

UWM College of Nursing

Challenging Behaviors--Physical and
Psychosocial/Environmental Care

Christine R. Kovach, PhD, RN, FAAN
University of Wisconsin-Milwaukee

**UWM Meet "Stretch" or Mr. Richard
Petersen and his wife Joan**





Adult Protective Services WI Chapter 51 Emergency detention

Mechanism to detain and force treatment

“Handcuffing an elderly person and putting them in the back of a car will not make them calm down.”





Adult Protective Services WI Chapter 55 placement

used for long-term placement or services

controlled by the principle that people should get the services they need in the most normal and natural setting

voluntary or ordered by a court

Goal of service: reduce risk to the point where the average person would feel comfortable and then ensure that quality services are actually provided

Problems: no providers
Reimbursement poor



Handcuffed: A Report of the Alzheimer’s Challenging Behaviors Task Force





Recommendations of the Task Force

1. Find alternatives to using Chapter 51 and the County Mental Health Complex for PWD.
2. **Establish a network of Alzheimer's care centers.**
 1. adequate and defined "levels of care"—community, skilled NH, ED, inpatient
 2. "lead agencies" assure accountability at all levels
 3. Develop cost sharing and blended funding approaches
 4. centralized resource and assessment center
 1. mobile "triage team"
 2. Combined medical, social, psych service unit



3. Provide adequate and appropriate training
4. Create an ongoing system for capturing data.
5. Support the next steps and follow-up work of the Task Force. Current workgroups (Phase II)
 - Training—repository of training
 - Law Enforcement
 - Legal Interventions
 - Psychoactive Medications



Paramount

- ▶ Keeping people in their facility or home
- ▶ Decrease transitions
- ▶ Make transitions smoother

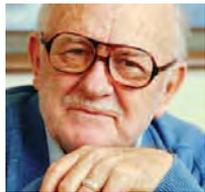


UWM State Supreme Court: Helen EF May 2012

- ▶ Chapter 51: short-term commitment and treatment of mentally ill individuals capable of rehabilitation
- ▶ Chapter 55: provides for long-term care for individuals with disabilities that are permanent or likely to be permanent (with incurable disorders)
- ▶ Like the Court of Appeals before, the high court declined to say how it would rule in a case of some suffering from both Alzheimer's and some other conditions that might be treatable under Chapter 51.

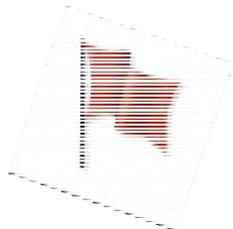
UWM Reports of Recent Disruptive Behavior

- ▶ Nursing home residents with dementia in WI (15,264)
 - ▶ Percent with recent disruptive behavior: 32%
 - ▶ People with dementia receiving home health services in WI (1,927)
 - ▶ Percent with recent disruptive behavior: 12%
- Milwaukee Police receive nearly 775 calls per year, with approximately 30 of these resulting in police-initiated emergency detention.**



UWM The controversial use of psychotropic medications for PWD

- ▶ Great variability in use of psychotropic drugs by county
 - Antipsychotics (4%–50%)
 - Antianxiety (4%–47%)
 - Antidepressants (4%–50%)





CMS

- ▶ Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
 - In excessive dose (including duplicate drug therapy);
 - For excessive duration;
 - Without adequate monitoring;
 - Without adequate indications for its use;
 - In the presence of adverse consequences which indicate the dose should be reduced or discontinued;
 - Any combination of the above reasons.





Alice Bonner, PhD, RN, FAANP

- ▶ "Clinicians, nursing home providers and advocates are trying to move away from a "culture of prescribing" for people with dementia, one that arose in part from a desire to improve distressing symptoms and behaviors, and because a paucity of research (up until now) had left us without strong evidence for many viable alternatives."
- ▶ National Partnership to Improve Dementia Care
 - promote effective, non-pharmacological interventions
 - reduce inappropriate antipsychotic drug use





UWM

It's a New Day



FreeFoto.com

UWM

What are alternatives?

