Behavioral Health:

Caring for a New Generation

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Assessing Human Needs

What is Quality of Life?

- Subjective, multidimensional, encompassing positive and negative features of life.
- A dynamic condition that responds to life events

http://www.forbes.com/sites/iese/2013/09/04/quality-of-life-everyone-wants-it-but-what-is-it/

NEW FEDERAL REGULATIONS
FINAL RULE, PHASE 2 (11/28/17)

F675

§ 483.24 Quality of life

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

NEW FEDERAL REGULATIONS FINAL RULE, PHASE 2 (11/28/17)

F675

§ 483.24 Quality of life

INTENT

The intent of this requirement is to specify the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by:

•Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and

•Ensuring that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

F675 § 483.24 Quality of life (11/28/17)

Definition: "Quality of Life"

- An individual's "sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem.
- For nursing home residents, this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and control over one's life."

SYSTEM FAILURES

- Diagnosis is not always known at the time of admission screening or condition is misdiagnosed as simply dementia;
- Staff education and training in caring for the residents with mental and behavioral health needs is lacking;
- Understanding of the differences between dementia, mental disorder, traumatic brain injury, and ID/DD is poor in many environments;
- Staff lack basic understanding of symptoms and how this impacts responses and other aspects of function; and

SYSTEM FAILURES

- Assessment procedures often fail to distinguish symptoms, reactions, and personality from *behavior.*
- Assessments often fail to identify the antecedents to behavior;
- Communication between disciplines is weak in tracking mood and behavioral patterns;
- Care teams rarely introduce behavior modification plans;
- Medication is the often the preferred intervention; and
- Little consideration is given to how boredom and a lack of meaningful activity impact mood, behavior and function.

New Considerations

- Capacity determinations for medical and psychosocial decision making;
- Medical Marijuana;
- Pain management – opioids and addiction;
- Sexuality/LGBT populations;
- Short-term vs. Long-term needs and practices;
- Complicated discharge planning/housing/financial concerns.

Potential Risks Associated with a Changing Demographic

- Elderly residents and younger residents have very different needs in terms of care.
- Elderly residents require a great deal of specialized medical care and supervision, while younger residents may need more attention to socialization or behavior.
- If nursing homes are not properly staffed and trained, it may be impossible for all age and need levels to get the care they really need.
- Most nursing homes are geared toward older adults, their interests and needs. This can lead to younger residents feeling resentful, restless, or lonely. These emotions coupled with physical or mental disability can easily result in negative attitudes and behavior, and are clear risk factors for substance abuse.

Regulatory Expectations

- Final Rule – Trauma Informed Care
- Identification of Stress-Related Illness
- Recognition of Substance Use and Addictions
- Dementia Care Standards/Dementia Focused Survey
- PASRR Coordination
- Non-Pharmacologic Interventions

Caring for the Woodstock Generation

- Four million baby boomers suffer from substance abuse/addiction
- About half of all baby boomers have experimented with illicit drugs
- Nearly 5 percent, or 4.3 million, of adults 50 years and older have used an illicit drug in the last year
- About 26.2 percent of new addictions started in the last five years among baby boomers involved cocaine

Caring for the Woodstock Generation

- Following close behind cocaine, about 25.8 percent of new addictions in this age group involved prescription drugs
- Nearly 75 percent of baby boomer admissions to rehab centers are for addictions that began before the age of 25
- Illicit drug use among this age group has increased by over 3 percent in the last eight years

http://www.promises.com/articles/addiction/drug-use-surges-among-baby-boomers/

Caring for the Woodstock Generation

Some baby boomers feel compelled to self-medicate with drugs to lower the impact of stress related to:

- Caring for family
- Dealing with potential health issues
- The uncertainty of retirement in a stagnant economy

Symptoms of Addiction in the Elderly

- Memory trouble after having a drink or taking a medication
- Loss of coordination (walking unsteadily, frequent falls)
- Changes in sleeping habits
- Unexplained bruises
- Being unsure of yourself
- Irritability, sadness, depression
- Unexplained chronic pain

Substance Use Disorders and Mental Illness among Adults Aged 18 or Older - 2014

- 43.6 Million Adults Had Mental Illness
- 35.6 Million Mental Illness, SUD
- 20.2 Million Adults Had SUD
- 12.3 Million SUD, no Mental Illness
- 7.9 Million SUD and Mental Illness

*SUD = substance use disorder

Increased Numbers of Disabled Young Adults

- The number of children and young adults with disabilities is increasing.
- Life-saving and life-prolonging medical care and new technologies have increased the survival of seriously ill younger people.
- These children, teens and young adults will need long-term care to assist them in their homes or in nursing homes and residential facilities.

