Toolbox for Improving Behavioral Health in Nursing Homes

Symposium presented at

The Gerontological Society of America's 66th Annual Scientific Meeting

New Orleans, LA November24, 2013

Symposium Overview

- 8-8:10 Introduction- Kimberly Van Haitsma
- 8:10-8:25 Staff education & leadership programs- Ann Boseen
- 8:25-8:40 Process of assessment- Laura Gitlin
- 8:40-8:55 Implementation of feasible interventions - Rita Jablonski
- 8:55-9:10 Methods for system integration- Marie Boltz
- 9:10-9:25 Discussant- Alice Bonner
- 9:25-9:30 Q&A

CMS National Partnership to Improve Dementia Care: First Year Goal

- Reduce national prevalence of antipsychotic medication use in long-stay nursing home residents by 15% by end of 2012
- Baseline: national rate based on MDS data (Nursing Home Compare takes an average of previous three quarters) in December 2011
  - National rate in long-stay residents was 23.9%
  - Denominator includes all residents except those with schizophrenia, Tourette's or Huntington's disease

Acknowledgements

Ann Kolanowski, PhD & Kimberly VanHaitsma, PhD- Co-PIs on Commonwealth Foundation **Toolbox for Improving Behavioral Health in Nursing Homes Project (Small Grant #20130170)**

This work was supported by grants from the Commonwealth Foundation and the Hartford Foundation. The funding agencies had no role in the preparation of this presentation.

Goal of Project

Convene a national, interdisciplinary group of geriatric behavioral experts to collaborate on the development of a behavioral health Toolkit for staff in nursing homes.

Toolbox Concept

- Compendium of peer-reviewed/expert-endorsed resources that will assist staff in the implementation of non-pharmacological approaches for challenging behaviors.
- Readily accessible
- Components: staff educational and leadership development programs; methods for assessing behavior; non-pharmacological approaches (NPA) to challenging behaviors; system-wide methods for integrating approaches into the culture of care
- Plan for wide dissemination of the Toolbox.

Subgroups Who Worked on Toolbox

- **<u>Philosophy</u>**- Karen Love, Jackie Pinkowitz
- **<u>Education & Leadership</u>**- Judy Lucas, Cornelia Beck, Brenda Cleary, Ann Bossen
- **<u>Assessment-</u>** Laura Gitlin, K. Marx, B. Hansen, & Kimberly VanHaitsma (Linda Teri , Kitty Buckwalter & Chris Kovach reviewed draft)
- **<u>Intervention</u>**- Sharon Nichols, Rita Jablonski, Andrea Gilmore-Bykovskyi, Darina Molkina, Natalie Baker, Ann Bossen (Lois Evans & Kelly Carney reviewed draft)
- **<u>System Integration</u>**- Marie Boltz, Carmen Bowman & Pat Parmelee
- **<u>Dissemination Plan-</u>** Barb Resnick
- **<u>Specific Behaviors-</u>** Andrea Gilmore-Bykovskyi , Justine Sufcik

Other Players

Advancing Excellence

American Health Care Association

American Medical Director's Association

Centers For Medicare and Medicaid Services (CMS)

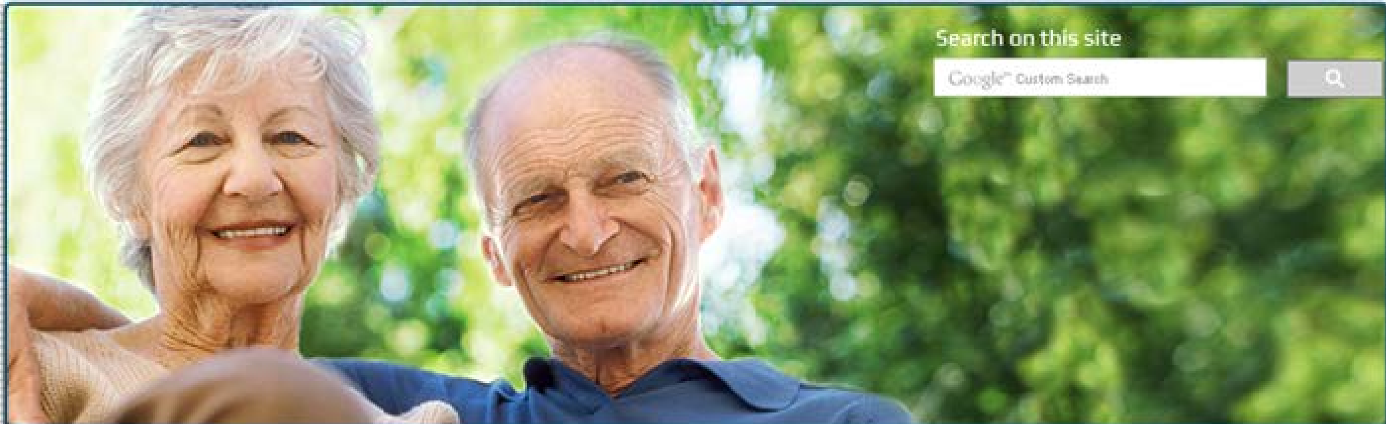
Leading Age

National Dementia Care Initiative

Workgroup Agenda

- Face-to-face meeting in San Diego, Nov., 2012
- Multiple phone conferences
- Meeting with Mary Jane Koran (Commonwealth Foundation)
- Web design and dissemination with gift from Hartford Foundation
- Conducted eight focus groups with nursing home staff (CNAs, LPNs, RNs, Recreational Therapy) in Centre County and Philadelphia, Pa.

