STATEWIDE CLINICAL OUTREACH PROGRAM FOR
THE ELDERLY (S-COPE):
A SYSTEM OF CARE FOR MANAGING
BEHAVIORAL DISTURBANCES IN DEMENTIA

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Objectives

- Describe the clinical services offered by NJ-based Statewide Clinical Outreach Program for the Elderly (S-COPE)
- Understand the unique challenges to NFs in caring for residents with behavior and psychological symptoms of dementia (BPSD)
- Provide rationale for use of nonpharmacological interventions as the first course of treatment in behavioral symptoms of dementia in non-emergent situations
- Describe nonpharmacological interventions for management of behavioral disturbances
A conservative estimate by NJ Department of Health (2005) identified that 60% of nursing home residents have Alzheimer’s disease.

Of 371 long-term care facilities in NJ, 24 self-identified as providing dementia-specific services.

Approximately 70% of crisis referrals to S-COPE in 2015 were for residents with dementia who manifested BPSD.

CONCLUSION:
Most individuals with dementia are placed in facilities that lack specialized staffing, training or resources to adequately meet the needs of residents who manifest BPSD.

DMHAS funded statewide response to older adults in LTC in crisis

Two teams (northern and southern) cover the state responding to calls through a toll free number

Multi-disciplinary clinical team consisting of psychologist, APN, social workers, professional counselors

Subcontracts with NJISA for 9 hours a week of geropsychiatric consultation
Mission

- Identify level of support needed for older adults (55+) who reside in nursing facilities and are referred to crisis services residents
- Avert unnecessary ER and hospital presentations
- Reduce recidivism to hospitalization
- Equip staff so that residents are able to age in place by providing dementia-capable skills training
Partnership with NJISA

- NJISA geropsychiatrist participates in weekly telephonic rounds
- NJISA geropsychiatrist participates in weekly virtual rounds utilizing multi-point videoconferencing through Extension for Community Healthcare Outcomes (ECHO) [www.echo.unm](http://www.echo.unm)
- NJISA geropsychiatrist provides weekly supervision of APN
- Consultation hours for clinicians through team
S-COPE Menu of Clinical Services

- Crisis assessment and response to nursing facilities and screening centers
- Comprehensive case review via telephonic and virtual rounds
- Provision of short-term counseling with a focus on coping skills enhancement offered to residents by clinicians and student clinicians
- Consultation to develop facility specific behavior response teams (BRTs)
- On-site mentoring, coaching and consultation
- In-service training, regional trainings, annual conference
Referrals

- Come through centralized toll free number from nursing facilities, screening centers, DMHAS, hospitals with STCFs and voluntary admissions
- Responded to with face-to-face assessment and follow-up clinical and phone consultations
- Mission to determine best level of behavioral health support
  - Advocating for admission for those needing hospitalization
  - Averting from hospitalization if behaviors can be managed in place
Crisis Response

- S-COPE operates 24/7 response to NF and screening center referrals
- Face-to-face response to identify level of support needs
- Consultation offered to nursing facilities regarding the need for presentation to the ER
- Consultation to screening centers regarding the need for hospitalization
- Consultation to Centralized Admissions regarding the need for longer term hospitalization in a state hospital
Screenings to identify if cognitive impairment, mood disturbance or delirium are contributing to behavioral presentation:

- Montreal Cognitive Assessment (MOCA)
- Mini-Cog
- SLUMS
- Short Portable Mental Status Questionnaire
- Confusion Assessment Method (CAM)
- PHQ-9
- Geriatric Depression Scale
Behavioral and Psychological Symptoms of Dementia (BPSD)

A range of psychological reactions, psychiatric symptoms and behaviors resulting from the presence of dementia

Symptoms of BPSD

Psychosis

Depression

Anxiety

Agitation

Irritability
## Behavioral Symptoms of Dementia

<table>
<thead>
<tr>
<th>Physical</th>
<th>Verbal</th>
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<tbody>
<tr>
<td>Hitting</td>
<td>Screaming</td>
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<tr>
<td>Pushing</td>
<td>Cursing</td>
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<tr>
<td>Scratching</td>
<td>Temper Outburst</td>
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<tr>
<td>Kicking and Biting</td>
<td>Complaining or Whining</td>
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<tr>
<td>Throwing Things</td>
<td>Repetitive Sentences</td>
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<tr>
<td>Wandering / Pacing</td>
<td>Verbal Sexual Advances</td>
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<tr>
<td>General restlessness</td>
<td>Constant request for attention</td>
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<tr>
<td>Hoarding</td>
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<tr>
<td>Social Inappropriateness</td>
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<td>Physical Sexual Advances</td>
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</table>

