

# Cognitive Impairment

Physician's Panel  
LTCIF May 2008

# Physician's Panel

## 1. Dr. Engleking

- ◆ Claims Viewpoint
- ◆ Severe Cognitive Impairment
- ◆ Emphasis on Behaviors

## 2. Dr. Margolis

- ◆ Underwriting Viewpoint
- ◆ Mild Cognitive Impairment
- ◆ Emphasis on Testing

## 3. Case Study / Questions

# LTCI Forum

May 9, 2008

Phoenix, AZ

## SEVERE COGNITIVE IMPAIRMENT

The Relationship to Behavior

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# Objectives

1. Review claims-related triggers for TQ LTC policies
2. Discuss in depth, the cognitive impairment trigger
3. Explore the relationship of behavior to cognitive impairment
4. Understand the spectrum & variability of behavior in dementia
5. Consider a framework for assessing behavior

# Health Insurance Portability & Accountability Act of 1996 (HIPAA)

- ◆ Establishes requirements for all TQ policies in the LTC universe
- ◆ Requires a Plan of Care (POC) from a licensed practitioner
- ◆ Requires claimant to be “chronically ill”

# Defining Chronically ill

- ◆ ADL Trigger
- ◆ Similar Level Trigger
- ◆ Cognitive Impairment Trigger

# The ADL Trigger

- ◆ Inability to perform at least two of six ADL's,
- ◆ without substantial assistance
- ◆ for at least 90 days

# The Cognitive Impairment Trigger (CI)

- ◆ Presence of severe cognitive impairment as defined by standardized neuropsychological tests & clinical evidence
- ◆ Need for substantial (continual) supervision to ensure safety
- ◆ Impairments may be in memory, orientation or judgment

# Neuropsychological Testing – Advantages

- ◆ MMSE currently most commonly used claim assessment tool
- ◆ Quantifiable requiring minimal reviewer judgment
- ◆ Excellent for serial comparisons

# Neuropsychological Testing - Disadvantages

- ◆ Lacks sensitivity/ specificity/ reproducibility
- ◆ Age, education & ethnicity are interpretative roadblocks
- ◆ Necessary, but insufficient to complete the full story

# Clinical Evidence

- ◆ Clinical evidence includes behavioral assessment
- ◆ Aberrant behaviors result in poor judgment
- ◆ Behaviors span the entire psychiatric spectrum

# The Behavioral Spectrum of CI

1. Depressive manifestations occur in 20 to 40% of CI
2. Agitated manifestations occur in 50 to 80% of CI
3. Psychotic manifestations occur in 30 to 40% of CI

# The Depressive Manifestations of CI

- ◆ These include social withdrawal, apathy, depression & suicidal ideas
- ◆ These are early findings present in mild dementia even preceding diagnosis
- ◆ They are more likely in mixed or vascular forms of dementia

# The Agitated Manifestations of CI

- ◆ These include anxiety, paranoia, irritability & wandering
- ◆ These are mid range findings present in mild to moderate dementia
- ◆ They frequently co-exist at the time of diagnosis

# The Psychotic Manifestations of CI

- ◆ These include delusions, hallucinations, socially unacceptable, uninhibited, sexually aggressive behaviors
- ◆ They are very late findings well after diagnosis in people with severe CI
- ◆ They are more common in non Alzheimer's Dementias

**Doctor – We've Got a Problem**

**IT'S OVER!**

# Behavioral Assessment in Dementia

**I**dentify the problem behavior (what)

**T**iming & frequency of the behavior (when)

**S**urroundings / environment (where)

**O**thers involved (whom)

**V**ery troubling / dangerous

**E**valuation of whole patient

**R**ecommendations

# Causes of Psychotic Behavior

- ◆ Schizophrenia
- ◆ Drug related side effects in Parkinsons Disease Therapy
- ◆ Delirium from medical illness
- ◆ Substance Abuse
- ◆ Dementia

# Standardized Behavioral Assessment Tool

## ◆ Neuropsychiatric Inventory (NPI)

- 10 behavior questionnaire
- Caregiver is the informant
- Jeffrey Cummings, MD  
UCLA School of Medicine
- Neurology 1994; 44; 2308-2314

# Medication Profiling

- ◆ Antidepressants: TCA's, SSRI's, Trazadone, Effexor, Cymbalta
- ◆ Older Antipsychotic Agents: Haldol, Thorazine & Mellaril
- ◆ Newer Atypical Antipsychotics: Risperidone, Seroquel, Zyprexa, Geodon & Abilify

# Behavior Logs

- ◆ Antipsychotic documentation required under OBRA Legislation in 1987
- ◆ Includes symptom severity & frequency
- ◆ Planning / response for dosage reductions to prevent chemical restraint

# Duke Clinical Research Institute

## Critical Challenges in Dementia

Dallas, TX

June 17, 2006

# Mild Severity of Dementia:

## Correlating ADL's, Behaviors & Cognition (MMSE)

- ◆ ADL's – problem with routine tasks (IADL's)
- ◆ Behaviors – personality changes, depressive manifestations
- ◆ Cognition – misplaces objects & mild confusion (MMSE > 21)

NIH 2003

# Moderate Severity of Dementia:

## Correlating ADL's, Behaviors & Cognition (MMSE)

- ◆ ADL's – needs help with basic tasks
- ◆ Behaviors – anxiety, paranoia, pacing & wandering
- ◆ Cognition – chronic recent memory loss, doesn't always know family (MMSE range 12 – 20)

NIH 2003

# Severe Dementia:

## Correlating ADL's, Behaviors & Cognition (MMSE)

- ◆ ADL's – total dependency of caregiver
- ◆ Behaviors – yelling, sobbing, groping, fighting
- ◆ Cognition – loss of speech, misidentifies people (MMSE range <12)

NIH 2003

# Final Thoughts

- ◆ Severe cognitive impairment is not always an easy call
- ◆ Many gray zones. Frequent overlap in the ABC's
- ◆ No single test or metric is sufficient
- ◆ Variability occurs more frequently with non Alzheimer's Dementias
- ◆ Clinical experience / judgment is very helpful whether it is internal or from qualified outside consultants