Designing and Disseminating the Next Generation of Interventions for Persons with Dementia

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- Eric Jutkowitz and Rosa Baier, Brown faculty
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- NIA R33AG057451 embedded Pragmatic Trial of Music & Memory in ADRD NH population
Purpose

- Summarize Evidence on the Effectiveness of non-pharmacologic interventions to ameliorate disturbed behavior among persons with Advanced Dementia
- Identify gaps in readiness to broadly disseminate “evidence based” interventions
- Present a framework to evaluate the readiness of an intervention for dissemination in health systems
- Provide Examples of intervention readiness
- Consider Implications for disseminating “evidence based” interventions in the “real world” of functioning health systems
Summary of Evidence Synthesis

Care-Delivery Interventions to Manage Agitation and Aggression in Dementia Nursing Home and Assisted Living Residents: A Systematic Review and Meta-analysis

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# ADRD Interventions

<table>
<thead>
<tr>
<th>Target</th>
<th>Outcomes</th>
<th>Method of Delivery</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person with ADRD</td>
<td>Quality of life, behaviors, specific behaviors, function, physical activity</td>
<td>Directly to the person with ADRD</td>
<td>Physical exercise</td>
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<tr>
<td></td>
<td></td>
<td>Through the care staff</td>
<td>Dementia care mapping</td>
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<tr>
<td></td>
<td></td>
<td>Through family member</td>
<td>Case conferences /decision aids</td>
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<tr>
<td></td>
<td></td>
<td>Through the environment</td>
<td>Functional modifications</td>
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<tr>
<td></td>
<td></td>
<td>Through the care delivery system</td>
<td>De-prescribing interventions</td>
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Hartford Center for Gerontological Nursing Conference 2018
Challenges

- Interventions for person with ADRD, care staff, family caregivers
- Multiple outcomes and measures
- Criteria to determine what is ready to be tested (NIH stage model)
Challenges

- Settings poorly described
- Heterogeneous interventions hard to summarize with evidence-synthesis tools
- Inconsistent terminology
- Many One-off studies (little replication)
Methods

- Search of systematic reviews

- Find signals
  - What interventions
  - What outcomes
  - What results
Methods

- **Data sources**: Medline, Cochrane, hand searches
- **Population**: individuals with dementia in facilities (nursing home, assisted living, other)
- **Interventions**: nonpharm interventions
- **Outcomes**: any outcomes in a person with dementia
- **Comparators**: usual care or no treatment, attention control or placebo, other nonpharm interventions, pharmacologic interventions
Included Studies

Database Search
383 references

Excluded at title/abstract
306 references

Pulled for full-text review
77 references

Excluded at full text
35 references

Eligible systematic reviews
42 references
Implementation Challenges Described

- Complexity
- Scalability
- Long term fidelity/maintenance
- Cost
Example: Dementia Care Mapping (DCM)

- Staff or trained experts systematically observe a person with dementia. Feedback is then provided to care staff who use the information to develop person centered care plans.

- Expert training, labor intensive, costly

- Scalable?
Dementia Care Mapping (DCM): Researcher vs. Provider Implementation

- Chenoweth 2009
  - Staff training in DCM followed by care mapping sessions by researchers and trained staff
  - Researchers implementing DCM “participated in hundreds of hours of intervention procedures”
  - Care plans implemented by staff with researcher input

- Van de Ven 2013
  - Two care staff trained in DCM, all staff provided with high-level briefing on DCM, two DCM cycles performed

- Rokstad 2013
  - Staff trained in DCM, care mapping by researchers and staff at beginning of study and at 6 months.
  - Care plans implemented by staff without researcher input
Dementia Care Mapping Results

Figure 1. Random-effects meta-analysis for the effect of dementia care mapping on frequency of agitation and aggression. SMD = standardized mean difference; CI = confidence interval.
Translating Researchers’ Interventions into Health Systems Programs

- Researcher Directed interventions done in NHs but separate from ongoing care systems
- Even careful training and monitoring of staff implemented interventions not like “usual care”
- Integrating new programs into existing care processes requires human re-engineering
- To really test whether “evidence based interventions” can be implemented, need Embedded Pragmatic Clinical Trial
The Simpler the Intervention the Easier Conducting a Pragmatic Trial

- **Easy**: Substitute one vaccine for another (e.g. high dose influenza vs Standard dose)

- **Surprisingly Complicated**: PROVEN -- Video Assisted Advance Care Planning for ALL in NH

- **Multi-pronged**: Music & Memory

- **Multi-pronged Complexity**: INTERACT, DCM-Dementia Care Mapping, Staff Training
How Pragmatic? How Replicable?

