Prevalenza di demenza per età

www.ncpc.org.uk

Paziente geriatrico

Frailty

→ Multimorbidità

→ Polifarmacoterapia

→ Declino Funzionale → Cognitivo Fisico psicologico Socio-economico

→ Incontinenza

→ Problemi nutrizionali

→ Cadute

→ Osteoporosi/Sarcopenia/Anemia
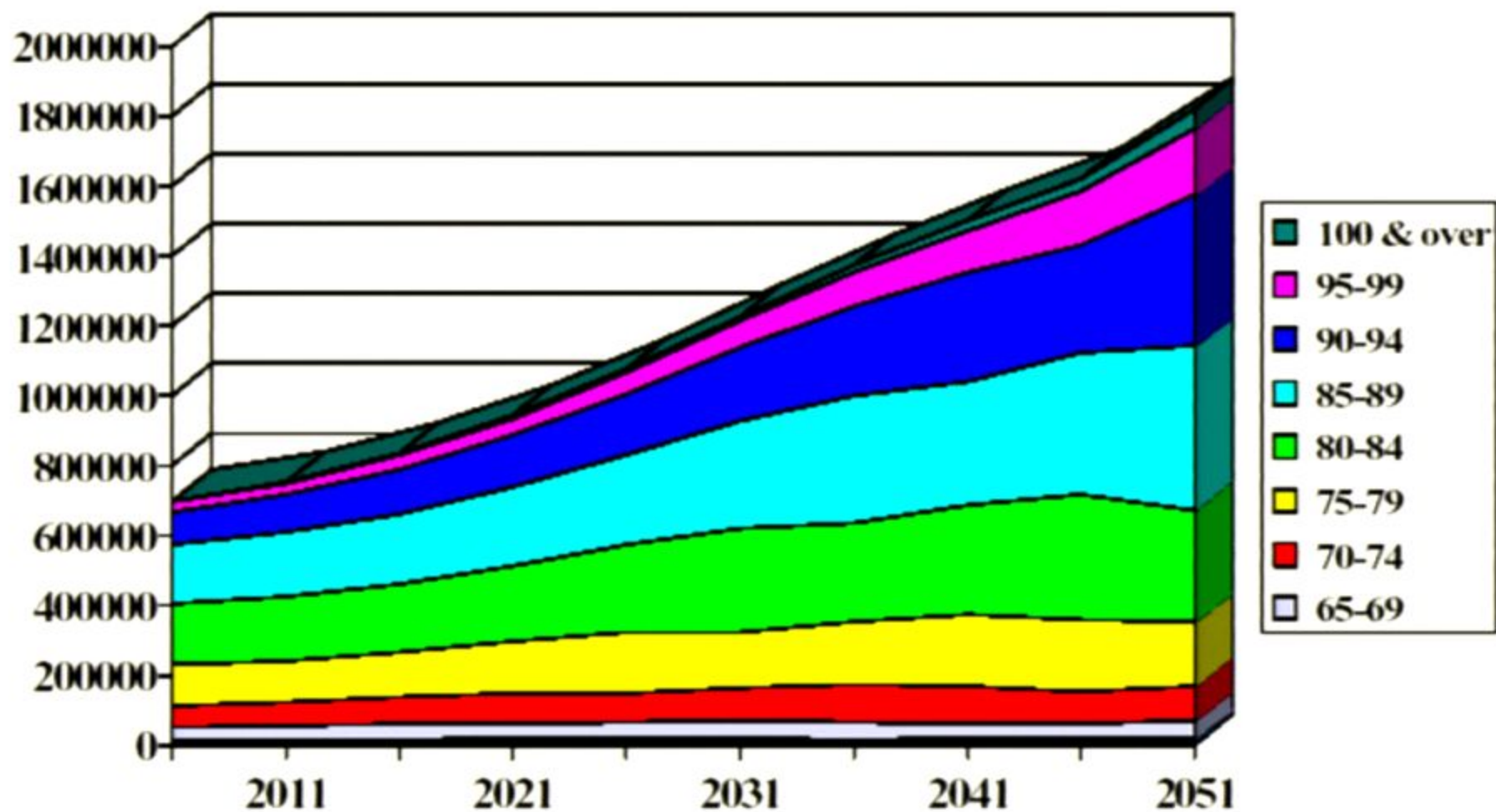
Comorbidity

disease-centered perspective

combination of additional diseases beyond an index disorder

Multimorbidity

individual-centered perspective

co-occurence of two or more chronic or acute diseases within one person
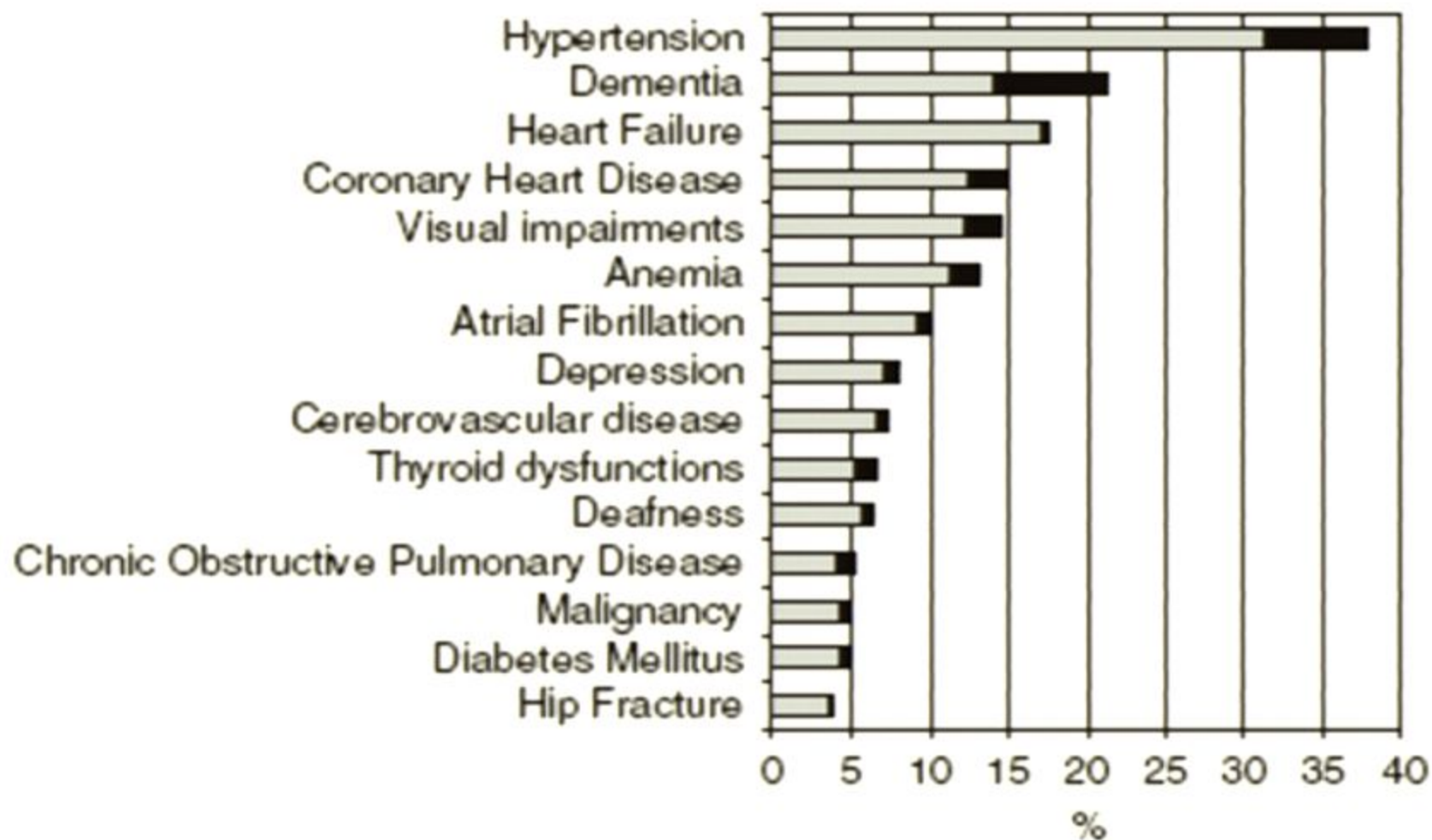
Marengoni et al. JAGS 2009

Figure 1. Prevalence per 100 of most frequent chronic diseases occurring independently of comorbidity (gray+black) or without any comorbidity (black).