- ▶ Solutions don't come in a pill
- ▶ Develop a new standard in your own setting
- ▶ EMBRACE YOUR POWER TO MAKE A DIFFERENCE
- ▶ The answer lies in YOU and your organization!



UWM

What are behaviors?



Behaviors Associated with Dementia

- ▶ Dementia-Biological Model
- ▶ Behavioral Models
- ▶ Environmental Vulnerability Models
- ▶ Unmet Needs Models

FIGURE 1 C-NDB MODEL
Consequences of Need-Driven
Dementia-Compromised Behaviors

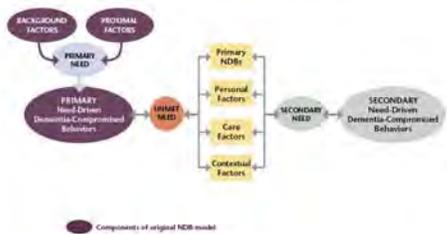
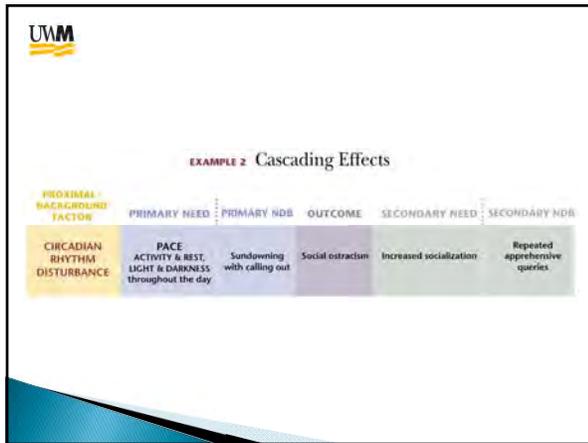
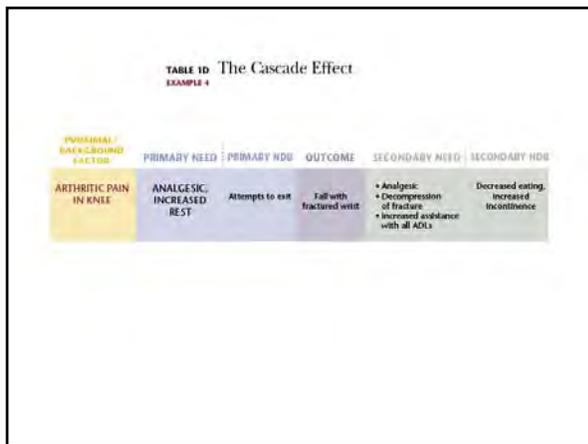


TABLE 1A The Cascade Effect
EXAMPLE 1

PROXIMAL (OR BACKGROUND) FACTOR	PRIMARY NEED	PRIMARY NDB	OUTCOME	SECONDARY NEED	SECONDARY NDB
THIRST	FLUIDS	Registive movement	Constipation & abdominal discomfort	Increased fiber & stool softener	Aggression







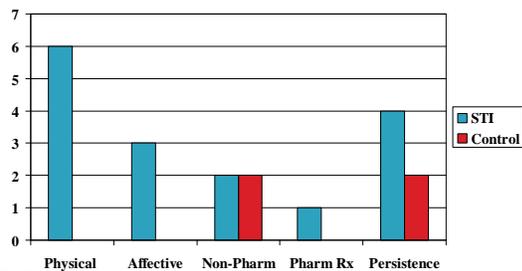


PROBLEM: It is hard to figure out the need behind the behavior of PWD

- ▶ Astounding lack of assessment in response to behavior change----NEED ALL DISCIPLINES---CONSISTENT CNAs
- ▶ Anticipating needs prevents behavioral symptoms



Differences in Process Variables





Compare identification of dementia behaviors and physical assessment needs between staff nurses and an expert

- Nurses:** 38 (26 LPNs, 12 RNs)
female (n = 37)
over age 45 (n = 24)
< 5 years in nursing (n = 3)
< 5 years working with dementia (n = 13)



