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Knowledge gains and intent to change practice patterns after the Leveraging Existing Abilities in Dementia (LEAD)™ Training Program

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Abstract

Few investigations have examined dementia training programs for rehabilitation professionals. To address this, the *L*everaging *E*xisting *A*bilities in *D*ementia (LEAD) program was developed and examined with a pilot study. LEAD addressed dementia knowledge; the Strength-Based Approach; strategies for communication, recognizing behaviors, and learning techniques; and documentation. Participants completed pre-program, post-program, and three-month follow-up questionnaires assessing confidence, practice patterns, and dementia knowledge. Confidence and use of treatment strategies increased through the three-month follow-up and dementia knowledge significantly increased following training. LEAD positively impacted rehabilitation professionals' knowledge, confidence, and use of evidence-based treatment strategies. Implications of LEAD and future research are discussed.

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Introduction

Patients with dementia pose unique challenges to rehabilitation professionals. A diverse range of deficits in memory, attention, judgement, communication, behavioral disturbances, and language are common in individuals with dementia (IWDs). IWDs have a higher rate of skilled nursing facility stays and home health referrals compared to those without dementia (Alzheimer's Association, 2018) leading to a greater likelihood for rehabilitative services, such as physical or speech therapy. While commonly thought that IWDs cannot benefit from rehabilitation services, research reveals they can benefit from rehabilitation and exercise (Dawson, Judge, & Gerhart, 2019; Schwenk et al., 2014; Suttanon et al., 2013). These successes, however, are not widespread due to reported barriers associated with service provision to these patients including limited knowledge and skills related to dementia. For example, understanding how various cognitive processes are impacted by the illness or understanding how to recognize and address different emotions and behaviors.

Current literature largely focuses on staff training programs for nursing staff and caregivers. These training programs have included education about dementia, how to recognize and manage behaviors, social support resources to reduce burden of care, and communication skills (Lewis, Hobday, & Hepburn, 2010; Pleasant et al., 2017). Several studies have demonstrated improved confidence (Lewis et al., 2010), increased knowledge about dementia care (Lewis et al., 2010; Pleasant et al., 2017), reduced caregiver stress (Gitlin et al., 2008), and reduced behavioral symptoms (Gitlin et al., 2008). While the successes of these programs are encouraging, participants were primarily identified as nurses, nursing aides, mental health providers, or other care staff, with only one study including 2% physical therapists and 2% occupational therapists in their sample (Karlin, Visnic, Shealy McGee, & Teri, 2014). It is important that rehabilitation specialists are included as they serve an integral part of an older adult's return to optimal functional level following injury or illness across all settings in the continuum of care.

Components of staff training programs have focused on increasing dementia knowledge, how to manage behavioral symptoms, communication skills, and/or problem solving skills for patient care. Each of these components are important to include when educating health care professionals; however, many programs do not include all of these key educational objectives. Further, many programs do not utilize an approach that incorporates specific strategies to include the individual as active participants in their care plan. The Strength-Based Approach has been found to be a beneficial tool for assessing and treating behavioral and psychosocial issues in individuals with chronic health conditions (Orsulic-Jeras, Shepherd, & Britton, 2003; Xie, 2017). This approach is well-suited for individuals with progressive and irreversible pathologies as it focuses on remaining abilities rather than deficits. While it is sometimes assumed that IWDs face only loss and decline due to the neurodegenerative nature of most dementias, emerging research is urging clinicians to assess and capitalize on remaining strengths from multiple domains in order to allow individuals to stay engaged in their own care (Judge, Yarry, & Orsulic-Jeras, 2009). For example, using evidenced-based techniques (e.g. errorless learning, spaced retrieval) that capitalize on

procedural long-term memory can circumvent and compensate for losses in short-term memory and cognitive processing (Brush & Camp, 1998). Identifying remaining strengths of physical function abilities, personal factors, and environmental factors that support the individual also is important. Another central focus of the Strength-Based Approach is the inclusion of the individual as an active participant in the treatment process. From a rehabilitation perspective, this is accomplished by emphasizing interests of the individual, giving the individual choices when selecting treatment interventions, and encouraging continuation of enjoyable activities while making appropriate modifications to facilitate success. Keeping these principles in mind during plan of care development can lead to increased enjoyment and treatment adherence (Dawson et al., 2019).

