Non-Pharmacological Management of Agitated Behaviors in Cognitively Impaired Older Persons

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Case Study
Learning Objectives

Participants will:

- Identify patients at risk for behavioral issues
- Showcase protocols and policies for non-pharmacological management of agitation and other behavioral derangements
- Discuss the role of the interdisciplinary team in management of behavioral and psychiatric symptoms of dementia
- Address the difference in presentation of delirium and dementia
Outline

- Scientific Evidence Base
- Implementing a Program
  - Building the team and mission
  - Structure and Function/Meetings and Interdisciplinary Processes
  - Clinical approaches
    - A,B,C,D,Es of behavior management
- Cases
- Discussion
Evidence Base for Management of Dementia Behavior

- Excellent recent review: VA Health Services Research and Development: Evidence Synthesis Program, March 2011

How do non-pharmacologic treatments of behavioral symptoms compare in effectiveness with each other, with pharmacologic approaches, and with no treatment?
Limited Evidence Does Support

- Animal-assisted (pet) therapy
- Behavior management techniques
- Exercise
- Massage and touch therapy
- Music therapy

A Synthesis of the Evidence: Non-pharmacological Interventions for Behavioral Symptoms of Dementia (VA HSR&D Management e-Brief)
Insufficient Evidence to Support

- Acupuncture
- Aromatherapy
- Light Therapy
- Reminiscence Therapy
- Trans-cutaneous electrical nerve stimulation
- Validation therapy

A Synthesis of the Evidence: Non-pharmacological Interventions for Behavioral Symptoms of Dementia (VA HSR&D Management e-Brief)
Behavioral Management Techniques

- Multiple systematic reviews positive
  - Nine high quality RCTs (VA HSR&D review)
    - Varied program descriptions and interventions
    - Caregiver training
    - Exercise
    - Pleasant experiences

- Methodologic issues:
  - Non-blinded, multiple outcome variable, etc.
  - Very difficult studies to design and perform

- Results
  - Inconsistent positive impact on behavioral problems
  - Multi-modality interventions may be most effective
Many programs have demonstrated significantly better outcomes with varied inter-disciplinary interventions; scientifically not clear which elements are most predictive of success.

Interdisciplinary approaches are required by CMS, AMDA and other best-practice guidelines and are common sense.

My personal experience is consistent with expert opinion and existing data; my experience would emphasize the value of creating a home-like environment and meaningful relationships.
Kindred Medical Hill
Neurobehavioral Program

- 55+ bed unit started 1993
- Initial patients largely from Napa State Hospital
- Vast majority of patients have Mental Health Conservatorship (>50% diagnosis = dementia; most also have defined major mental illness)
- 19 different California counties
- All patients unmanageable and/or not able to be placed for long periods prior to referral
- 80+% success rate
Steps to Effective Management of Dementia in Long Term Care

- Mission/culture and team
- Structured interdisciplinary processes
- Clinical Algorithms
Step One
Developing a Mission &
Building the Team
Building the Team and Mission

“Since feeling is first
who really cares about
the syntax of things?”
E. E. Cummings

The heart of the process
is a patient-centered
culture with individuals
who care about
individuals
Building a Culture of Caring

- Every person on a neurobehavioral unit should understand they are a part of a special program (or PI initiative) that provides improved, compassionate care to challenging patients.
Culture: Program Elements to Build Optimal Culture

- Mission Statement
- Hiring practices
- Training/Education
- Modeling(Champions!)
- Staff mix
- Consistent assignment
- Positive reinforcement
- Communication
- Facility as training site (Idealistic students!)
- Retreats
- Fun !
Best Practices: Defining the Team

- On-site program Champion/Manager essential
  - Nurse manager has been most effective to communicate with nursing and CNA
- Medical Director/Physician involvement essential
- Mental health professional involvement essential
- Other disciplines also very important
  - All rehab staff valuable
  - Dietary, pharmacy, recreation staff all critical.
  - Housekeeping etc. also must be involved
  - Administrative staff & leaders needed
Patient Centered NBU: Interdisciplinary Team

- Cognitive behavioral approaches
- Conservator/Family
- Neuro-psychology
- Cultural Practices
- Recreation
- Pharmacological treatment
- Rehabilitation (Rehab)
- Nursing
- Social Services
- Psychiatry
- Administration
- Dietary
- Environmental
- Social/functional skills training
- Pharmacological treatment
- Cognitive behavioral approaches
- Conservator/Family
- Neuro-psychology
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- Recreation
- Pharmacological treatment
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- Social Services
- Psychiatry
- Administration
- Dietary
- Environmental
- Social/functional skills training
Kindred Medical Hill Team

