Opening Remarks

In our mission of easing the suffering of neurocognitive degenerative disease in the populations we serve; we understand fully that these tragic conditions do not equally affect all populations. We know that in the United States, African Americans are twice as likely to suffer from Dementia as the general population. Hispanics are also disproportionately affected at 1.5 times the general population. It is well known from multiple factors that approximately two thirds of Dementia sufferers are women. We recognize that each individual brings a diverse background, diverse cultural needs, and diverse expectations to those involved with their care.

We are profoundly committed to the care of all of these patients, with the greatest expertise that we can offer. We are pleased to be conducting research, which recognizes the diverse populations we serve, and we are committed to being culturally engaged and culturally sensitive with all of our patients.

Objectives:

- Describe the role of psychological assessment in establishing the initial diagnosis
- Explain the role of assessment in specific supportive treatment of neurodegenerative disorders
- Discuss the role of anticipatory non-insight based psychological interventions in enhancing the quality of life for the patient

Part 1: Diagnostic Challenges and Concerns

Patients with Primary Psychiatric Conditions

These Long-Term Care Facility (LTCF) residents typically have a life-long history of psychological and pharmacological treatment of their disease. These diagnoses are substantiated by clearly documented histories of these conditions. Verification of this psychiatric history may be located in: social histories, PASRR (level 2), acute psychiatric hospitalization records, family report, PCP, and outpatient psych history.

Primary Psychiatric Conditions

The most common of these include:

- Major Depressive disorders
  - Single vs. recurrent episode
  - Specify severity:
    - mild, moderate, severe with or without psychotic features
  - Avoid unspecified depressive disorders
  - Secondary to medical conditions/medication
    - Not dementia
  - Any age including involutional/geriatric onset

Primary Psychiatric Conditions

- Bipolar related disorders:
  - Bipolar I shows consistent cycling and extreme mood fluctuations (mania)
  - Bipolar II shows consistent cycling of modulated mood fluctuations (hypomania), but the most common feature is depression
- If Bipolar, there should be no stand-alone depressive or mania diagnoses
- Psychosis secondary to mood extremes
- Young and middle age (~40y.o.) onset - No de novo late onset
- Commonly a Genetic Disorder

Primary Psychiatric Conditions

- Schizophrenia
- Schizoaffective
  - Bipolar type
  - Depressive type
- Onset younger than 40 years old
- Most common onset 15 – 25 years old

- Very Late Onset Schizophreniform Disorder – Clinically and prognostically differentiated from Schizophrenia. Greater than 50% of these individuals are demented within five years
  - No such thing as Schizophrenia or Schizoaffective de novo onset after 60 years old
  - Very rare for Schizophrenia or Schizoaffective de novo onset after 40 years old
- Multiple etiologies of psychosis secondary to general medical conditions / medications
  - Not dementia
- Don’t confuse with delirium

Key Points to Remember:

- Major Depressive Disorder – Recurrent: recurrent major depressive episodes do not occur in a regular pattern of cycling. If it is a predictable pattern, then a mood cycling disorder should be considered
- If Bipolar, there should be no stand-alone depressive or mania diagnoses
- Bipolar I shows consistent cycling and extreme mood fluctuations
- Bipolar II shows consistent cycling with modulated mood fluctuations (hypomania), but the most common feature is depression

Key Points to Remember:

- Schizoaffective disorder presents with cyclical major mood disorder, with concurrent and persistent psychotic features
- Intermittent psychosis associated only with mood extremes is not schizoaffective psychosis
- Schizophrenia is never de novo diagnosed over the age of 40

Major Neurocognitive Disorders and the Biological and Psychological Symptoms of Dementia (BPSD)

These residents have a neurological basis for their presentation:

- Cognitive impairment/dementia, memory loss, poor attention/concentration, poor executive functioning, motor/sensory dysfunction, sensorium impairment, movement/balance dysfunction, and linguistic impairment
  - These are all signs of neurologic disorder
- Psychiatric symptoms such as depression, anxiety, agitation, aggression, apathy, fear/panic, hoarding, lability, impulsivity, disinhibition, inappropriate sexual behaviors and psychosis (BPSD) are **secondary** to their neurologic disorder, and not classified as a primary diagnosis.
- For this category of residents, there is no documented or reported history of pre-morbid major psychiatric illness

The Primary Neurologic Conditions Include:

Dementias/Neurocognitive Impairments

- Alzheimer's Disease – G30.0 early onset, G30.1 onset after age 65
- Cerebral Vascular Disease – I63.9
- Mixed Dementia
- Parkinson's Disease – G31.20
- Lewy Body Dementia – G31.8
- LATE Dementia
- Frontotemporal Dementias – G31.0 (primary code needed)
- Toxic/Metabolic Encephalopathies
- Post infectious conditions (e.g. COVID-19)

Continued - The Primary Neurologic Conditions Include:

- Huntington's Disease – G10
- Traumatic Brain Injury + CTE – S06
- Multiple Sclerosis – G35
- HIV/Infection (Creutzfeldt-Jakob Disease) – B20
- Communicating Hydrocephalus – G91.0
- Encephalopathies – G93.49 (primary code needed)
  - Chronic Traumatic Encephalopathies

The conditions listed may stand alone, without behavioral or mood disturbance, but it is highly unlikely in this population.

Example: G30.1 and F02.80 would be a resident who has AD, but no BPSD. They present in early stages as pleasantly confused with no problematic behaviors.

The Role of Psychologists in an Integrated Delivery System Designed for Geriatric Neuropsychiatric Patients in Long-Term Care Settings

BPSD should always be diagnosed secondary to the identified neurologic condition (as noted above), and thus coded below the causative illness.

Typical presentations of BPSD include:

- Depressive Symptoms
  - F06.31 indicates ongoing depressive features
  - F06.32 is categorized by major depressive features
  - F06.33 is manic like features, eg. Lability, Agitation, Anxiety and Impulsivity
  - F06.34 is mixed features, including depression, hypomania and mania is present but not predominant
- Anxiety – F06.4 Symptoms of anxiety or panic attacks are predominant
- Obsessive Compulsive Behavior, including Hoarding – F06.8 symptoms present as primarily behavioral rather than mood disturbed
  - Examples include hoarding, skin-picking, hair-pulling, and other body focused repetitive behaviors
  - Perseverative verbalizations
  - Stereotyped, repetitive verbalization/behavior without external referent (PBA)
- Psychosis
  - F06.0 reflects predominance of hallucinations, typically integrated Audio or Visual
  - F06.2 reflects predominant delusional thinking with increased paranoia
- Apathy – R45.3 is demonstrated by a lack of emotion or interest – may manifest before Dementia
- Agitation – R45.1 typically presents as irritable, argumentative or restless, examples can include pacing, wandering and elopement
- Aggression (includes verbal & physical) – R45.6
  - Verbal may include yelling, threatening, and cursing
  - Physical can be seen as biting, kicking, and punching
- Impulsiveness – R45.87

Part 2: Development of a Comprehensive Treatment Plan to Treat the Behavioral and Psychological Symptoms of Dementia

Developing a Treatment Plan

- Essential to initially establish the type, level, and severity of Dementia
  - Differential diagnosis
  - Cognitive screening, i.e. Montreal Cognitive Assesment (MoCA), Mini-Mental State Examination (MMSE), etc., to assess current level of Baseline Cognitive Functioning
  - Determine whether the Major Neurocognitive Disorder is Mild, Moderate, or Severe
  - Administer the Dementia Severity Rating Scale (DSRS) to determine the current level of functional and decision-making abilities

Developing a Treatment Plan

- Identify the specific mood and behavior issues (BPSD) that are secondary to the patient's Dementia
  - Assess the patients current symptomatic presentation through follow-up clinical sessions and the administration of normed, validated instruments, including:
    - Geriatric Depression Scale (GDS)
    - Geriatric Anxiety Inventory (GAI)
    - Cornell Scare for Depression in Dementia
    - Neuropsychiatric Symptom Inventory Questionnaire (NPIQ)

Part 3: Treatment Protocols due to the Typical Course of Decompensation

Treatment Protocols

All Dementias are progressive so the treatment course must account for decompensation

- Patients should be seen for follow up services that are designed to provide high frequency, low intensity sessions and therapies
- On-going administration of normed, validated instruments is essential
- Patients must be continually assessed for the development of new symptoms and diagnoses

Vanguard Eldercare

Embracing Our Past. Building The Future.

Thank you for your time!

Q&A?

P: 888-837-5440
F: 574-546-1999

2100 Main Street, Suite 304, Crown Point, IN 46307
info@vanguardeldercare.com