Using a Strength-Based Approach to facilitate communication and learning while addressing behaviors may reduce common barriers experienced by clinicians. To address this important issue, an innovative training program, *L*everaging *E*xisting *A*bilities in *D*ementia (LEAD), was developed to meet the needs of rehabilitation professionals (i.e., occupational therapists, physical therapists, and speech-language therapists). The current study aimed to (1) describe the core components of the LEAD program and (2) investigate its effects on rehabilitation professional's dementia knowledge base, confidence handling common patient care situations, and practice patterns.

Methods

Description of LEAD Training Program

Using the Strength-Based Approach as an overarching framework, LEAD is a structured two day, 12-hour training program that uses lecture, discussion, case studies, and active learning activities. The LEAD curriculum (Table 1) consists of six content areas: (1) Overview of Dementia; (2) Strength-Based Approach to Rehabilitation; (3) Treatment Strategies to Facilitate Successful Outcomes; (4) Identifying and Addressing Barriers to Management of Individuals with Dementia; (5) Assessment and Developing Therapeutic Goals and Plans of Care; and (6) Documentation and Reimbursement Issues in Dementia Care.

To address barriers reported in the current literature, the learning objectives of the LEAD program are: (a) distinguish between normal and pathological cognitive aging; (b) understand the different types of dementia and their impact on various aspects of communication, functional activities, self-care, and well-being; (c) identify differences between Strength-Based Approach and traditional medical model; (d) assess remaining strengths and domains requiring compensation in patients with dementia; (e) develop appropriate treatment goals for each stage of dementia; (f) develop plans of care using current evidenced-based interventions and best practices in literature; and (g) demonstrate ability to document medical necessity and skill needed for reimbursement.

The LEAD Training Program was developed and taught collaboratively by a cognitive aging psychologist and a board-certified geriatric physical therapist with academic and research training in applied aging psychology. Both instructors have over 15 years of experience in their respective fields including direct interactions with IWDs and their family caregivers.

Table 1. *L*everaging *E*xisting *A*bilities in *D*ementia (LEAD) Training Program—Curriculum overview.

Content area	Specific issues covered
Overview of dementia	• Understanding cognitive processing and aging • Dementia versus normal aging • Types of dementia • FDA-approved medications • Available non-pharmacological therapies • Importance of maintaining personhood
Strength-Based Approach to rehabilitation	• What is a Strength-Based Approach? • Remaining cognitive strengths • Benefits of using a Strength-Based Approach
Treatment strategies to facilitate successful outcomes	For therapists: • Communication strategies • Recognizing emotions and behaviors Treatment facilitators: • Errorless learning • Learning by observation • Spaced-retrieval • External memory aids • Cognitive task analysis • Montessori-based activities
Identifying and addressing barriers to management of individuals with dementia	• Roles of therapeutic intervention • Difficulty following directions • Conversational barriers • Lack of engagement and motivation • Behavioral issues • Limited follow through and adherence • Family dynamics and interference
Assessment and developing therapeutic goals and plans of care	• Role of rehabilitation professionals • Recommended assessment tools • Dementia and exercise
Documentation and reimbursement issues in dementia care	• Medically necessary • Skilled interventions • Goal writing • Documenting progress

