

**Applying the Wisconsin Star Method
to Behavioral Health Issues in
Long Term Care:
Addressing Complexity in the Face of Scarcity**

Tim Howell MD, MA

Department of Psychiatry
University of Wisconsin-Madison School of Medicine & Public
Health

Mental Health Service
Geriatric Research, Education, & Clinical Center (GRECC)
Madison VA Hospital

October 2009

**Geriatrics: Challenges to Usual
Clinical Approaches**

- Characteristics of geriatric problems:
- Complexity: multifactorial, interacting, changing over time
- Atypical/unusual presentations
- Colored by unique personalities, experiences, and values of participants (patients, families, providers, support staff, administrators, institutions, regulators, etc.)
- Associated with significant, complex feelings/emotions for all involved

**Geriatrics: Risks for Cognitive &
Affective Errors-1**

- High degrees of clinical complexity: computationally intractable
- Higher levels of ambiguity re diagnoses, treatments, & prognosis
- Incomplete clinical information
- Multiplicity of plausible interventions

Geriatrics: Risks for Cognitive & Affective Errors-2

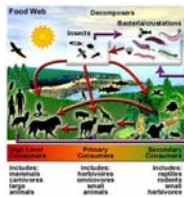
- Common approaches to problems:
 - Occam's razor: simplest, most elegant hypothesis is best
 - Linear: rigorous, but "piecemeal," overly focused
 - Holistic: broader, but "piecemeal," diffuse
 - Practice guidelines:
 - Evidence-based medicine: from research on single problems
 - Clinical pearls (rules of thumb): based on experience, clinical lore, case reports

Geriatrics: Risks for Cognitive & Affective Errors-3

- Economic issues:
 - Productivity, efficiency, effectiveness
 - Limited time and resources
- Lack of integration at multiple levels:
 - Competition vs. collaboration
 - Specialization & subspecialization:
 - complexity-driven
 - different cultures within and between systems
 - Communication: ongoing, on transfer of care
- Conflicting values/priorities:
 - Cultural issues
 - Medical-legal concerns
- Emotionally intense clinical situations
- Need for an integrated ecological approach

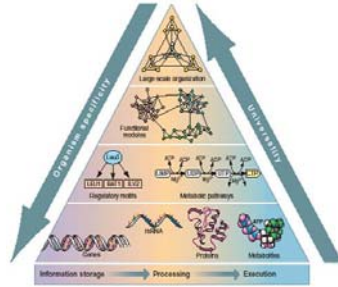
Ecology: Interacting Individuals & Interacting Systems

- Individual:
 - Atoms, molecules
 - Cells, organs
 - Organisms, groups
 - Organizations
- Systems:
 - Chemical solutions
 - Metabolic pathways
 - Executive functions
 - Ideas, values
 - Social networks
 - Cultures
 - Political units
 - Economies
 - Global environment

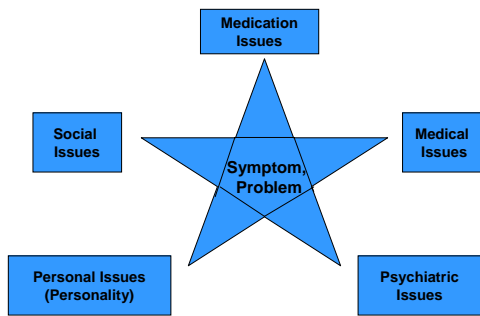


Ecological Levels in Geriatrics

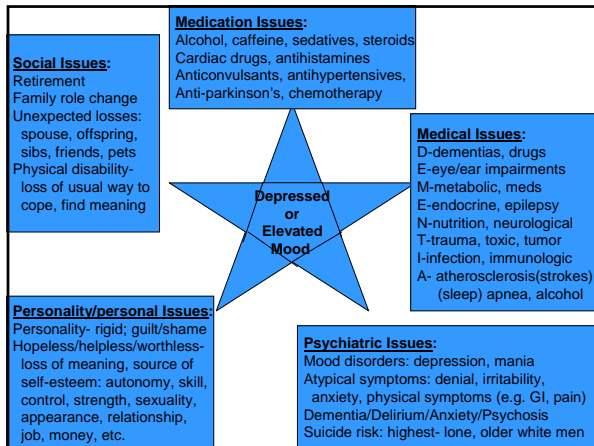
- Environmental
- Political
- Social
- Family
- Personal
- Physiological
- Metabolic
- Biochemical
- Physical