Psychological Symptoms of Dementia

- Psychiatric symptoms can include anxiety, depression, hallucinations or delusions
- Hallucinations are perceptions without stimuli and are more commonly auditory or visual
- Delusions are fixed, false perceptions or beliefs with little if any basis in reality and are not the result of religious or cultural norms

What drives behavioral disturbance among residents with no history of mental health disorder?
Theoretical Frameworks

Environmental Vulnerability / Reduced Stress Threshold Model

- Dementia process results in a lowered stress threshold which causes a decreased ability to cope and manage stress as the disease progresses.

- Behavioral symptoms such as agitation, night wakening and combativeness emerge when internal or external stressors exceed their stress threshold.

Theoretical Frameworks

Behavioral/Learning Model

- Model assumes that a connection between antecedents, behavior and reinforcement have been learned
- A different learning experience is needed to change the relationship between the antecedents and the behavior
- Antecedent → Behavior → Consequence

Behavioral Response Team

- An integrated interdisciplinary approach to identifying individuals who manifest symptoms of BPSD and can benefit from reduction in medication and increase in non-pharmacological interventions
- Interdisciplinary team meets on a regular basis to assess the severity of behavioral problems
- Develop individualized behavioral interventions for residents and track effectiveness
- Modify interventions as needed
Behavioral and Psychological Symptoms

- Treatment is complex and may require several interventions as part of a comprehensive care plan
- The goal is reduction in frequency and intensity rather than elimination of the distressing behavior

Theoretical Frameworks

Unmet Needs Model

Some dementia patients may exhibit inappropriate behaviors as a result of their basic needs being overlooked. These behaviors might be misinterpreted by caregivers as acting-out behaviors:

- Fatigue due to poor sleep
- Vision loss or lack of proper eyeglasses
- Hearing loss or lack of working hearing aid
- Dehydration
- Need to urinate
- Hunger / Thirst
- Pain / Discomfort
- Loneliness / Boredom
Theoretical Frameworks

Unmet Needs Model

- Behavioral disturbances occur due to an inability of the individual to verbalize their needs
- Behaviors are seen as an attempt to communicate physical or emotional distress
- Behavior viewed in this way is seen as a symptom of unmet needs

Behaviors are Forms of Communication

- What is a person trying to communicate through their behavior?
- A person with dementia may be unable to communicate well and must find other methods to get their needs met
- Usually their needs, thoughts and feelings are expressed through their behavior
- Making sense of behavior is critical to meeting the person’s needs

Know the Person: The Key to Understanding Behaviors

- Understanding the person behind the illness makes recognizing their particular presentation and their “problem behaviors” much easier to treat.

- Life story
- Cultural background
- Past habits & usual behavior
- Likes and Dislikes
- Preferred activities
- Remaining abilities
Whose Problem Is It?

- Is the behavior problematic for the resident?
- Is the behavior endangering, irritating, upsetting to other pts/residents/family members/visitors?
- Is the behavior problematic for the staff?
- Does the behavior upset staff or interfere with care?
  - Does it happen on all shifts?
  - With all staff?
  - Just one staff?
Nonpharmacological Approach to Management of Behavioral Disturbances
Nonpharmacological interventions should be the **FIRST** course of treatment in Behavioral and Psychiatric Symptoms of Dementia in non-emergent situations
Management of Behavioral Disturbances

- Assess for Danger to Self, Others or Property
- Treat Medical Conditions
- Treat Psychiatric Symptoms
- Encourage Medication Adherence
- Modify the Environment
- Create a Behavior Monitor Log
- Develop and Implement the Resident Centered Care Plan
- Encourage Activities
- Interdisciplinary Behavioral Team
- Provide Ongoing Training of Staff
Danger to Self, Others or Property

- Ensure that the resident is not in imminent danger to self, others or property
- Is the resident Suicidal or Homicidal?
- If the resident is a danger to self, others or property, the resident should be evaluated immediately by the local Screening / Crisis Center
Treat Medical Conditions

- Conduct a careful medical evaluation
- Assess for
  - Delirium
  - Comorbid medical illness
  - Pain
  - Drugs
  - Other factors that may be causing the behavioral disturbance

Treat them!
<table>
<thead>
<tr>
<th>Clinical Features of Delirium</th>
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<tbody>
<tr>
<td>- Acute onset</td>
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<td>- Fluctuating course</td>
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<td>- Inattention</td>
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<tr>
<td>- Disorganized thinking</td>
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<td>- Altered level of consciousness</td>
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<tr>
<td>- Cognitive deficits</td>
</tr>
<tr>
<td>- Perceptual disturbances</td>
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<tr>
<td>- Altered sleep wake cycle</td>
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<tr>
<td>- Emotional disturbances</td>
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***Delirium in an elderly person requires medical attention***
Delirium secondary to an underlying condition such as dehydration, urinary tract infection, pneumonia, medication toxicity or pain is a common cause of abrupt behavioral disturbances in patients with dementia.

