Behavioral Recovery Outreach (BRO) Team: A New Paradigm for Dementia Care

JAMIE STARKS, MD, LEAH GAUSE, PSYD, LP, KAYLEE SMITH, LICSW, LEAH SHARKEY, OTR/L, OTD, MARY DUNN, RN, WCC

MAGIC CONFERENCE

NOVEMBER 9, 2018

Disclosures

We have no financial conflicts to disclose

We will briefly discuss off-label use of medications (e.g., antipsychotics)

Objectives

1) Understand the mission, vision, and role of the Behavioral Recovery Outreach Team within the Minneapolis VA Healthcare System

2) Describe various behavioral management strategies and interventions for management of distressed behaviors in dementia

3) Identify initial outcomes of the Minneapolis VA Behavioral Recovery Outreach team and goals for the future

Outline

Case Introduction
What is the BRO Team?
Background and History
Core Philosophies of Dementia Care
Team Member Roles & Case Conclusion
Preliminary Outcomes
Future Directions

Case Study

Case Study: Mr. X

76 y/o M presents from ALF with "aggressive and sexually inappropriate behavior"

Emergency department: "Is having increased behavior issues. Striking out at staff, inappropriately groping staff. They do not feel they can care for pt in their facility any more. Pt denies any problems and does not know why he is here."

- Limited history
  - New to VA system
  - No known family or collateral information

Case Study: Mr. X

What we do know (per ALF records):

- Diagnosis: "Dementia NOS"
- Prior history of similar behavioral symptoms
  - 2 recent ED visits
  - Recent geriatric psychiatry admission
- Behavioral Medications:
  - Divalproex sprinkles 500 mg TID
  - Risperidone 0.5 mg BID + Q4H PRN agitation
  - Trazodone 100 mg qhs + 50 mg qhs PRN insomnia
  - Gabapentin 100 mg QID + 50 mg Q4H PRN agitation
  - Duloxetine 60 mg daily
- Social Issues:
  - Professional Guardian
  - No payer source

VA Hospital Course

Admitted to medicine service

- No inpatient psych beds available
- ALF will not take patient back

VA Hospital Course

Hospitalized for 1 month

Increasing behavioral issues throughout admission

- Verbal and physical aggression
  - Multiple staff injuries
  - Threat to other patients
- Police called multiple times
- Transfer to inpatient psych requested again
  - Denied again

Multiple medication changes:

- New: Olanzapine 5 mg BID + 5 mg Q6H prn agitation, escitalopram 10 mg daily
- Continued: Divalproex sprinkles, PRN gabapentin
- Discontinued: Risperidone, trazodone, duloxetine, scheduled gabapentin

Case Summary

Patient with "Dementia NOS", dangerous behaviors, and complex social situation

→ Difficult to place (and keep) in a long-term care setting

Sound familiar?

Who wants this patient on their team??

Behavioral Recovery Outreach (BRO) Team

Who is the BRO Team?

Provider
- Dr. Jamie Starks

Social Worker/Program Manager
- Kaylee Smith

Registered Nurse
- Mary Dunn

Occupational Therapist
- Leah Sharkey

Psychologist
- Dr. Leah Gause

Others Involved
- Minneapolis VA Community Living Center (CLC) staff including nursing, pharmacy, recreational therapy, physical therapy

What is the BRO Team?

An interdisciplinary team whose mission is to serve veterans with distressed behaviors (i.e., behavioral disturbances) associated with neurocognitive disorders (i.e., dementia)

Program designed to implement behavior modification treatment plans, stabilize distressed behaviors, and provide ongoing behavioral stabilization/consultation as veterans transition to long-term community placements

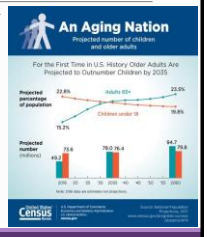
Why Does the BRO Team Exist?