Evaluation of LEAD Training Program

Participants in the study were rehabilitation professionals employed by a home health agency. The impact of the LEAD training program was assessed by examining program acceptability, dementia knowledge, confidence in managing dementia practice, and practice patterns using treatment strategies considered evidence-based and best practices. To assess *program acceptability*, participants were asked to rate the LEAD training program (1 being poor and 5 being excellent) on the following metrics: instructor ability, organization of material, instructor effectiveness, and whether or not the content met the objectives, was

relevant to their work, and whether the handouts provided were useful. *Dementia knowledge* was assessed via the Dementia Knowledge Assessment Scale (DKAS; Annear et al., 2015). *Confidence in dementia practice* was measured through five questions regarding level of confidence (6-point Likert scale with 0 being "Very Uncertain" and 5 being "Very Confident") in managing various practice situations encountered during treatments with patients with dementia (e.g., "effectively providing daily care or treatment of a patient with moderate dementia", "justifying medical necessity and skilled interventions need for patients with dementia"). Finally, *practice patterns* were examined through questions asking how often attendees used 10 specific techniques (Table 2) to enhance communication and treatment (e.g., spaced-retrieval, learning by modeling, reframing behaviors) on a 6-point Likert scale with 0 being "I don't know that method" to 5 being "Daily".

Procedure

Prior to the course, the attendees completed a baseline survey and questionnaire inquiring about professional designation, highest educational degree, years of practice, and experience working with patients with dementia. The questionnaire included questions regarding practice confidence and practice patterns working with patients with dementia. Finally, attendees completed the DKAS.

Immediately following the two-day LEAD training program, attendees completed a second survey and questionnaire that assessed program acceptability and rated whether their *practice confidence* level changed in the same situations asked on the initial questionnaire on a 5-point Likert scale (0 being "Feel Less Confident" and 5 being "Definitely More Confident"). Attendees discussed intent of *practice patterns* being asked how often they thought they plan to use the communication and treatment strategies taught in the course with 0 being "I still don't understand it enough to use it" and 5 being "Daily". And finally, attendees repeated the DKAS to examine changes in their *dementia knowledge*.

A follow-up survey was sent to each attendee three months after the program via Qualtrics using the e-mail address provided during intake. The follow-up survey assessed practice confidence and current practice patterns being used following the LEAD training program.

Statistical analysis

Data were input into SPSS Software (version 22, IBM Statistics) for analysis. Descriptive statistics were analyzed for sample representation. Additionally, frequencies identified the level of endorsement of questions regarding practice confidence, practice patterns, and program acceptability of the LEAD training program. A paired samples *t*-test was used to examine changes in dementia knowledge.

Results

Sample

Ten attendees completed the pre-program and post-program surveys. These attendees (7 PT/PTA, 2 OT/COTA, 1 SLP) had an average of 12.25 (SD 9.0) years of clinical experience with 9.43 (SD 7.83) years in dementia care. The attendees had a range of educational background

Table 2. Specific techniques described in LEAD Training Program.

Technique	Brief description	Example
Validation	Active listening and acknowledgment of a person's feelings, emotions, or thoughts; not discounting or correcting what someone says	When someone says "I don't need therapy I'm fine", respond with "I'm glad you feel fine and I think you would really enjoy some of the new activities" rather than "well you fell and need help, don't you remember?"
*K*eep *I*t *S*hort and *S*imple (KISS)	Avoid unnecessary details or fillers during directions and conversations	To facilitate standing, use the phrase "stand up" rather than a 5–6 step direction
Reframing behaviors	Useful when there is not an easy solution or when the situation is not modifiable; changing how you think about a situation instead of changing the situation	Ms. Smith continually repeats herself during therapy and tells the same stories about her family when she was a child over and over again. Instead of viewing as a negative, change how you think about her behavior. She is practicing remaining verbal and language abilities and is sharing information about herself that you can use to build rapport, redirect, and/or engage with Ms Smith.
Narrowing choices	Asking questions that can be answered in a few words; providing 1, 2, or 3 choices alternatives	Rather than saying "'what would you like to do?" rephrase as "do you want to toss a ball inside or walk around outside?"
Multi-modal cuing	Repeating information verbally and/or using physical cues to direct attention and cognitive resources	Displaying a bright sign on door "remember to take your cane" to provide a visual cue for the individual
Spaced-retrieval	Method of learning and retaining new information by recalling target information over increasingly longer periods of time	Can be used to assist individual to lock wheelchair brakes, consistently use walker, or use compensatory swallowing techniques
Montessori-based activities	Provides structure and opportunities for meaningful and purposeful engagement through activities based on the Montessori method	Treasure hunt; shape sort; eating and swallowing; standing and walking activities (Camp, 1999)
Cognitive task analysis	Process of breaking down a task into its simplest components, so that each step can be completed more easily	Breaking a sit to stand transfer into 5 steps and working on those individually before attempting the entire task
Errorless learning	Using feedback from the task or environment to ensure individuals learn the correct information	Using puzzles with distinct shapes to allow for only one correct answer; immediate correction during an activity to only allow proper completion

