BPSD Management and Lessons Learned Post-Covid

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Disclosures

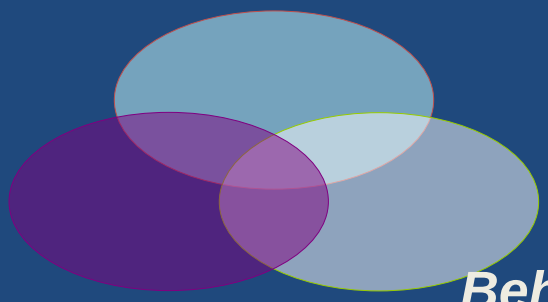
- Financial:
  - No conflicts to report
- Non-approved FDA uses
  - Medications that will be discussed to manage NPS of dementia/BPSD are off-label use w/ exception of pimavanserin (approved for Psychosis of PD)

Objectives:

- Review non-pharmacological and pharmacological approaches to managing BPSD
- Identify specific tools that can help with assessment and tracking of BPSD
- Discuss experiences incorporating telepsychiatry into managing BPSD, including the benefits and challenges of using telepsychiatry to help manage BPSD

Dementia/Major Neurocognitive Disorder

Dementia:



Behavior:
"BPSD"
"NPS"

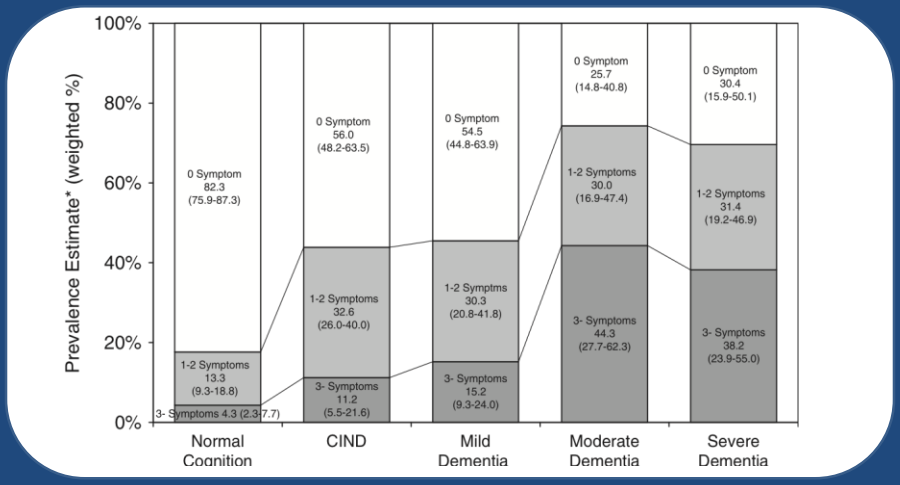
Epidemiology of NPS/BPSD

Prevalence:

- Up to 97% pts at some point during course of dementia (apathy > dep > aggression)
- 43-59% with MCI (dep > apathy > irritability)

Lyketsos et al. Am J Psychiatry 2000; Lyketsos et al. JAMA 2002; Feldman et al. Neurology 2004; Aalten et al. Int J Geriatr Psychiatry 2005; Zhao et al. J Affective Disorders 2016

BPSD Natural History



Okura et al. JAGS 2010

Public Health Significance

- Dep sxs associated with increased risk of conversion from MCI to AD.
- BPSD associated with 25-35% of total care costs in community-residing patients with AD.
- BPSD confer increased risk for institutional placement & hospitalization.
- Higher risk for CG depression and distress
- CG distress → increased risks of ED, hosp, healthcare costs

Wilson et al. Neurology 2002; Modrego et al. Arch Neurol 2004; Beeri et al. Int J Geriatr Psychiatry 2002; Steele C et al. Am J Psychiatry 1990; Tun et al. Am J Geriatr Psychiatry 2007; Yaffe et al. JAMA 2002; Peters et al 2015; Maust et al. Am J Geriatr Psychiatry 2017

What about Acute Covid Infection?

