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Medicine, Nursing and Health Sciences



Implementing evidence-based dementia guidelines: Using the views of GPs to inform behaviour change interventions

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**Paper presented at the Alzheimer's Australia 14th National Conference
May 2011
Brisbane Australia**

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IRIS: Investigating Research Implementation Strategies for care of people with dementia

Aim

- **To improve outcomes of people with dementia by increasing the uptake of evidence-based guidelines for diagnosis and management by general practitioners**

Objectives

- **To develop a targeted strategy designed to help practitioners follow evidence-based guidelines**
- **To test the effectiveness and cost-effectiveness of the strategy to change general practitioners behaviours and improve outcomes for people with dementia and their carers**

IRIS Research Team



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Diagnosis and Management of Dementia - Recommended Behaviours

- **Diagnostic Behaviours**
 - **Cognitive Assessment**
 - **Depression Assessment**
 - **Pathology**
 - **CT Scan**
 - **Medication Review**
 - **Referral for Medication**
- **Management Behaviours**
 - **Disclosure of Diagnosis**
 - **Caregiver training**
 - **Cognitive stimulation**
 - **Recreational activities**
 - **Driving assessment**
 - **Legal Issues**



Problem Recognition - Diagnosis – Management Process

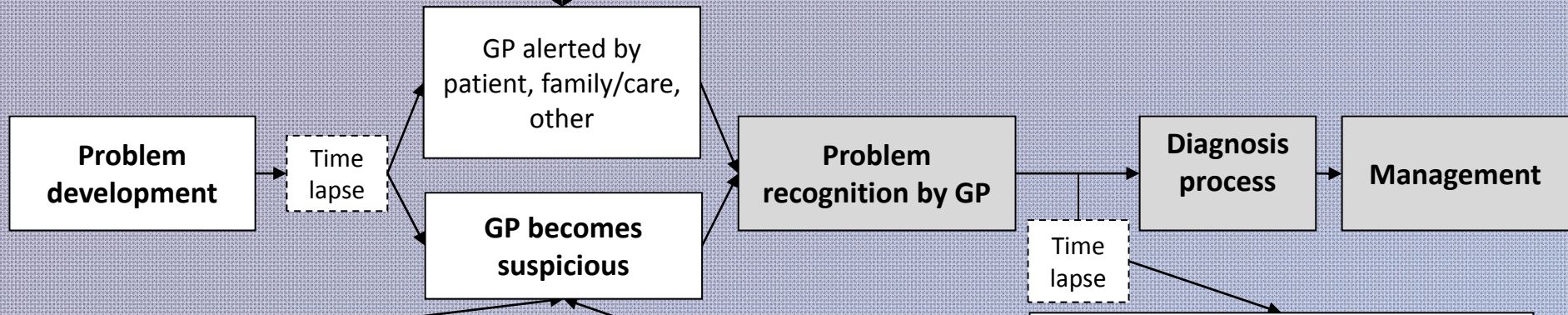


Enablers

- Patient has family/carer who recognise problem
- Family/carer want patient assessed
- Neighbours/community members concerned and alert GP

Barriers

- Family not recognise as a disease – see signs as normal ageing so not report to GP
- Family in denial
- Family not see patient regularly
- Patient doesn't have family/carer
- Patients rarely report it themselves*



Enablers

- Regular conduct of 75+ health assessment
- Time/resources to conduct 75+
- Patient willingness to participate in 75+
- Ability to conduct 75+ in patient's home
- Familiarity with patient – if know well may notice changes OR if don't know well may notice behaviour
- Frequency with which GP see patient - if not see regularly may notice changes
- Patient sees same GP consistently

Barriers

- Patients can cover up in a short consultation
- Carer/family compensate for patient in consultation GPs no longer doing home visits – can't assess patient's living situation
- Familiarity with patient – if know well may not notice subtle changes OR if don't know well behaviour may not stand out
- Frequency with which see patient – if see frequently may not see subtle changes
- Patient seeing several GPs in the one practice

Possible reasons

- Need to schedule another appt. as insufficient time to assess at initial consultation
- Delay in patient presenting for assessment (eg if can't commence at initial visit)
- Other medical conditions more immediate
- Cognitive assessment results inconclusive/borderline & need to reassess
- Delay in accessing pathology
- Delay in accessing CT facilities
- Delay whilst GP treats other medical conditions that may impact cognitive function (eg depression, etc)
- Delay in accessing CDAMS/specialist
- Patient reluctance to pursue at that time
- Carer reluctance to pursue at that time
- GP reluctance to pursue at that time



Phase 1 AIMS – Qualitative Interviews

- **To explore the barriers and enablers to application of evidence-based dementia care for patients by GPs**
- **To inform the development of a survey for use in a larger representative sample of general practitioners**
- **To use these data to inform the development of an intervention to improve dementia guideline implementation by GPs**



Phase 1 SAMPLE

- **General practitioners randomly selected from AMPCo database and invited to participate**
- **30 general practitioners**
- **Sex**
 - 18 male
 - 12 female
- **Practice location**
 - 13 metro
 - 17 rural

