Mental Health & Behaviors in LTC

Joint Provider Training
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Introductions

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Introductions

- Let’s get to know each other
  - Administrators
  - DONs
  - Social Services
  - MDS
  - Other

- What type of communities
  - SNF/NF
  - NF/MH
  - Other
Objectives

- Identify regulations pertinent to meeting the needs of residents with mental illness residing in nursing facilities.
- Identify challenges in combining residents with mental illness with the elderly in long term care facilities/communities.
- Understand the significant elements of assessment, care planning and documentation in caring for residents with mental illness.
- Understand the significant elements of behavior management in caring for residents with mental illness.
Mental Health & Behaviors

- Current long term care environment challenges
  - New Requirements of Participation
  - Emergency & Disaster Preparedness
  - Revision of the Survey process
  - Affordable Care Act
  - Repeal & Replace, Medicaid block grants
  - Quality Reporting
  - Value based purchasing
  - Kansas Medicaid challenges
  - CMS imposition of CMPs
Mental Health in SNF/NF

- Considerations
  - Regulatory
  - Caring for elderly residents & mentally ill residents in the same facility/community
  - Pre-admission screening
  - Availability of providers and services
  - Safety & security
  - Meaningful activities and programming
  - Particularly challenging diagnoses
  - Staff considerations
Regulatory

- Applicable regulations

ALL of THEM
Regulatory

- Federal regulations specific to mental health
  - CFR 483.40 Behavioral Health Services
  - CFR 483.65 Specialized Rehabilitative Services

Regulatory

• F279-develop and implement a baseline care plan within 48 hours
  • Includes the minimum healthcare information necessary to properly care for a resident
    • Initial goals based on admission orders
    • Physician, dietary orders
    • Therapy, social services
    • PASRR recommendations, if applicable
Regulatory

- **F319**
  - Ensure that residents who are trauma survivors receive culturally competent, trauma informed care
    - Phase 3 November 2019
  - Provide the necessary behavioral health care and services...includes but is not limited to the prevention and treatment of mental and substance use disorders
    - Phase 2 November 2017
Regulatory

- F319
  - Have sufficient staff with the appropriate competencies and skills sets, includes knowledge of caring for residents with mental and psychosocial disorders, history of trauma, PTSD
    - Phase 2 November 2017
  - Competencies and skills sets include knowledge of and appropriate training and supervision for
    - Caring for residents with mental and psychosocial disorders, history of trauma, PTSD identified in the facility assessment
      - Phase 3 November 2019
    - Implementing non-pharmacological interventions
      - Phase 2 November 2017
Regulatory

• F328
  • If rehabilitative services, including rehabilitative services for mental disorders are required in the comprehensive plan of care, the facility must
    • Provide the required services including *specialized rehabilitation services* (F406) or,
    • Obtain the services from an outside resource from a Medicare and/or Medicaid provider of specialized rehabilitative services
    • “The non-availability of program funding does not relieve a facility of its obligation to ensure that its residents receive all needed services....For services not covered, a facility is required to assist the resident in securing any available resources to obtain the needed services.”
Regulatory

- F406
  - If specialized rehabilitative services, including rehabilitative services for mental illness, or services of a lesser intensity are required in the resident’s comprehensive plan of care the facility must
    - Provide the required services or,
    - Obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs
Regulatory

- F406-Intent
  - Specialized rehabilitative services are differentiated from restorative services which are provided by nursing staff. Services are provided by or coordinated by qualified personnel.
  - Specialized services for mental illness are those services to be provided by the state which can only be delivered by personnel or programs other than those of the nursing facility because the overall level of nursing facility services is not as intense as necessary to meet the individual’s needs.
    - Example: Inpatient psychiatric unit or hospital
Regulatory

- F406 Intent
  - Preadmission Screening and Annual Resident Review (PASRR) indicates the specialized services required by the resident.
    - If the resident DOES NOT require specialized services, the facility is not responsible to provide all services.
    - Mental health rehabilitative services for mental illness refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff
Regulatory

- **F490**
  - Behavioral Health. A facility must provide behavioral health training consistent with the requirements at 483.40 and as determined by the facility assessment
  - Implemented Phase 3 November 28, 2019
Regulatory

- If your facility/community is licensed as a Kansas Nursing Facility for Mental Health
  - State regulations specific to mental health can be found on the KDADS website

https://www.kdads.ks.gov/provider-home/statutes-and-regulations
Regulatory

- 28-39-229 Resident Rights
  - Permitted to leave facility and surroundings unless written justifiable reasons established by physician, mental health professional or administrator denying
- 28-39-231 Resident behavior and facility practices
  - Consent for the use of psychotropic medication
  - Restraints
- 28-39-232 Quality of life, activity programs
  - Directed towards community integration, large and small group
- 28-39-233 Resident assessment
  - Includes MDS
  - Psychosocial assessment prepared by a mental health professional
Regulatory

- 28-39-234 Quality of care
  - Development of a mental health plan of care
  - Progress monitored by a mental health professional
    - Physician, psychologist, social worker, psychiatric nurse
  - Assist in obtaining access to academic services, transportation, treatment and vocational education as needed (from facility or other providers)
  - Services provided in least restrictive environment and incorporate the use of community experiences
Regulatory