Prevalence of behavior changes detected by staff nurse and expert

Behavior Change	Staff nurse		Expert	
	f	%	f	%
Nonspecific vocalization	11	7.1%	21	13.0%
Verbal symptoms	31	20.0%	44	28.0%
Passive behavior	10	6.4%	8	5.2%
Motor agitation	10	6.4%	17	11.0%
Body part cues	20	12.9%	42	27.1%
Needing Assessment	79	51.0%	113	72.9%



97-year old non-communicative PWD yelling out with movement

- ▶ full ROM lower extremities, denies pain repeatedly
- ▶ bilateral knee pain controlled with scheduled Vicodin
- ▶ Hx anxiety, scheduled lorazepam
- ▶ “help me,” “No, No No” or “ooh, ooh ooh,”
- ▶ resistive to care and looked frightened when approached
- ▶ Interpretation: anxiety





- ▶ Give care slowly
- ▶ Explain actions and the reason for the care
- ▶ Positive feedback every time she was “cooperative with cares”
- ▶ Reassured that “she will be all right and not fall” when transferred
- ▶ Day 13: when asked about pain, responded “yes” and touched her upper left leg
- ▶ Day 21: Vicodin and lorazepam 1 h before am care
- ▶ Day 22: right leg touched → she yells out
- ▶ Day 23: X-ray left intertrochanteric FX



91-year-old pleasant, persistently smiling

- ▶ Verbally communicates her back pain regularly
- ▶ Well controlled scheduled acetaminophen, prn tramadol
- ▶ Day 8: c/o hemorrhoid pain → med and cushion
- ▶ Day 11: clear change in condition, smile, withdrawn, refused meals, spit out meds
- ▶ Day 12, 13: “spitting out yellow phlegm.” VS normal, afebrile, lungs clear, no cough
- ▶ Day 14: fell
- ▶ Day 15: restless, spitting up larger amounts of “yellow phlegm.”





- ▶ Day 16, 17: smiling while grabbing staff Clothing and jabbing them
- ▶ Day 18, c/o fatigue, refused to open mouth, no c/o pain
 - nurse looked into her mouth, multiple “pus pockets”
 - Started on antibiotic → daughter orders hospice, all meds stopped
- ▶ Day 22: dentist DX acute abscess
 - antibiotic and opioid injections,
 - clonazepam orally disintegrating tablets and viscous lidocaine for the jawline
- ▶ Day 23: Much weaker
- Day 25: Died





Physical Problems Over 6 Weeks (149 problems in 61 participants)

PROBLEM	f	%
Musculoskeletal	35	23
Skin	17	11
Neurological	17	11
Gastrointestinal	17	11
Genitourinary	16	10
Respiratory	15	10
Other	12	8
Eye, Ear, Nose and Throat	11	7
Cardiovascular	9	6



Frequency of Behaviors Accompanying New Infections and Other New Physical Problems N = 134 New Problems *

New Problem	Resistive		"Help Me" "Something is Wrong"		Distressed Facial Expression		Restlessness	
	f	%	f	%	f	%	f	%
Infection n = 36	17	47	14	39	9	25	7	19
Other Physical n = 98	38	39	15	15	35	36	29	30

*Problems of severe psychosis and unresponsiveness were omitted from this analysis



Predictors of Time to Identify New Problems

Variable	Estimate	SE	t	CI
Assessment	-0.43	0.09	-4.62*	(-0.62,-0.24)
Ratio of new to standard interventions	-1.35	0.40	-3.38*	(-2.16,-0.54)
Specific physical symptoms	-0.82	0.30	-2.78*	(-1.42,-0.22)
Length of Stay	0.013	0.006	2.40*	(0.002,0.025)

p < .05



Implications

- Behaviors: are they sensitive indicators of new physical problems?
- Assessment: can better assessment ↓ time to identify physical problems?
- New to existing interventions: artifact or static care?
- Psychotic behavior: tremendous needs and suffering



Summary

- Staff nurses' skills in assessment of behavior and physical conditions may be key factors in timely identification and treatment of new physical problems

Solution: Serial Trial Intervention



SERIAL TRIAL INTERVENTION





Background Research on Dementia

- ▶ Pain inadequately assessed
- ▶ Pain under treated
- ▶ Early and some moderate dementia can still accurately report pain symptoms.