Sarcopenia and Physical fRailty IN older people: multi-componenT Treatment strategies (SPRINTT)

Finanziamento totale: circa 50 milioni di euro (50% da fondi UE + 50% in personale e servizi delle case farmaceutiche)

Trial Clinico Randomizzato
Esecuzione, Centri di reclutamento, numerosità del campione

1,500 partecipanti

Arruolamento: 12 mesi
Follow-up: fino a 36 mesi

14 centri clinici
9 Paesi Europei coinvolti
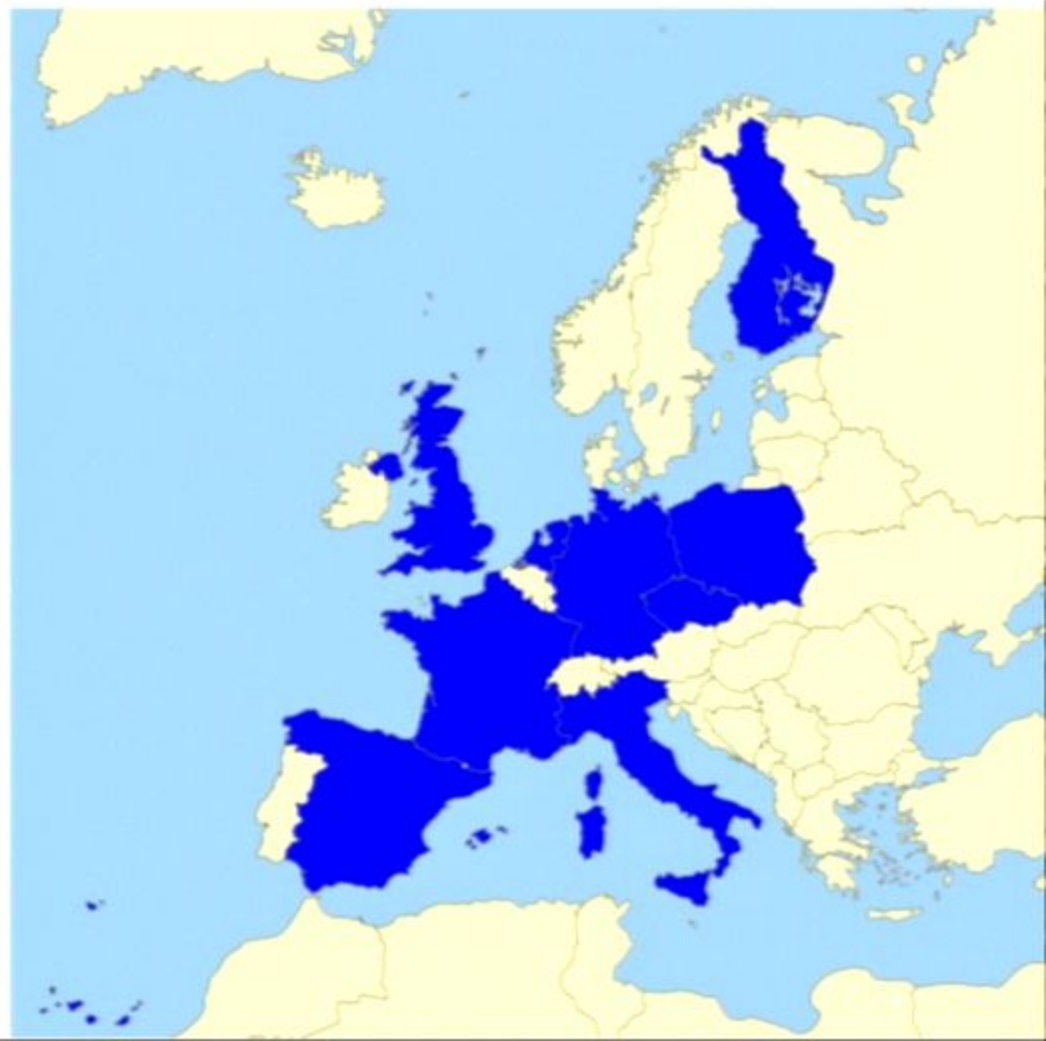
SPRINTT RCT

- 1,500 anziani residenti in comunità, età:70+

- Ridotta massa muscolare (DXA, FNIH)

- SPPB 3-7 (n = 1,200) e 8-9 (n = 300)

- In grado di eseguire il test dei 400m

- Criteri di esclusione: incapacità o rifiuto di esprimere consenso informato, malattie in fase terminale, patologie in fase di instabilità clinica, deficit cognitivo (MMSE<24), emodialisi, progetto di trasferimento in altra località durante il periodo dello studio

- Due bracci di trattamento: Intervento Multicomponente e Programma di Educazione alla Salute

Paziente con Demenza

Frailty

- declino cognitivo
- Declino funzionale
- BPSD
- Multimorbidità/polifarmacoterapia
- Incontinenza
- Problemi nutrizionali
- Cadute
- Isolamento sociale
- Caregiver distress

Valutazione Multidimensionale

Geriatric
Assessment
Technology:
The State of the Art

L.Z. Rubenstein
D. Wieland
R.Bernabei

• I pazienti con demenza rappresentano il paradigma dell'anziano fragile

• La valutazione multidimensionale (VMD) fornisce una metodologia standardizzata di assessment, volta all'individuazione delle diverse aree problematiche e allo sviluppo di un piano di cura individualizzato.

Rosow-Breslow

CES-D

GDS

ADL-Katz

Barthel Index

Quale strumento di VMD?

Inter-RAI

Norton scale

S.C.A.G.

IADL-Lawton

CIRS

NAGI scale

MMSE

Tinetti scale

SVAMA

Disability Rating Scale

Hamilton Rating scale

Esempi di aree valutate

- Stato cognitivo
- Comunicazione
- Umore
- Comportamento
- Sfera psico-sociale
- Stato funzionale
- Continenza

- Malattie somatiche
- Malattie psichiche
- Stato nutrizionale
- Pelle
- Engagement sociale
- Supporto sociale
- Farmaci
- Tattamenti

Limiti degli strumenti tradizionali

- Descrittivi

- Nessuna inferenza eziologica possibile

- Assessment di un'area singola

- dati non confrontabili

Multidimensional Geriatric Assessment: Back to the Future

**Second and Third Generation Assessment Instruments:
The Birth of Standardization in Geriatric Care**

Roberto Bernabei, Francesco Landi, Graziano Onder, Rosa Liperoti, and Giovanni Gambassi

- Omnicomprensivo

- inferenza eziologica possibile

- 'Care planning oriented'

- possibili i confronti

interRAI

North America
Canada
USA
Mexico

Europe
Iceland, Norway, Sweden, Denmark, Finland
Netherlands, Germany, UK, Switzerland,
France, Poland, Italy, Spain,
Estonia, Czech Republic,
Belgium Austria, Portugal,
Lithuania

**Central/
South America**
Chile, Mexico,
Brazil, Belize,
Peru, Cuba

Middle East
Israel

Asia/Pacific Rim
Japan, South Korea, Taiwan, China,
Hong Kong, Australia, New Zealand, India

interRAI Mission Statement

interRAI believes that <u>standardized assessment</u> provides crucial information about the needs of the elderly population which is rapidly growing world-wide. <u>Comprehensive evaluation</u>, including functional, psychosocial and environmental needs, is the <u>key to care planning decisions</u> resulting in <u>quality care</u> for the individual and information for <u>wider policy issues.</u>

InterRAI Suite tools

- Nursing Home (LTCF)
- Home Care (HC)
- Post-Acute Care (PAC)
- Assisted Living (AL)
- Palliative Care (PC)
- Independent settings in the Community (Community Health Assessment - CHA)

- In-patient Mental Health Care (MH)
- [Community Mental Health Care (CMH)](#)
- [Community Cognitive InterRAi assessment](#)
- Setting for persons with Intellectual Disabilities (ID)
- interRAI Acute Care Hospitals (AC)

interRAI Long-Term Care Facility (LTCF) ©

SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING
Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do

  0. *Independent*—Decisions consistent, reasonable, and safe
  1. *Modified independence*—Some difficulty in new situations only
  2. *Minimally impaired*—In specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times
  3. *Moderately impaired*—Decisions consistently poor or unsafe, cues / supervision required at all times
  4. *Severely impaired*—Never or rarely makes decisions
  5. *No discernable consciousness, coma [Skip to Section G]*

2. MEMORY/RECALL ABILITY
Code for recall of what was learned or known
  0. Yes, memory OK   1. Memory problem

  a. **Short-term memory OK**—Seems / appears to recall after 5 minutes
  b. **Long-term memory OK**—Seems / appears able to recall distant past
  c. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues
  d. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS
[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time]

  0. Behavior not present
  1. Behavior present, consistent with usual functioning
  2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

  a. **Easily distracted**—e.g., episodes of difficulty paying attention, gets sidetracked
  b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
  c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—e.g., restlessness, lethargy, difficult to arouse, altered environmental perception
  0. No   1. Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)
  0. Improved   2. Declined
  1. No change   8. Uncertain