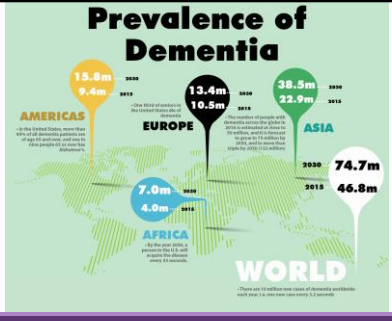
Initially formed at the Des Moines, IA VA Medical Center
- Served veterans with dementia and veterans with serious mental illness
- Primary focus later shifted to dementia care

Recognition of increase in aging population
- Rise in incidence of dementia with distressed behaviors
- Increasingly strict long term care regulations

Rolled out within the VA midwestern region (VISN 23)

In the process of being rolled out nationally





Why is the BRO Team Important?

Unique group of patients who, in the traditional health care system:

- Bounce around from hospital to community placement (and back again)
- Cost the health care system millions of $
- Are, by definition, challenging to work with

Innovative program designed to stabilize distressed behaviors while inpatient in the Community Living Center (CLC) at the VA Medical Center, as well as when discharging to the community, and in maintaining successful placement

What's Different About the BRO Team?

Provide regular in-person community follow-up and additional consultation as needed

Primary goals:

- Reduce distressed behaviors
- Prevent behavioral rehospitalizations

Additional goals:

- Decrease health care costs
- Improve stakeholder satisfaction (patient, family, caregiver, staff, community facility)
- Reduce patient and staff injury
- Reduce inappropriate use of psychotropic medications (i.e., antipsychotics)

BRO Team Philosophies of Care: People, not "Problems"

Individualized care is essential

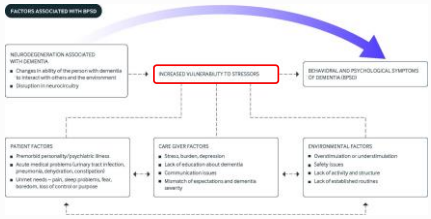
- Patient-centered
- More successful

Compassion fatigue

"Agitation" does not occur spontaneously

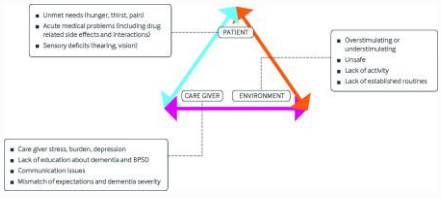
- Signifies underlying distress
- Our job is to figure out what that is …

BRO Team Philosophies of Care: Progressively Lowered Stress Threshold



Kales HC, Gitlin LN, Lyketsos CG. BMJ 2015.

BRO Team Philosophies of Care: Unmet Needs



Kales HC, Gitlin LN, Lyketsos CG. BMJ 2015.

BRO Team Philosophies of Care: Change OUR Behaviors Not Theirs

Capacity for learning is limited in dementia patients

Role of caregiver education and training
- Creating realistic expectations
- Meeting patients where they are at
- Modifying our approaches to patients

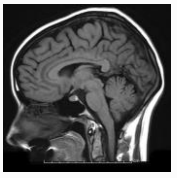
Easier to adapt our behavior than to expect learning of behavioral change from patients with cognitive impairment

BRO Team Roles & Case Conclusion

Provider

Team Role:

- Establish/verify dementia diagnosis
  - Identify cognitive deficits & strengths
- Identify contributing medical issues
  - Uncontrolled pain
  - Poor vision or hearing
- Identify psychiatric comorbidities
- Pharmacologic management of behavioral symptoms
- Family/caregiver education about diagnosis
- Palliative care



Principles of Pharmacologic Management

Non-pharmacologic strategies are always first-line

- At least as effective as medications (Brodaty 2012)
- Behavioral medications have significant risks/adverse effects

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

See full prescribing information for complete boxed warning.