LTC Panel Report 2009

PASRR COMPLIANCE

- **F644 § 483.20(e) Coordination**. A facility must coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

  - § 483.20(e)(1) Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care.

  - § 483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

PASRR
Significant Change

A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental disorder or intellectual disability for resident review.

Behavioral Health
New Federal Regulations

F740

- **§ 483.40 Behavioral health services.**
  Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
- Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the ***prevention and treatment of mental and substance use disorders.***

Behavioral Health
New Federal Regulations

- "**Mental disorder**" is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

- "**Substance use disorder**" is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems or disability.

Behavioral Health

New Federal Regulations

F741

• **§ 483.40(a)** The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with § 483.70(e).

Behavioral Health

New Federal Regulations

F741

•These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

- § 483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to § 483.70(e), and as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3).

- § 483.40(a)(2) Implementing non-pharmacological interventions.

Behavioral Health

New Federal Regulations

(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

•A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

Behavioral Health

New Federal Regulations

- A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder ***does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors,*** unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and

Behavioral Health

New Federal Regulations

- A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

NEW FEDERAL REGULATIONS
Final Rule, Phase 2 (11/28/17)

F742

Treatment and Services for Mental/Psychosocial Concerns:

§ 483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

§ 483.40(b)(1)
A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

NEW FEDERAL REGULATIONS
Final Rule, Phase 2 (11/28/17)

“Mental and psychosocial adjustment difficulty” refers to the development of emotional and/or behavioral symptoms in response to an identifiable stressor(s) that has not been the resident’s typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms.

(Adapted from Diagnostic and Statistical Manual of Mental Disorders - Fifth edition. 2013, American Psychiatric Association.).

NEW FEDERAL REGULATIONS
Final Rule, Phase 2 (11/28/17)

INTENT § 483.40(b) & § 483.40(b)(1)

•The intent of this regulation is to ensure that a resident who upon admission, was assessed and displayed or was diagnosed with a mental or psychosocial adjustment difficulty or a history of trauma and/or post-traumatic stress disorder (PTSD), receives the appropriate treatment and services to correct the initial assessed problem or to attain the highest practicable mental and psychosocial well-being.

•Residents who were admitted to the nursing home with a mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD, must receive appropriate person-centered and individualized treatment and services to meet their assessed needs.

NEW FEDERAL REGULATIONS
Final Rule, Phase 2 (11/28/17)

****KEY ELEMENTS OF NONCOMPLIANCE § 483.40(b) & § 483.40(b)(1)**

To cite facility deficient practice at F742, the surveyor's investigation will generally show that the failed to:

•Assess the resident's expressions or indications of distress to determine if services were needed;

•Provide services and individualized care approaches that address the assessed needs of the resident and are within the scope of the resources in the facility assessment;

•Develop an individualized care plan that addresses the assessed emotional and psychosocial needs of the resident;

•Assure that staff consistently implement the care approaches delineated in the care plan;

•Monitor and provide ongoing assessment as to whether the care approaches are meeting the emotional and psychosocial needs of the resident; or

•Review and revise care plans that have not been effective and/or when the resident has a change in condition and accurately document all of these actions in the resident's medical record.

****Most long-term care facilities fail to meet one or more of these regulatory standards.****

Dementia Focus Survey

- Is behavior acknowledged as a form of communication?
- Is it expected that all staff strives to understand the meaning behind these behaviors?
- Are non-nursing staff (particularly recreational therapy staff) trained in dementia care practices?

Dementia Focus Survey

- Does the overall philosophy of care in the nursing home acknowledge behaviors as a form of communication and is there an expectation that all staff strives to understand the meaning behind these behaviors?

Dementia Focus Survey

- Does the QAA Committee monitor for consistent implementation of the policies and procedures for the care of residents with dementia?
- Has the QAA Committee corrected any identified quality deficiencies related to the care of residents with dementia?

Assessment:
Understanding the Individual

Who is the person behind the behavior?