---

interRAI Home Care (HC)©

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VMD: scopi

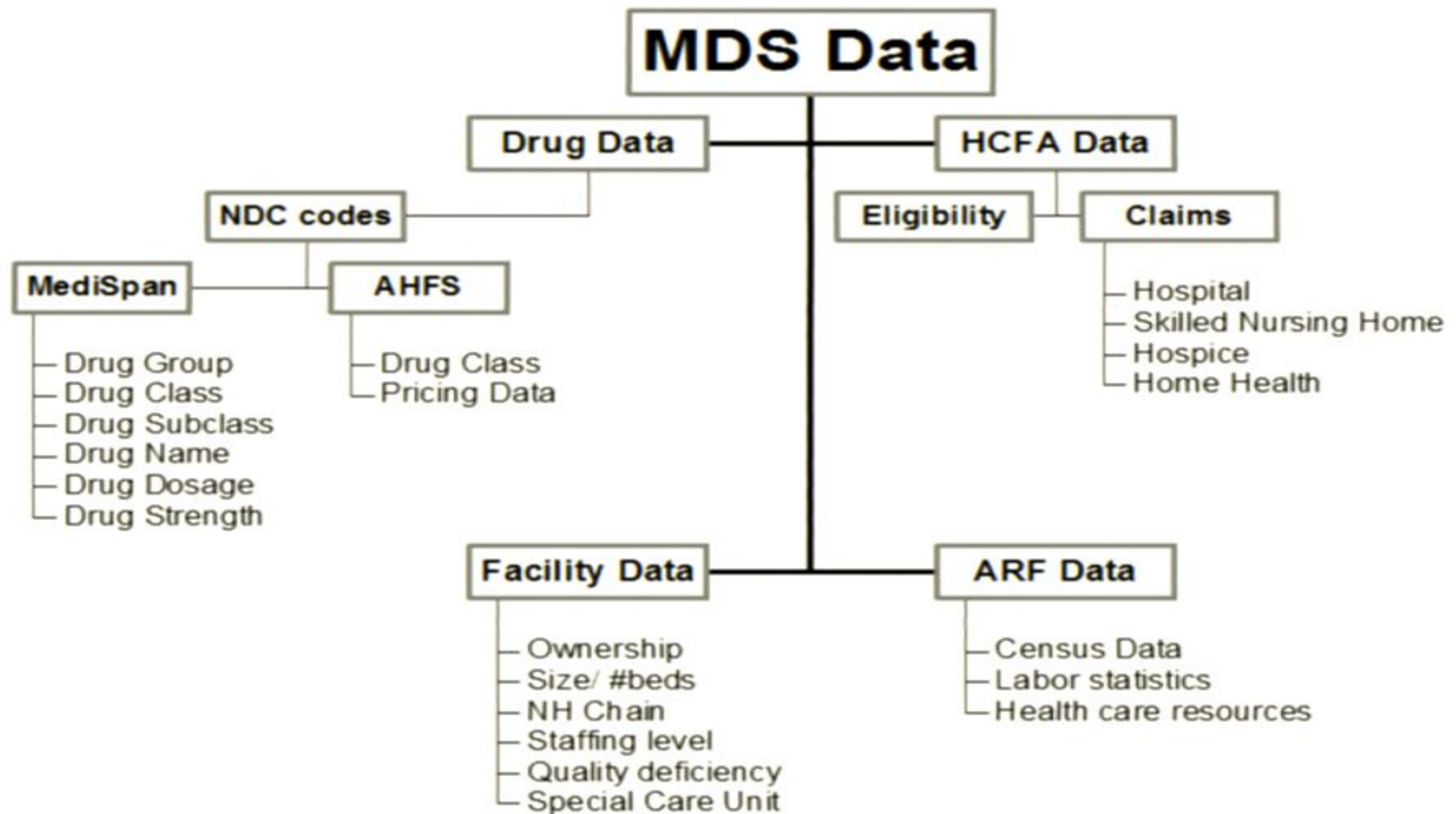**Livello paziente** → Completa esame fisico; piano di cura individualizzato

Livello popolazione → Database
- Dati descrittivi
- Bisogni assistenziali
- Allocazione delle risorse
- Fattori prognostici
- Indicatori di qualità
- Studi di outcome
- confronti

The SAGE database

MDS Data

Drug Data
HCFA Data

NDC codes
Eligibility
Claims

MediSpan
AHFS
— Hospital
— Skilled Nursing Home
— Hospice
— Home Health

— Drug Group
— Drug Class
— Drug Subclass
— Drug Name
— Drug Dosage
— Drug Strength

— Drug Class
— Pricing Data

Facility Data
ARF Data

— Ownership
— Size/ #beds
— NH Chain
— Staffing level
— Quality deficiency
— Special Care Unit

— Census Data
— Labor statistics
— Health care resources

FDA Public Health Advisory
Deaths with Antipsychotics in Elderly Patients with Behavioral Disturbances

- The treatment of behavioral disorders in elderly patients with dementia with atypical antipsychotic medications is associated with increased mortality.

- Most were either due to heart related events (e.g., heart failure, sudden death) or infections (mostly pneumonia).

- The Agency will ask the manufacturers of these drugs to include a Boxed Warning in their labeling describing this risk and noting that these drugs are not approved for this indication.

April 11, 2005

Risk of Death in Elderly Users of Conventional vs. Atypical Antipsychotic Medications
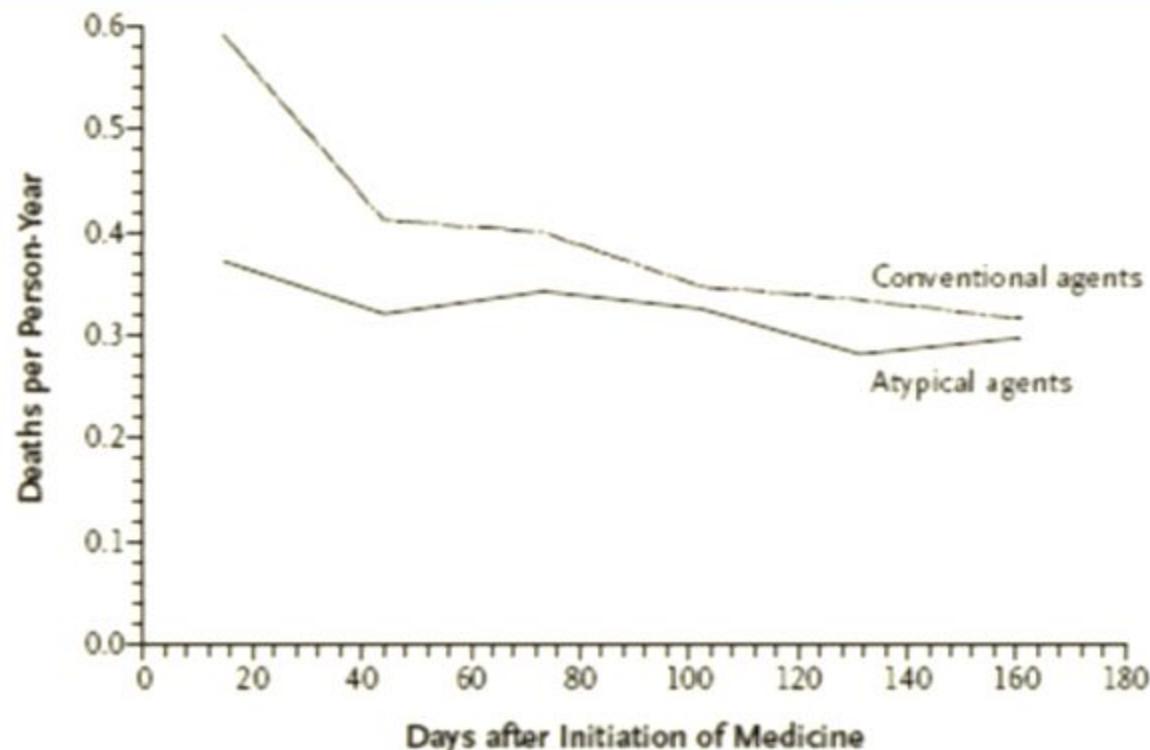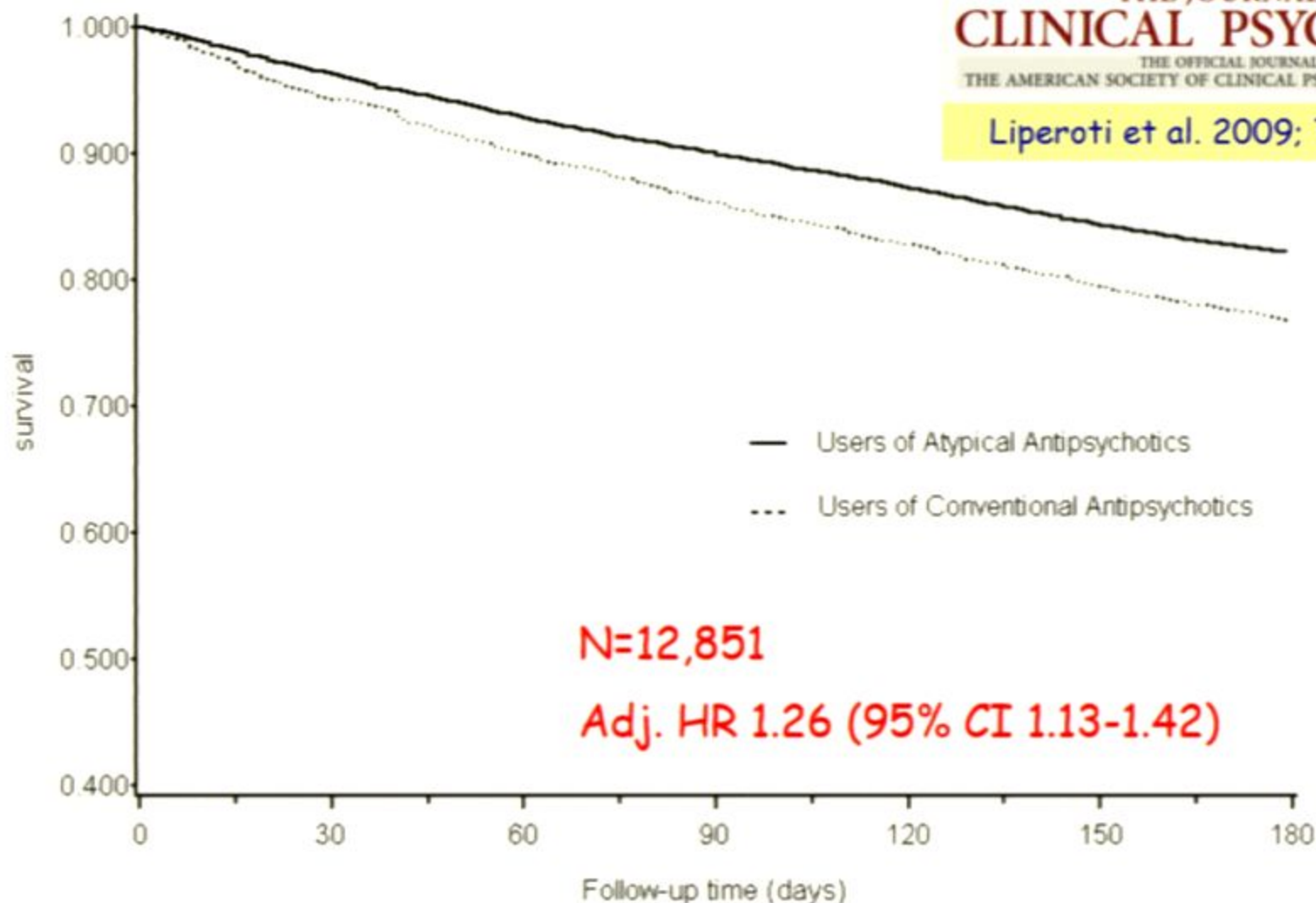

Figure 1. Rates of Death after the Initiation of Conventional and Atypical Antipsychotic Medications.