- 28-39-239 Administration
  - Addresses required policies for, safety, psychosocial and resident self esteem needs, protection of personal and property rights
  - Maintain an affiliation, coordination, planning with community mental health center for services and discharge planning
- Also specific regulations around utilization of psychiatrists and psychiatric nurses
Mental Health in LTC

• Typical Nursing Home Resident
  • Age
  • Physical Condition
  • Medical Condition
  • Mental Condition
  • Mood & Behavior
  • Social Relationships
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Elderly & Mentally Ill

- Elderly & mentally ill residing in the same community or facility
  - Dementia
    - Wandering
    - Awareness of personal space
  - Vulnerable elders
    - Ability verbalize
    - Ability to defend self or move away
    - Fearful
  - Staff expectations and competency
    - They don’t look or act sick
    - Task orientated, escalation of behaviors
  - Sexuality, sexual expression
    - Consent
Elderly & Mentally Ill

- Elderly & mentally ill residing in the same community or facility
  - Ability to cohort or utilize neighborhoods
  - Environment
    - Noise levels, temperature levels
    - Crowding or congested areas
    - Physical plant layout, supervision
    - Camera systems in common areas
    - Smoking
  - Activity program and programming
  - Providers & available services
Pre-Admission Screening

- Onsite screening if possible
- From an acute setting, reason for admission
- From another long term care facility, reason for discharge
- Who has decision making capacity
  - Resident
  - DPOA/Guardian
- Sex offender check
  - Facility/community policy
  
  http://www.kbi.ks.gov/registeredoffender
Pre-Admission Screening

- CARE-PASRR
  - The CARE assessment (Client Assessment, Referral & Evaluation) assessment in Kansas meets the federal requirements for PASRR (Pre-Admission Screening & Resident Review)
    - Data collection, individual assessment, referral to community based services, appropriate placement in long term care facilities
  - Level I-identifies the need for Level II referral
    - Section B, question 6 “Referred for a Level II Assessment”
  - Level II-is required if the individual has a serious mental illness, intellectual/developmental disability or other related conditions
  - Services identified on a Level II must be provided by the facility regardless whether licensed as an NFMH or not
  - CARE assessment and sample Level II letters

https://www.kdads.ks.gov/provider-home/care-provider-information
Available Services

- Psychiatry
  - As medical director/co-medical director
  - Onsite psychiatry required for NFMH
- Psychology & Counseling
  - Individual and/or group counseling
  - Onsite
  - Telemedicine
- Social Services
  - Experience in working with mentally ill
  - Licensed SW preferable
- Crisis management/emergency services
- Support groups and 12-step programs
- Meet service requirements of Level II PASRR
Safety & Security

• Self Harm
  • Suicidal-ideation vs attempts, history
  • Self mutilation-nature, history
  • Risky behavior-mania, sexual, drugs, alcohol

• Harm to Others
  • Impulse control-personal space, hypersensitivity, paranoia
  • Homicidal-ideation, history
  • Vulnerable elders
Safety & Security

- Elopement
  - Or an executed plan
- Access to community & assessment for safety
  - Nursing facility security measures, door key pads
  - Nursing facility for mental health
  - Community privileges
- Supervision
- Events requiring 1:1 supervision
  - Allegations of abuse
  - Elopement attempts
  - Resident to resident events
Meaningful Activities

I do weird stuff when I'm bored.
MAYHEM
ACHIEVED,
BOREDOM
RELIEVED.
Hell is more like boredom, or not having enough to do, and too much time to contemplate one's deficiencies.
Activities vs Programming

- An Activities Program is what we think of as our usual nursing facility programs
  - Music
  - Crafts
  - Games
  - Intergenerational programs
  - Sensory
  - Exercise
  - Meets preferences of the residents
Activities vs Programming

- Could be dramatic differences in activity preferences between younger mentally ill and the elderly
  - Music
  - Crafts
  - Games
  - Intergenerational
  - Sensory
  - Exercise
- Meets preferences of the residents
Activities vs Programming

- Programming are those activities and services to assist mentally ill residents in attaining their highest level of functioning including skills to return to a less structured environment.
- Frequently identified on the PASRR.
- Some examples:
  - Life skills-money management, shopping, hygiene, nutrition.
  - Techniques to manage mental illness-medication management & compliance, symptom awareness.
  - Relaxation techniques-art and music therapy, journaling.
  - Drug & alcohol cessation programs.
Challenging Diagnosis

• Personality Disorders
  • Antisocial-impulsive, irresponsible, callous, belligerent, aggressive, violent, lack of remorse, frequently have had involvement with law enforcement
  • Borderline-extremes, unstable interpersonal relationships, unpredictable, self destructive, impulsive, attention seeking, manipulative
  • Narcissistic-exaggerated sense of self importance, attention seeking, multiple somatic complaints, exploit interpersonal relationships
• Expect
  • To provide two individuals for all care/interactions
  • Escalated behaviors when many things are going on in your facility: survey, staff changes, crisis event
  • To be frequently investigating allegations of abuse, by other residents, by staff
Staff