Older adults without dementia

- Up to 30% with MS changes
- 59% with psychiatric diagnoses (new psychosis, neurocog d/o and affective d/o most common)

NPS of acute Covid infection in PWD

- Delirium most common (hypo>hyperactive) and altered consciousness and agitation
- Exacerbation of dementia and BPSD

Dellazizzo et al. J Pers Med 2021; Manca et al. Frontiers in Psychiatry 2020; Simonetti et al. Frontiers in Psychiatry 2020

What about Impact of Pandemic Isolation?

2^0 Social/environmental/CG impacts of isolation for pts with NCD (both mild and major):

- >40-50% w/ ↑BPSD sx
- >30% reported social isolation
- ↑ loneliness, anxiety, depression, apathy, sleep disturbances, aggression, irritability, psychosis, motor agitation, loss of appetite
- >50-80% worsening of cognitive sxs
- Additional impact on CG emotional wellbeing

Dellazizzo et al. J Pers Med 2021; Manca et al. Frontiers in Psychiatry 2020; Simonetti et al. Frontiers in Psychiatry 2020

DICE

- Describe – CG describes problem behavior
- Investigate – Provider investigates potential causes of problem behavior
- Create – Provider, CG/team work together to create/implement Tx Plan
- Evaluate – Provider evaluates whether Tx safe and effective

Kales, et al. JAGS 2014

Evaluation of NPS/BPSD

- Anticipatory guidance and routine surveillance
- Behavior = communication of unmet needs
- Assess triad:
  - Pt – CG- Environmental factors
  - Mismatch of abilities of patient and environment

NPI-Q

NPI-Q SUMMARY

	No	Severity	Caregiver Distress
Delusions	0	1 2 3	0 1 2 3 4 5
Hallucinations	0	1 2 3	0 1 2 3 4 5
Agitation/Aggression	0	1 2 3	0 1 2 3 4 5
Dysphoria/Depression	0	1 2 3	0 1 2 3 4 5
Anxiety	0	1 2 3	0 1 2 3 4 5
Euphoria/Elation	0	1 2 3	0 1 2 3 4 5
Apathy/Indifference	0	1 2 3	0 1 2 3 4 5
Disinhibition	0	1 2 3	0 1 2 3 4 5
Irritability/Lability	0	1 2 3	0 1 2 3 4 5
Aberrant Motor	0	1 2 3	0 1 2 3 4 5
Nighttime Behavior	0	1 2 3	0 1 2 3 4 5
Appetite/Eating	0	1 2 3	0 1 2 3 4 5
TOTAL			

J Cummings. http://npitest.net (last accessed 11/4/21)

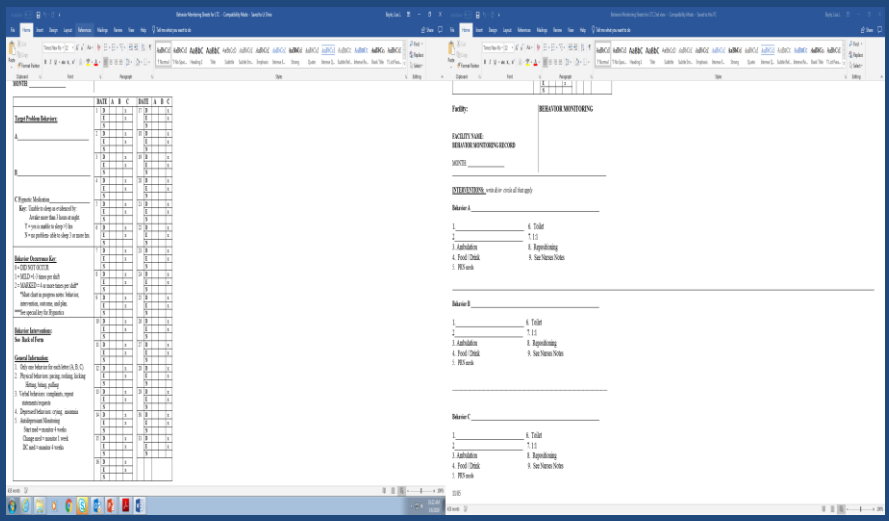
Describe/Investigate: NPS/BPSD

- ABC's (Antecedants – Behavior – Consequences)
  - A: Context? Triggers?
  - B: What are the specific, observed behaviors?
  - C: How does the CG/environment respond?
- Use Behavioral Tracking Sheets to collect objective data