What happens if pain is untreated?

- ▶ Increased Morbidity
- ▶ Increased Mortality
- ▶ Sleep Disturbances
- ▶ Decreased Socialization
- ▶ Malnutrition
- ▶ Depression
- ▶ Impaired Immune Function
- ▶ Impaired Ambulation
- ▶ Increased health care use and costs
- ▶ Cognitive, Social and Functional Decline



Why use the STI?

1. Time: 5.7 to 201.5 minutes (mean = 23.1 minutes) to manage disruptive behavior.





Why use the STI?

2. Agitated behavior is contagious





Why use the STI?

- 3. Satisfaction: Your competence, person's comfort
- 4. Primary reason for transfer out of home





Table 1. Description of Behavior Initiating STI (57 Subjects had 98 Behaviors)

Behavior	f	%
Verbal: nonspecific vocalization	23	40.35
Combative/resistive	16	28.07
Restless Body Movement	15	26.32
Verbal: specific complaint/need	9	15.79
Crying/tears in eyes	8	14.03
General agitation	7	12.28
Exiting Behavior	5	8.77
Changes in appetite	3	5.26
Withdrawn/quiet	3	5.26
Rubbing/holding area	2	3.51
Facial grimacing	2	3.51
Confusion	2	3.51
Changes in sleep	1	1.75
General change in behavior	1	1.75
Change bowel elimination	1	1.75



Physical Assessment Findings From 57 residents 51 + findings

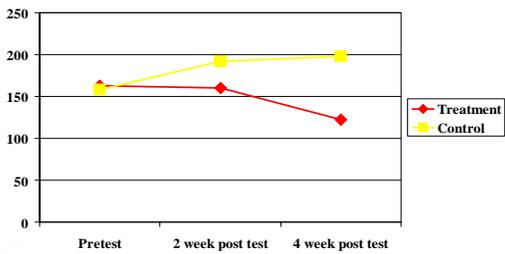
- ▶ 7 Changes in activity: lethargy, frequent falling, ↑ wiggling, exiting, agitation
- ▶ 6 Verbal Complaint: 5 pain, 1 yelling
- ▶ 6 M-S: ↓ ROM, pain
- ▶ 5 Urinary: 5 UTI
- ▶ 5 ↑ confusion
- ▶ 4 Resp: 3 Pneumonia, 1 ↓ pulse oximetry



- ▶ 4 Neuro/Psych: 2 delusions 1 suicidal 1 peripheral neuropathy
- ▶ 4 Body Part Cues: rubbing, restless
- ▶ 3 fevers
- ▶ 2 Skin: scratching to excess, skin tear
- ▶ 2 Vascular ↑ edema
- ▶ 2 Other: hearing aide malfunction, exiting
- ▶ 1 GI: guiac+

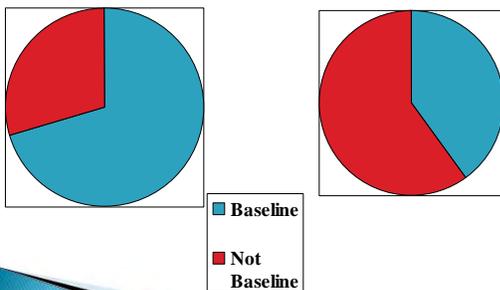


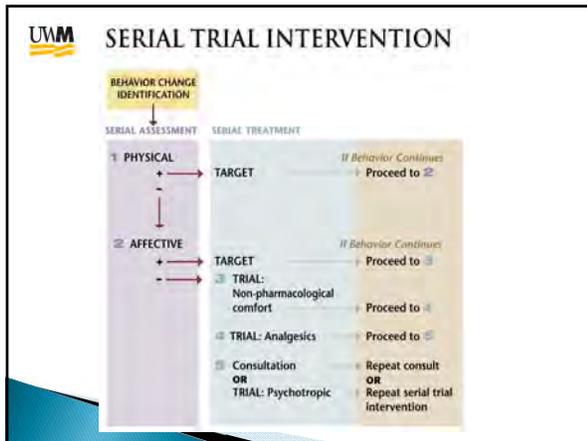
Differences in Discomfort Between Treatment and Control Groups





