Introduction

Psychiatric vs. Neurologic Diagnoses in Behavioral & Psychological Symptoms of Dementia

Dr. Steven Posar, M.D.

- GuideStar Eldercare, Founder/CEO
- Steven L Posar Eldercare Foundation, President
- St. Mary's College at Notre Dame, Clinical Professor of Geriatric Neuropsychiatry

Dr. Daniel Heiser, Psy.D.

- GuideStar Eldercare, Senior VP of Behavioral Health

Speaker Disclosures

Dr. Posar has no relevant financial relationship(s).

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Summary of Session

The overall focus of this session is to identify the root causes of behaviors from a person-centered approach through proper clinical diagnoses. Understanding behavioral triggers and clinical management can lead to improved care planning and positive outcomes, based on proper individual neurologic and/or psychiatric diagnoses.

Outline of Topics

Topic 1: Psychiatric vs. Neuropsychiatric Diagnoses

Topic 2: The clinical presentation of neuropsychiatric illnesses across varied types of Dementia

Topic 3: Behavioral triggers and clinical management of LTCF residents with psychiatric and neuropsychiatric diagnoses

Learning Objectives

By the end of the presentation, participants will be able to:

1. Describe the symptoms of neuropsychiatric illness versus primary psychiatric illness.
2. Express the possible diagnoses of Behavioral and Psychological Symptoms of Dementia (BPSD).
3. Identify behavioral triggers and specific steps to improve clinical management of long-term care facility (LTCF) residents with psychiatric & neuropsychiatric diagnoses

Psychiatric vs. Neuropsychiatric Diagnoses

Objective: Describe neuropsychiatric illness versus primary psychiatric illness.

Topic 1: Psychiatric vs. Neuropsychiatric Diagnoses

- Over 90% of the patients treated have a neurological etiology
- 95% of these patients have no history of serious mental illness (SMI)
- Their psychiatric status is an expression of a primary neurological disorder (**NOT a primary psychiatric disorder!**)

Topic 1: Psychiatric vs. Neuropsychiatric Diagnoses

- 98% of Dementia patients residing in Long-Term Care Facilities (LTCF) will develop at least one DSM-5 Axis I Psychiatric condition
- 70% of these patients will exhibit severe symptoms
- Severe = CMS qualified diagnosis for acute inpatient psychiatric hospital admission
- 50% of these severe patients will have multiple episodes

Topic 1: Psychiatric vs. Neuropsychiatric Diagnoses

- Less than 10% of the severe episodes are ever admitted for acute inpatient psychiatric hospitalization
- This low admission rate is secondary to the lack of inpatient specialty beds
- Therefore: Most severe decompensations remain in the facility

Topic 1: Psychiatric vs. Neuropsychiatric Diagnoses

- The Challenge: prevent or mitigate severe Behavioral and Psychological Symptoms of Dementia (BPSD) without chemical restraint in neurologic patients with progressive neurocognitive disease

- Proven neurologic-based pharmacotherapy will meet this challenge

- Effective neurologic-based pharmacotherapy is dependent on <u>accurate diagnosis</u>

Topic 2 Intro

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

Objective: Express the possible diagnoses of Behavioral and Psychological Symptoms of Dementia (BPSD).

Dementia diagnosis is becoming increasingly complex

- Alzheimer's Disease (AD)
- Vascular Dementia – macro/micro
- Lewy Body Disease (LBD)
- Parkinson's Disease Dementia (PDD)
- Limbic-Predominant Age-Related TDP43 Encephalopathy (LATE)
- Fronto-temporal Dementia
  - Behavioral variant, agrammatic, semantic, logopenic
- Primary Age Related Tauopathy (PART)
- Huntington's Disease
- Normal Pressure Hydrocephalus
- Traumatic Brain Injury (TBI)
- Encephalopathies (toxic, metabolic, etc)

Complex secondary conditions

- Delirium
- Medication
- Pseudo-Bulbar Affect (PBA)
- Partial Complex Epilepsy
- Adrenergic Cerebral Dysautonomia
- Recurrent microvascular events