The Toolkit
www.nursinghometoolkit.com



Tools to Integrate Non-pharmacologic Treatment of Behavioral Manifestations of Distress in Residents with Dementia

Marie Boltz, Patricia Parmelee, Carmen Bowman,
G. Allen Power, Kimberly Van Haitsman,
Ann Kolanowski

Our Goal

Identify best practices related to:

- implementation
- evaluation
- sustainability

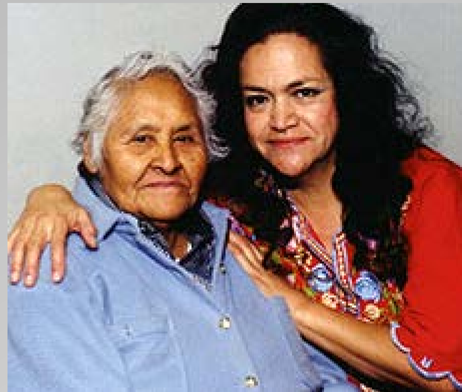
of systemic approaches that support safe and effective alternatives to antipsychotic use for behavioral symptoms of distress experienced by nursing home residents with dementia

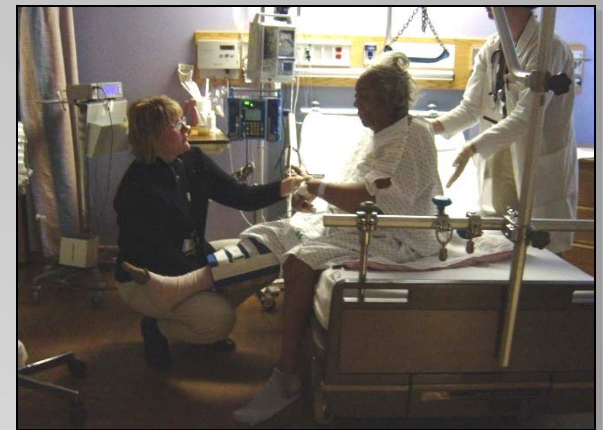
Methods

Iterative:

- Literature review
- Website reviews
- Consultation with experts
- Committee discussions

Recognizing the complexity of the nursing home setting





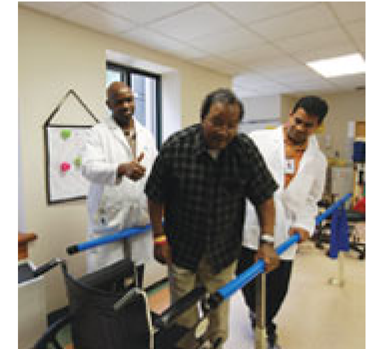
Anderson RA, McDaniel R. Taking complexity science seriously: New research, new methods. In: Lindberg C, Nash S, Lindberg C, editors. On the Edge: Nursing in the Age of Complexity. Bordentown, NJ: Plexus Press; 2008. pp. 73–95.

Results: Social –ecological Factors

- Baseline and ongoing appraisal of the social and physical **environment**
- Educational methodology to support resident, family and staff **interpersonal** communication and relationship
- **Intrapersonal** tools to support evidence-based, individualized clinical interventions
- Performance improvement measures, tool, and initiatives to support adherence with regulatory **policy**

Step 1: Organizational evaluation

Appraisal of the social and physical environment



Long-term Care Improvement Guide Self-assessment Tool (Planetree)

LONG-TERM CARE IMPROVEMENT GUIDE SELF-ASSESSMENT TOOL

This self-assessment tool is provided as a resource to assist users in navigating through the Long-Term Care Improvement Guide, particularly those struggling with where to begin. The assessment tool is organized around important aspects of a resident-centered culture, each of which is addressed in-depth in its own section of the Guide. Completing the self-assessment may help to identify important opportunities for improvement or to prioritize a list of initiatives your organization may be eager to undertake. The process of completing the tool and using the findings is an opportunity for modeling organizational values. Including stakeholders from throughout the organization in the assessment process is important, as perceptions may differ across the organization. Sharing the findings in a transparent manner builds trust and helps to create urgency for change, and incorporating the identified priorities into the goals of the coalition/steering team will be important for maintaining momentum. Change is dynamic; accordingly, it will be important to revisit this tool routinely as part of the process for sustainable improvement.

INSTRUCTIONS:

1. Complete the table below by marking the box that most appropriately captures the current status of the described practice in your organization.
2. Tally up your score for each section using the following scale:
   2 points for every practice that is **fully implemented.**
   1 point for every practice that is **partially implemented.**
   0 points for every practice that there is **no activity** or it is **not applicable.**
3. Calculate your organization's performance in each area, and refer to the section of the Guide addressing those areas which your performance indicates as the greatest opportunities for improvement. (low percent score=opportunity for improvement)
4. Use the **Prioritization Tool** to prioritize the implementation of the initiatives.
5. Take the time to celebrate your accomplishments! (high percent score=areas of achievement)

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas)*	*No activity*	*Not applicable*
Building Community: Establishing Urgency, pg. 51				
We routinely use an internal assessment and/or measurement system for developing goals.				
We have a process in place to listen to the stakeholders of our organization. (Examples: focus groups, learning circles)				
We have a process to routinely communicate our organizational challenges, financial, clinical, operational and cultural goals and vision to stakeholders. (Examples: community meetings, town hall meetings, daily stand-ups)				
Total Score out of a Possible of 6		**Percent of Total:**		%

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Long-Term Care Improvement Guide | Self-Assessment Tool

INITIATIVE PRIORITIZATION TOOL:

Instructions:

1. From the completed assessment, fill in those initiatives that you rated either partially implemented or no activity.
2. Tally up the number of "Yes" responses to identify top initiatives. Items with the greatest number of Yes responses = higher priority.
3. Refer to the Guide sections that correlate to the top priorities for your organization.
4. Empower the Guiding Coalition or Steering Team to use these priorities to set organizational goals and work groups.

Assessment Item	Does this initiative satisfy an expressed resident, family and/or staff need?		Does this initiative support our organizational goals and priorities?		Does this initiative present an opportunity for a high-impact, short-term win?		Do our organizational resources allow for the implementation of this initiative?		# of Yes Responses
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	

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Putting the P.I.E.C.E.S. Together website. http://www.piecescanada.com/

TESS -NH
(Therapeutic Environment Screening Survey)

A 37-item checklist consists of a range of environmental domains (safety / security, orientation, privacy/control), as well as staff interaction, resident involvement in activities, and physical environmental atmosphere.

Garcia LJ et al. Perceptions of family and staff on the role of the environment in long-term care homes for people with dementia. International Psycho geriatrics 2012; 24(5):753-65.