- PRagmatic Explanatory Continuum Indictor Summary (PRECIS)
- Refers to BOTH trial design AND implementation design and flexibility in the organization of the intervention
- PROVEN: Researchers trained Corporate Staff who trained facility staff and monitored intervention adherence
  - Changes required based on monitoring data
* PRECIS-2 diagram from Loudon et al, BMJ, 2015 with adapted formatting.
## Implementation RT vs. HCS: ORGANIZATION

<table>
<thead>
<tr>
<th>ASPECT</th>
<th>Approach</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>TRAINING</td>
<td><strong>RT:</strong> Developed training materials - e.g., printed toolkit, webinars, laminated card</td>
<td>• HCS’ had different preferred modalities: HCS1: Centralized, in-person HCS2: Multiple Webinars • Turnover of NH champions required multiple re-trainings</td>
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<tr>
<td></td>
<td><strong>HCS:</strong> Leveraged existing corporate infrastructures to do trainings</td>
<td></td>
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<td></td>
<td><strong>RT &amp; HCS:</strong> Co-led trainings</td>
<td></td>
</tr>
<tr>
<td>PERSONNEL</td>
<td><strong>HCS:</strong> Corporate-level leader appointed to oversee project; Site champion(s) at each NH</td>
<td>• Turnover of both corporate leaders • Extensive champion turnover</td>
</tr>
<tr>
<td>RESOURCES</td>
<td><strong>RT:</strong> Developed intervention; supplied tablets with videos</td>
<td>• Tablets stolen at one site so RT replaced them</td>
</tr>
<tr>
<td></td>
<td><strong>HCS:</strong> Provided training venues; embedded video status report into EMR</td>
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*RT=research team; HCS=health care system*
## Implementation: FLEXIBILITY (DELIVERY)

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<th>Challenges</th>
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<tr>
<td><strong>PROTOCOL-DRIVEN</strong></td>
<td><strong>RT:</strong> Guidelines for timing of video OFFERING proscribed**&lt;br&gt;Flexible guidelines for:&lt;br&gt;-which videos to offer which patient&lt;br&gt;-who shows videos (mostly SW)</td>
<td>• Higher adherence for admissions vs. LTC&lt;br&gt;• Competing responsibilities a barrier&lt;br&gt;• LTC-patients hard to find “right time”, family often not at care planning meeting</td>
</tr>
<tr>
<td><strong>CO-INTERVENTIONS</strong></td>
<td><strong>HCS:</strong> Allowed other ongoing ACP activities to continue in NHs</td>
<td>• Other ACP programs highly variable&lt;br&gt;• Many other initiatives to ↓ hospitalizations (1&lt;sup&gt;o&lt;/sup&gt; outcome)</td>
</tr>
<tr>
<td><strong>MONITORING</strong></td>
<td><strong>RT:</strong> Designed Video Status Report (VSR)**&lt;br&gt;<strong>HCS:</strong> Embeds VSR into EMR at all NHs</td>
<td>• Champions interpreted compliance as offering (i.e., VSR completion) vs showing video</td>
</tr>
</tbody>
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*RT=research team; HCS=health care system*
### Implementation: FLEXIBILITY (ADHERENCE)

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<tbody>
<tr>
<td><strong>PRE-SCREENING</strong></td>
<td><strong>HCS:</strong> Excluded sites with major organizational or regulatory difficulties</td>
<td>• Determination of ‘dysfunctional’ sites was subjective based on corporate leaders’ assessments</td>
</tr>
<tr>
<td><strong>SITE WITHDRAWAL</strong></td>
<td><strong>RT:</strong> NHs with low implementation adherence rates were NOT dropped</td>
<td>• HCS divested several NHs mid-implementation</td>
</tr>
<tr>
<td><strong>SITE MONITORING</strong></td>
<td><strong>HCS:</strong> Internal monthly reports for VSR completion for admissions only</td>
<td>• HCS internal reports for admissions only and based on offering videos, so missed low compliance among Long Stay</td>
</tr>
<tr>
<td></td>
<td><strong>RT:</strong> Quarterly reports were completed for admissions and LTC; champion interviews uncovered issues (lack of focus on LTC, champion turnover)</td>
<td>• Monitored ‘show’ rate only later</td>
</tr>
</tbody>
</table>

*RT=research team; HCS=health care system*
Goal: Disseminating Interventions

- Once FDA approved, Pharmacological treatments promulgated by advertisement
- Pharmacy based treatments are simple; substitute one drug for another OR add new drug; no change in staff routine.
- Non-pharmacologic treatments require BOTH not prescribing AND doing something different
- Passing pills same across NHs; restructuring staff time for other tx may differ across NHs
When is an Intervention Ready for Diffusion in a Health Care System?