- Selection & Interviewing
- Realistic expectations
- Consistency
  - In personnel
  - In routines
  - In behavior management interventions
- Resident Rights
- Training
  - Escalation of behaviors
  - De-escalation of behaviors
  - Crisis management
  - Resident targeted behaviors & interventions
Clinical Assessment

- Chronic or acute illness
- Significant change in health status
- Health status contributing factors - pain, nicotine or alcohol withdrawal and illegal drugs
- Infection, Dehydration, Medication side effects, hungry, thirst, fatigue, constipation, symptoms of diagnosis
Behavior Assessment

- History of behaviors (mood, physical & verbal), triggers, & nonpharmacological interventions contributing to de-escalation
- History of sexual, physical, or verbal abuse, other traumatic events
- History of combat or PTSD
- History of restraint or seclusion
- History of coping strategies
- Rejection of care
Behavior Assessment

- Identify target behaviors
- Identify individualized interventions
- Understand how unmet needs are expressed
- Possible environmental triggers: room temperature, lights-too bright/too dark, overstimulation, under stimulation
- Possible Emotional triggers: change in routine, losses, family dynamics, depression, boredom
Targeted Behavior Monitoring

- Identify the diagnosis for the medication
- What behaviors were displayed when diagnosed
- No generic behaviors anxiety, agitation, etc...
- How do they display anxiety, agitation, etc...
Routine Behavior Monitoring

- New behaviors or other unidentified behaviors
- Identify precursors or escalation
- Side effects of medications
- Indication of acute health status changes
- Pain
Medication & Side Effects Management

- Antipsychotic Use Assessment
  - Gradual dose reductions
  - Clinical Contradictions
- Side Effect Monitoring: AIMS/DISCUS
  - Identified SE such as EPS, lethargy, increase sleeping, decrease appetite, change in cognition
  - Need to change medications
- Adjunct Therapy
  - Off label medications (Depakote, Dilantin, Tegretol, Trazodone)
  - Multiple AP use to potentiate other medications
Complementary & Alternative Medications

- Communication-coping strategies
- Aroma Therapy
- Sensory Room-Snozelen
- Music
Care Planning

- Identification of behavior triggers
  - Behavior and clinical assessments identify behavior triggers
  - Are they hungry, thirst, or need to use bathroom? Have we met these needs? How?
  - Do they want attention or someone to talk with?
  - Are they bored? Why?
  - Identifying the medication, diagnosis, behavior and interventions
Care Planning

- Effective interventions or methods to de-escalate
  - One on one interaction
  - Quiet are
  - Calm and soothing voice tones
  - Eye Contact
  - Listen
  - Don’t correct the resident
  - No reality orientation
  - Activities
Behavior Management Strategies

- Be mindful of your own reactions
- Maintain rational detachment
- Be attentive
- Use positive self talk
- Recognize your limits
- Debrief
Care Planning

• Routines
  • Very important
  • Bathing, meals, staff
  • Activities

• Activities
  • Scheduled engaging activities
  • Spontaneous activities
  • Follow through with activities
Care Planning

- PASRR- mental health monitoring
- Mental Health Services Addresses
  - Psychologist
  - Psychiatrist
  - Local Mental Health
  - Crisis intervention hotline (if applicable)
Documentation

- Objective documentation of the behavior (describe in detail the behavior and reactions)
- Events leading up to the behavior
- Interventions attempted and successful/unsuccessful
- Assessment, vital signs, pain, head to toe, psychosocial need
- Outcome—what did you learn from this event?
“As is true for most people, our behavior is a form of communication.”
Behavior Management

- Recognizing & eliminating triggers-staff need to be educated on the triggers and recognize when a behavior is about to occur.

- Escalation vs. de-escalation- the approach of the staff will determine the outcome of the behavior.
Behavior Management

- Approach-if entering a room, knock and ask for permission to enter
- Always approach from the front
- Watch your facial expression and make eye contact
- Do not rush or make sudden movements
- Always identify yourself
- Always explain before doing
- Remember to listen more than you speak
- Let the other person get their emotions out & Acknowledge their feelings
- Set boundaries/limits if necessary
Documentation of Behavior Event

- Progress Note template—provides a guide for documentation
- “Normalized” behaviors—everyday behaviors are not normal, if you did this in public would it be acceptable?
Involvement & Communication w/front line staff

- Education & training on behaviors and individualized approaches
- Ask how this started?
- What was the resident doing prior to the escalation?
- Was this their everyday routine?
- What was the residents mood and behavior leading up to the event?
QAPI

- Behavior tracking & trending
  - When
  - Where
  - Who was involved
  - What was going on in the facility or with the resident
  - How often has the behavior occurred
  - Findings
  - Action Plan
  - Effectiveness of plan
  - Revision if necessary
  - Outcome
QAPI-Let’s Review

- Many “behaviors” have their roots, ultimately, in something that can be identified early in a process and addressed.
- This requires exploring the behavior thoroughly, looking at trends and identifying root causes.
- When only the expressed behaviors are treated, then only the surface symptoms are addressed and not the underlying cause.