Models of Care Instrument

MODELS OF CARE ASSESSMENT INSTRUMENT

Resident ID: __________ Facility Code: _________ Date:________________________

Assessor: ________________________ Proxy Informant: _______________________

For each of the following questions, please check one answer that is most similar to the care practices and features of your unit/facility. Only use the "other" line when no other answer is appropriate. After checking a box, you may write additional comments if further explanation is necessary.

#	Code	Item
1	H	□ Dining tables accommodate fewer than six residents.
	R	□ Dining tables accommodate six or more residents.
	M	□ There are several sizes of dining tables.
	O	□ Other: ______
		Comments:
2	M	□ Residents are served the meal of the day, but may request alternative.
	R	□ Residents can select from a wide range of choices, there may be a menu, buffet, etc.
	H	□ Residents select and control choice of food items at meals, as in family style dining.
	O	□ Other: ______
		Comments:
3		Residents are encouraged or assigned to eat with residents:
	M	□ with similar diets or need for assistance.
	R	□ whom they choose
	H	□ who live near them
	O	□ Other:
		Comments:
		At meals, staff assume the role of:
	H	□ an adult child or close relative.
	R	□ a maitre d' or waiter/waitress.
	M	□ a health monitor.
	O	□ Other: ______
		Comments:

© IDEAS Inc. 2000

O □ Other: ________________________________

19. Mrs. Smith values her independence and privacy in dressing. When she comes out of her room, her clothes are usually mismatched. Sometimes buttons are done wrong or a garment is on backwards. It this situation, staff usually will:
H □ Do nothing unless she is indecently exposed
R □ Anticipate the time when she will get up and be there to assist her
M □ Take her to her room and help fix the problem. Involve occupational therapy or add dressing supervision to her care plan.
O □ Other: ________________________________

20. Mr. Thomas is a new resident on the unit. He has not entered into any group activities in the two weeks that he has been there. Staff are most likely to:
R □ Use pep and enthusiasm to encourage him to come.
H □ Drop in his room to establish 1:1 rapport and then try to get him to come.
M □ Call his family and share concerns. Involve a social worker or mental health professional to screen for adjustment difficulty or depression.
O □ Other:
____

21. Mrs. Jones has always been a very independent and private person. She is angry that staff come into her room to check on her during the day and night. Unit staff are most likely to:
M □ Explain that it is unit policy and for her safety, then look for a small compromise to pacify her.
H □Stop obvious checks but stop in to visit a few times during the day and listen at her door at night.
R □Stop obvious checks but stop in to see if she needs anything or bring her a snack that she likes and listen at her door at night.
O □Other:
____

Thank you for your time.

Calkins MP, Weisman GD. Models for environmental assessment. In: Schwarz B, Brent R, eds. Aging, Autonomy and Architecture. Baltimore, MD: Johns Hopkins University Press, 1999, 130–142.

Person-centered care assessment tool (P-CAT)

An Australian Government Initiative

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	Disagree completely 1	Disagree 2	Neither agree or disagree 3	Agree 4	Agree completely 5
1. We often discuss how to give person-centred care.	☐	☐	☐	☐	☐
2. We have formal team meetings to discuss residents' care.	☐	☐	☐	☐	☐
3. The life history of the residents is formally used in the care plans we use.	☐	☐	☐	☐	☐
4. The quality of the interaction between staff and residents is more important than getting the tasks done.	☐	☐	☐	☐	☐
5. We are free to alter work routines based on residents' preferences.	☐	☐	☐	☐	☐
6. Residents are offered the opportunity to be involved in individualised everyday activities.	☐	☐	☐	☐	☐
7. I simply do not have the time to provide person-centred care.	☐	☐	☐	☐	☐
8. The environment feels chaotic.	☐	☐	☐	☐	☐
9. We have to get the work done before we can worry about a homelike environment.	☐	☐	☐	☐	☐
10. This organisation prevents me from providing person-centred care.	☐	☐	☐	☐	☐
11. Assessment of residents' needs is undertaken on a daily basis.	☐	☐	☐	☐	☐
12. It is hard for residents in this facility to find their way around.	☐	☐	☐	☐	☐
13. Residents are able to access outside space as they wish.	☐	☐	☐	☐	☐

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Edvardsson, D. et al 2009). Construction and psychometric evaluation of the Swedish language person-centred climate questionnaire—staff version. Journal of Nursing Management, 17, 790–795.

Person-directed Care Measure

50 items

- personhood
- autonomy/ choice
- knowing the person
- comfort
- nurturing relationships
- physical environment
- organizational environment

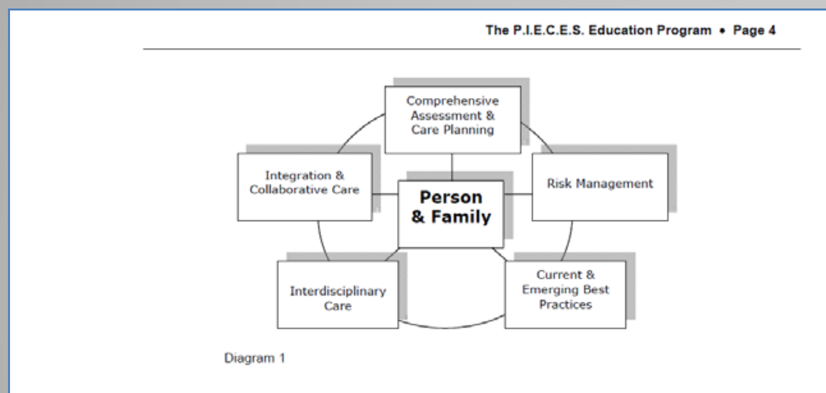
White, D. L., Newton-Curtis, L., & Lyons, K S. (2008). Development and initial testing of a measure of person-directed care. *The Gerontologist*, *48*, 114–123.

Step 2: Education: staff, residents, family

Project Management that supports uptake

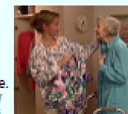
Step 2
Use of an evidence-based educational program

P.I.E.C.E.S.:
Human resource development and project management tools to support changes in practice



STAR—Staff Training in Assisted-living Residences

STAR Staff Training for Assisted Living Residences



Older adults who experience memory problems often have difficulties that interfere with their enjoyment of life and quality of care. Challenging behaviors, depression, and anxiety accompany memory problems and can be disabling to those affected and to their families.