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. RISPERDAL® is not approved for use in patients with dementia-related psychosis. (5.1)

Brodaty H, Arasaratnam C. Am J Psychiatry 2012

Principles of Pharmacologic Management

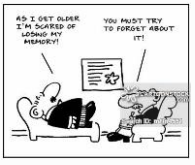
When medications *are* needed
- Use only for palliation of psychological distress
  - Concept of "total pain"
- Target specific symptoms and/or psychiatric comorbidities
- Trial & error is often necessary
  - Literature on specific pharm interventions in this population is very limited
- Avoid long-term use of antipsychotics as able
  - Again, block box warnings, increased mortality rates, suboptimal side effect profiles
  - But also: long-term care regulations!
- When antipsychotics are needed
  - Risperidone has best evidence for efficacy
  - If discharging to nursing home, trial taper (and document clearly if it fails)
- Open & honest communication with family/caregivers

Our Patient

- Diagnosis:
  - Extensive work up considered during medicine admit due to unclear history
    - Neurology recommendations included:
      - Large-volume LP (NPH?)
      - Paraneoplastic panel
  - Outside records tracked down
    - Diagnosed with Alzheimer's disease in 2013
- Cognitive symptoms defined:
  - Severe anterograde amnesia
  - Extremely confabulatory
  - Impulsive and disinhibited
- No additional medical factors identified
  - Possible underlying depression
- Medication management:
  - Olanzapine and divalproex tapered
    - Encephalopathic on admission
    - No clear indication for ongoing use
  - Escitalopram continued

Psychologist

Team Role:
- Dementia-related behavioral management education to VA and community staff
- Family/caregiver support and education
- Creation and implementation of behavior and transition plans
- Administration and interpretation of psychological assessments



Core Principles of Behavioral Management

ABCs
- **A – Activator**
  - Medical (e.g., pain, constipation)
  - Psychological (e.g., anxiety, depression)
  - Interpersonal (e.g., staff approach, repeated demands)
  - Environmental (e.g., too much light/noise, too many staff, lack of activity/boredom)
- **B – Behavior**
- **C - Consequence**

Modifying Expectations
- Understanding distressed behaviors as communicating **unmet or underlying need**
- Adjust our expectations to fit the patient's abilities

Core Principles of Behavioral Management

Communication
- Verbal vs. non-verbal
- Can be the **activator** to a distressed behavior – can be **prevented**
- Good communication in **response** to a distressed behavior can reduce severity and frequency

Creativity
- "Thinking outside the box"
  - Can be in direct contrast to our training
- Interventions often incorporate our approach:
  - Redirection, rather than opposition
  - Therapeutic fibs
  - Validation, reassurance, reorientation

Our Patient

Behavior Planning
- Identifying target behaviors:
  - Sexually inappropriate comments/gestures
  - Physical and verbal aggression
  - Refusal of cares
  - Impulsivity
- Identifying potential activators:
  - Interpersonal approach (standing too close, approaching from side)
  - Tone of voice
    - Friendly = interpreted as flirtatious
    - Stern = interpreted as confrontational
  - Overstimulation
  - Confusion/disorientation
  - Boredom
- Modifying activators:
  - Approach from side
  - Define professional relationship
  - Minimize stimulation (e.g., lights, noise, staff)
  - Simplify communication, reduce expectations
  - Provide enjoyable activities
- Modifying responses:
  - Avoid rationalization/corrective statements
  - Positive reinforcement for good behavior (rather than punishment)
  - Redirection (e.g., handshake rather than hug, other conversation)
  - Incorporate robotic dog ("Sarge")
  - Utilize confabulations for redirection & completion of cares

Occupational Therapist

Team Role:

- Creation and leadership of dementia-related programming
- Assessment and development of ADL strategies
  - Adaptive equipment
- Environmental assessment and recommendations
- Education and training for staff about ADL strategies and environmental interventions

Our Patient

ADL Tasks

- Mechanical Lifts as relevant objects (aircraft)
- Using robotic dog for motivation
- Adding equipment for safety: auto-lock wheelchair brakes

Meaningful Tasks

- Matching tasks to cognitive level and strengths
- Required frequent reorientation to task
- Did well with repetitive tasks like sorting
- Enjoyed talking and visiting with others but needed assistance for social cues.
- Co-treat with physical therapy to assist with applying recommendations. Vet only used ergometer when he thought it made the music play.