- **Psychologist**
  - 2 dedicated behavioral medicine psychologists
  - 24 hour call coverage
  - 30 hours weekly on-site presence
  - 5-6 graduate psychology students each on-site 15 hours weekly
  - Psychologists attend weekly meetings and dedicate substantial time to staff orientation and teaching

- **Social Work**
  - Experienced MSW with psychiatric experience
Kindred Medical Hill Team

- Closed panel two geriatricians and nurse practitioner
  - Interest in neurobehavioral care
  - Provide medical care and call
  - Attend weekly neurobehavioral meetings

- Psychiatrist
  - Interest in neurobehavioral care
  - Attends weekly meetings
  - 24/7 hour call
Step Two
Structured Interdisciplinary Processes
Structured Interdisciplinary Processes

- Structured-- Planned, organized with defined inputs
- Interdisciplinary vs. multi-disciplinary, each member takes ownership of the whole and shares full range of experience in care planning (not just their discipline)
- Processes -- defined inputs and outputs
Definition

- **multidisciplinary adj.** Of, relating to, or making use of several disciplines at once: *a multidisciplinary approach to teaching.*
  
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- **interdisciplinary adj:** drawing from or characterized by participation of two or more fields of study; "interdisciplinary studies"; "an interdisciplinary conference"
  
  *Source:* WordNet® 1.6, © 1997 Princeton University
Systems for Behavioral Care Management

- Must be able to communicate to all staff on all shifts
- 24/7 availability of staff aware of complex neurobehavioral issues and able to provide support and make new orders
  - Psychologist/Psychiatrist/PCP
  - Nursing program director
- Weekly team meetings highly advised
  - Pre-meeting preparation by key personnel can make this meeting exciting and rewarding
Structured Interdisciplinary Processes

- Weekly staff care planning meetings
- IDT meetings precede quarterly review
- Psychology meeting with students
- Staff retreats
- Staff training programs
- Systematic meetings of management staff with front-line personnel on all shifts
- 24/7 on-call physicians and others engaged in behavioral program
Structured Interdisciplinary Processes

- Weekly Team Meetings
  - Checklists on forms facilitate reproducible review of behavior
  - All staff except front line nursing and rehab
  - Structured pre meeting data gathering
  - Quarterly behavioral care plan reviews
  - All new patients reviewed three times
  - All unstable patients and follow-ups from previously unstable patients
  - Patient, staff interviews and bedside visits prn
Meeting Preparation

- **Pre-work/homework**
  - Review detailed care plan
  - Social/roommate other changes
  - Detailed information from MAR especially quantitative measurements of behaviors
  - Observations of frontline staff (if they cannot attend the meeting)
  - Pre-meeting detailed IDT

- **Post-meeting follow-up**
  - Clearly defined person
    - Responsible to write-up details of care plan changes
    - Ensure staff are aware of changes
      - 24 hour report & staff training
  - Conduct separate meetings
    - Details of fall prevention or behavioral planning interventions
    - Do not try to do full care plan review with all staff present
      - Time consuming
      - May miss details
Step Three:
The Clinical

ABCDDEs
ABCDEs of Neurobehavioral Care

- **A**ntecedents
- **B**ehaviors
- **C**onsequences
- **D**ocumentation
- **E**motion
- **S**ystematic

Adapted from Teri, L. (1997) who developed initial A,B,C components of algorithm
### Antecedents
- Diagnoses (Detailed understanding is valuable)
- Fatigue, hunger, pain
- Levels of stimulation
- Restraint
- Staff or resident approaches
- Gender & Cultural Issues
- Lack of exercise

### Behaviors
- Crying
- Yelling
- Biting
- Hitting
- Grabbing
- Fecal play
- Time of day
- Exact setting and details as possible

### Consequences
- Attention
- Isolation
- Abuse
- Injury
- Medication response
- Other positive reinforcement
<table>
<thead>
<tr>
<th><strong>Antecedents</strong></th>
<th><strong>Behaviors</strong></th>
<th><strong>Consequences</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Patient Evaluation: Type of dementia and all additional diagnostic factors</td>
<td>Redirect</td>
<td>Care plan revision</td>
</tr>
<tr>
<td>Triggers</td>
<td>Reframe</td>
<td>Behavioral contract</td>
</tr>
<tr>
<td>Environmental Factors</td>
<td>Respond to emotion</td>
<td>Rewards</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Give choices</td>
<td>Reinforce + behaviors</td>
</tr>
<tr>
<td>Activity/exercise etc.</td>
<td>Model</td>
<td>Agree to disagree</td>
</tr>
<tr>
<td>Patient Warning Signs</td>
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</table>
# Examples of Diagnostic Screening Tools

