation.

What Are Available Treatments For Dementia

Symptomatic Treatments

Cholinesterase inhibitors and NMDA receptor antagonists help balance neurotransmitters and relieve cognitive symptoms without altering disease progression.

Disease-Modifying Therapies

Monoclonal antibodies target amyloid-beta plaques to slow cognitive decline in early Alzheimer's disease.

Treatment Usage and Monitoring

Symptomatic drugs are common for mild to severe stages; antibodies require strict monitoring and are used early.

Why Do We Need to Distinguish Dementia (Major NCD) from Other Conditions

* Delirium
* Intellectual/Developmental Disability
* Serious Mental Illness

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Distinguishing Dementia vs Delirium

Characteristic	Delirium	Dementia
Onset	Acute	Insidious
Course	Fluctuating	Gradual deterioration
Awareness	Impaired	Often clear until advanced stages
Attention	Disturbed	Often good until advanced stages
Memory	Poor working memory and immediate recall	Poor short-term memory
Delusions	Often short-lived or changing	More fixed
Sleep disturbances	Fragmented sleep	Sleep-wake reversal

Distinguishing IDD from Dementia

Feature	Intellectual / Developmental Disabilities (IDD)	Dementia
Onset	Present from childhood or adolescence	Acquired later in life
Course	Non-progressive (static)	Progressive decline
Baseline	Stable lifelong cognitive and adaptive functioning	Measurable decline from prior baseline
Etiology	Neurodevelopmental	Neurodegenerative or neurological disease

Key Points on Distinguishing SMI from Dementia (Major NCD)

SMI reflects long-standing psychiatric illness with fluctuating cognition; dementia is defined by progressive cognitive and functional decline from a prior baseline.

SMI is a psychiatric condition that usually starts earlier in life and tends to be chronic or episodic, not steadily progressive.

Dementia is a neurodegenerative condition with later-life onset and a progressive, irreversible decline in cognition and functioning.

How SMI and Dementia Can Look Alike. Both can involve:

- Poor concentration and memory complaints
- Disorganized or slowed thinking
- Social withdrawal or apathy
- Irritability, agitation, or mood changes
- Reduced daily functioning
- Suspiciousness or psychotic-like behaviors

At a surface level, a person with severe depression, psychosis, or bipolar disorder can appear “forgetful,” confused, or functionally impaired in ways that resemble dementia.

PBS News Hour: March 4, 2023
A Brief But Spectacular take on memory loss and healthy aging

PASRR Determinations & Case Example

Rationale Writing: Support the PASRR Decision

Statements of Cognitive Decline and ADLs:

- Orientation (person, place and time)
- Cognitive status
- Stage along the continuum
- Behaviors signaling disease progression
- IADLS and ADLS

Decision Making:

- Dementia primary = Halt
- SMI/DD = include in PASRR population
- SMI/DD = non primary Dementia = include in PASRR population

Example 1: Dementia Primary (accurate)

- 82 y/o NF resident
- Resident review submitted. LI reported the new diagnoses of Schizoaffective d/o, MDD, Anxiety d/o and Unspecified Dementia with behavioral disturbance.
- Reported behaviors include difficulty interacting with others; difficulty thinking through or completing task, and recent hallucinations/delusions.
- Receiving Remeron 15 mg (for appetite), Buspar 30mg, Memantine 5mg, and Seroquel 50 mg (LI and supporting documentation report hx of psychosis).
- Currently resides in a memory care unit at NF
- Documented weight loss secondary to progression of Dementia.
- Has a documented BIMS score of 0/15
- Has A PHQ9 score of 15; however, the problems/behaviors identified with frequent symptoms are consistent with a dementia diagnosis (loss of appetite, low energy, trouble sleeping, trouble concentrating, and being easily annoyed).
- Oriented to self only
- Requires reminding and cueing along with extensive assistance with ADLs/IADLs.
- Diagnosis of schizoaffective disorder was not supported in the submitted documentation.

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OR

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https://www.surveymonkey.com/r/COProviderQA