Social Worker

Team Role:

- Expertise about dementia-related legal issues and resources
  - Guardianship, conservatorship, power of attorney, fiduciary

  Intimate knowledge about local community care settings
  - Determination of appropriate setting for each individual (Assisted Livings, Residential Group Homes, Nursing Homes, etc.)
- Coordination of discharge plans
- Outreach and relationship building with community partners
- Family/caregiver education about VA benefits/resources and county resources
  - Contract nursing home program, respite care, Adult Day Health Centers, Medical Assistance, Elderly Waiver, Metro Mobility, etc.

Our Patient

- Lack of payer source:
  - Needed to apply for Medical Assistance to pay for community care setting
  - Collaborated with guardian to apply veteran for Medical Assistance
- Discharge planning:
  - Determined appropriate care setting/environment for veteran
  - Outreach to facilities with environments and staffing that would best suit veteran's needs
- Collaboration with community facility:
  - Provided education to facility staff on BRO Team
  - Provided education on veteran's behaviors and behavior plan
  - Invited nursing home staff to complete onsite visit

Nurse

Team Role:

- Nurse champion of recommended behavioral interventions
- Consult triage
- Staff training and education
- Create weekly behavior summaries based off of chart review and document all team members behavioral interventions
- Warm hand-offs to community facilities on day of discharge
  - Meet with DON, nurse managers, recreational therapy, and any available nursing staff
- Resource and liaison to community partners

Our Patient

- Pleasurable events & preferences:
  - Rock & roll music, dancing
  - Airplane mechanic
  - Basketball, baseball
- Ongoing staff behavior plan education:
  - Play into confabulations, use therapeutic fibs
  - Redirect rather than oppose
  - Utilization behaviors
  - Communication techniques
  - Non-verbal signs of agitation
- On-site assessment by facility staff
- Transition to facility:
  - Behavior plan and discharge summary discussed with DON and dementia educator
  - Follow-up site visits:
    - Doing well behaviorally
    - Frequent falls → environmental and behavioral strategies recommended to staff

Case Summary: Successes

No major behavioral incidents throughout stay
- Inappropriate sexual comments and occasional inappropriate touching continued but redirectable

Antipsychotic and sedating meds successfully tapered off

Accepted by community nursing home
- Admission considered by NH because of BRO Team's involvement

VA staff sad to see him go!

Remains in community setting today! (9 months later!)
- No readmissions
- Thriving
  - Facility greeter
  - Female companion
  - NH staff really enjoys having him there

Preliminary Outcomes and Future Directions

Preliminary Outcomes

ADMISSIONS & DISCHARGES

Total Episodes of Care: 29

Total Residents Served: 26

Total Discharges: 23

Total Behavioral Readmissions: 2 (both prior to implementation of day programming)

Other readmissions: 1 (psychosocial concerns)

Average Length of Stay: 64.8 days

DISCHARGE DESTINATIONS

Assisted Living Facility: 5

Nursing Home: 7

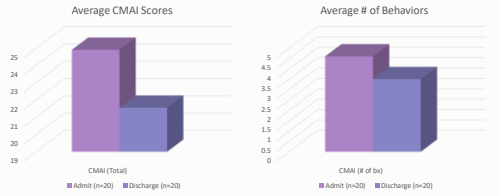
VA-Contract Nursing Home: 7

Group Home: 1

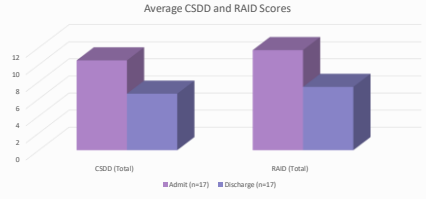
Silver Bay Veteran's Home: 1

Deceased: 2

Preliminary Outcomes



Preliminary Outcomes



Preliminary Outcomes

"Thank you so much for all of the great care you are giving my dad. Being on your unit and under your care has been the best thing to happen to him since we started this journey with his dementia. There are not enough words to express how much I truly appreciate all you have done."