The rate of death before 10 days was not calculated, owing to insufficient data.

Wang et al., NEJM 2005; 353:2335-41.

Convenzionali vs. atipici

Adj . HR (95% CI)

1.37 (1.27-1.49)

n=22,890

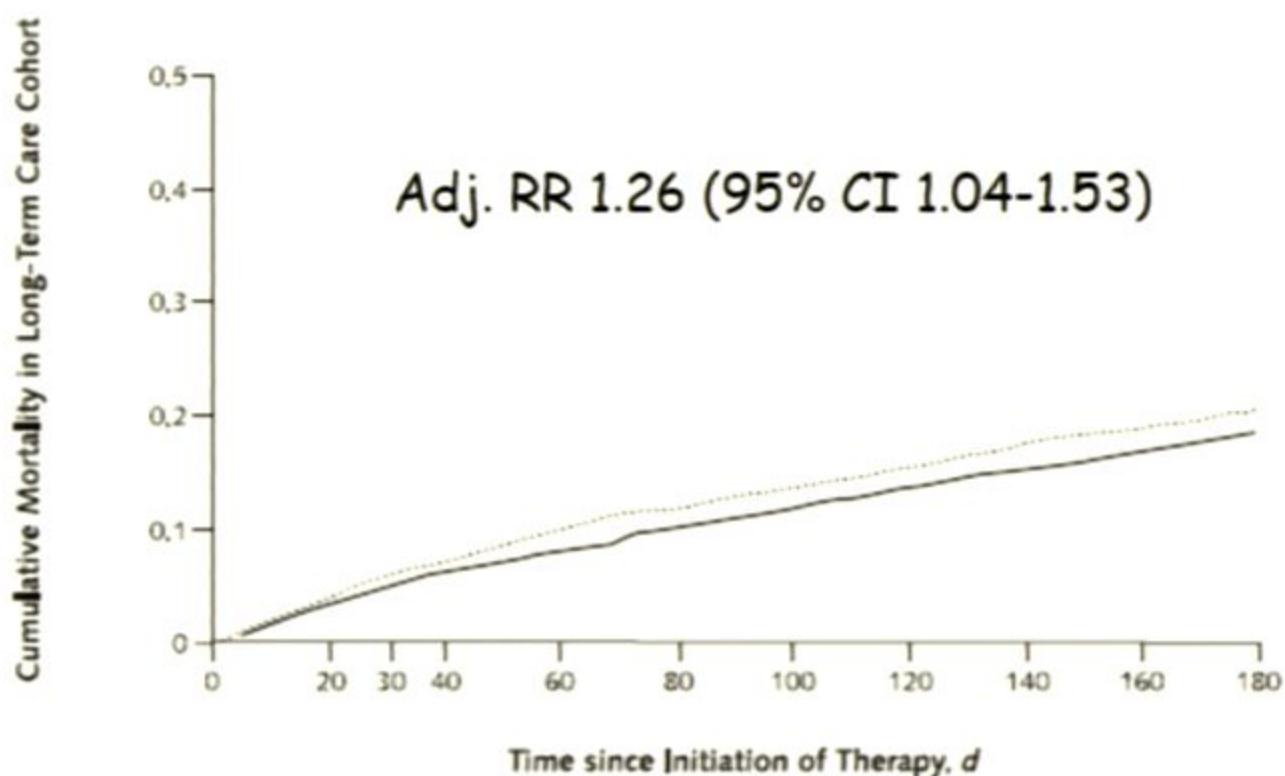# Risk of death associated with the use of atypical and conventional antipsychotics

THE JOURNAL OF
CLINICAL PSYCHIATRY
THE OFFICIAL JOURNAL OF
THE AMERICAN SOCIETY OF CLINICAL PSYCHOPHARMACOLOGY

Liperoti et al. 2009; 70:1340-7.

Users of Atypical Antipsychotics
Users of Conventional Antipsychotics

N=12,851

Adj. HR 1.26 (95% CI 1.13-1.42)

U.S. Food and Drug Administration

Information on Antipsychotics

Audience: *Neuropsychiatric and geriatrics healthcare professionals*

[Posted 06/16/2008] FDA notified healthcare professionals that **both conventional and atypical antipsychotics** are associated with an **increased risk of mortality in elderly patients treated for dementia-related psychosis.** In April 2005, FDA notified healthcare professionals that patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death. Since issuing that notification, **FDA has reviewed additional information that indicates the risk is also associated with conventional antipsychotics.** Antipsychotics are not indicated for the treatment of dementia-related psychosis. The prescribing information for all antipsychotic drugs will now include the same information about this risk in a BOXED WARNING and the WARNINGS section.
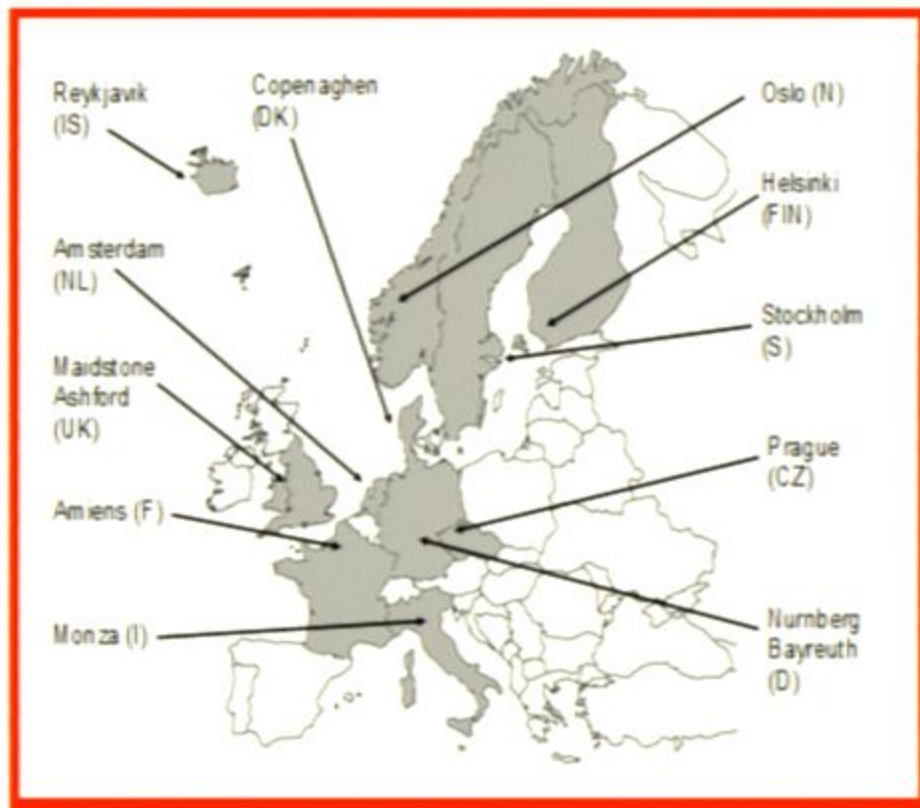
Developing an evidence-base for community care services in Europe
The Aged Home Care project
ADHOC