(continued)

Table 2. Continued

Technique	Brief description	Example
Learning by modeling	Demonstrating how to perform an activity while individual observes and then performs themselves	Therapist showing the individual how to put on a shirt then the individual repeating

with three having an Associate's degree, four had a Bachelor's degree, two had a Master's degree, and one had a professional Doctorate.

Program acceptability

The two-day program was found to be highly acceptable with instructor ability, organization of material, content of the program, and relevance of the program to participant's work all being endorsed with a rating of 5 or "excellent" by all attendees. Instructor effectiveness was rated on average as a 4.89 (SD 0.33) and usefulness of handouts was rated at 4.78 (SD 0.44).

Pre–post comparison of dependent measures

All outcomes demonstrated improvements immediately following the LEAD training program. Scores on the DKAS significantly increased from a mean of 22.3 (max 27) before the program to 24.9 at post-test ($t = -3.23$, $p = 0.01$), indicating that on average attendees improved by correctly answering 2.6 more ($\sim$10%) questions after the program. All attendees expressed an increase in practice confidence following the LEAD training program (Figure 1) with 80% of attendees being "definitely more confident" in their ability to effectively communicate the plan of care to the patient's family or other members of the healthcare team and 90% being "definitely more confident" in justifying medical necessity and skilled intervention for patients with dementia.

Additionally, all attendees demonstrated an intent to use the communication and treatment strategies taught in the program. See Figure 2 for visual representation of attendee responds at pre-program, immediately following the training program, and three months following. At baseline, attendees' endorsement of "I don't know that method" ranged between 30% and 100% (with an average of 54%) while endorsement of using the strategy "daily" ranged from 0% to 30% (with an average of 9.3%). Following the program, almost all responses (7 out of the 10 strategies endorsed 100% with average of 82.6% across all) indicated that these strategies would be used "at least once per week" or "daily". This indicates a definitive intention to change practice patterns to include these best practices and evidence-based strategies in provision of care to their patients with dementia. Additionally, research consistently has found the important link between behavioral intentions and behavioral change; in that successful change in one's behaviors is intricately linked to one's cognitive intentions (Ajzen, 1991).

Follow-up measures

Of the 10 attendees of the LEAD Training Program, five (50%) responded to the three-month follow-up survey. At this time, attendees continued to report being "fairly confident"