Return of Behaviors to Baseline





- UWM Behaviors Associated with:**
- | Dementia | Pain |
|-------------------------|--------------------------|
| ▶ Agitation | ▶ Agitation |
| ▶ Aggression | ▶ Combative/Angry |
| ▶ Wandering | ▶ Restless Body Movement |
| ▶ Activity Disturbances | ▶ Change in Behavior |
| ▶ Depressed Affect | ▶ Moaning |
| ▶ Withdrawn Behavior | ▶ Withdrawn Behavior |
| ▶ Crying | ▶ Crying/Tears |

- UWM Looking for Physical Causes of Discomfort**
- ▶ Verbal
 - ▶ ADLs
 - ▶ Activity
 - ▶ Social
 - ▶ Vital Signs
 - ▶ Cognition
 - ▶ Body Part Cues
 - ▶ Body Systems – Focus on the most common causes of pain in this population
 - Arthritis, Old Fractures, Neuropathies, Malignancies



Neuropathic pain assessment

- ▶ Sensory adjectives used by patients: electric-shock, burning, tingling, cold, prickling, itching
- ▶ Evoked pain: either by a stimulus that does not usually evoke pain (allodynia) or increased response to a stimulus that is normally painful (hyperalgesia)



Vital Signs, B/P, P, T, Sweating

Acute Pain is more likely to:

- ▶ Increase Blood Pressure
- ▶ Increase Pulse
- ▶ May cause sweating

We check a temperature to determine if there could be an underlying infection.





What if you find a physical cause for the behavior?

- ▶ Treat it with PRN “as needed medications”, or nursing treatments/orders
- ▶ Contact the MD/DO/APNP for orders to diagnose or treat new conditions/concerns
- ▶ Think about treatment consistent with overall goals of care



2. Does the person have regular meaningful human interaction?

- ▶ Everyone needs meaningful human interaction - it provides feelings of comfort and safety.
- ▶ If necessary, order 10 minutes of 1:1 time two times/day as a nursing order.





3. How stressful is the person's environment?

- ▶ When environmental stressors exceed the person's stress threshold, the result is stress. This may ↑ agitation.





What are environmental stressors?

Noise

- ▶ TV on all day
- ▶ Pounding pill crushers
- ▶ Background conversations
- ▶ Phones turned too loud
- ▶ Echoes in bathrooms or other tiled areas
- ▶ Public address systems





What are environmental stressors?

Tactile

- ▶ Itchy skin conditions
- ▶ Rough handling
- ▶ Room temperature too cold or too warm
- ▶ Vinyl furniture
- ▶ Hard, unpadded chairs
- ▶ Wrinkled bed linens or clothing
- ▶ Poorly fitted shoes or clothing

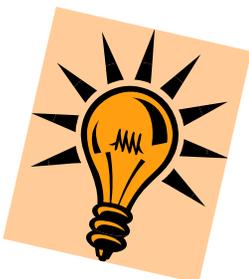




What are environmental stressors?

Visual

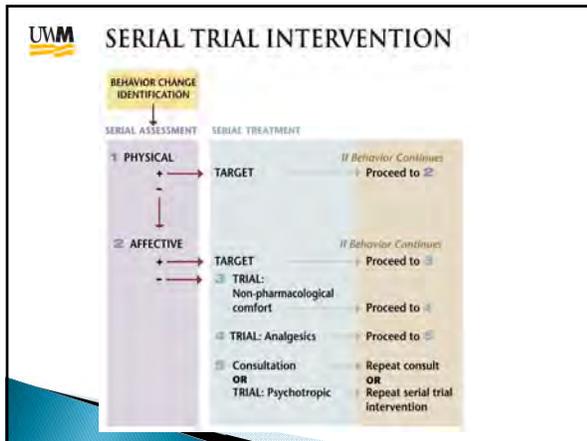
- ▶ Glare from lights
- ▶ Shiny floors
- ▶ Clutter
- ▶ Spaces that are too big or too small
- ▶ Unfamiliar environments or people





4. Are there any other psychosocial factors the nurse feels may be affecting a person's behavior?





UWM Non-Pharmacological Treatments

- ▶ These treatments were found useful by nurses.
- ▶ Try 2-3 things in a row (do not move onto step 4 for 30-60 minutes).