A change in behavior (or sleep pattern in LTC) is often the first sign of onset of a health problem.

Hallucinations, particularly visual hallucinations, can be a symptom of delirium.
Confusion Assessment Method (CAM)

1. History of acute onset of change in patient’s normal mental status & fluctuating course
   AND
2. Lack of attention
   AND EITHER
3. Disorganized thinking
4. Altered Level of Consciousness:
   ➢ Alert, hyperalert, lethargic or drowsy, stupor, coma

*Sensitivity: 94-100%*
*Specificity: 90-95%*

Behavioral disorders in general, and verbal agitation in particular, have been shown to be associated with pain.

Large controlled study showed that use of analgesics significantly decreased behavioral disorders in persons with dementia.

Agitation was significantly reduced in the intervention group compared with control group after eight weeks.

Several tools are available to measure pain in older adults with dementia: Numeric Rating Scale (NRS), the Verbal Descriptor Scale (VDS) and Faces Pain Scale-Revised (FPS-R)

- Pain Assessment in Advanced Dementia Scale (PAINAD)
  - An observational tool to measure the presence of pain in non-verbal adults with dementia

- Breathing, negative vocalizations, facial expression, body language and consolability

S-COPE staff identify depression and other psychiatric illness

Facility staff are trained on implications of depression in the care of older residents

Clinicians work with residents to establish a positive routine including behavioral activation through activity participation and increased socialization
Screen for and treat:

- Mental Illness or specific psychiatric symptoms
  - Depression
  - Psychosis
  - Delusions
  - Hallucinations
- All of which respond better to pharmacological interventions

Depression

- Seen in up to 40% of Alzheimer’s patients
  - May precede onset of dementia
- Signs include sadness, loss of interest in usual activities, anxiety and irritability
- Suspect if patient stops eating or withdraws
- May cause acceleration of decline if untreated
- Recreational programs and activity therapies have shown positive results

Screening for Depression

- Depression is common among residents in NFs
- Treatment is often effective
- Some appropriate screening tools include:
  - Geriatric Depression Scale
  - Cornell Scale for Depression in Dementia
  - Patient Health Questionnaire (PHQ-9)
Modify the Environment

- Modify the environment to reduce stress, anxiety and frustration: decrease noise, crowding, task demands
- Decrease the institutional appearance of the nursing facility
- A wall mural over an exit door can decrease exit attempts
- One dining room

Calkins M. Evidence-based design for dementia. Long-Term Living. 2011;60:42–6.
Create a Behavior Monitor Log

- Identify patterns in behaviors and likely triggers
- Document all antecedents (triggers), target behaviors and consequences
- Analyze the data to identify any patterns of behaviors
- Success in management of behavioral disturbances depends on accurate identification of the cause
Behavior Monitor Log

Know your A-B-C’s

A = Antecedent (Trigger)
B = Behavior
C = Consequence

Antecedent (Trigger)

- “What occurred directly before the behavior?”
- Determine what factors are triggering the behavior. Who was there? What were the circumstances?
- If a behavior pattern has a specific trigger then a strategy can be developed to modify the behavior
- Remove the trigger or provide education or counseling to the patient to develop new behaviors in the presence of the trigger.
Understand Common Triggers

<table>
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<tr>
<th>Internal</th>
<th>External</th>
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<tr>
<td>Physical discomfort/pain</td>
<td>Chaotic environment</td>
</tr>
<tr>
<td>Toileting needs</td>
<td>Shift change</td>
</tr>
<tr>
<td>Hunger/Thirst</td>
<td>New or unfamiliar staff</td>
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<tr>
<td>Feeling tired or overwhelmed</td>
<td>Change in routine</td>
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<tr>
<td>Sensory deficits</td>
<td>Lack of stimulation – boredom</td>
</tr>
<tr>
<td>Emotions: fear, anxiety, anger, sadness</td>
<td>Demands to achieve beyond ability</td>
</tr>
<tr>
<td>Underlying medical conditions</td>
<td>Communication style used by staff, visitor, or other residents</td>
</tr>
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</table>
Develop and Implement the Resident Centered Care Plan