Future Directions

Construction of secured memory care unit within the Minneapolis VA Medical Center

Roll out of BRO Team Program nationally
- 2.5 day training occurred September 2018
- Inaugural partners: Tuscaloosa VA, Hampton VA, North Florida/South Georgia (Lake City) VA, Houston VA

Additional community partnerships, education, outreach, and consultation

Additional analysis of health care cost savings and other stakeholder satisfaction outcomes

Questions?

References

Alzheimer's Association, (2018a). *Alzheimer's myths.* Retrieved from: https://www.alz.org/alzheimers_disease_myths_about_alzheimers.asp

Alzheimer's Association, (2018b). *What is Alzheimers? Retrieved from:* https://www.alz.org/alzheimers_disease_what_is_alzheimers.asp#brain

Alzheimer's Association, (2018c). *Korsakoff syndrome.* Retrieved from: https://www.alz.org/dementia/wernicke-korsakoff-syndrome-symptoms.asp

Brodaty, H. & Arasaratnam, C. (2012). Neuropsychiatric symptoms of dementia. *American Journal of Psychiatry, 169(9), 946-953.*

Brodaty, H. & Arasaratnam, C. (2013). Meta-analysis of nonpharmacological interventions for neuropsychiatric symptoms of dementia. *American Journal of Psychiatry, 170(2), 227.*

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013). American Psychiatric Association: Washington, DC.

References

Gitlin, L. N. & Piersol, C. V. (2014). *A Caregiver's Guide to Dementia: Using Activities and Other Strategies to Prevent, Reduce, and Manage Behavioral Symptoms.* Camino Books, Inc.: Philadelphia, PA.

Karlin, B. E., Teri, L., McGee, J. S., Sutherland, E. S., Asghar-Ali, A., Crocker, S. M., Smith, T. L., Curyto, K., Drexler, M., & Karel, M. J. (2017). *STAR-VA Intervention for Managing Challenging Behaviors in VA Community Living Center Residents with Dementia: Manual for STAR-VA Behavioral Coordinators and Nurse Champions.* Washington DC: U.S. Department of Veterans Affairs.

Leblanc, G. J. (2013). Managing Alzheimer's and Dementia Behaviors: Common Sense Caregiving. Outskirts Press, Inc.: Parker, CO.

Lewy Body Dementia Association, Inc. (2016). *What is Lewy body dementia?* Retrieved from: https://www.lbda.org/category/3437/what-is-lbd.htm

References

National Institute on Aging, (2017a). *Types of frontotemporal disorders.* Retrieved from: https://www.nia.nih.gov/health/types-frontotemporal-disorders

National Institute on Aging, (2017b). *What is vascular dementia?* Retrieved from: https://www.nia.nih.gov/health/what-vascular-dementia

Nelson, A. L. & Algase, D. L. (eds.) (2007). *Evidence-Based Protocols for Managing Wandering Behaviors.* Springer Publishing Company: New York, NY.

Treloar, A., Crugel, M., Prasanna, A., Solomons, L., Fox, C., Paton, C. & Katona, C. (2010). Ethical dilemmas: should antipsychotics ever be prescribed for people with dementia? The *British Journal of Psychiatry, 197(2),88-90.*

Weinder, M. F. & Lipton, A. M. (2009). *Textbook of Alzheimer's Disease and Other Dementias.* American Psychiatric Publishing, Inc.: Arlington, VA.