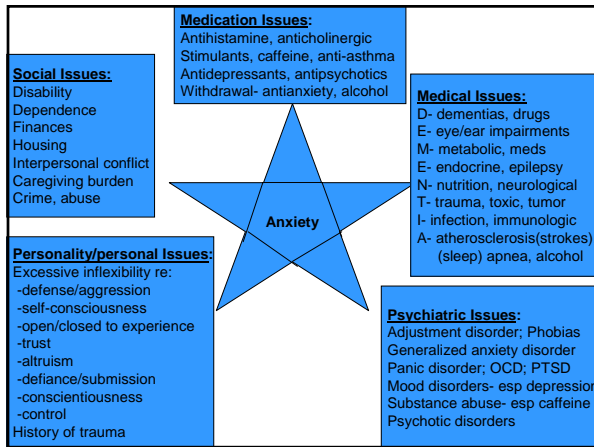


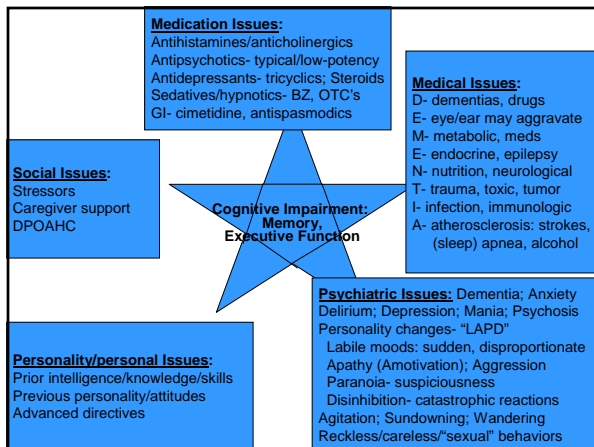
Understanding & Addressing Geriatric Problems: The Wisconsin "Star" Method



| | | |
|--|---|---|
| <p>Social Issues: Expected changes: loss of people, roles, independence Retirement: freedom/boredom Environment Finances; Housing Transportation; Legal Access to services</p> | <p>Medication Issues: Multiple meds/providers Interactions; Adherence Rx, OTC, saved, borrowed Side effects (self/others)</p> | <p>Medical Issues: Varied rates of decline in organ function Functional impairments Chronic illnesses Excess impairment Atypical symptoms Ambiguities: -diagnostic -prognostic, -therapeutic Young-old vs. old-old</p> |
| <p>Normal Aging</p> | | |
| <p>Personality/personal issues: Stable personality- if this changes, think disease Unique mix of traits: assets/liabilities Coping: flexibility vs. rigidity Personal/cultural values re: life, aging, illness, functional decline, mortality, religion Developmental- meaning, integrity vs. despair</p> | <p>Psychiatric Issues: Cognition: reduced speed; harder to learn/multi-task, but good retention Not normal: -significant memory loss -sustained low mood</p> | |