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Phase 1 DATA COLLECTION

- **Semi-structured interviews, guided by behavioural theory¹**
- **Focused on recommended behaviours in the diagnosis and management of dementia (SIGN guideline)**
- **Audio taped and transcribed verbatim, and checked by participants**
- **Recruitment continued until saturation**

¹ Michie (2005). *Journal of Quality and Safety in Health Care*



Theoretical framework used to guide interviews and analysis

1. Knowledge
2. Skills
3. Social/professional role and identity
4. Beliefs about capabilities
5. Beliefs about consequences
6. Motivation and goals
7. Memory, attention and decision processes
8. Environmental context and resources
9. Social influence
10. Emotion
11. Behavioural regulation
12. Nature of the behaviours



Phase 1 ANALYSIS METHODS

- **Thematic and content analysis (guided by theoretical framework) of barriers and enablers**
- **Subset checked by independent researcher for reliability**
- **Discrepancies discussed to reach consensus**

What are the recommended **DIAGNOSTIC** behaviours?

1. Complete a **review of all current medications** that could explain cognitive impairment
2. Complete **pathology tests**
3. Conduct a **formal cognitive assessment** using the Mini Mental State Examination (MMSE). This behaviour is a two-part behaviour (i) screen for cognitive impairment and (ii) use of a validated scale
4. Assess **co-morbid depression** using the Geriatric Depression Screen (GDS) (a validated tool). This behaviour is a two-part behaviour (i) screen for depression and (ii) use of a validated scale
5. Refer for a **CT scan**
6. Offer **referral to a specialist** for access to medications

Barriers to following **DIAGNOSIS** guideline recommendations: **Formal Cognitive Assessment**

- **Beliefs/skills**
 - MMSE and other scales are not good for measuring impairment, believe clinical judgment is better
 - Condition not problematic at this stage
- **Emotion**
 - Patients find it embarrassing/uncomfortable/confronting/demeaning to be tested using the MMSE



Barriers to following **DIAGNOSIS** guideline recommendations: **Formal Cognitive Assessment**

- **Social**
 - Patients and their families refuse to have the test/cognitive assessment
- **Environmental context**
 - Lack of time/resources so prefer someone else to administer test

Barriers to following **DIAGNOSIS** guideline recommendations: **Assessing Co-morbid Depression**

- **Beliefs/skills**
 - Dislike scales, believe clinical judgment just as effective
 - Cannot treat depression if person has dementia
 - Limited training using Geriatric Depression Scale

Barriers to following **DIAGNOSIS** guideline recommendations: **Assessing Co-morbid Depression**

- **Knowledge**
 - Unaware of what standardised scale to use
 - Not aware that this is part of dementia diagnosis
 - Not aware that depression can affect cognition
- **Emotion**
 - Demeaning to patient, patient uncomfortable

Barriers to following **DIAGNOSIS** guideline recommendations: **Referral to Specialist for Medications**

- **Beliefs**

- Cognitive impairment is not sufficient to be eligible for medication
- Medication not effective
- Patient's other conditions are higher priority

- **Social influences**

- Patient, carer or family refuse

- **Environmental context**

- Limited access to specialists, CADMS



Phase 2 Intervention Development

- **We have identified the behaviours that need to change and will use the following behaviour change techniques informed by the Theory-Technique Matrix**



Phase 2 Intervention Development: Behaviour Change Techniques

- Self-monitoring
- **Persuasive communication**
- **Information regarding behaviour, outcome**
- Feedback
- Goal/target specified: behaviour or outcome
- Monitoring
- Rewards/incentives (incl self evaluation)
- Graded tasks
- Increasing skills: problem solving, decision making goal setting



Phase 2 Intervention Development: Behaviour Change Techniques

- Coping skills
- Rehearsal of relevant skills
- Social processes of encouragement & support
- **Modeling/demonstration of behaviour by others**
- Homework
- Self talk
- Motivational interviewing
- Stress management



Phase 2 Intervention Development: Techniques and content example

- To improve knowledge and change beliefs use face-to-face or DVD presentation by opinion leaders:
 - Opinion leader uses **persuasive techniques** to highlight importance to screen for depression using validated scales, why a scale is helpful/beneficial and how the information is used/useful and reasons why (as opposed to clinical assessment). Directly challenge belief that assessing depression clinically is as valid/reliable as using a validated tool to screen for co-morbid depression (**information regarding behaviour**)

Phase 2 Intervention Development: Techniques and content example

- To improve knowledge and change beliefs use face-to-face or DVD presentation by opinion leader:
 - Description/demonstration of his/her approach to completing the GDS (**Modeling**)
 - Acknowledge potential challenges of using validated tools for assessment
 - Include examples of beliefs reported in GP interview
 - Acknowledge that own clinical judgement is important also and they are complementary
 - Acknowledge that it is appropriate for patient to be depressed if experiencing cognitive symptoms (**information regarding behaviour**)



Conclusion

- **Using behaviour change theory is useful in identifying barriers to and enablers of the implementation of clinical guidelines**
- **Categorising barriers according to theory can inform best intervention techniques**
- **We are now finalising the intervention**