- Many non-pharmacologic interventions have been shown to be effective in meeting NH patients’ needs
- BUT, generally not replicated
- Rarely replicated under control of Health System
- If Health Systems don’t take charge, hard to imagine real diffusion
# Readiness Assessment for Pragmatic Trials (RAPT)

## Table 1

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>1. Intervention protocol</td>
<td>The intervention must have a well-articulated protocol in order to be replicated.</td>
</tr>
<tr>
<td>2. Evidence</td>
<td>There must be some evidence demonstrating the efficacy that the intervention and/or its components improves the clinical outcomes of interest.</td>
</tr>
<tr>
<td>3. Risk</td>
<td>The intervention should be low risk. Adverse events and unintended consequences need to be carefully considered in this vulnerable population.</td>
</tr>
<tr>
<td>4. Feasibility</td>
<td>It should be possible to implement the intervention under real-world conditions within health care systems.</td>
</tr>
<tr>
<td>5. Measurement</td>
<td>The intervention’s impact should be measurable using existing data or with minimal burden by health care partners.</td>
</tr>
<tr>
<td>6. Cost</td>
<td>An intervention should be cost-neutral or cost-effective for health care partners and/or incentivized by insurers.</td>
</tr>
<tr>
<td>7. Acceptability</td>
<td>Health care partners should believe that the potential impact of the intervention is important and that it can be adopted.</td>
</tr>
<tr>
<td>8. Alignment</td>
<td>The intervention should address priorities for health care partners and other stakeholders.</td>
</tr>
<tr>
<td>9. Impact</td>
<td>The intervention’s outcomes should inform clinical decision making and policy.</td>
</tr>
</tbody>
</table>

PCT, pragmatic randomized, controlled trial.
Implementation protocol
Is the protocol sufficiently detailed to be replicated?

Impact
How useful will the results be?

Evidence
To what extent does the evidence base support efficacy?

Alignment
To what extent does the intervention align with external stakeholders’ priorities?

Risk
Is it known how safe the intervention is?

Acceptability
How willing are providers likely to adopt the intervention?

Feasibility
To what extent can the intervention be implemented under existing conditions?

Cost
How likely is the intervention to be economically viable?

Measurement
To what extent can outcomes be captured?
PROVEN: Video Assisted Advance Care Planning RAPT scoring

B) Advance Care Planning Specialist Program

Impact
Evidence
Risk
Feasibility
Acceptability
Alignment
Cost
Measurement
Implementation protocol
Music & Memory: RAPT Score
What is Music & Memory?

- **Music & Memory** is a personalized music program.

- **Description**: Staff identify music a nursing home resident with dementia preferred when s/he was a young adult and load music on a personal music device (MP3 player).

- **Popularity**: Thousands of nursing homes in the US have become certified in the program, several state initiatives, subject of a powerful documentary “Alive Inside”.

- **Potential benefits**: *non-pharmaceutical alternative to managing agitated behaviors; improve sleep / alertness; decrease resistance to staff assistance with dressing or bathing; appetite stimulation; improve quality of life.*

- **Limitation**: Rigorous evaluation is necessary to establish efficacy and to characterize factors associated with effective implementation.
Music & Memory Pilot (R21)

- 4 nursing homes, 1 per partnering corporation

- 47 residents with moderate or severe dementia received the Music & Memory program during the 6-month pilot (January, 2018 – June, 2018)

- 34 of the 47 residents had data available pre-music and post-music

- Measured agitated behaviors by:
  - Directly observing residents when using and not using music (Agitated Behaviors Mapping Instrument),
  - Interviewing staff members about resident behaviors (Cohen-Mansfield Agitation Inventory), and
  - Using available administrative data (MDS 3.0, Section E)
## Music & Memory Pilot (R21)

### Unpublished Pilot Data: Within-Person Changes in Agitated Behaviors Before and After Using Music & Memory, Based on Staff Interviews using the Cohen-Mansfield Agitation Inventory*

<table>
<thead>
<tr>
<th></th>
<th>Before Music &amp; Memory</th>
<th>After Music &amp; Memory</th>
<th>Within Person Change</th>
<th>Wilcoxon signed rank test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>p-value</td>
</tr>
<tr>
<td>Total Score</td>
<td>61.24(16.32)</td>
<td>51.24(16.05)</td>
<td>-10.00(18.94)</td>
<td>0.002</td>
</tr>
<tr>
<td>Physically aggressive behaviors</td>
<td>18.03(7.16)</td>
<td>15.03(5.78)</td>
<td>-3.00(5.98)</td>
<td>0.013</td>
</tr>
<tr>
<td>Physically nonaggressive behaviors</td>
<td>15.85(6.51)</td>
<td>13.38(6.84)</td>
<td>-2.47(5.07)</td>
<td>0.002</td>
</tr>
<tr>
<td>Verbally agitated behaviors</td>
<td>13.74(6.20)</td>
<td>11.03(6.02)</td>
<td>-2.71(7.47)</td>
<td>0.033</td>
</tr>
<tr>
<td>Hiding and hording behaviors</td>
<td>2.65(1.23)</td>
<td>2.44(1.69)</td>
<td>-0.21(1.93)</td>
<td>0.303</td>
</tr>
</tbody>
</table>

*Includes 34 of the 47 residents with moderate to severe dementia who received Music & Memory during the pilot and had staff interviews before and after receiving the Music & Memory program. Higher scores = more frequent behaviors.
Summary

- Not enough for researchers to test Non-pharmacologic behavioral interventions for persons with ADRD
- To be used, health systems must be willing to substitute these for drug treatment
- Requires evidence of feasibility AND effectiveness in fully functioning HCS
- Researchers must partner with HCS to implement the most salient features of researchers’ interventions