More and more older adults with cognitive problems choose Assisted Living as the ideal residence for their own safety, satisfaction and comfort, and for their families' peace of mind.

Living with the difficulties associated with memory problems every day is stressful to both the affected person and to those around her or him. Such stress can be eased by awareness of the roots of the difficulties and knowledge of skills and techniques for alleviating the effects.

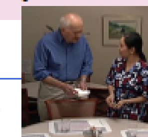
Specialists at the University of Washington have created an educational program, Staff Training in Assisted Living Residences—STAR. The program is for staff of Assisted Living residences who care for residents with dementia and associated behavioral symptoms.

The training program is available to Assisted Living facilities for their direct care, licensed, and administrative staff, as well as other staff members who are in frequent contact with residents.

The program deals sensitively with memory problems by showing everyone involved how to anticipate problems and prevent them from interfering with daily living and harmonious relationships.

Topics covered include:
- Realistic expectations
- Enhancing communication
- Observing and using the ABCs
- Increasing pleasant events
- Working with families
- Putting skills into action

- **Two 4-hour Workshops** teach direct care staff to recognize difficult behaviors and use new skills to change reactions and improve care. The Workshops cover topics relevant to the daily work of direct care staff.
- **Four 1/2-hour Individualized Training Sessions** with each trainee while she/he is working help the trainee integrate *STAR* skills and techniques into everyday tasks.
- **Three 1/2 to 1-hour In-Services** with Licensed staff demonstrate the *STAR* techniques and skills and show how supervisors can work with direct care staff to improve the caregiving environment.



Facility Support: The program requires the help of the administrator or Assisted Living supervisor to describe typical "problem behaviors" or "challenging care issues" and to match each direct care staff member with a resident she/he frequently cares for. Connecting the STAR training with real problems or challenges ties the new skills to genuine caregiving situations.

The facility should be prepared to provide floor coverage to allow direct care staff to attend the 4-hour Workshops that are vital to the effectiveness of the training program.

The *STAR* program includes forms for evaluation of the training.

Please contact us for more information:

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STAR is an approved Washington State Alternative Curriculum.

Educational Methodology

Practices that support integration

- Mandatory inservices, scheduled as part of routine work time
- Incentives to participate (such as a meal) facilitate reach
- Ongoing educational opportunities at the bedside

Resident /family education

- Orientation to include philosophy, policy, and alternatives
- Revisit as needed at care planning

Resnick et al. Implementation of the 6-week educational component in the Res-Care intervention: process and outcomes. Journal of Continuing Education in Nursing 2009; 40(8):353-60.

Rodwell et al. Supervisors are central to work characteristics affecting nurse outcomes J Nurs Scholarsh 2009; 41:310–319.

Step 3: Policy development

- ✓ Clinical protocol
- ✓ Interdisciplinary care planning processes

Clinical protocol (monitored by champion{s})

Preferences for Everyday Living Inventory

- **Assessment** of:
  - Social profile, coping measures, preferences, triggers.
  - Clinical presentation of cognition, mood, function

Van Haitsma, K. (2000). The assessment and integration of preferences into care practices for persons with dementia residing in the nursing home. In Rubinstein R., Moss M., and Kleban M. (Eds). The Many Dimensions of Aging. New York: Springer.

Clinical protocol

- A plan for:
  - family involvement as desired
  - a structured routine (24-hour) that reflects resident preference and capability
  - therapeutic communication
- Management of medical and psychiatric disorders
- If antipsychotics are used, conservative approach
- An individualized plan of care to avoid behavioral symptoms and manage acute behavioral episodes

1.Insel, K.C. & Badger, T.A. (2002). Deciphering the 4 D's: cognitive decline, delirium, depression and dementia – a review. Journal of Advanced Nursing 38 (4)360–368.

2.Westbury, J., Jackson, S. & Peterson, G. (2009). Psycholeptic use in Tasmanian aged care homes. *International Journal of Clinical Pharmacy and Therapeutics.* 35(2):189-93.

3.Westbury, J., Jackson, S. Gee P, & Peterson G. An effective approach to decrease antipsychotic and benzodiazepine use in nursing homes: the RedUSe project. *International Psychogeriatrics* 2010; 22 (1): 26–36

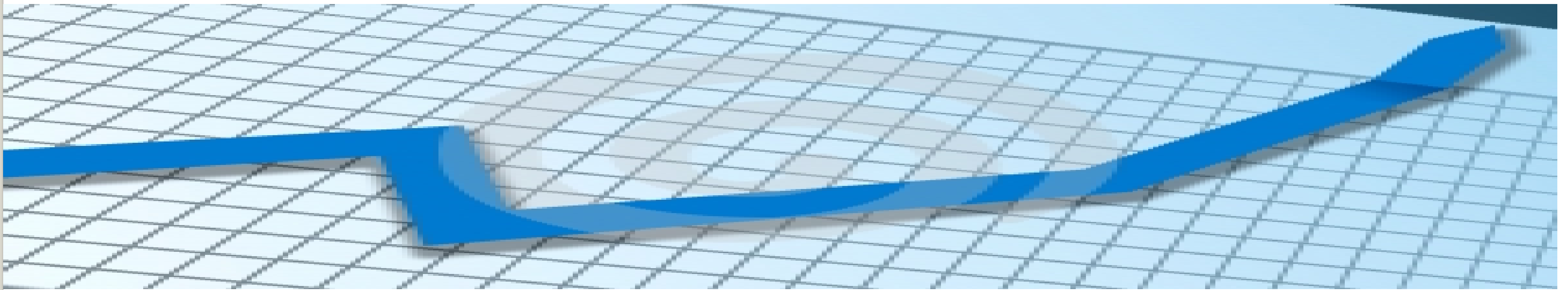
Interdisciplinary care planning processes

that include:

- the resident and family with a copy of care plan provided to family
- nursing assistants in care planning

Step IV. Sustain the improvement

Quality assurance/ improvement activity



Evidence-based **measures**

- Pharmacist audit of psychoactive use (outcome measure) with feedback to staff
- Steering committee to develop process measures
- Include assessment of congruence to resident preference

Evidence-based approach to continuous performance improvement

- Include all levels of staff in QA/QI activity. Share results.
- Use of "QAPI at a Glance"
- http://cms.gov/Medicare/Provider-Enrollment-andCertification/QAPI/Downloads/QAPIAtaGlance.pdf.