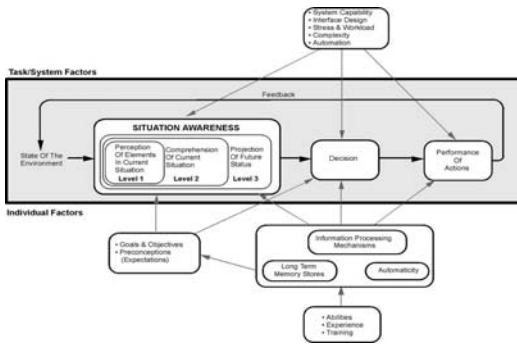




Executive Functions

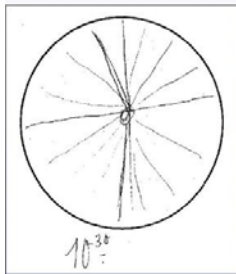
- Attention
- Response inhibition: blocking distractions
- Memory: working memory ("desktop")
- Planning: sense of the future
- Abstract thinking
- Implementing plans: decide/start/sustain/stop
- Set-shifting: flexibility
- Organization: categorizing, sequencing
- Multi-tasking
- Monitoring: awareness of self & others
- Judgment
- Problem-solving: new (vs. familiar/learned)
- Modulation of feelings/emotions/behavior

Situation Awareness



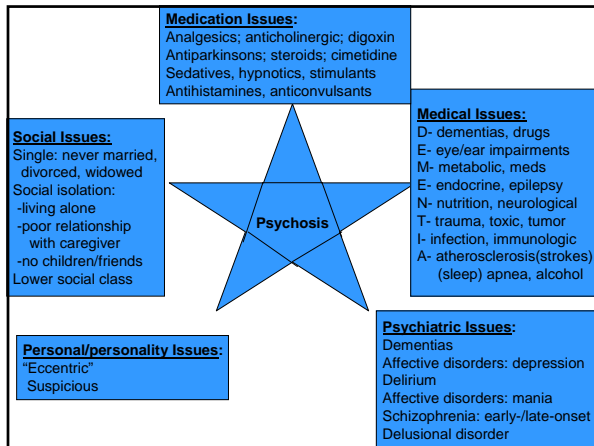
Cognitive Impairment: Executive Dysfunction with Intact Memory

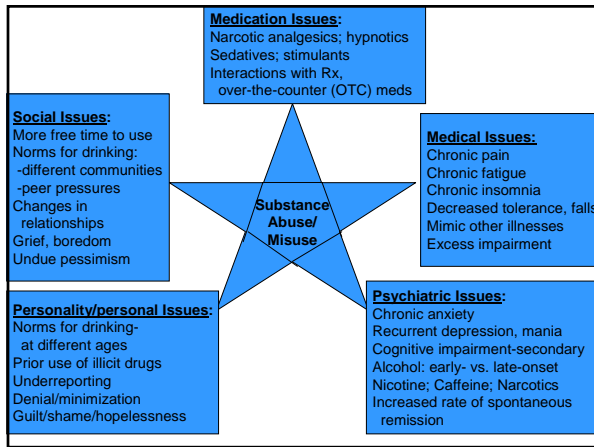
Draw a clock!

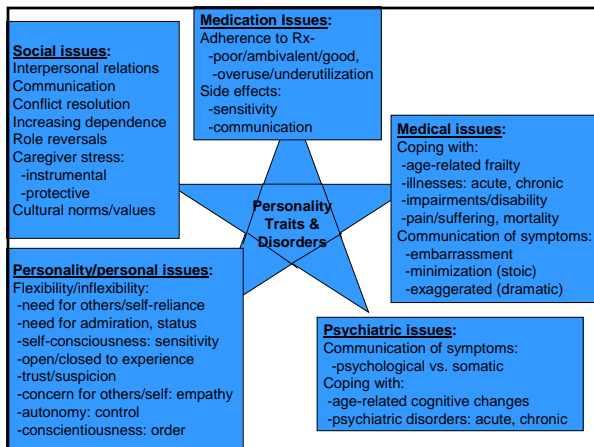


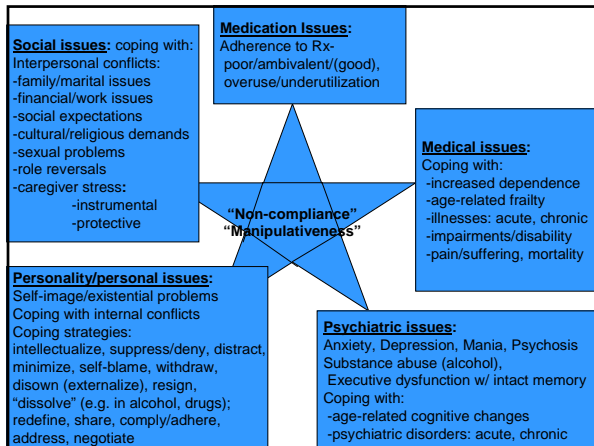
Patient
• Male, 75 years old
• MMSE = 28 points