Behavioral Tracking

Date	Day of Week	Time	Describe Behavior	What Was Occurring Before the Behavior	What Helped the Behavior (including prn's)

Behavioral Tracking in LTC



Describe/Investigate: NPS/BPSD -2-

- Establish/Revisit Medical Diagnoses
  - Consider delirium, untreated pain (Pain-AD), sensory impairments, etc.
- Establish/Revisit Psychiatric Diagnoses
- Evaluate for offending or change in medications or substance use
  - Anticholinergics
  - Sedative/hypnotics
  - Drug withdrawal?
  - Drug interactions?

General Approaches to BPSD

- Patient & caregiver education
- Anticipatory guidance & future-care planning
- Safety/Risk management
- Optimize environment (keep routines, calm)
- Routine mental and physical activity, socialization
- Optimize physical and mental health
- Support and linkages
  - Alzheimer and Dementia Alliance/Alzheimer's Association/ADRCs are great places to start.

Create/Evaluate: Consider Pt, CG, and Environment

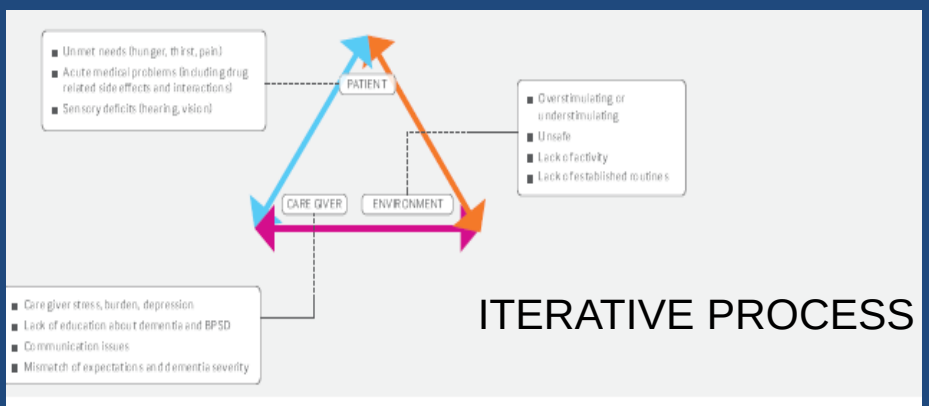


Fig 3 | Modifiable causes of behavioral and psychological symptoms of dementia

Kales, et al. JAGS 2014

Create/Evaluate: Non-Pharm Treatment Approaches

Behavioral/CG/Environmental Modifications

- Remove offending triggers
- Acknowledge emotion then calm reassurance and/or distraction
  - T-A-Da (Tolerate – Anticipate - Don't Argue)
- Positive reinforcements to support welcome behaviors and reduce unwelcome behaviors
- CG education, respite and supports

Create/Evaluate: Non-Pharm Treatment Approaches – 2-

Enlist help of loved ones who know that person best

- Personal hx, likes and preferences

Address unmet Pt needs, what could make one feel better?

- Stimulation if under-stimulated
- Reduce stimulation if over-stimulated
- Exercise
- Social activities
- Music and Memory

Create/Evaluate: Pharmacological Approaches

- ***No FDA-indicated pharmacological treatment of NPS***
  - ***Exception: pimavanserin with Parkinson's Psychosis***
- Strategies for choice of off-label med:
  - Diagnosable syndrome?
  - Target sxs? Are symptoms responsive? (e.g., wandering is not medication-responsive)
  - Acuity/Severity/Distressing sxs?
  - Safety concerns - aggression?
  - Risks?
    - Are benefits >> risks given pt's comorbities?
- Informed consent
- Start low, go slow, keep going….