Westbury, J., Jackson, S. Gee P, Peterson G. An effective approach to decrease antipsychotic and benzodiazepine use in nursing homes: the RedUSe project. *International Psychogeriatrics* 2010; 22 (1): 26–36.

http://www.abramsoncenter.org/pri/projects/PELI.htm

Toolkits to achieve quality goals
Advancing Excellence in America's Nursing Homes

Process Goals:

o Improving staff stability;
o Increasing use of consistent assignment
o Increasing person-centered care planning and decision making;
o Safely reducing hospitalizations;

Clinical Goals

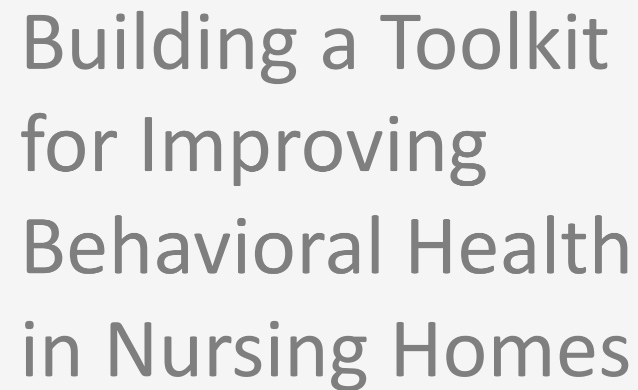
o Using medications appropriately;
o Increasing resident mobility;
o Preventing and managing infections safely;
o Reducing the prevalence of pressure ulcers; and
o Decreasing symptoms of pain.

In conclusion……

The social ecological view supports a systematic approach to promoting the well-being of persons with dementia,

including alternatives to anti-psychotic medication.

We are still on the journey….



Building a Toolkit for Improving Behavioral Health in Nursing Homes

Cornelia Beck, Ann Bossen, Brenda Cleary, Judith A. Lucas, Imani Baker, Ann Kolanowski , and Kimberly Van Haitsma.

GSA Annual Scientific Conference,
New Orleans, LA., Nov. 20-24, 2013

Education Committee

- Cornelia Beck, PhD, RN,FAAN, University of Arkansas for Medical Sciences
- Ann Bossen, PhD, RN, University of Iowa
- Brenda Cleary, PhD, RN, FAAN, Healthcare Consultant
- Judith A. Lucas, EdD, RN, GCNS-BC, Seton Hall University
- Ann Kolanowski, PhD, RN, FAAN, Penn State School of Nursing
- Kimberly Van Haitsma, PhD, Polisher Research Institute
- Imani Baker, Rutgers University

Goal of education committee;

- To conduct a search to identify nursing education sources on existing non-pharmacological approaches to behavioral management in dementia care

Educational and Leadership Development Programs

- Educational Programs for Implementing Non-Pharmacological Approaches
- Leadership Opportunities for Professional Staff
- Educational Resources Available on the Portal of Geriatric Online Education (POGOe) Website
- Geriatric Certification Opportunities

Features identified

- Name of program
- Sponsoring agency
- Abstract/ brief description
- Intended learning audience
- Peer reviewed
- Evidence-based
- Learning resource type & format
- CEUs available
- Duration
- Link
- Cost involved

Product formats included;

- 5 webinars, 8 power point presentations, 1 CD-ROM , 6 videos, 1 audio conference, 3 continuing education presentations and modules, instructional materials, 3 pocket cards, 2 case studies, journal articles and 1 book.

Focus group input

- Direct care staff indicated that video and other types of demonstration were the most useful sorts of educational materials for helping them respond to behavioral symptoms.

Portal of Geriatric Online Education (POGOe)

- An existing database of educational materials supported by the Reynolds Foundation
- 20 resources identified

Leadership development programs

- 15 programs were identified with material specific for administrators and supervisory staff.

The Coalition of Geriatric Nursing Organizations

- 10 geriatric certification opportunities for management and professional staff were found
- These certification opportunities are designed for licensed practical nurses and registered nurses in long-term care and assisted living.

Challenges

- Finding products that were *specifically* for direct care staff. Limited to those products where the sponsoring organization did not charge a fee.
- Database itemized when there was a fee for use of the product.
- Costs for some products were higher for non-members of the organization, and may reduce access for facility use.

Thank you

Assessing Neuropsychiatric Symptoms in Persons with Dementia: A Review of Measures

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- Assistance preparing GSA slides, Ian Stanley, Health Educator for Center for Innovative Care in Aging, Johns Hopkins University

Research Support and Disclosures

- Dr. Gitlin supported in part for work on this project from the:
  - NIA Grant #R01AG041781
  - Alzheimer's Association Grant # NPSASA-10-174625
- Commonwealth funds awarded to Drs. Van Haitsma and Kolanowski

No relevant financial or conflict of interest disclosures

Objectives

- Why assess behavioral symptoms in persons with dementia?
- Summary of available tools
- Research and Clinical Implications

Why Assess Behavioral Symptoms?

- **Behavioral symptoms occur throughout disease progression**
- **Nearly universal** - almost all persons with dementia will have one or more behavioral symptoms, regardless of dementia etiology
- **Associated with poor patient outcomes**:
  - Reduced quality of life
  - More rapid disease progression
  - Increased health care utilization and costs
  - Increased safety concerns