G I Carpenter   Canterbury   V Garms-Homolova   Berlin

E Topinkova   Praque   P Jonsson   Reykjavik

M Schroll   Copenhagen   D Frijters   Utrecht

H Finne-Soverei   Helsinki   L W Sørbye   Oslo

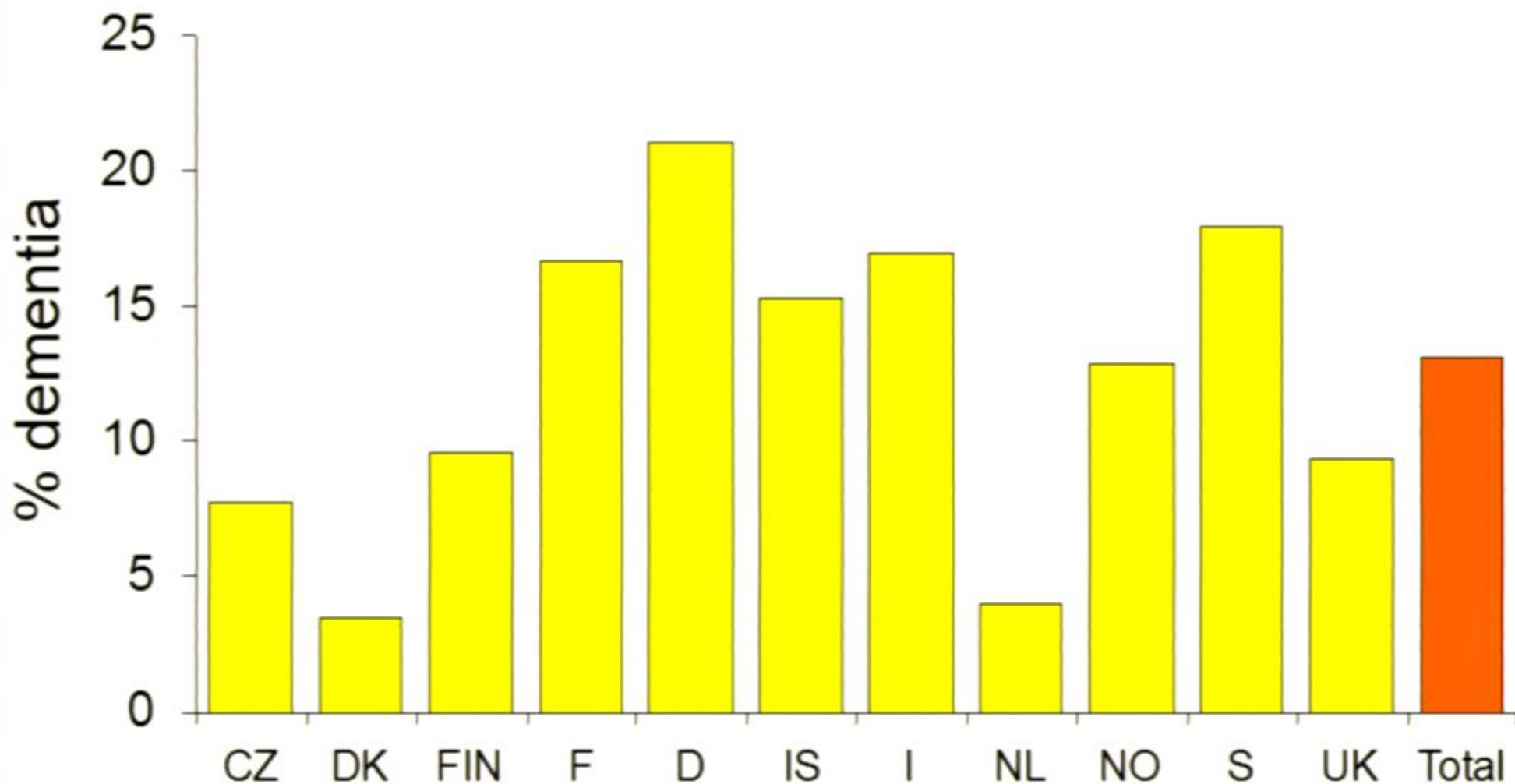J-C Henrard   Paris   G Ljunggren   Stockholm

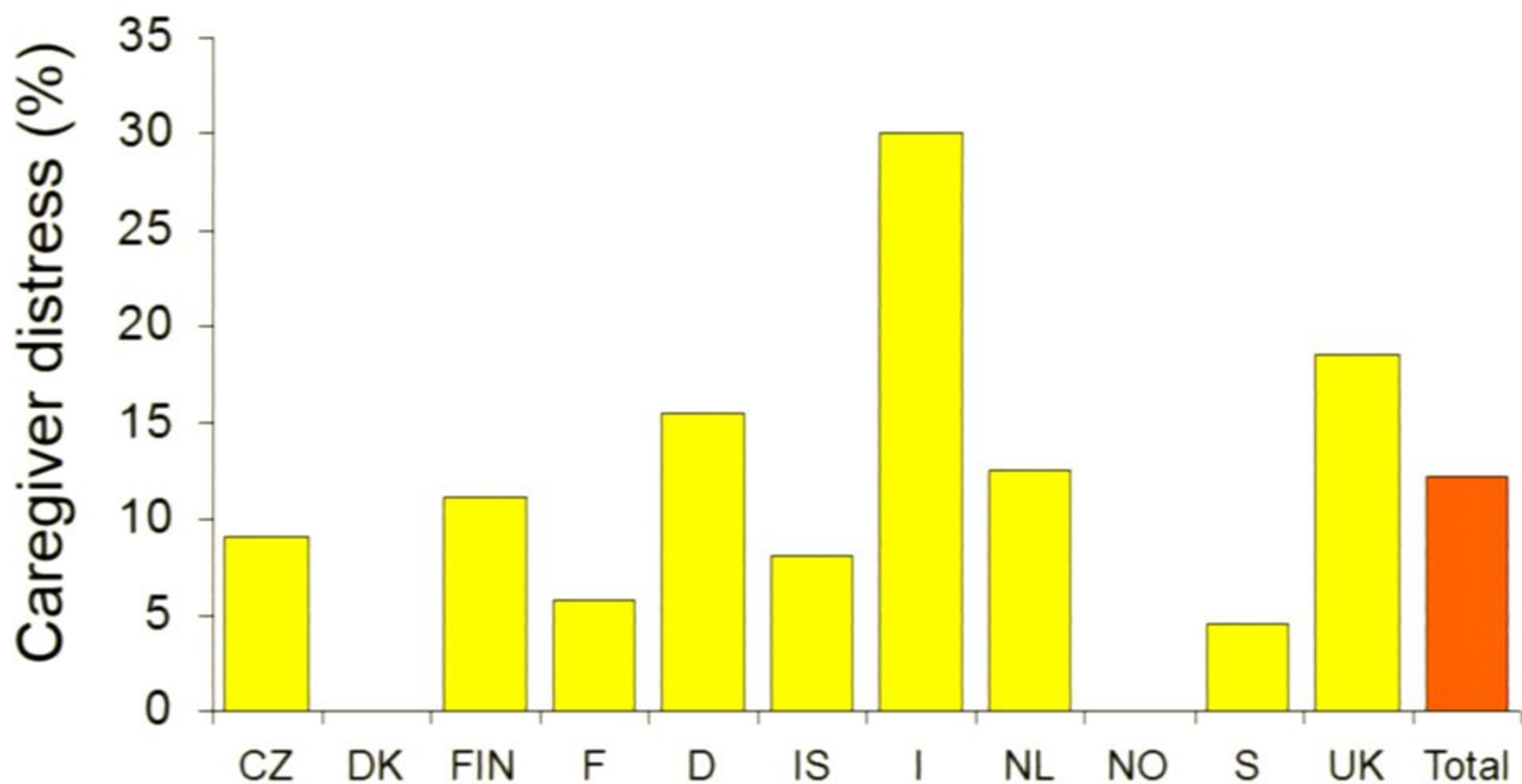R Bernabei Rome (Principal Investigator)
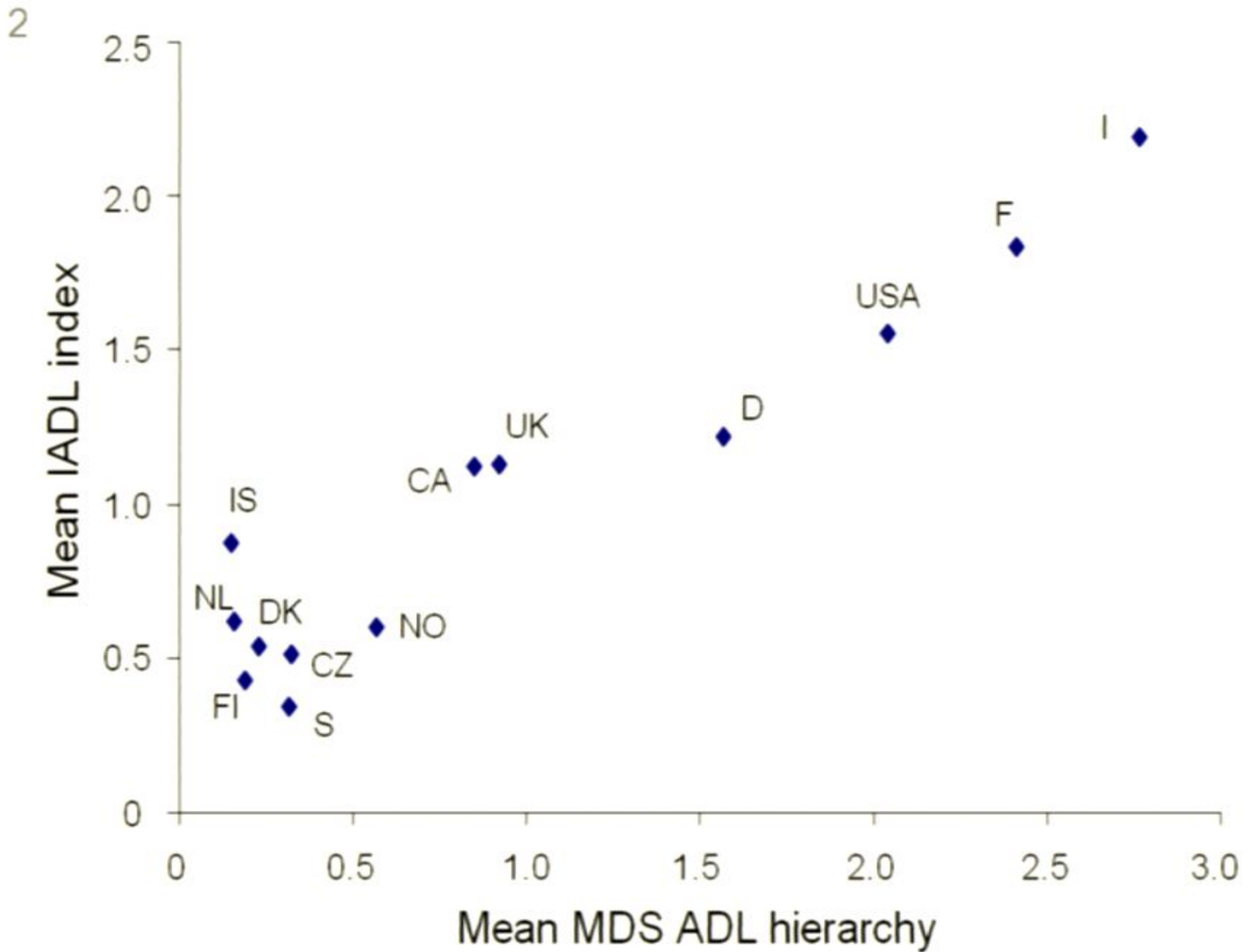
11 Countries