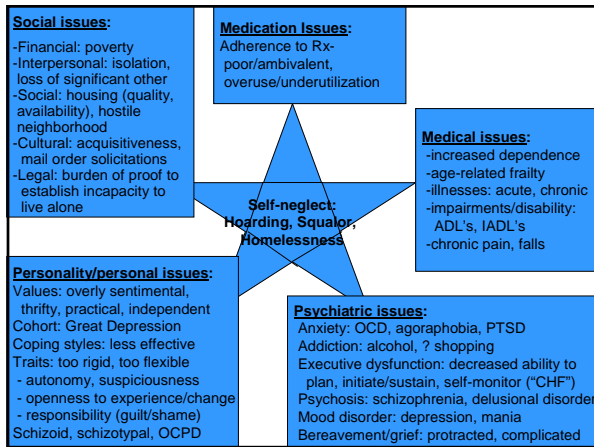
Diagnosis
• Definite AD
(4 years after the drawing)

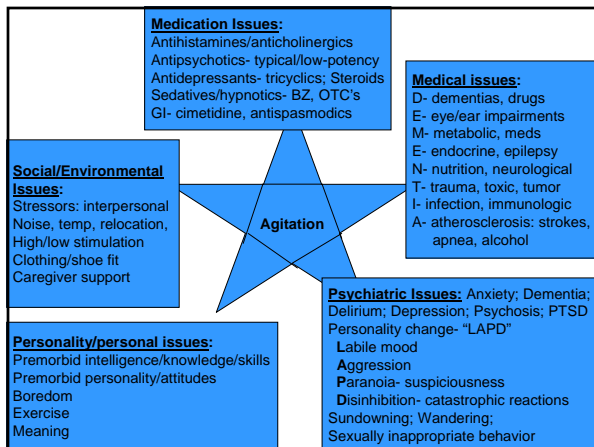












Assessment/Management of BPSD

- Evaluate for delirium:
 - Consider changes in environment, social milieu, medication, & medical problems (e.g. fecal impaction, pneumonia, urinary infection, etc.)
- Evaluate for needs that the dementia patient is unable to communicate normally
 - Consider pain, loneliness, over-/under- stimulation
- Psychosocial interventions are the initial strategies of choice for mild to moderate BPSD.
- Pharmacological interventions-- reserve for symptoms that are:
 - severe: major depression, psychosis, aggression
 - not responsive to nonpharmacologic strategies alone

BPSD: Pharmacologic Interventions

- Use initially (along with nonpharmacologic measures) for:
 - patient and/or others at risk of harm
 - severe depression, psychosis, agitation/aggression
- Initiate with low dosage, titrate slowly
- Monitor for effectiveness and tolerability
- Attempt to taper after 3 months of stability (absence of target symptoms)

BPSD: Pharmacologic Interventions

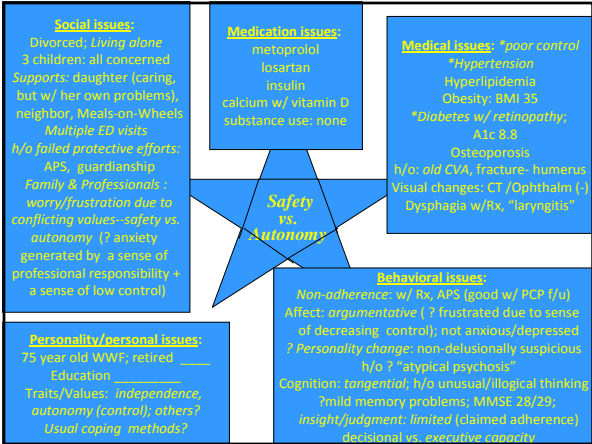
- SSRI's: first choice for non-emergency BPSD
 - Best studied: citalopram (Celexa)
- Trazodone: "insufficient evidence" for agitation without psychotic symptoms
- Benzodiazepines: only for short periods
 - Acute emergencies, procedures requiring sedation
 - Best studied: lorazepam (Ativan)

