Question & Answer (Q&A): Promising Practices for Meeting the Needs of Dually Eligible Older Adults with Schizophrenia Webinar

Webinar participants asked the following questions during the Q&A portion of the 2018 Geriatric-Competent Care webinar, Promising Practices for Meeting the Needs of Dually Eligible Older Adults with Schizophrenia held on November 6, 2018. Please note, the questions and responses in this document have been edited slightly for clarity. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website:
https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Older_Adults_Schizophrenia

Featured Webinar Speakers:

- Naila Azhar, MD, MPH, Assistant Professor of Psychiatry & Supervising Attending - Schizophrenia Outpatient Clinic, University of Connecticut School of Medicine
- Tracy Beavers, BSN, RN, EMT-P, Case Manager, CareSource Ohio
- Ann Marie Luongo, LPC, Program Manager, Advanced Behavioral Health, Inc.
- Heidi, Family Caregiver

Q1: How can you tell the difference between dementia and late onset/very late onset schizophrenia?

Dr. Naila Azhar: A sharp decline in cognitive functioning over the course of several months to a few years is suggestive of dementia. Older adults with late or very late onset schizophrenia typically have persistent cognitive challenges in processing speed, working memory, and visual and verbal learning, but generally do not have a decline in cognitive functioning or increase in occupational or social impairment over a short time period.

Q2: Is there a difference in level of functioning between individuals with schizophrenia and individuals with Alzheimer's disease? Do the non-pharmacological treatments differ for the two?

Dr. Naila Azhar: Changes in cognitive functioning among individuals with schizophrenia may include onset of psychosis and disorganized speech and behavior that manifest in early adulthood or middle age and then become relatively stable.[1] These changes in functioning due to schizophrenia typically do not include changes in memory. By contrast, Alzheimer's disease (AD) may present as rapid and progressive memory loss among older adults (e.g., misidentification of caregivers on multiple occasions). Psychosis may be experienced by both older adults with schizophrenia as well as older adults with AD, but the nature of the

[1] Shepherd, S., Depp, C. A., Harris, G., Halpain, M., Palinkas, L. A., & Jeste, D. V. (2010). Perspectives on schizophrenia over the lifespan: a qualitative study. *Schizophrenia bulletin*, *38*(2), 295-303.

experience varies. Older adults with schizophrenia more frequently experience auditory hallucinations as well as "bizarre delusions" (i.e., delusions that are completely implausible). Older adults with AD are more likely to experience temporary visual hallucinations and "non-bizarre delusions" (i.e. delusions that involve situations that could occur in real life).[2]

Recommended non-pharmacological treatments for older adults with AD often include environmental modifications and training for family caregivers to improve problematic behavior (e.g., agitation), whereas the recommended treatments for older adults with schizophrenia often include social and functional skills training.[3] Cognitive-behavioral therapy is recommended for both older adults with AD and older adults with schizophrenia.

Q3: In our agency, we often see individuals who are quite isolated. These individuals may be reluctant to undergo neuropsychological testing, attend PCP appointments, or take antipsychotic medication. If we need to involuntarily hospitalize them it typically results in a very brief hospitalization with no medications and they do not want to return to us for psychotherapy or care management at that point. Do you have any comments on how to address this lack of engagement following short hospitalizations (maybe 2-3 days if the petitioned person signs themselves in)?

Dr. Naila Azhar: For short hospitalizations, the inclusion of the older adult's primary care physician and family in treatment planning often helps to re-engage patients in psychotherapy and care management afterwards. In addition, close coordination between the treatment teams at outpatient and inpatient facilities may help to achieve continuity of care. Further, it is helpful if outpatient teams conduct regular reviews of advance psychiatric directives, including issues related to decisional capacity and appointments of conservators.

Q4: Do you have any data on whether or not antipsychotic medications tend to be effective among older adults with late onset schizophrenia? I remember reading that only a third respond to this treatment— is this accurate?

Dr. Naila Azhar: Antipsychotic medications can be an effective option for treating older adults with late onset schizophrenia, but it is important to consider dosage and monitor closely for adverse effects. Typically, a lower dosage is preferred in treating late onset schizophrenia versus normal onset schizophrenia due to the increased risk of metabolic syndrome and movement disorders. It is important to monitor the risks and benefits of administering antipsychotic medication, and in some cases, it may be necessary to reduce or discontinue

[2] Jeste, D. V., & Finkel, S. I. (2000). Psychosis of Alzheimer's disease and related dementias: diagnostic criteria for a distinct syndrome. *The American Journal of Geriatric Psychiatry*, *8*(1), 29-34.

[3] Jeste, D. V., & Finkel, S. I. (2000). Psychosis of Alzheimer's disease and related dementias: diagnostic criteria for a distinct syndrome. *The American Journal of Geriatric Psychiatry*, *8*(1), 29-34.

antipsychotic medication in older adults with schizophrenia who are experiencing serious adverse effects. For more information on the use of antipsychotic medications among older adults with schizophrenia, see the following resource: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3756792/.[4]

Q5: How is the use of antipsychotic medications monitored? What guidance is provided for their use, especially given broader medical concerns about the use of antipsychotic medications in older adults?

Dr. Naila Azhar: There are several national and international guidelines for prescribing antipsychotics in older adults with schizophrenia. One is the American Psychiatric Association's practice guidelines, which can be found here: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf.