UWM Non-Pharmacological Interventions

- ▶ Therapeutic Communication
 - Calm approach
 - Use name often
 - Eye contact
- ▶ Quiet environment/quiet time
- ▶ Relaxation
- ▶ Change environment





Non-Pharmacological Interventions

- ▶ Hugging
- ▶ Cueing/Redirecting
- ▶ Gentle touch
- ▶ Massage/warm foot soak
 - Provides distraction, relaxation, and increases superficial circulation





Non-Pharmacological Interventions

- ▶ Dress warmly
- ▶ Providing fluids
- ▶ Providing a snack
- ▶ Toileting
- ▶ Personal hygiene assistance
- ▶ Use 2 caregivers for ADLs
- ▶ Nap





Non-Pharmacological Interventions

- ▶ Disimpaction of bowel
- ▶ Dressing treatment to wound
- ▶ Apply heating pad
 - Increases blood flow to the area, improves tissue nutrition and metabolism, reduces muscle spasm
- ▶ Apply ice
 - Provides vasoconstriction, decreasing nerve conduction velocity, swelling, and cell metabolism



Non-Pharmacological Interventions

▶ Repositioning/movement

- Exercise may improve circulation, reduce joint stiffness
- Rummage boxes
- *** No items small enough to choke on secondary to hyperorality ***
- Handballs
- Bean bags
- Ambulating with staff
- Up in wheelchair





Non-Pharmacological Interventions

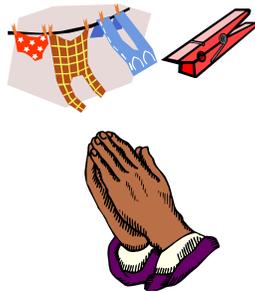
▶ Normalization "work-based" activity

- Folding laundry
- Cooking
- Scrubbing vegetables

▶ Cognitive activities

- Reminiscence
- Poetry readings
- 1:1 visiting/therapeutic communication

▶ Spiritual intervention





Non-Pharmacological Interventions

▶ Sensory stimulation

- Pet therapy
- Music therapy
- Bread baking
- Coffee club
- Gardening

▶ Art Activity

▶ Viewing a film

▶ Television



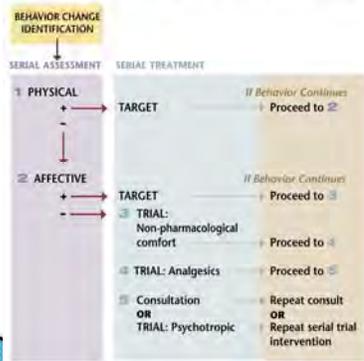


Non-Pharmacological Interventions

- ▶ Which of these can you do now with the resources you have?
- ▶ Which could be done in under one minute?
- ▶ Which could be done in ten minutes or less?
- ▶ Which could you do if you had a few extra resources?



SERIAL TRIAL INTERVENTION





Begin a trial of analgesics...

- ▶ Pain in the elderly
 - Often not reported
 - Prevalent
 - Start low and go slow



Challenges to Assessing Pain



- ▶ Stoicism, not wanting to be a “complainer”
- ▶ Concerns about taking pain medicines
- ▶ Belief that pain is part of growing old
- ▶ Fear of the meaning of the pain



“I don’t have any pain, but I sure am sore!”

No c/o ≠ no pain



Acetaminophen (APAP)

- ▶ For mild to moderate pain
- ▶ Routine dosing up to 2000 - 3000 mg/day maximum in older adults
- ▶ Avoid in hepatic compromise
- ▶ With renal disease, use q 6 h dosing rather than q 4h
- ▶ Be aware of “hidden” doses of APAP in combination products



NSAIDs

- ▶ Indicated for pain from acute inflammatory process (such as gout)
- ▶ Effective for mild to moderate pain
- ▶ Too many adverse effects