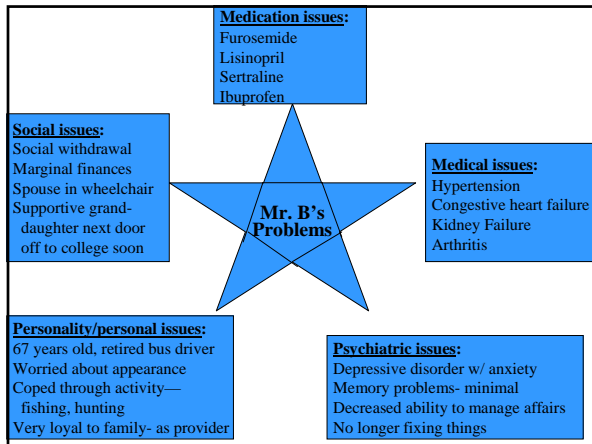
BPSD: Pharmacologic Interventions

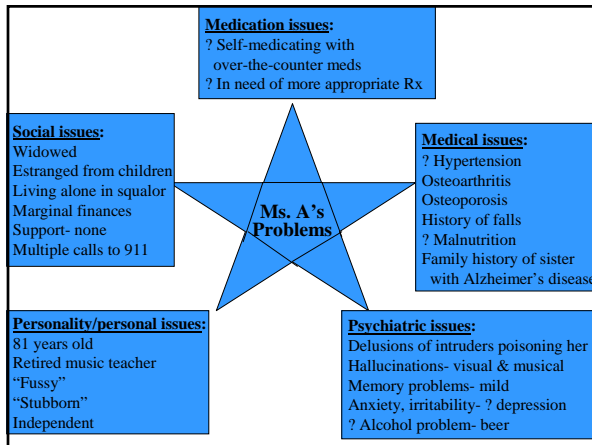
- Atypical antipsychotics: initial choice for:
 - psychosis
 - severe agitation
 - major aggression
 - delirium
- FDA-related issues:
 - black box warning re risks
 - cerebrovascular events: data now conflicting
 - death: 3.5% vs. 2.3% for controls (meta-analysis of 15 studies)
 - "not approved" for use in these situations
- Other: mood-stabilizers
 - Valproate (Depakote); Carbamazepine (Tegretol)

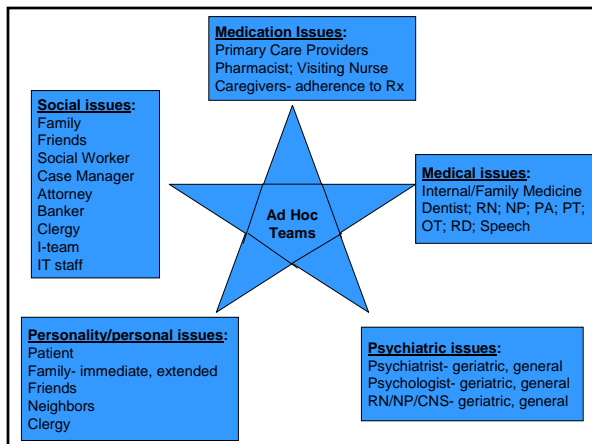
Pharmacologic Interventions: CAVEATS

- Lack of evidence (about effectiveness) *does not necessarily mean* evidence of a lack (of effectiveness):
 - need to know data base on which evidence-based recommendations are made
 - e.g. trazodone has long been a generic Rx, hence little incentive to conduct expensive research on it
- When an Rx is not FDA-approved for use w/ Z:
 - does not mean FDA disapproves of using Rx for Z;
 - it means FDA hasn't found enough evidence for/against using Rx for Z