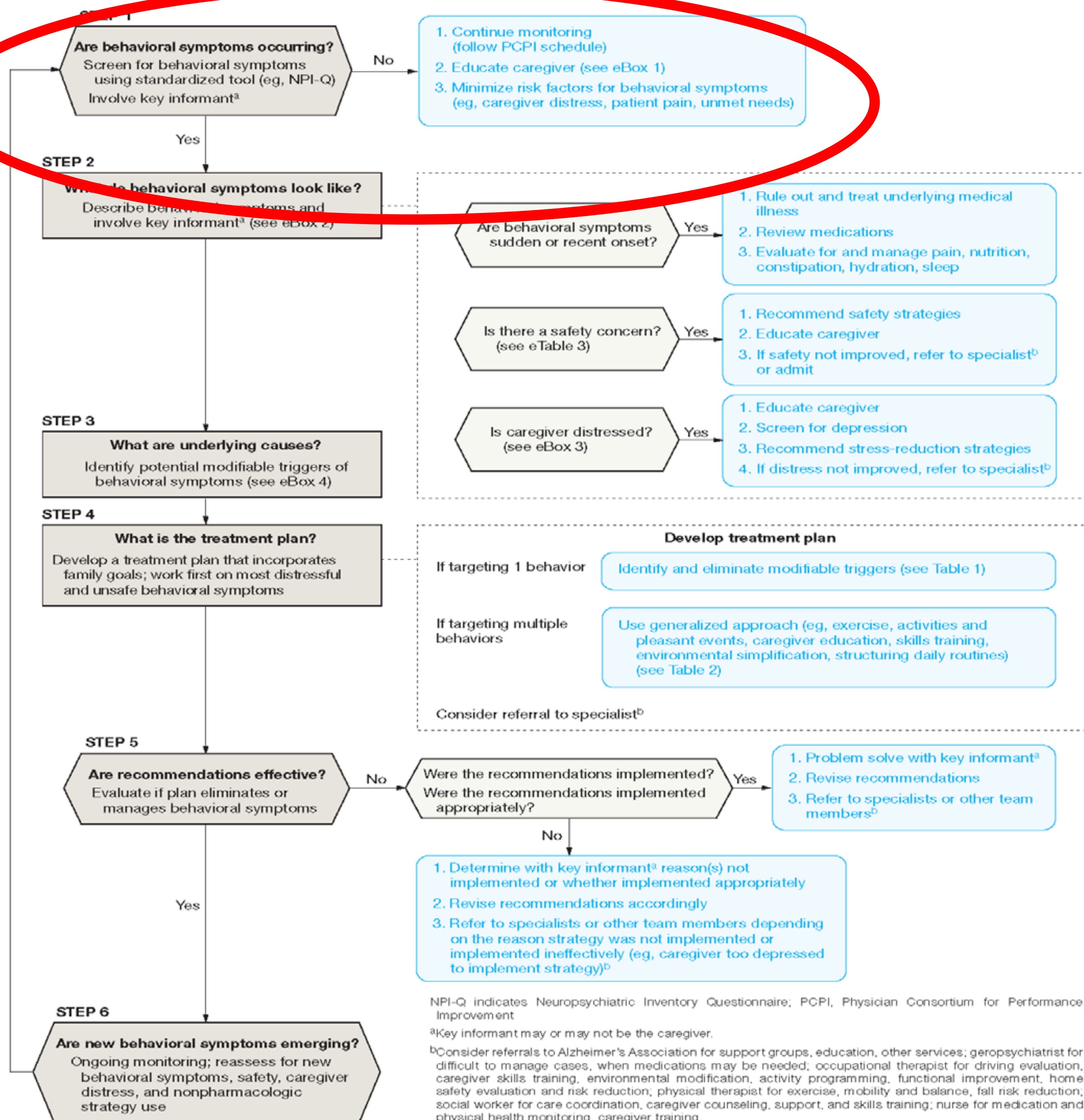
- **Associated with poor caregiver outcomes**:
  - Increased depression, burden and upset
  - Increased need for vigilance and time spent caregiving
  - Poor quality of life
  - Increased risk for placing person in nursing home care
  - Increased safety risk
- **Under recognized and undertreated**

Common Behavioral Symptoms of Most Concern to Caregivers (N=239)

Behavioral Symptoms	# (%) of Caregivers Reporting Behavior Past Month
Repetitive questioning	218 (80.1%)
Refusing care	147 (54.0%)
Argumentativeness	183 (67.3%)
Toileting issues	173 (63.6%)
Upset/agitated/restless	157 (57.7%)
Wakes up at night	145 (53.3%)
Verbal Aggression	145 (53.3%)
Wandering	52 (19.1%)
Inappropriate behaviors	20 (7.4%)

Gitlin, et al.,(2007). Design and methods of Project ACT. *Clinical Interventions in Aging, 2(4),* 695-703. PMCID: PMC2670989; Gitliin et al., (2010). JAGS, 58 (6) 1465-1474.

6-Steps for Identifying and Addressing Behavioral Symptoms



Gitlin, Kales, Lyketsos, JAMA 2012

Assessing Behaviors

- AMA Physician Consortium for Performance Improvement (PCPI) 2011 Dementia Performance Measurement Set suggests minimum yearly screen
  - Measure #4: Neuropsychiatric Symptom Assessment

    Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period.
- No widely agreed upon standard for screening for behavioral symptoms or one recommended tool
  - Behaviors typically brought to physician's attention by concerned caregiver after occurrences or by staff in a facility

Odenheimer, et al., in press, *Neurology; Marx et al., poster, AAIC, July 17th, 2013*

Search Strategy

- A computerized search of:
  - Peer reviewed published studies of measures (1980 to present)
  - English
- Search terms: neuropsychological tests, neuropsychological measurements, dementia, Alzheimer's disease, behavior, delusions, hallucinations, agitation, aggression, depression, anxiety, eating, euphoria, apathy, disinhibition, irritability, motor disturbance, sleep, and vocalizations.
- Articles were further searched for additional measures.

Evaluation of Scales for:

- Number of Items
- Domains of Behavior
- How Administered
- Response Categories (domain and specific response)
- Target Population
- Reliability and Validity

RESULTS

2,260 articles identified

- -2,233 articles from direct search
- -27 additional articles

78 measures identified

44 (56%) measures
With adequate psychometric properties

- Fifteen (34%) broad-based measures
- Twenty-nine (65.9%) behavior specific measures

General Behavior Scales (n=15)

1. Alzheimer's disease assessment scale non-cog
2. Multi-dimensional observation scale for elderly subjects
3. Nurses' observation scale for geriatric patients
4. The neurobehavioral rating scale
5. The nursing home behavior problem scale
6. **BEHAVE-AD**
7. **Neuropsychiatric inventory (NPI-Q; NPI-C)**
8. **Revised memory and behavior problem checklist**
9. Computer assisted behavioral observation scale
10. Clinical dementia rating scale
11. Behavioral syndromes scale for dementia
12. Dementia signs and symptoms scale
13. CERAD Behavior rating scale for dementia
14. Key behavior change inventory
15. Dementia Behavior disturbances scale