- Alzheimer's Disease (AD):
  - 20% of Alzheimer's Disease brains have only AD
  - 25% of AD brains have 2 causes
  - 55% of AD brains have 3 or more causes

- Lewy Body Disease and Dementia (LBD) is increasingly common
- Parkinson's Disease Dementia (PDD), LBD, AD and Frontotemporal Dementia (FTD)
- The Psychiatric/Psychological impact is severe

- TAR DNA binding protein 43 (TDP-43) is increasingly common
- FTD, Limbic-predominant Age-related TDP-43 Encephalopathy (LATE), Amyotrophic Lateral Sclerosis (ALS) and AD
- Variable clinical presentation

- Tau is ubiquitous
- Probable driver of Alzheimer's Dementia (AD)
- AD, Fronto-Temporal Dementia and Primary Age-Related Tauopathy (PART)
- Variable clinical presentation

- Pure Alzheimer's Dementia (AD) is uncommon
- Characterized by slow progression and predictable psychiatry
- Early stages of AD: Anosognosia and mild to moderate depression
- Mid to late stage AD is characterized by increased anxiety
- Preventable/Treatable

- Mixed Dementia = Alzheimer's + Vascular Dementia (VaD)
- Severe Behavioral and Psychological Symptoms of Dementia (BPSD)
- Psychosis, Agitation and Aggression
- Preventable/Treatable

- Alzheimer's Dementia and TDP-43 (LATE)
- Rapidly progressive + severe BPSD
- Psychosis, Agitation, Aggression and Sexual Acting Out (SAO)
- Mitigation/Treatment

- Parkinson's Disease Dementia and Lewy Body Disease Dementia
- Both: Psychosis is early and common
- PDD sensitive to Medication-induced psychosis
- Prevention, Mitigation and Treatment
- Acetylcholinesterase Inhibitors (ACEI) are the core treatment

- Fronto-Temporal Dementia and Vascular Dementia
- Highly variable clinical presentation
- Can be challenging
- Careful diagnosis with individual therapy (Psychological and Pharmacologic)
- Frequent assessment and therapeutic adjustment

Five Step Treatment Approach

- Neurologic, Psychiatric and Psychological Evaluation
- Polypharmacy review
- Initiate neurological pharmacotherapy
- Evaluate and treat specific BPSD after neurological therapy optimized
- Frequent reassessment with therapeutic adjustments

Topic 3 Intro

Behavioral Triggers and Clinical Management of LTCF Residents with Psychiatric and Neuropsychiatric Diagnoses

Objective: Identify behavioral triggers and specific steps to improve clinical management of long-term care facility (LTCF) residents with psychiatric & neuropsychiatric diagnoses

Topic 3: Behavioral triggers and clinical management of LTCF residents with psychiatric and neuropsychiatric diagnoses

Intervening when patients are triggered

- When psychiatric patients decompensate they are “emotionally” overwhelmed - **stressed**
- When neuropsychiatric (Dementia) patients decompensate they are “cognitively” overwhelmed – **confused**
- Both benefit from empathic listening and validation
- No benefit for insight-based psychotherapy
- Managing psychiatric patients is enhanced by engaging them in therapeutic conversation
- Managing neuropsychiatric patients is enhanced by creating a calm environment and redirecting them

Explanations of Dementia behaviors

- Needs-driven model
- Environmental model – both physical and social
- Reconceptualizing Dementia behaviors – disease-driven model

Creating a therapeutic partnership – role of Facility Staff

- What defines a behavior – Suffering and Safety
- Key elements to Document – **DICE** Approach:
  - **Describe**: Define, Frequency and Severity
  - **Investigate**: Other contributing factors such as medical or environmental factors
  - **Create**: Person-centered Care (Treatment) Plan
  - **Evaluate**: Assess and Modify as needed

Role of Behavioral Health Staff

- Administer normed, validated instruments as part of the initial psychological evaluation to help determine accurate diagnosis
- Consistent follow-up sessions to re-assess patient functioning and identify changes before significant decompensation occurs
- Patient's clinical status evolves weekly/monthly
- Utilize Evidence-based therapeutic approaches as part of the treatment process