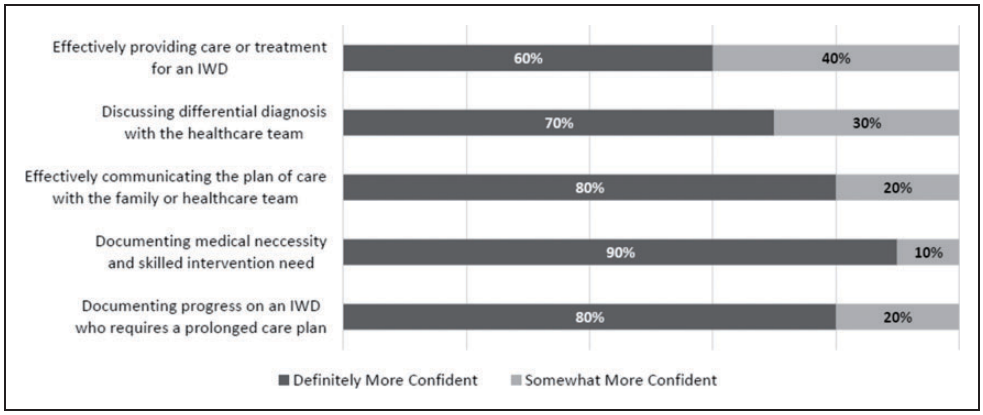

Figure 1. Immediate post-program confidence levels handling clinical situations. Note: Survey question: How confident are you in the following situations? Answers rated using a 5-point Likert scale (0 being "Feel Less Confident" and 5 being "Definitely More Confident).

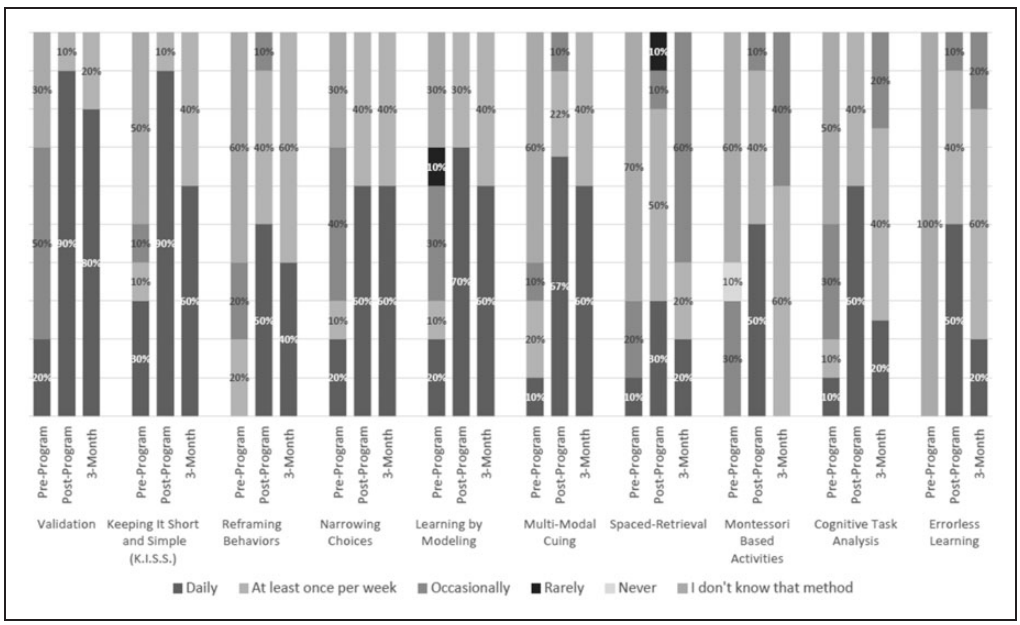

Figure 2. Frequency of using communication and treatment strategies. Note: Survey question: How often do you use the following communication and treatment strategies? Answers rated using a 5-point Likert scale (0 being "I don't know that method" and 5 being "Daily").

to "very confident" in handling various clinical situations involving patients with dementia. These attendees reported continued use of the best practices and evidence-based strategies with most using these techniques "at least once per week" to "daily" (range 40% to 100%; mean 88%). No attendee endorsed "never" or "I don't know that method" on the follow-up survey.

Discussion

With the growing number of patients across various medical settings presenting with symptoms of dementia, it is imperative that clinicians are trained to handle the challenges of this patient population. The current study evaluated the LEAD Training Program, an innovative training program developed to meet the needs of rehabilitation professionals and designed to overcome barriers, such as dementia knowledge along with communication and behavioral challenges. Attendees found the program to be acceptable with high ratings across all metrics of instructor ability and effectiveness as well as organization of the program and the program's relevance to their work.

