Mass General Brigham
McLean

An Interdisciplinary Behavioral Health Team in the ALF Environment

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ALCA 2023

HARVARD MEDICAL SCHOOL
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Introduction | Assisted Living Facilities (ALFs)

- **Utilization**
  - As of 2016, approximately 811,500 individuals in the US resided in ALFs across 28,900 facilities[3]
  - 78% of older adults preferred to reside in AL vs. 12% in a nursing home[4]
  - Median cost $4500/month
  - Expected to grow by 1M residents by 2040

- **Regulation**
  - ALFs are regulated by states and as a result vary widely in their approaches to:
    - *Standards*
    - *Procedures*
    - *Staffing*

- **Services**
  - 24-hour supervision and assistance, health/wellness programs, housekeeping/maintenance, meals/dining, medication management, transportation, and personal care services
  - Many also offer specialized units for individuals with dementia (memory care)[5]

Prevalence

Prevalence | Behavioral Health

- **Community Prevalence**
  - In adults over 50, mental illness, defined as mental, behavioral, or emotional disorders, is 14.1%[6]
  - In adults over 65, 11% have a diagnosis of dementia[7]

- **Non-Cognitive Psychiatric Disorders**
  - Upon entry to ALFs, 32.5% of residents have a diagnosis of depression, anxiety, or another psychiatric disorder[8]
  - Serious Mental Illness (SMI), defined as Bipolar Disorder and Schizophrenia are more commonly diagnosed in Assisted Living residents under 65 compared to older resident age groups[9]

- **Cognitive Disorders**
  - Studies indicate a range of dementia prevalence from 42% to 67.7% of ALF residents [10,11]
  - Significantly more ALF residents (33.9%) have dementia compared to their age-matched controls (8.4%)[12]

Outcomes

Outcomes | Emergency Department (ED) Visits

- **Frequency**
  - An average of 3.4 ED visits per 1,000 resident days were reported among 13,051 AL and nursing home residents[21]

- **Environmental Causes[22]**
  - Falls (64%)
  - Change in Condition (9%)
  - Upper Respiratory Infection (6%)

- **Behavioral Causes**
  - Medicare enrollment and claims data has demonstrated that 30.3% of ALF-residing beneficiaries (n=293,336) had an ED visit due to depression, AD, or related dementias from 2016 to 2017[23]
  - For 71 patients in two dementia specific ALFs, there were 207 ED visits over the course of 6 months[22]

Outcomes | Hospitalizations

- **Rates**
  - Over 3 years, 48.3% of residents had at least one hospitalization compared to 31.4% of community dwellers[12]
  - Residents with dementia have a 4-fold higher rate of hospitalization than long-term care residents with dementia[26]

- **Risk Factors**
  - Residents with any of the following are at an increased risk of hospitalization[26]
    - *Use of antipsychotics*
    - *Considered frail*
    - *Over 90*
    - *Poor Social Relationships*
    - *11+ Medications*
    - *2+ Hospitalizations in the last year*

Outcomes | ALF Discharge

- **Discharge Outcomes**
  - Long-Term Care & Nursing Homes
  - Home
  - Death

- **Nursing Homes**
  - Residents with the following are more likely to be discharged to a nursing home[8]:
    - Married
    - Older
    - Psychiatric Disorder
    - Greater number of prior hospitalizations

- **Behavioral Health**
  - Residents with depression at baselines are 1.5 times more likely to be discharged than non-depressed residents[25]
  - Dementia residents remain in ALFs on average, 209 days fewer than those without dementia

Model of Care (I)

- Geriatric psychiatrist (MD) and neuropsychologist (PsyD) team embedded into a local memory care facility
- Business/financial agreement between academic medical center (McLean Hospital) and an ALF company
- Geri psych team in place for patient care, education and support of families and staff
  - **Goals:**
    - **Decreased behavioral disturbance**
    - **Decreased hospitalizations**
    - **Decreased family distress/caregiver burden**
    - **Increased staff confidence in caring for BPSD of dementia**
- Co-management model with medicine

Model of Care (II)

- On the ground:
  - Weekly on-site visits to ALF
  - MD/neuropsychologist team sees patients together on site
  - Interdisciplinary team rounds:
    - Geri psych team
    - ALF staff – executive director, RN supervisors, SW
    - PCPs
  - Follow-up with families for collateral, clinical discussion, informed consent, treatment planning
- Available throughout week for other clinical issues/questions

Approach with patients

- Population: moderate-severe dementia, with behavioral disturbance
  - Background gathering/baseline
  - Determine specific diagnosis and features when possible ***
  - Allow adjustment to milieu
  - Nonpharmacologic interventions
  - Pharmacologic interventions

- Palliative psychiatry
  - Clarifying Goals of Care (GOC)
  - Treating in place / avoiding hospitalization
  - Working with hospice