Summary- Assessment

- **Problems in the elderly are often:**
 - Multifactorial, interacting, initially daunting
 - Characterized by unusual presentations
 - Colored by each individual's unique personality, lifetime experiences, and personal values
 - Associated with significant feelings/emotions for all involved
- **Avoid cognitive/affective errors**
 - Cultivate a higher tolerance of ambiguities re diagnosis, treatment (trade-offs), & prognosis, to avoid coming to premature closure
 - Utilize emotional intelligence to avoid affective errors
 - Seek input from collateral sources of information
 - Keep re-assessing, especially as situations change

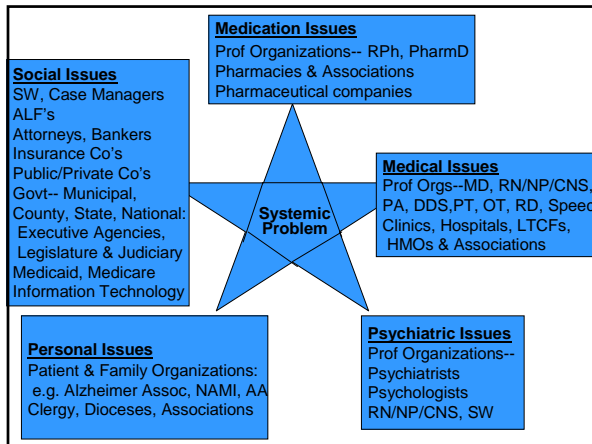
Summary- Approach

- **Build & maintain a therapeutic alliance:**
 - Adjust approach according to each participant's individual cognitive/affective/personality styles, history, values, current abilities/disabilities
 - Appreciate & allow for the underlying anxieties that may be driving dysfunctional behaviors
- **Nurture empathy:**
 - discover/share some things in common
 - appeal to, build on patient-partner's strengths/assets
 - facilitate grieving of irretrievable losses:
 - "don't just do something, be there"

Summary- Interventions

- **Take an integrated ecological approach:**
 - Attend to factors in all 5 domains (holistic perspective)
 - Look for patterns of interactions (ecological perspective)
 - Respond to situations with cognitive/emotional integrity
 - Look for vicious cycles; foster virtuous cycles (linear perspective)
 - Readjust goals as situations evolve
 - Remember: even small improvements can make big differences in quality of life
 - Establish ad hoc teams with members supporting each other as well as the patient-partner
 - Use analogous approaches to address larger systems issues
- **To achieve clinical integrity: Remember the STAR!!***

*D Krahn 2003



Addressing Complexity Issues in Geriatrics

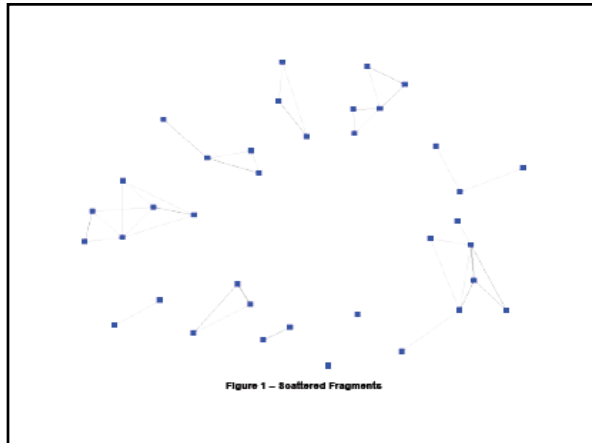
- Need for re-integration, initiative/engagement:
 - team approaches at multiple levels
 - network weaving
 - interdisciplinary (vs. multidisciplinary): diversity
 - collective intelligence:
 - novel problem-solving
 - "connecting the dots"
- Amplification of existing (scarce) resources
- Implementation: "Make it so"