It is the responsibility of treating physicians to review available evidence and base their practices on this evidence. Because older adults with schizophrenia have complex health care concerns, using a checklist will help ensure appropriate monitoring in routine visits and assist in the identification and treatment of problems. Additional monitoring tools include: therapeutic drug monitoring by measuring serum drug levels; objective screening for side effects; Abnormal Involuntary Movement Screen; screening for cognitive decline; and algorithms for assessment and monitoring of drug induced QTC prolongation.

Q6: During your presentation, I noticed ECT treatment (electroconvulsive therapy) was briefly presented on the screen. What is the inclusion criteria for this treatment modality and is this still being used?

Dr. Naila Azhar: Electroconvulsive therapy (ECT) can be an effective treatment for severe depression, catatonia in older adults with schizophrenia, and schizoaffective disorders.[5] ECT has no absolute contraindications (i.e., situations where ECT itself could cause a life-threatening situation). However, since this procedure is performed under general anesthesia, a basic medical work-up and a medical clearance is necessary in older adults.

ECT is often the treatment of choice for older adults with schizophrenia who also have catatonia or psychosis, or those whose depression presents with life-threatening symptoms or behavior, such as suicidality or refusal to eat. A history of favorable response to ECT in past episodes of severe depression also suggests that ECT may be an effective treatment option. In addition,

[4] Jeste, D. V., & Maglione, J. E. (2013). Treating older adults with schizophrenia: challenges and opportunities. *Schizophrenia bulletin*, *39*(5), 966-968.

[5] Rohland, B. M., Carroll, B. T., & Jacoby, R. G. (1993). ECT in the treatment of the catatonic syndrome. *Journal of affective disorders*, 29(4), 255-261.

patients with less severe symptoms are often referred for ECT when they do not respond to medication trials.

Q7: Are there any recent advances in psychotropic medication for older adults?

Dr. Naila Azhar: The FDA is encouraging development of psychotropic medications that target cognitive dysfunction in individuals with schizophrenia, but no major progress has been made so far. However, there is an FDA-approved medication (Nuplazid [pimavanserim]) to reduce delusions and hallucinations associated with Parkinson's disease in older adults.[6]

Q8: How many individuals with a severe and persistent mental illness does a care manager typically work with at one time?

Tracy Beavers: As a RN Behavioral Health Case Manager, I typically work with 70 members that I primarily manage and 12-15 members that I secondarily or episodically manage. Of the 70 members that I work with, four have a High Acuity Level and 19 have a Medium Acuity Level. Acuity level is determined by severity and persistence of mental illness, number of diagnoses and medications, and utilization of emergency services and in-patient admissions.

Q9: There are sometimes situations where an older adult does not disclose the full extent of his or her symptoms due to a fear of being "locked up," which then prevents appropriate treatment. Do you have any suggestions for what to do in these types of situations?

Ann Marie Luongo: Regular objective assessment services by the Visiting Nurse Association (VNA), coordination with caregivers, and networking with primary care providers (PCP) are some ways to improve assessments and ensure that complete information is collected on the older adult. Ideally, the initial assessment should use an interdisciplinary approach that includes the individual, family, or other knowledgeable observers, psychiatrist, psychiatric nurse practitioner or physician assistant, social worker, caseworker, chaplain (if appropriate), and a nurse. The initial assessment may take 2 to 3 visits to complete.

Q10: What do you do when an older adult declines behavioral health case manager referrals?

Tracy Beavers: As a Behavioral Health Case Manager, I follow up annually with members that have refused case management. I also follow up with providers and reach out to members to offer assistance following every significant change event. It is every member's choice to participate in case management. Coordinating with a caregiver or a family member can be done

[6] Cummings, J., Isaacson, S., Mills, R., Williams, H., Chi-Burris, K., Corbett, A., ... & Ballard, C. (2014). Pimavanserin for patients with Parkinson's disease psychosis: a randomised, placebo-controlled phase 3 trial. *The Lancet*, *383*(9916), 533-540.

with the permission of the member. A wellness check is recommended in the event of health and safety concerns.

Q11: I work with individuals with schizophrenia who are also addicted to marijuana—how does marijuana impact antipsychotics that are often used to treat the symptoms of schizophrenia?

Dr. Naila Azhar: Cannabis may reduce efficacy of certain antipsychotic medications, especially olanzapine and clozapine.[7] Chronic cannabis use can also lead to lack of motivation and memory problems.[8,9] Cannabis use should be avoided in individuals with a history of psychosis due to increased risk of psychotic relapse.

Q12: How has the introduction of long acting injectable antipsychotics in the treatment of older adults with schizophrenia helped them remain in the community?

Dr. Naila Azhar: Use of long acting injectable antipsychotic medications reduces the risk of hospitalization and psychotic relapse and in this way may help to keep older adults in the community. However, effective dosage of the injection needs to be periodically reviewed as older adults with schizophrenia may require adjustment to a lowered dose.

[7] Brzozowska, N. I., de Tonnerre, E. J., Li, K. M., Wang, X. S., Boucher, A. A., Callaghan, P. D., ... & Arnold, J. C. (2017). The differential binding of antipsychotic drugs to the ABC transporter p-glycoprotein predicts cannabinoid–antipsychotic drug interactions. *Neuropsychopharmacology*, 42(11), 2222.

[8] Looby, A., & Earleywine, M. (2007). Negative consequences associated with dependence in daily cannabis users. *Substance abuse treatment, prevention, and policy*, *2*(1), 3.

[9] Solowij, N., & Battisti, R. (2008). The chronic effects of cannabis on memory in humans: a review. *Current drug abuse reviews*, *1*(1), 81-98.