Adjuvants

- ▶ Anticonvulsants: Gabapentin (Neurontin[®]), Lamotrigine (Lamictal[®]), Pregabalin (Lyrica[®])
 - Adverse effects: unclear thinking, forgetfulness, and other CNS side effects
- ▶ Tricyclic Antidepressants
 - Adverse effects: anticholinergic effects (Desipramine and nortriptyline are preferred over amitriptyline or doxepin), morning grogginess, postural hypotension, can cause blood levels of other drugs to be much higher
- ▶ Newer Antidepressants, expensive, duloxetine (Cymbalta[®]), venlafaxine (Effexor[®]),
 - work better, fewer side effects



Topical Agents

- ▶ Local action with minimal systemic side effects
- ▶ Indicated for neuropathic pain but can be effective in musculoskeletal pain as well





Opioids

- ▶ Addiction–Tolerance–Physical Dependence
- ▶ Side effects:
 - Sedation (→ falls, ↓appetite)
 - Nausea, vomiting, dry mouth
 - Constipation
 - Urinary retention
 - Confusion
 - Dysphoria, hallucinations
 - Respiratory depression (rare)



Opioids: Use Info

- ▶ Residents with regular recurring pain should have scheduled dosing rather than prn dosing
- ▶ Residents requiring multiple doses of short-acting combination or straight opioids should be switched to long-acting opioids
- ▶ Always start on bowel regime



Combination drugs

- ▶ Inexpensive
- ▶ Widely available
- ▶ Short-acting
- ▶ Be aware of acetaminophen limits
- ▶ Which drug working or causing adverse effects?
- ▶ Acetaminophen With Codeine (constipation, nausea, not that effective)
- ▶ Oxycodone (Percocet) combination contains 325 mg acetaminophen
- ▶ Hydrocodone (Vicodin, Lortab) combination contains 500 mg acetaminophen
- ▶ Tramadol (Ultram)



Opioid Options

- ▶ Hydrocodone 2.5 mg / 325 mg APAP
 - can be split to give a 1.25 mg dose
- ▶ Tramadol 37.5 mg / 325 mg APAP
 - Can be split to give 18.75 mg dose
- ▶ Morphine 10 mg / 5 ml solution
 - Can give 2 mg in one ml of solution



Long Acting Opioids

- ▶ Morphine Sustained Release (MS Contin[®], Kadian[®], Avinza[®])
- ▶ Oxycodone Sustained Release (Oxycontin[®])
- ▶ Transdermal Fentanyl (Duragesic[®])
- ▶ Methadone
- ▶ Tramadol (Ultram ER[®])
- ▶ Oxymorphone (Opana ER[®])





Physical Non-Drug Techniques

- ▶ **Massage** → ↑ relaxation, ↑ blood flow
- ▶ **Cold** → numbs nerve endings (itch), ↓ inflammation, muscle spasm
- ▶ **Heat** → ↓ inflammation, soreness, sensitivity to pain, ↑ blood flow
- ▶ **Vibration** → ↓ painful feeling ↑ pain threshold
- ▶ **Positioning/movement** → correct body alignment helps muscles, movements and fluid, blood flow



Non-Drug Techniques

Pain → Stress → Pain

- ▶ Distraction
- ▶ Relaxation
- ▶ Music
- ▶ Comfort Foods
- ▶ Imagery
- ▶ Controlled Breathing





What if analgesics are ineffective?

- ▶ Fork in the road





Next Step: Consultation Psychotropic ?

- ▶ Consult with the MD/DO/APNP
- ▶ Is a psychotropic drug indicated?
 - Antidepressants
 - Antipsychotics
 - Sedatives/hypnotics



Serial Trial Intervention – Community





To obtain more information

- ▶ The Serial Trial Intervention (STI) Teaching Manual: An Innovative Approach to Pain and Unmet Need Management in People with Late Stage Dementia

Contact Sue Braden at (414)229-2729 or <http://www.ageandcommunity.org/products.html>.