Specific Behavior Scales (n=29)

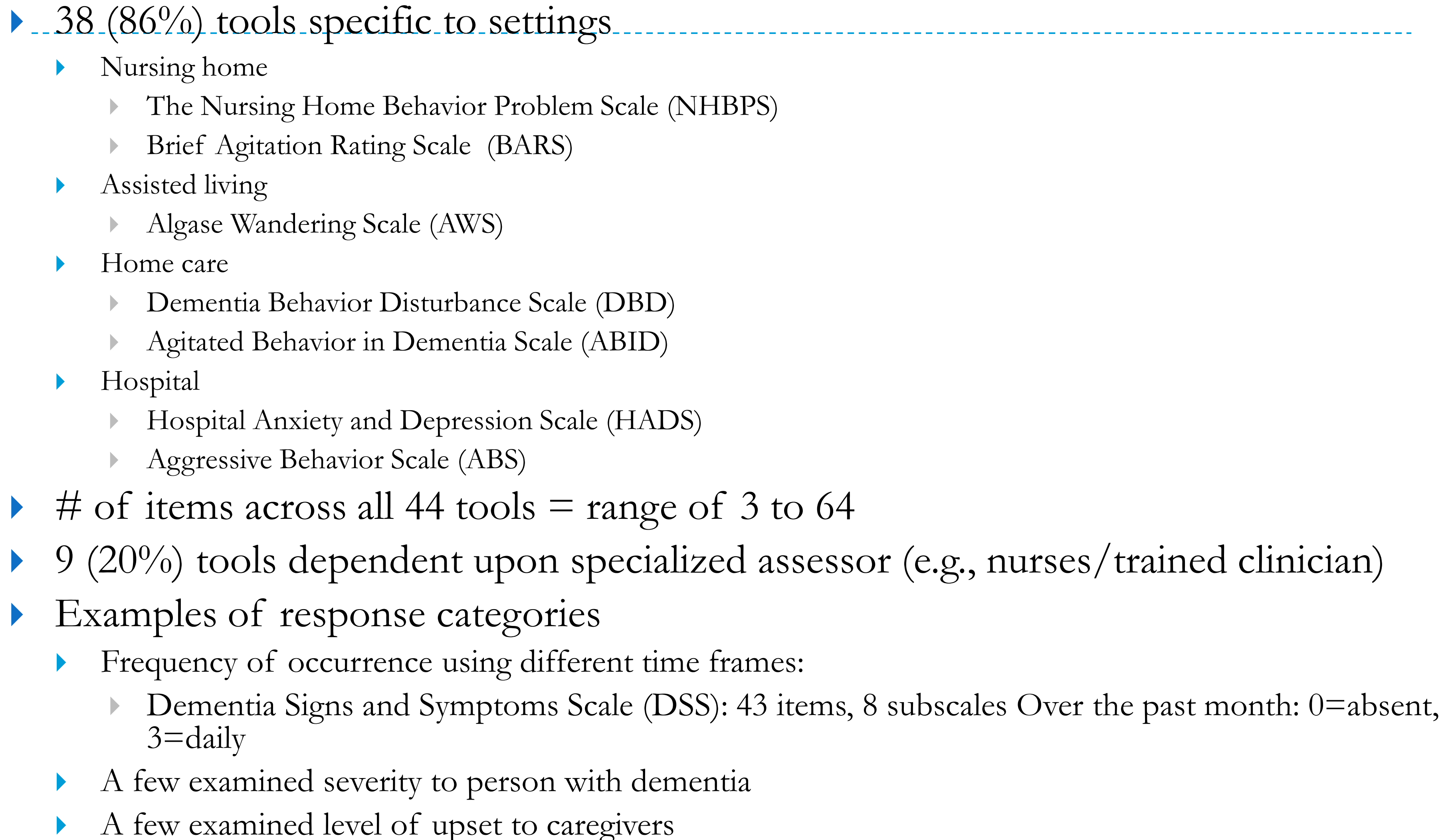
- **Agitation**
  1. Cohen-Mansfield agitation inventory
  2. Agitated behavior in dementia scale
  3. Pittsburgh agitation scale
  4. Brief agitation rating scale
  5. Overt agitation severity scale
  6. Disruptive behavior rating scales
- **Apathy**
  1. Dementia apathy interview and rating scale
  2. Apathy evaluation scale
  3. Lille apathy rating scale
  4. Irritability-apathy scale
  5. Frontal system behavior scale
  6. Apathy inventory
- **Aggression**
  1. Aggression behavior scale
  2. Overt aggression scale
  3. RAGE
  4. Ryden aggression scale
- **Depression**
  1. Cornell scale for depression in dementia
  2. Patient health questionnaire – 9
  3. The dementia mood assessment scale
- **Depression & Anxiety**
  1. Hospital anxiety and depression scale
  2. Depression anxiety stress scale
- **Anxiety**
  1. Rating anxiety in dementia
  2. Geriatric anxiety inventory
  3. Beck anxiety inventory
  4. The worry scale
- **Sleep**
  1. Pittsburg sleep quality index
  2. The sleep disorders inventory
  3. Epworth sleepiness scale
- **Wandering**
  1. Algase wandering scale

No measures specific to:

- Euphoria
- Hallucinations
- Irritability apart from aggression or anxiety
- Motor and verbal disturbances

Observational tools (n=10)

- Multi-dimensional Observation Scale for Elderly Subjects (MOSES)
- Nurses' Observation Scale for Geriatric Patients (NOSGER)
- The Nursing Home Behavior Problem Scale (NHBPS)
- Computer Assisted Behavioral Observation Systems (CABOS)
- Pittsburgh Agitation Scale (PAS)
- Overt Agitation Severity Scale (OASS)
- Disruptive Behavior Rating Scales (DBRS)
- Overt Aggression Scale (OAS)
- Rating Scale for Aggressive Behavior in the Elderly (RAGE)
- Algase Wandering Scale (AWS)