Approach with staff

- Consultation/Liaison approach
  - Identifying/communicating about dynamics of a case
  - Encourage discussion of emotions
    - Validation
    - Support
  - Psychoeducation
  - Discussion of types of interventions and why
  - Incorporation of medical team
- Education of support staff on the ground

Approach with families

- Psychoeducation
  - Regarding dementia presentation, expectations, time course
    - Behavioral interventions
    - Medications
- Support
  - Validation of emotions
    - Grief, worry, etc.
- Coordination of interaction with staff

Behavior Management: Background and Rationale

- Agitation is associated with poorer quality of life, caregiver stress, increased hospitalizations[1]
- Behavioral Interventions are underutilized, often with greater emphasis on pharmacological treatments
- Helps improve communication between staff
  - Avoid/define unclear terminology: “agitation,” “behavioral disturbance,” “problem behaviors,” “disruptive behaviors”
- Helps target interventions
- Tracks progression of the underlying disease
- No “gold standard” for assessment, though many have tried….

Behavioral Assessment

- Cohen Mansfield Agitation Inventory (CMAI) [2]
  - Versus the Neuropsychiatric Inventory-Questionnaire (NPI-Q)[6] and Pittsburg Agitation Scale (PAS)[5]
- At the ALF:
  - Who completes this?
  - How often
  - Other logistics (e.g., in a separate binder? At nursing station?)
- Then what?

Methods:

- Staff nurses to complete this each shift
- Put a check mark for each behavior observed at each shift
- Space to indicate if NO behaviors were present

Ideally:

- Scales completed consistently
- Data to be used in weekly clinical rounds, compared against changes in medication regimen and behavioral interventions (e.g., Individual Behavior Plans)
- Collated into graphical format to showcase changes in behavior

Resident Name:	**DAY:**	M			T			W		
	SHIFT:	7a-3p	3p-11p	11p-7a	7a-3p	3p-11p	11p-7a	7a-3p	3p-11p	11p-7a
Check if NO BEHAVIORS were present during shift										
Cursing or verbal aggression										
Hitting (including self), kicking, pushing, biting, scratching, aggressive spitting (include at meals)										
Grabbing onto people, throwing things, tearing things or destroying property										
Other aggressive behaviors or self-abuse including: Intentional falling, making verbal or physical sexual advances, eating/drinking/ chewing inappropriate items, hurt self or other										
Pace, aimless wandering, trying to get out of the room, building										
General restlessness, performing repetitive movements, tapping, strange movements										
Inappropriate dress or taking off clothes										
Handling things inappropriately										
Constant request for attention or help										
Repetitive sentences, calls, questions or words										
Complaining, saying negative things, refusal to follow directions										
Strange noises, (weird laughter or crying)										
Hiding or hoarding things										
Screaming										

Staff Training

- Great variability in RCA staff background
  - Most hands-on staff
  - Intention to empower them, give them a voice, and give them additional skills to keep them and residents safe
  - Degree of experience with this population
  - Cultural background
    - Familiarity with English
    - Educational background
    - Ethnicity

Individual Behavior Plans

- Prompt decreases in agitation and increase in pleasure and interest [3]
- Created upon request by ALF staff, usually in the context of an uptick in agitated behavior.
- Based in part on Cohen-Mansfield's TREA (Treatment Routes for Exploring Agitation) Model [4]
  - Assessment of possible unmet needs and/or etiologies: infection, pain, over- /under-stimulation, isolation, fear, poor sleep, etc.
  - Incorporate personalized interests and remaining strengths.
- Feasibility of certain environmental factors is discussed with team (e.g., changing signage, décor choices).
- Strategies to improve staff approach is most common type of intervention.
- Over time, plans may need to be re-adjusted
- Repetition, repetition, repetition….

Treatment Outcomes

- Not measured but anecdotal
  - **Reduced hospitalizations/ED visits**
  - **Staff satisfaction**
  - **Family satisfaction**

Conclusions

- Our interdisciplinary McLean team provides:
- ALF staff with general education about dementia, behavioral/psychological symptoms
- Families with education, diagnostic information, clarity about treatment planning, additional support
- Tools to limit problematic behaviors that could affect the milieu
- Customized strategies/plans to support an individual's function and prevent hospitalization or discharge
- Medication management around behavioral/psychological issues

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Acknowledgements

Caroline Bader, MD- Associate Medical Director, Geriatric Psychiatry Outpatient Program, McLean Hospital

Elise Welton, PhD- Neuropsychologist, McLean Hospital

Brent Forester, MD- Former Chief of the Division of Geriatric Psychiatry, McLean Hospital

Catharyn Gildesgame, MBA-Senior VP of Strategy, McLean Hospital