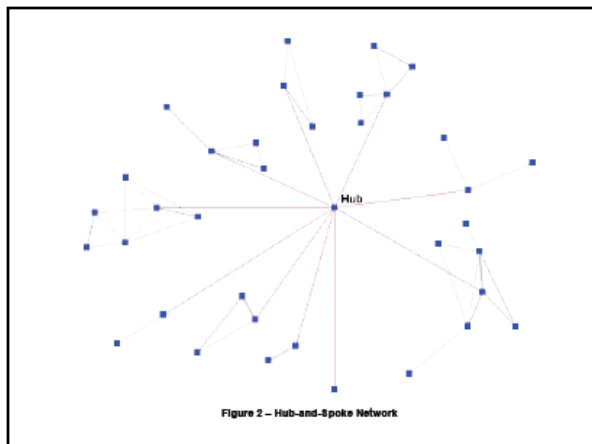
Traditional Approaches to Behavioral Health Issues of Older Adults

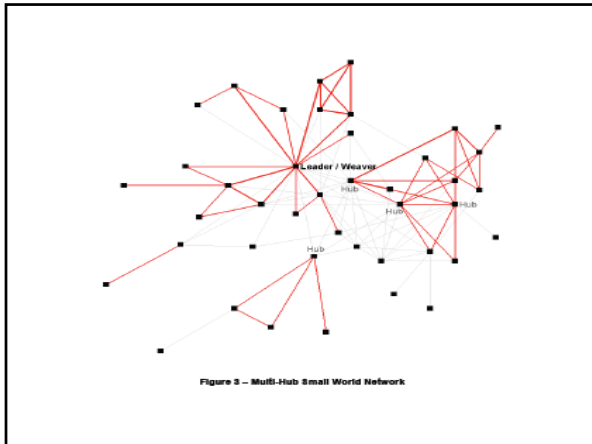
- Direct care by psychiatrists:
 - Low-integration: e.g. "carved out," separate MH facilities
 - High-integration: "imbedded" in primary care (PC)
- Problems with traditional approaches:
 - Values: many older adults decline referral to psychiatrists
 - Training: many psychiatrists under-trained/experienced in geriatrics
 - Geography: most psychiatrists in urban/suburban areas
 - Numbers of providers: nowhere near sufficient to meet current/future needs through direct care alone
- Default: most BH care done by under-trained/under-supported primary care providers (PCPs)

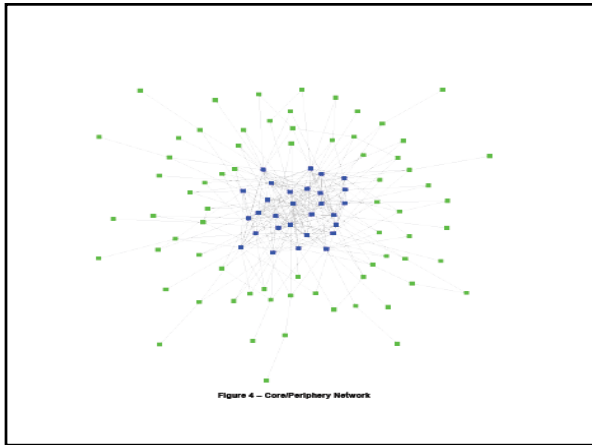
Potential Remedy:
Indirect Care with Integrated Methods

- Increase competence of BH workforce/PCPs
- Augment traditional approaches
- Consultative teaching by geriatric psychiatry-trained staff : "co-enzyme" analogy
- BH teams: local, regional, state-wide
- Wisconsin Star Method
- Network weaving to shape existing infrastructure
- On-line resources (virtual network):
 - website to facilitate access to specific information, help
 - training modules
 - links to other BH teams with expertise in specific issues (e.g. hoarding)









Wisconsin Geriatric Psychiatry Initiative (WGPI)

- Goal:
 - to enhance the delivery of mental health services to older adults in Wisconsin
- Method:
 - more widely disseminate principles of geriatric psychiatry to different groups in:
 - health care: medical and psychiatric
 - long-term care
 - aging network
 - other organizations