Nurse Responses to Dementia Behaviors as Predictors of Recurrence of Dementia Behaviors



Dismissive

- ▶ The nurse does no treatment in response to behavior change



DISMISSIVE

CASES 1-3

- 1 Wandering and socially inappropriate behavior
→ oriented only to person, sleep is adequate, + edema, skin intact, no pain, eats 25-50% of meals
→ 0% better
- 2 Calling out X4 in 24H, no S & S pain
→ 0% better
- 3 Calling out X4, confused and very agitated
→ 25% worse



STATIC

The nurse continues to utilize the same 1 or 2 assessment and/or treatment technique(s), even though the behavior does not improve, or the improvement is only temporary.

CASE 7

- 2/10/04, 8am: urinating on floor in room → redirected → 75% worse
- 1pm: urinated on floor in front of closet → redirected by staff → 100% worse
- 2pm: urinated on floor in room. Laughs at staff attempts at redirection. Denies UTI symptoms → 100% worse.
- Pm's urinated X2 on floor → redirection → 100% worse
- Over next 4 days 14X documented urination → redirection → ineffective

CASE 8

- 2:30/04: groping at female staff member → vitals stable → redirect → 0% better
- 3/1/04: grabbing and patting CNA butt & trying to bite breasts while dressing → redirect & re approach → 0% better
- 3/2, 3/3, 3/8 same → 0% better
- 3/10 grabbing → physical assessment → 1:1, walk, snack, drink → 50% better
- Next 11 days groping → redirect → 0% better

REACTIVE

The nurse provides one or more treatments without comprehensive assessment.



REACTIVE

CASES 4-6

- 4 Pacing → 1:1 activity
→ 0% better
- 5 ↑ Confusion → 1:1, redirected, juice given
→ 100% better
- 6 Striking out while being dressed, angry facial expression
→ talked to resident calmly, explained breakfast time,
procedure and reason
→ 50% better



COMPREHENSIVE

The nurse assesses 3 or more body systems, functional or affective parameters and provides 1 or more treatments.



COMPREHENSIVE

CASE 9

- C/o pain in left temple → ↓ activity noted past couple of days, BP 120/84, P76, R22, T98.6. C/o pain to contracted hand, able to move 2 digits. Also c/o bladder pain and pain to R flank. Denies burning or difficulty urinating. Lungs clear, bowel sound active. Urine dipstick - → 0% better
- Hx CVA, contractures, DJD
- 0 environmental stress, activities well paced.
- Lotioned hand and arm with minimal ROM, assisted with transport to activity room → 25% better
- Tylenol given → no change after 1 hour
- Prescriber notified new c/o pain. Vicodin ordered and given → 100% relief

COMPREHENSIVE

CASE 10

- Agitated. Sitting at nurses station c/o burning in leg and deep itch. "I could go down there and pull my skin off."
- No redness, rash, physical assessment negative. Adjusted brace, no relief. Still fidgeting in chair.
- Provided attention → 25% better
- Tylenol given → 75% better
- Doxepin ordered → 100% better. "Day and night difference. Much more relaxed."

HIERARCHICAL REGRESSION with Recurrence of Behavior as Criterion N=112

STEP AND PREDICTOR VARIABLE	β	ΔR^2	F
1 Functional Level	.029	.029	1.80
2 Functional Level Behavior Symptom Profile	.121	.092**	2.01* 3.36**
3 Functional Level Behavior Symptom Profile Reactive Responses	.256	.134***	2.05* 2.75** 4.37***
4 Functional Level Behavior Symptom Profile Reactive Responses Static Responses	.457	.201***	2.01* 3.49** 1.95 6.24***

*p<.05 **p<.01 ***p<.001

PROBLEM: Time & Information Overload

- ▶ Decision Support Tools
- ▶ Efficient Use Assessment & Diagnostics



UWM Family Meeting Individual Needs & Preferences---shifting goals of care

Comfort QOL Human Dignity Maintaining Personhood

↓ ↓ ↓ ↓

□ □ □ □



UWM **The good news**

- ▶ These sorts of talks and conversations are happening around the country
- ▶ We do have the power to make this better



UWM **If you could do one thing.....**

- ▶ To change systems in which care is delivered
- ▶ To change transitions between care settings
- ▶ To teach others about assessing challenging behaviors
- ▶ To teach others about managing challenging behaviors
- ▶ To work with families
- ▶ To work together as a team