Characteristics of Assessment Tools
38 (86%) tools specific to settings
Nursing home
The Nursing Home Behavior Problem Scale (NHBPS)
Brief Agitation Rating Scale (BARS)
Assisted living
Algase Wandering Scale (AWS)
Home care
Dementia Behavior Disturbance Scale (DBD)
Agitated Behavior in Dementia Scale (ABID)
Hospital
Hospital Anxiety and Depression Scale (HADS)
Aggressive Behavior Scale (ABS)
# of items across all 44 tools = range of 3 to 64
9 (20%) tools dependent upon specialized assessor (e.g., nurses/trained clinician)
Examples of response categories
Frequency of occurrence using different time frames:
Dementia Signs and Symptoms Scale (DSS): 43 items, 8 subscales Over the past month: 0=absent, 3=daily
A few examined severity to person with dementia
A few examined level of upset to caregivers

Implications

- Assessing behavioral symptoms using reliable and valid measures should be part of routine and comprehensive care of persons with dementia.
- Good news - Measures exist with strong psychometric properties
- Choice of measure should depend upon:
  - Clinical setting or research context
  - Specific behaviors of concern
  - Method of ascertainment (clinician versus nonclinician; self-report versus observation).
- Recommendation:
  - Use general measure that captures a broad spectrum of behavioral symptoms as screen
  - For a behavioral occurrence, followup with specific measure to obtain more nuanced understanding.
- Existing measures represent an initial step for behavioral symptom detection
- Only a few evaluate severity to patient and level of upset to caregiver

Implications Con't

- Existing measures represent an initial step for behavioral symptom detection but:
  - Only a few evaluate severity to patient and level of upset to caregiver
  - Do not capture phenotype of behaviors
  - Do not capture context in which behaviors occur
- These 44 assessments start the process only
- Most common measure used in research/clinical context is NPI (NPI-C; NPI-Q)

Measurement Development Needs

- Systematically characterize risk factors for behaviors
- Systematic measurement protocol for characterizing behavioral occurrences and contextual features
- Determine congruence between items and caregiver knowledge/understanding and own characterization of behavioral symptoms
- Determine whether self-report by proxies accurately captures behavioral occurrences
- Advance measurement protocols:
  - Quick screens for risk
  - Quick screens for behavioral symptoms
  - In-depth followup of context of occurrences
  - Link assessment tools to potential nonpharmacologic strategies
  - Cross train health professionals and caregivers in identifying/assessing for behavioral symptoms

Non-Pharmacological Interventions to Reduce Agitation in Persons with Dementia: Considerations for Feasibility and Future Research

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Workgroup Objectives

1. Evaluate the efficacy and feasibility various non-pharmacologic interventions for nursing home residents with dementia in reducing behavioral symptoms, primarily agitation
2. Identify relevant barriers to disseminating information regarding non-pharmacologic approaches to long-term care facilities via the Behavioral Health Toolkit

Identified Areas of Need

- Practical guidance for providers that integrates both **efficacy and feasibility** of various non-pharmacologic interventions
- Information about what **types** of non-pharmacologic interventions or basic care approaches are likely to be effective for which symptoms
- Reasonable expectations regarding the **effect** of different interventions and the **duration** of those effects

Challenges of Disseminating NPI to Nursing Home Care Providers

- Limitations of existing evidence-base for non-pharmacologic interventions
  - Methodological
  - Small to moderate effects for short durations

- Constraints of the nursing home environment
  - ✓ Assessment of feasibility
    - Training
    - Time
    - Cost
    - Personnel

Effective Non-pharmacologic Interventions

- Systematic reviews and review of recent trials of clinical-decision support interventions
- Non-pharmacologic interventions that were most consistently found to be effective were sensory stimulation interventions
  - Music therapy, hand massage/gentle touch, aromatherapy
  - Medical/Nursing Interventions
    - ✓ Pain treatment
    - ✓ Clinical-decision support interventions

Feasibility Assessment

- Feasibility was defined as the overall resources required to successfully implement the intervention including: staff training, staff time, the need for specialized environments or equipment, changes in regulations, and resident/family time requirements.

Interventions with strongest evidence-base and high feasibility

- Music Therapy
- Massage/Touch Therapy
- Pain Management

Interventions with strongest evidence-base and moderate feasibility

- Clinical Decision-Support Interventions
  - Serial Trial Intervention (STI)
  - Treatment Routes for Exploring Agitation (TREA)
- Aromatherapy

Approaches and Responses to Specific Behavioral Symptoms

nursinghometoolkit.com

nursinghometoolkit | Managing Specific Behaviors

Apathy/Withdrawn

A person who is withdrawn or apathetic is someone who is socially withdrawn and is experiencing a loss of interest and motivation. Behaviors that reflect being withdrawn or apathetic might include sitting alone in one's room, avoiding contact with others and making limited eye contact with others.

Agitation

Agitation is a broad term that refers to a variety of verbal, vocal or physical behaviors that appear distressing to the person with dementia or are considered inappropriate or unusual or are disruptive to others.

Common behaviors observed in a person experiencing agitation are restlessness, complaining, repetitive statements or repetitive movements and constant requests for attention.

Inappropriate or Disruptive vocalizations

Disruptive vocalizations are any verbal noises (screaming, yelling, nonsense talking, cursing) which are generally considered unusual, inappropriate or are upsetting to others.

Aggressive behaviors

Aggressive behaviors are actions that are threatening or harmful and can be physical in nature (hitting, kicking, biting, grabbing people or things, throwing things) or verbal (screaming, cursing, making threats).

Please select the behaviors for details

Wandering

Wandering or pacing is sometimes referred to as "aimless" walking. This can also refer to restlessness or excessive moving around during the day or evening.

Identification of Barriers to Dissemination

- Getting the information “out there”
  - Passive versus active diffusion
- Identifying and effectively communicating potential risks associated with interventions.
- Limited understanding of knowledge base of direct care providers regarding behavioral symptoms.
  - Direct care staff (CNAs) often perceive behaviors as “normal”

Discussion

- Urgent need for emphasis on potential translatability of interventions into practice.
- Study designs that allow for assessment of singular impact of intervention components (i.e. social contact/music) and individualization are needed.
- Development/evaluation of implementation and dissemination methods for clinical decision-support interventions, which may make wide-scale translation of these interventions more feasible.