Evidence-based Components of WGPI

- Principles of geriatrics and geriatric psychiatry
- Wisconsin "Star" method
- Teaching, utilizing the Wisconsin "Star" method:
 - on-site, case-based consultative teaching with teams
 - talks, in-services on topics: e.g. depression, dementia
 - consultations with administrators at systems levels
- Network weaving, utilizing:
 - existing resources: shaping (i.e. not creating) an infrastructure
 - principles of small-world networks
 - strength of 'weak ties'
- Social entrepreneurial approach to financing
- Advocacy:
 - on behalf of patient/provider partners
 - at multiple levels: from individual persons to statewide systems

WGPI: Results

- Utilized to establish and organize:
 - Highly successful CBRF for elderly patients with chronic mental illnesses (Milwaukee)
 - Geriatric Mental Health certification program
 - Univ. Wisc. Dept. of Professional Development
 - Proposal for a pilot program at the state level:
 - to address systemic placement issues of dementia patients with behavioral problems in hospitals/LTCF's
- American Geriatrics Society website :
 - integrated into Continuing Medical Education section: americangeriatrics.org

WGPI Results: Common Issues

- Patient-partner attitudes/behaviors distressing to staff:
 - non-adherence: "non-compliance"
 - agitation
 - conflict of values/priorities
 - personality traits/disorders: "manipulativeness"
- Diagnoses
- Medications
 - Indications: ? appropriate use
 - Polypharmacy
 - Drug interactions

WGPI Results (Anecdotal):
Variable Responses by
Individuals, Teams, Systems

- Knowledge: increasing awareness of BH issues, e.g.
 - executive dysfunction
 - side effects of benzodiazepines
 - self-defeating personality traits
- Skills:
 - holistic assessment
 - increased empathy
 - comfort with complexity
 - smoother transfer of care:
 - better communication between organizations where both familiar with the Star Method

WGPI Results (Anecdotal):
Variable Responses by
Individuals, Teams, Systems

- Attitudes:
 - external validation of efforts
 - sense of moral support
 - more understanding/patient/confident
 - less stressed
 - “don’t buy it” (infrequent)
 - “we’re all seeking the same goals” (interagency relationships ‘on the same page’)

WGPI Results

- New diagnoses, approaches:
 - As suggested in CT session
 - Newly discovered by team
- Outcomes: excellent to no change, e.g.
 - Patient-partner & caregivers: less anxiety, greater well-being, no change
 - Team: staff more insightful/confident/optimistic -> patient less anxious -> staff less apprehensive (virtuous cycle) [even where no significant change in patient]
 - System:
 - Fewer frantic calls, ED visits, hospitalizations
 - Reduced staff turnover (@ CBRF)

WGPI: Challenges-1

- Developing better ways to address:
 - Staff too busy (“fighting fires”): high case loads, expanding systems (e.g. Family Care)
 - Staff/team/system attitudes: BH issues “not my/our job”
 - Individual team dynamics: e.g. rigid thinking
 - Staff adopting regular use of the Wisconsin Star Method
- Establishing optimal frequency of CT sessions
- Developing better outcome criteria
- Capturing more outcome data

WGPI: Challenges-2

- Developing geriatric psychiatry infrastructure:
 - linkages with local partners/resources
 - tele-geropsychiatry CT sessions
 - Network weaving: more hubs/connectors in network
 - developing local/regional BH teams/coalitions
 - recruiting additional geriatric psychiatrists
 - linking with regional/state organizations: e.g. AAA's, ADRC's, CMHC's, CWC, DHS, I teams, MCDA, PH Clinics, UW Dept Fam Med, WAHSA, WAI, WALA, WHCA, WHA
 - upgrading WGPI website
 - funding streams for indirect care
 - advocacy

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has.”

Margaret Mead

Suggested Attributes of Successful Individuals, Teams, Systems

- trust
- openness: non-dogmatic
- flexibility: well-modulated
- tolerance of ambiguities
- initiative
- tolerance of frustration
- perseverance
- respect for self and others
- sober enthusiasm
- tolerance of risk
- tact
- optimism: "hopeless hope"
- healthy executive functions
- emotional intelligence