N 3,877 participants

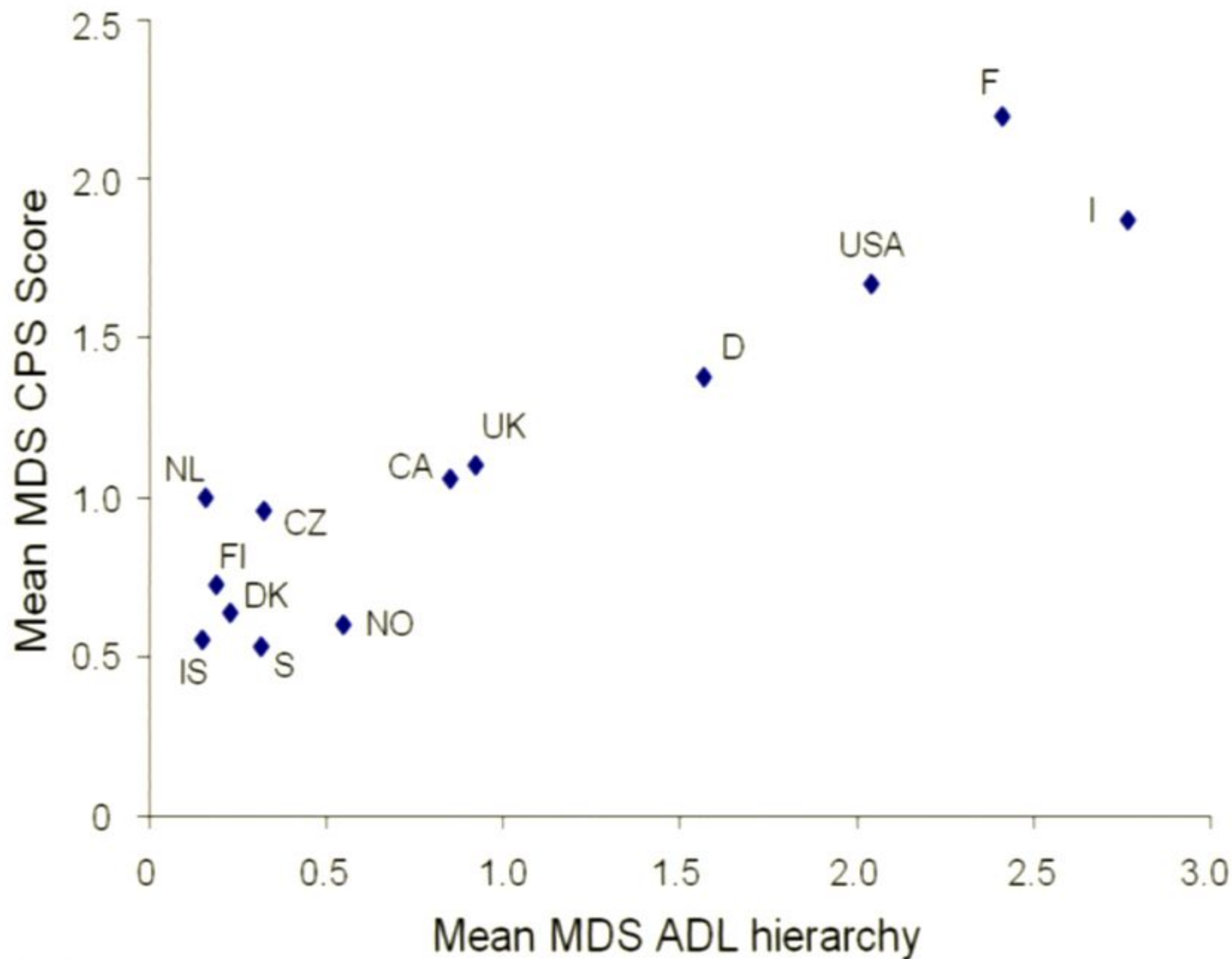*Carpenter I et al, Aging Clin Exp Res. 2004;16(4):259-69.*

Patients with dementia in home care
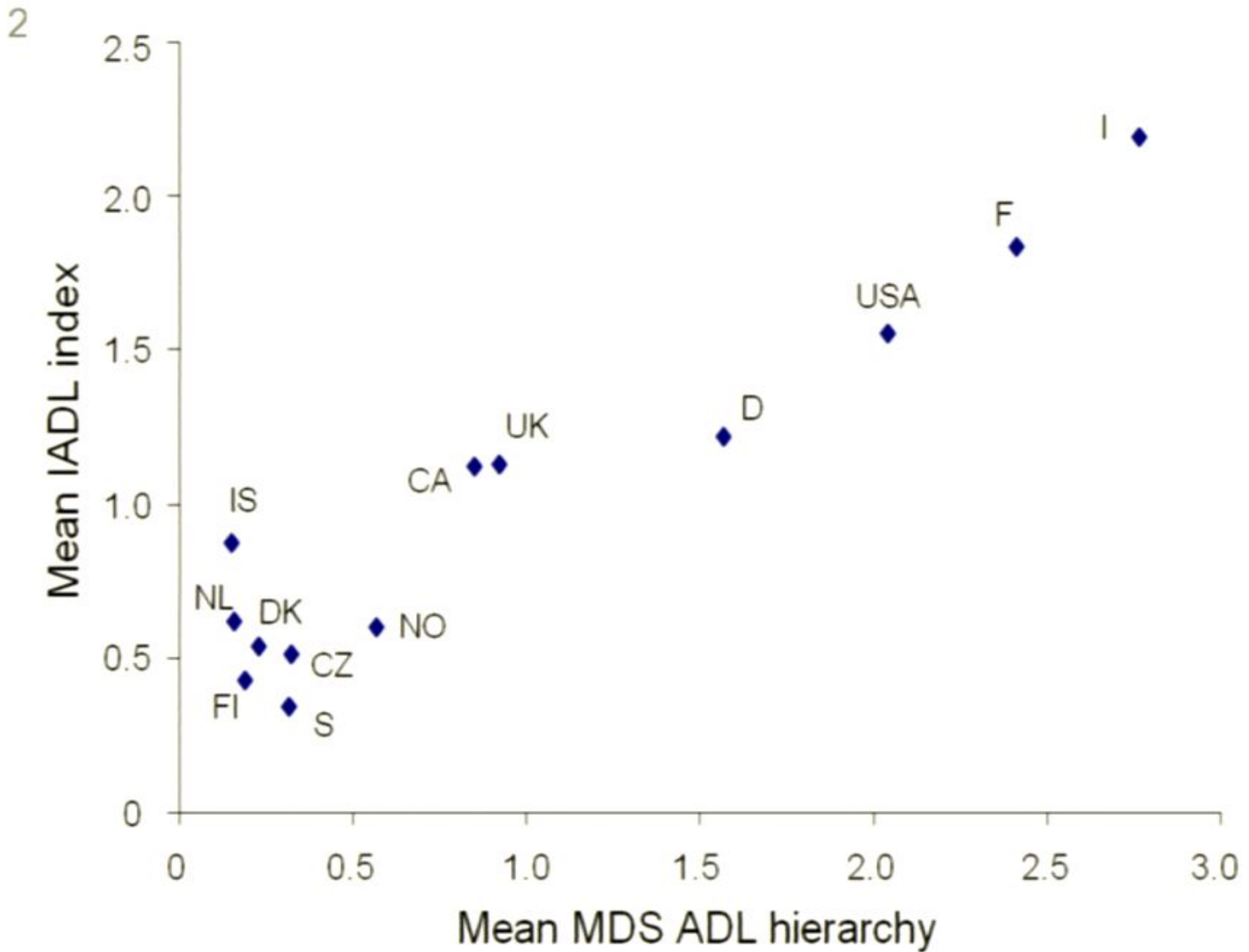
Onder et al., 2008