Support of Evidence

- Limited empirical evidence/RCT support
- Mixed results, outcome measures
- Trials of short duration (usually up to 16 wks)
- *Approach pt as if N* of 1
  - variable etiology of behavioral disturbance
  - medical and psychiatric comorbidity
  - age
  - phenomenology
  - history of prior illness and treatment
  - vulnerability to adverse effects, and so forth

Pharmacological Options

- Antidepressants – Citalopram* (Sertraline)
- Antianxiety agents (Caution with BZD)
- Mood stabilizers – (CBZ, VPA, Lithium, LMT)
- Others (Melatonin, Trazodone, Prazosin)
- Atypical or typical antipsychotics - Risperidone, Olanzapine, Aripiprazole (Quetiapine, Clozapine) *
- Pimavanserin (FDA approved for PDP)*

*FDA BLACK BOX

Kales et al., BMJ 2015l;AHRQ Comparative Effective Review 43, 2011; Ballard et al. Cochrane Database of Systematic Reviews 2006; Porsteinsson, et al. JAMA 2014; Seitz et al. Cochrane Database of Systematic Reviews, 2011; Rosenberg, et al. Am J Geriatr Psychiatry 2010; Weintraub, et al. Am J Geriatr Psychiatry 2010

Antipsychotics

- Start low, go slow
- Response in 1st 2 wk predictive of response by 8 wk
- Special caution with DLB
- Atypical antipsychotics
  - EPS (Risp>Arip>Olz>Quet>Cloz), sedation, falls, QT prolongation, cog decline, metabolic syndrome (ADA et. al., Diabetes Care, 2004)
- Typical antipsychotics (e.g., haloperidol)
  - Also increased risk of adverse outcomes (hosp, death), higher mortality than atypicals
  - EPS, falls, TD>>atyp, QT prolongation
  - Anticholinergic effects, falls for lower potency agents

Rochon et al. Arch Intern Med 2008; Gill et al. Annals Intern Med 2007; Schneider et al. JAMA 2005; Wang et al. NEJM 2005; AHRQ Comparative Effective Review 43, 2011; Vigen et al. Am J Psychiatry 2011; Yoshida et al. AJGP 2017

Antipsychotics for Agitation/Psychosis

- FDA BLACK BOX WARNING for both atypicals and typicals (includes pimavanserin), RR ~1.7x of death (< 4%)
- Increase % mortality; NNH:
  - Haloperidol 3.8%; 26
  - Risperidone 3.7%; 27
  - Olanzapine 2.5%; 40
  - Quetiapine 2.0%; 50
  - Higher than c/w antidepressants
  - Higher dose, higher risks

Scheider et al. JAMA 2005; Maust et al. JAMA Psychiatry 2015

APA: 15 Guidelines for Antipsychotic for Agitation/Psychosis of Dementia

- Assessment guidelines
- "APA recommends that nonemergency antipsychotic medication should only be used for the treatment of agitation or psychosis in patients with dementia when symptoms are severe, are dangerous, and/or cause significant distress to the patient. (1B)"
- Risks/benefits assessment
- Start low then titrate to min effective dose as tolerated; taper if no response after 4 wk; consider taper after 4 mo
- Subsequent Cochrane review suggests that pts with more severe sxs - more likely to relapse with rx taper

Reus et al. AJP 2016; Van Leeuwen et al. Cochrane Database Syst Rev 2018

Post-Covid Reflections on Management/Lessons Learned

Increased reliance on medications for BPSD

CG & dementia support services are essential

Masking – challenges of communication for hearing impaired

Ethics & increased awareness of disparities

Telepsychiatry /Telemedicine growth

Telepsychiatry/Telemedicine

- Increased access
- Decreased infection exposures
- Family in other locations can participate despite lockdown in facilities
- Empower CG participation & education
- Facilitate multidisciplinary team meetings and consultations
- Favorable satisfaction and outcomes (psychiatric, older adults, neuropsych)

Telepsychiatry/Telemedicine

Limits:

- Access to tech and connectivity challenges
- Familiarity
- Reliance on CG to assist/ technical support
- Hearing/visual impairments
- Physical / neuro exams
- Rapport building

Questions?

Further Discussion:
What have your experiences been like since the pandemic?

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