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Screening Tool</th>
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</thead>
<tbody>
<tr>
<td>Cognition</td>
<td>MMSE, SLUMS</td>
</tr>
<tr>
<td>Pain 5^{th} vital sign</td>
<td>Johns Hopkins Pain Rating Instrument/Pain AD scale</td>
</tr>
<tr>
<td>Delirium</td>
<td>Confusion Assessment Method</td>
</tr>
<tr>
<td>Dementia</td>
<td>Mattis Dementia Rating Scale/FAST scale</td>
</tr>
<tr>
<td>Depression</td>
<td>Geriatric Depression Scale, Cornell Scale for Depression in Dementia, Hamilton Rating Scale for Depression</td>
</tr>
<tr>
<td>Suicide</td>
<td>Suicide Ideation Scale</td>
</tr>
</tbody>
</table>
Common Reasons for Difficult Behaviors

- Environment
- Medical
- Personality/Behavior History
- Iatrogenic
- Psychosis/Misperception
- Other Discomfort
- Mood Instability
- Peer Interactions
- Social/Caregiver
- Sleep
- Cognitive/Other impacts of disease
- Pain
- Problems Behaviors
### Examples of Environmental Factors

- Television function/malfunction
- Music
- Touch / Massage
- Family visits, calls, or not
- New roommates
- Death on unit
- Showers and care experiences

- Incorrect meal temperature
- Late meals
- Overhead pages and ambient noise
- Staff turnover
- New rules
- Is this my home?
- Other
B = Behaviors: Systematic Management

- Quantitative Monitoring
- Accurate Definition
- Interdisciplinary Assessment
- Causal Dx(s)
- Systemic Follow up
- Focus on Patient Centered Goals
C = Consequences

- Programmatic
- Behavioral
- Pharmacologic
Cognition and Consequences

- As cognition diminishes antecedent control becomes more important.
- Residents with severe dementia can demonstrate remarkable learning in some situations.
- Patients with psychiatric problems will need clear boundaries and consistent feedback.
Considerations for “Consequences” (or “Care-planning”)

- Cycles of activity and rest are often critical to optimizing behavior
- Consistency and routine are powerful

Mittelberger’s Three Ps
- Keep things **Pleasant**
- Monitor and treat **Pain**
- Engage residents as a **Person**
Efficient Documentation is Key to Survival in Skilled Nursing Facilities

Meeting Templates Should Include Consideration of Range of Non-Pharmacologic Interventions

Recognize Risks: Document Goals of Care: e.g. “highest practicable level of function and quality of life at lowest effective levels of medication”
E= Emotion: Personhood: Key to Effective Behavioral Care Planning

The Poet

Ms. K
The Forgotten

The Scholar

The Caring SNF Community

Marielitos (Afraid sent back to Cuba)

The Singer

Love and Work
Diagnosis Precedes Treatment

Not all dementia is Alzheimer’s Disease

- Traumatic brain injury
- Huntington’s Chorea
- Vascular dementia
- Fronto-temporal dementia
- Lewy-body dementia

- Comprehensive patient history is critical to understanding behavior
Diagnosis Precedes Treatment

A comprehensive history and physical is critical to effective dementia care plan

- Etiology of dementia
- Personality and prior behavior history
- Concomitant mental illness
- Pain and sources of discomfort (PainAD scale)
- Goals of care/Values/Intensity of Treatment
“Post Hoc – Ergo Hoc” and N of 1 Trials

Use AMDA criteria for Urinary Tract Infection Treatment Decisions

- UTI not likely to cause delirium without evidence of significant inflammation (fever, elevated WBC, significant change in pyuria)
- Regression to the mean and chance may create “post-hoc-ergo hoc” (Type 1) errors.
- Carefully assess all burdensome interventions
Clinical Pearls/Algorithms: Delirium

Delirium

- One of most important and often missed syndromes, often an early marker
- Use Confusion Assessment Method
  - Acute onset/Fluctuating Course
  - Inattention
  - Disorganized thinking or altered level of consciousness
- Actively engage staff in looking for any significant deviation in function

Review

- Build the team and culture
- Define and implement processes (A,B,C,D,E)
- Maintain a passionate resident centered focus
Resources

  www.hsrд.research.va.gov/publications/esp/dementia_nonpharm.cf