- Utilize the data obtained from the behavior monitor log to develop and implement interventions to modify the antecedent, target behavior and consequences
- Behavior modification using positive reinforcement of desirable behavior has been shown to be effective
- Focus on prevention strategies instead of intervention techniques to modify behaviors
US Department of Veterans Affairs conducted a systematic evidence review of non-pharmacological Interventions for behavioral symptoms of dementia:

- Pet Therapy
- Exercise
- Massage and Touch
- Music Therapy

Nonpharmacological Interventions

- Remove the Stimulus that Triggers the Behavior
- Relieve any Physical Discomfort and Attend to any Unmet Needs
- Provide Comfort Measures: Soft Blanket, Favorite Item, Food, Drink
- Provide Calm Reassurance and Unconditional Positive Regard
- Distract and Redirect Activities
- Move the patient to a tranquil, quiet setting
- Reduce environmental stress - too many people in area
- Eliminate misleading stimuli such as TV, radio, mirrors
- Maintain daily routine – simplify, adhere to preferences
Nonpharmacological Interventions

- Outdoor activities
- Provide calm or rest periods at the same time every day
- Avoid putting excessive demands on the resident
- Honor cultural, religious, ethnic values and traditions
- Identify and reduce anxiety provocoking situations
- Place individuals that need the most supervision closer to the nurses’ station
- Have a box of activities to give to individuals who are up and roaming during the night
- Set-up a rummage station
Nonpharmacological Interventions

- Set-up safe walking/wander routes for residents
- Consider having more disruptive individuals eat separately from others or bringing them in last to the dining area
- Provide some choices so that the resident has a sense of control of daily routine
- Provide opportunities for peer support and contact
- Multisensory Rooms (Snoezelen Room)
- Reality Orientation - environmental cues and memory aids such as clocks, calendars, door labels
Activities

- Plan activities in anticipation of addressing difficult times of the day for the resident such as change of shift, sundowning, psychomotor wandering during the night.
- Provide preferred activities that provide an opportunity for peer contact, mental stimulation, use of residual skills.
- Introduce activities involving repetitive motion (sorting clothing, folding towels, putting coins in container).
Snoezelen Room

- Provides sensory stimuli to stimulate the primary senses of sight, hearing, touch, taste and smell, through the use of lighting effects, tactile surfaces, meditative music and the smell of relaxing essential oils.

- Some evidence of effectiveness with depressed, aggressive and apathetic behaviors of people with dementia

S-COPE provides consultation to nursing facilities to develop their own Behavior Response Team.

- Individuals with dementia are identified for GDR.
- Non-pharmacological interventions are identified to replace medical management of agitation.
Centers for Medicare & Medicaid Services launched a national initiative targeting nursing facility (NF) residents to improve their behavioral health and reduce their use of antipsychotic medications.
Drug therapy for behavioral disorders aims to decrease behavioral disinhibition by changing the balance of neurotransmitters.

The most common class of drugs for behavioral disorders is antipsychotic medication which has severe side effects including increased mortality rates.


1. Don’t prescribe antipsychotic medications to patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring.

2. Don’t routinely prescribe two or more antipsychotic medications concurrently.

3. Don’t use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia.

4. Don’t routinely prescribe antipsychotic medications as a first-line intervention for insomnia in adults.

5. Don’t routinely prescribe an antipsychotic medication to treat behavioral and emotional symptoms of childhood mental disorders in the absence of approved or evidence supported indications.

Trainings

- Annual conferences 2012 – present
- In-service trainings 2015 – present
- On-site mentoring, coaching and guided practice
- Beginning 2016, weekly Extension for Community Healthcare Outcomes (ECHO) sessions involving interprofessional team (M.D., APN, Psychologist, Social worker) and partner facilities provide comprehensive case review
- Weekly full staff telephonic case review
Ongoing Training of Staff

- Ongoing education and training addresses increasing staff knowledge, increasing staff skills and addressing attitudes regarding care in order to improve the care and quality of life of NF residents

- Staff learn best from on-site mentoring and coaching rather than one-and-done workshops or in-services

- Education and training programs have been found to be effective in the reduction of BPSD in both nursing home environments and the community

QUESTIONS
Thank you!

If you have any questions or comments, please contact:

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