As in previous studies focusing on direct care workers (e.g., aides, nurses, direct caregivers; Gitlin et al., 2008; Lewis et al., 2010; Pleasant et al., 2017), the current study found positive effects regarding dementia knowledge and confidence in care situations. Additionally, attendees of the LEAD Training Program demonstrated improvements in communication strategy use, specifically with the strategies of "keeping it short and simple", "narrowing choices", and "multi-modal cuing", which has been supported in previous studies with direct staff (Teri, Huda, Gibbons, Young, & Van Leynseele, 2005). The rehabilitation professionals learned about these techniques, intended to use them in their daily practice immediately following the training, and followed through with changing their communication patterns up to three months following the training. Using these communication strategies regularly can assist rehabilitation professionals in developing a strong therapeutic relationship with their patients, which is the foundation of each episode of care and may facilitate improved participation and adherence by these patients as it capitalizes on the remaining emotional memory available to IWDs (Moayeri, Cahill, Jin, & Potkin, 2000).

The current study adds to the literature by highlighting the innovative approach utilized by the LEAD program in addressing barriers rehabilitation professionals encounter when providing care to IWDs. The attendees of the LEAD program, not only reported increased use of communication strategies, but also regular use of other evidence-based strategies to facilitate optimal outcomes (e.g., spaced-retrieval, errorless learning, cognitive task analysis, external memory aids). The pre-program survey supports the literature regarding the potential barriers to successful rehabilitation with patients with dementia demonstrating the crucial need for this type of training program. The attendees demonstrated a lack of knowledge, abilities, and skills in meeting the unique needs of this patient population and benefited greatly from the training intervention. Many of these barriers were addressed during the two-day training session demonstrating the potential for change across these metrics.

There is evidence to support that patients with dementia can benefit from rehabilitation similarly to a cognitively intact patient. However, Lenze et al. (2004) found success in rehabilitation following a hip fracture was mediated by participation. These results indicate that individuals with cognitive impairment did not participate in therapy as much as those without cognitive impairment and therefore may not have had as good of outcomes as cognitively intact older adults. However, it should not be surprising that a patient must actively participate in therapy services to maximize outcomes. Therefore, in IWDs, it may not be the cognitive impairment limiting progress but rather the lack of knowledge and skill by the provider. Therefore, it is imperative that the rehabilitation professional knows the proper techniques to facilitate optimal participation and engagement by these patients. As such, the LEAD Training Program should be considered a viable intervention to provide rehabilitation professionals with the tools needed to successfully provide beneficial therapy services to their patients with dementia.

Limitations and future directions of research

While the findings of this project are valuable, the sample of attendees was small and homogeneous with all participants coming from the same home health agency. This might limit generalizability to other companies in that the administration was supportive as well as coworkers might have reminded each other to use various strategies throughout the three-month timeframe. Future research should utilize a randomized control trial design with a larger and broader sample to examine the LEAD Training Program, including immediate, short-term and long-term effects.

Future directions of research also could evaluate different modes of training. In the current study, the LEAD Training was conducted in person, which could be cost prohibitive and logistically challenging for wide dissemination. Training via webinar or video could potentially produce similar results but would need to be evaluated. Finally, the LEAD Training Program is designed to impact the knowledge and practice of the clinician; however, it would be interesting to understand how the clinicians' improved knowledge and change in practice patterns impact the patient. Therefore, future research should measure direct patient outcomes, such as participation in rehabilitation and levels of improvement in key outcomes.

Conclusion

The LEAD Training Program was highly acceptable and positively impacted rehabilitation professionals' confidence when handling dementia patient care situations, their understanding and use of evidence-based strategies, and their overall dementia knowledge. Confidence gains and practice patterns remained influenced at three-month follow-up. This study highlights that rehabilitation professionals can be influenced to gain knowledge and confidence in working with patients with dementia through a targeted, comprehensive training program.

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