Caregiver distress in patients with dementia in Home Care

Onder et al., 2008

Bernabei R et al 'International Gerontology' in Hazzard's Principles of Geriatric Medicine and Gerontology, Sixth Edition, 2009
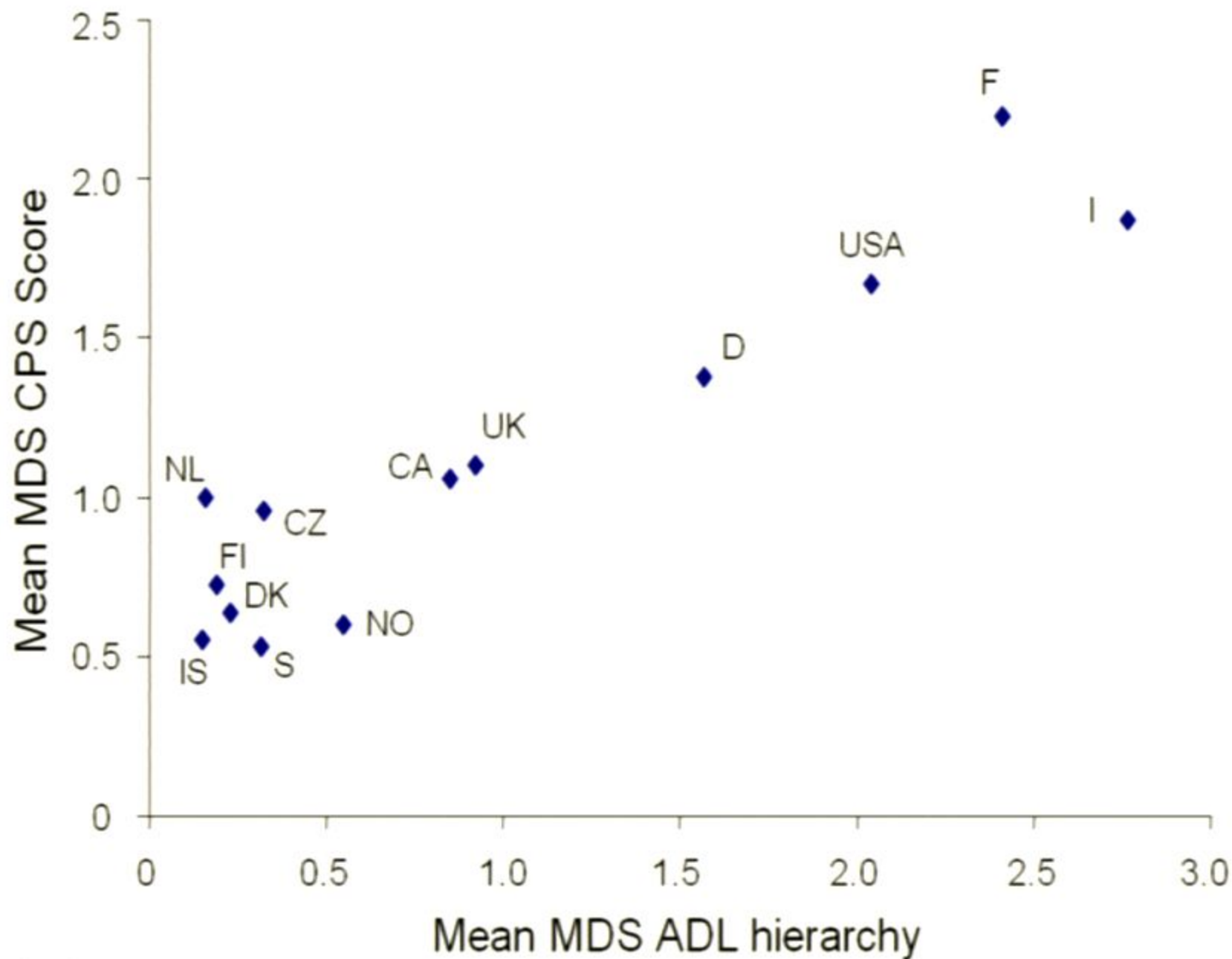
Bernabei R et al 'International Gerontology' in Hazzard's Principles of Geriatric Medicine and Gerontology, Sixth Edition, 2009.

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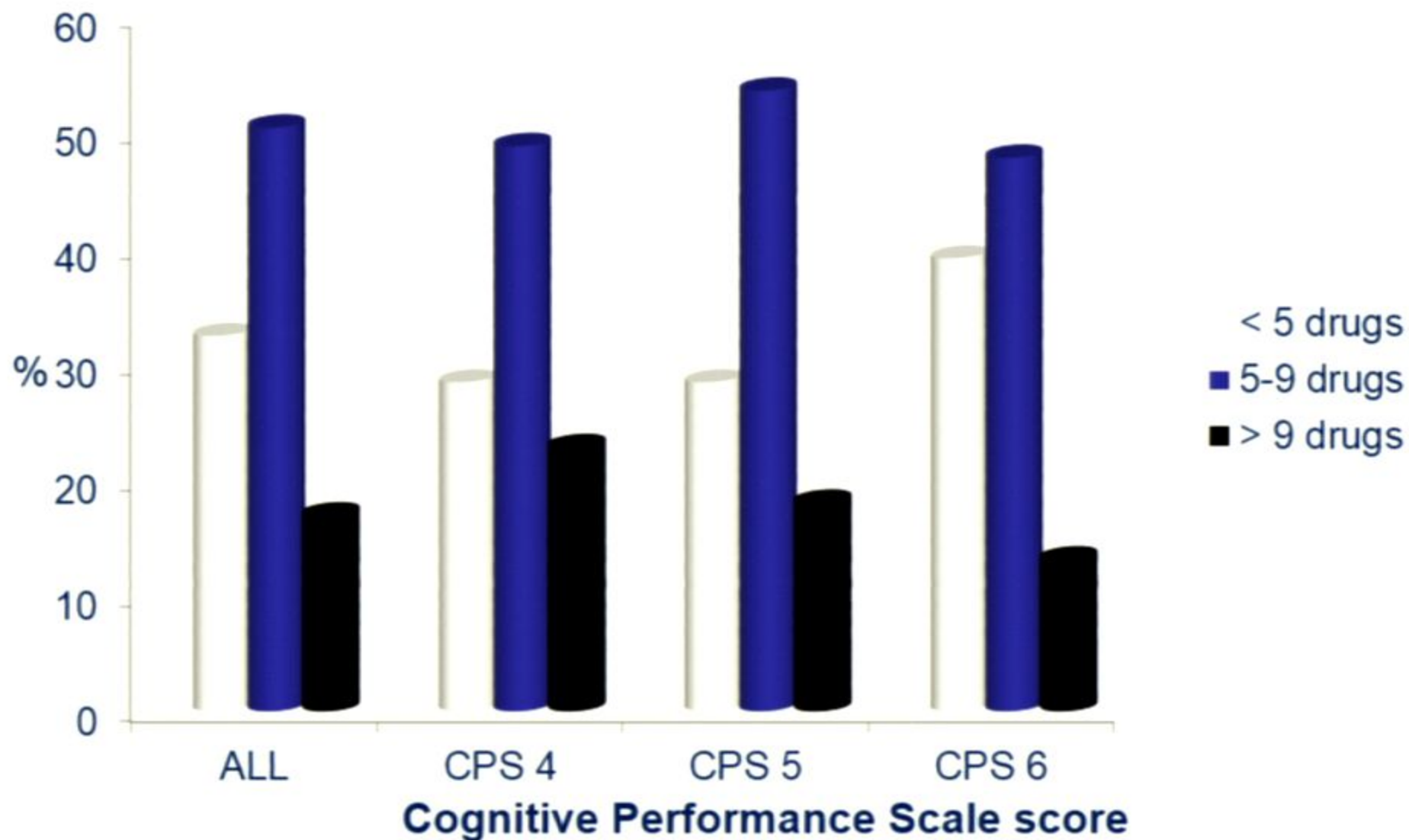
4.156 residents assessed with theInterRAI LTCF

57 facilities in Europe

7 EU countries + Israel

Funding FP7 of the EU

Polypharmacy and Excessive Polypharmacy in Dementia - SHELTER

Vetrano DL et al. Alzheimer's & Dementia 2013

Use of Antipsychotic Drugs Among Residents With Dementia in European Long-Term Care Facilities: Results From the SHELTER Study

Andrea D. Foebel PhD [a, b, *], Rosa Liperoti MD, MPH [b], Graziano Onder MD, PhD [b], Harriet Finne-Soveri MD, PhD [c], Jean Claude Henrard PhD [d, e], Albert Lukas MD [f], Michael D. Denkinger MD [f], Giovanni Gambassi MD [b], Roberto Bernabei MD [b] on behalf of the SHELTER Study Investigators
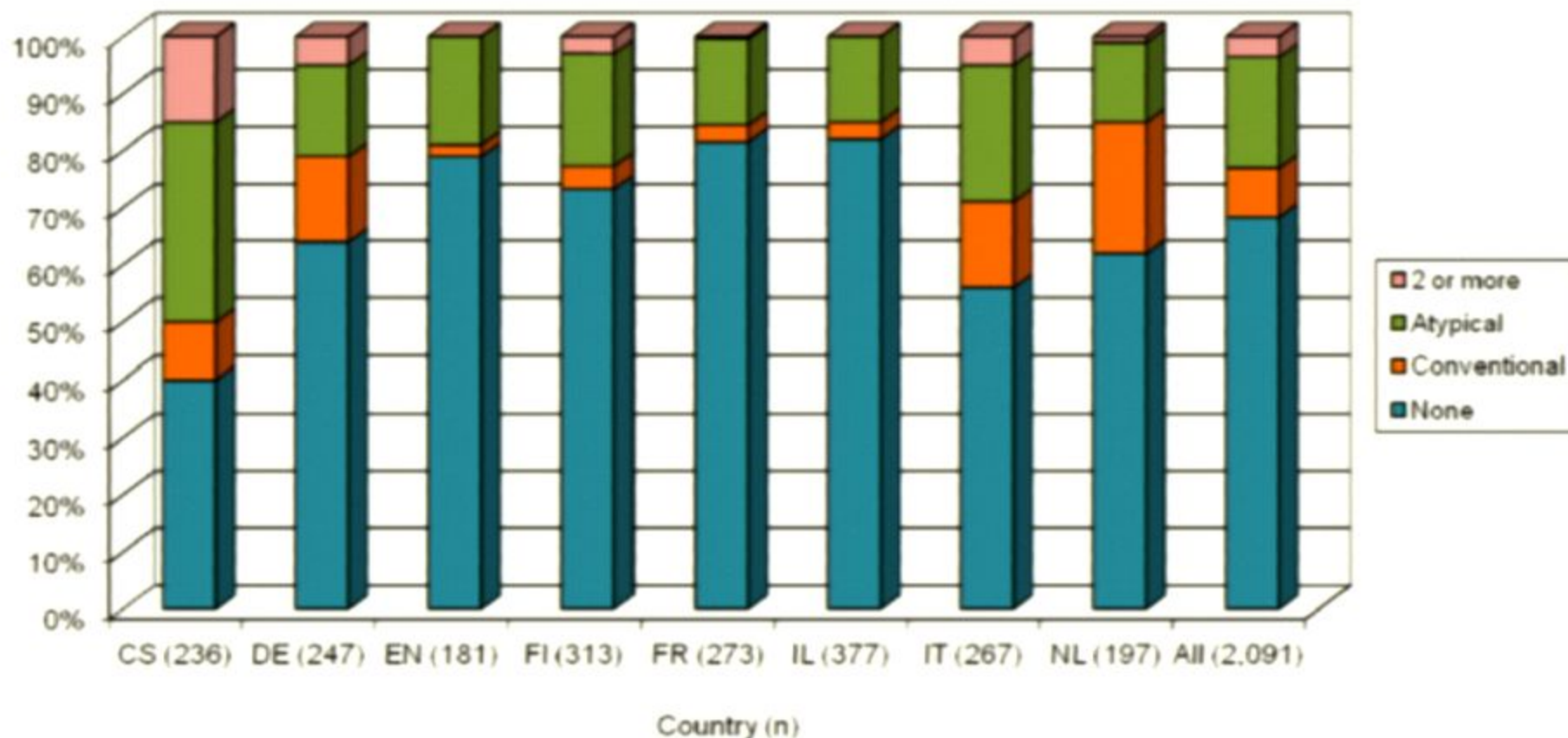
Correlates of Likelihood of Receiving an Antipsychotic Drug Among Nursing Home Residents With Dementia (n = 2016)

	Receipt of Any AP Drug Odds Ratio (95% CI)	P
Age, y		
75–84	0.82 (0.60–1.10)	.20
85+	0.86 (0.61–1.21)	.39
Female gender	0.92 (0.72–1.17)	.49
BMI, kg/m^2		
18.5–25	1.41 (1.06–1.90)	.02
25–30	1.24 (0.88–1.73)	.21
>30	1.55 (0.98–2.47)	.06
ADL impairment		
Moderate	1.59 (1.06–2.41)	.03
Severe	1.39 (0.81–2.38)	.23
Cognitive impairment		
Moderate	1.34 (0.95–1.88)	.10
Severe	1.57 (1.13–2.18)	.007
Behavior index		
Moderate	2.31 (1.80–2.95)	<.0001
Severe	2.84 (1.66–4.86)	.0001
Psychotic symptoms	1.82 (1.32–2.50)	.0002
Delirium	0.83 (0.66–1.05)	.12
No. of drugs*		
5–9	1.18 (0.89–1.58)	.25
10+	1.57 (1.07–2.30)	.02
Drug use		
CV Drugs	1.05 (0.83–1.34)	.67
AChE or memantine	0.98 (0.77–1.25)	.88
Antidepressants	0.89 (0.67–1.19)	.44
Anxiolytics/Hypnotics	1.58 (1.26–1.98)	<.0001
Anti-Parkinson	0.93 (0.56–1.54)	.77
Any analgesic	0.84 (0.66–1.06)	.14

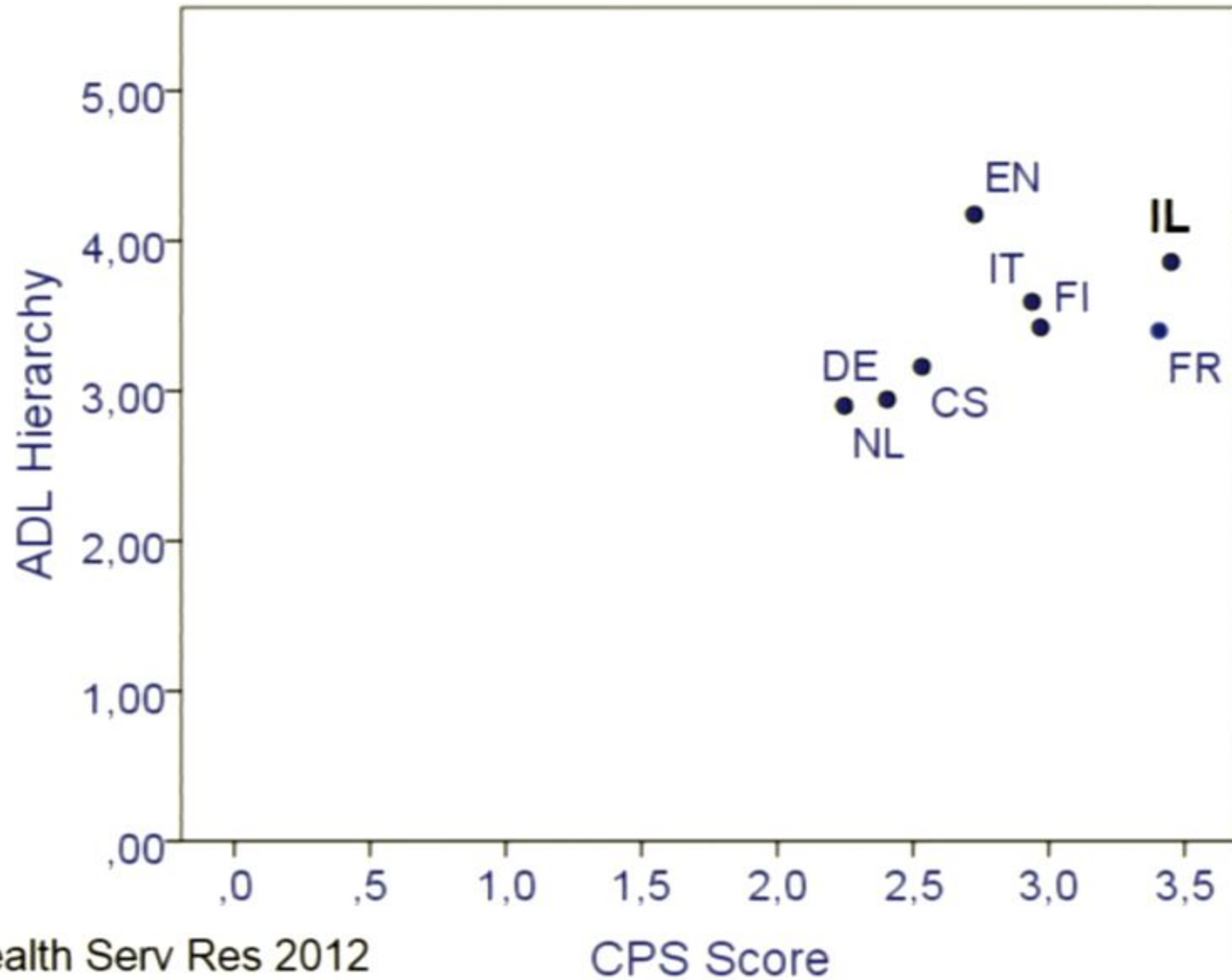# Correlates of Likelihood of Receiving an Antipsychotic Drug Among Nursing Home Residents With Dementia (n = 2016)

	Receipt of Any AP Drug Odds Ratio (95% CI)	P
Clinical conditions		
Parkinson disease	1.19 (0.69–2.03)	.53
Diabetes	0.98 (0.72–1.32)	.88
CHF	0.78 (0.60–1.02)	.07
Depression	1.06 (0.88–1.27)	.56
Mood disorder	1.59 (1.21–2.10)	.0009
Incontinence		
Bladder	1.03 (0.71–1.48)	.89
Bowel	0.85 (0.66–1.09)	.19
Pain	0.92 (0.73–1.16)	.46
Recent fall(s)	1.21 (0.83–1.76)	.31
Physical restraint use	0.72 (0.53–0.96)	.03
Bedbound	1.38 (0.92–2.07)	.11
Facility characteristics		
Geriatrician services	1.61 (1.04–2.50)	.03
Pharmacist services	1.14 (0.68–1.92)	.61
Dementia care services	0.77 (0.53–1.13)	.18
Psychiatric care services	2.14 (1.28–3.56)	.004

Characteristics by country

SHELTER
NH residents

Onder G et al. BMC Health Serv Res 2012

Characteristics by country

Onder G et al. BMC Health Serv Res 2012