- Personality
- Ego
- Common triggers
- Responses
- Rituals
- Preferences

Understanding the Individual

- Known or potential triggers to behavior
- Known self-soothing remedies
- The pre-dementia or pre-illness personality
- Social and occupational history
- Family dynamics
- Preferences and routines

What Is Behavior?

- **Symptom**: Related to or caused by clinical diagnosis, such as dementia, mental illness, pain, etc. Behavior in this category should be anticipated, based on what the clinical team understands about the diagnosis.
- **Reaction**: Related to or caused by circumstance or environment. Behavior in this category should also be anticipated, based on what the team understands about human nature and human response.
- **Personality**: This type of "behavior" is usually the caregiver's issue, not the resident's. In many circumstances, the expression of a preference is labeled **behavior**.

Behavioral Health Assessment Considerations

Psychosocial Adjustment:

The "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM/IV)," specifies that adjustment disorders develop within 3 months of a stressor (e.g., moving to another room) and are evidenced by significant functional impairment.

*Bereavement with the death of a loved one is not associated with adjustment disorders developed within 3 months of a stressor.

Behavioral Health Assessment Considerations

Other manifestations of mental and psychosocial adjustment difficulties may, over a period of time, include:

- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

Social Triggers: Relationships

- How well do staff interact with residents?
- How well does the team do at pairing roommates?
- How effective are the procedures for resolving grievances and conflicts?

Behavioral Health
Assessment & Care Plan Considerations

Clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken for depression associated with mental or psychosocial adjustment difficulty are: (This list is not all inclusive.)

- Metabolic diseases (e.g., abnormalities of serum glucose, potassium, calcium, and blood urea nitrogen, hepatic dysfunction);
- Endocrine diseases (e.g., hypothyroidism, hyperthyroidism, diabetes, hypoparathyroidism, hyperparathyroidism, Cushing's disease, Addison's disease);

Behavioral Health
Assessment & Care Plan Considerations

- Central nervous system diseases (e.g., tumors and other mass lesions, Parkinson’s disease, multiple sclerosis, Alzheimer’s disease, vascular disease);
- Miscellaneous diseases (e.g., pernicious anemia, pancreatic disease, malignancy, infections, congestive heart failure);
- Over-medication with anti-hypertensive drugs; and
- Presence of restraints.

Evaluate Existing Medications

- Consider the following issues:
  - Drug induced cognitive impairment
    - **Anticholinergic Load**
  - Medication induced electrolyte disturbance
  - Recent medication additions that may alter metabolism of a drug that the person has been taking for a while
  - Withdrawal reaction to a recently discontinued medication

Behavioral Health
Unnecessary Drugs: Evaluation

To determine if each resident receives:

- Only those medications that are clinically indicated in the dose and for the duration to meet his or her assessed needs;
- Non-pharmacological approaches when clinically indicated, in an effort to reduce the need for or the dose of a medication; and
- Gradual dose reduction attempts for antipsychotics (unless clinically contraindicated) and tapering of other medications, when clinically indicated, in an effort to discontinue the use or reduce the dose of the medication.

Behavioral Health
Unnecessary Drugs: Evaluation

To determine if the facility in collaboration with the prescriber:

- Identifies the parameters for monitoring medication(s) or medication combinations (including antipsychotics) that pose a risk for adverse consequences; and for monitoring the effectiveness of medications (including a comparison with therapeutic goals); and
- Recognizes and evaluates the onset or worsening of signs or symptoms, or a change in condition to determine whether these potentially may be related to the medication regimen; and follows-up as necessary upon identifying adverse consequences.

Behavioral Health
Clinical Documentation

Did staff describe the behavior in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible?

- Onset
- Duration
- Intensity
- Possible precipitating events
- Environmental triggers
- Related factors (appearance, alertness, etc.)

Behavioral Health
Care Plan Strategies

Appropriate treatment and services for psychosocial adjustment difficulties may include:

- Providing residents with opportunities for self-governance;
- Systematic orientation programs;
- Arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and
- Maintaining contact with friends and family.

Appropriate treatment for mental adjustment difficulties may include crisis intervention services; individual, group or family psychotherapy, drug therapy and training in monitoring of drug therapy and other rehabilitative services.

Non-pharmacological Interventions

- Increasing the amount of resident exercise;
- Reducing underlying causes of distressed behavior such as boredom and pain;
- Individualized bowel regimen to prevent or reduce constipation and the use of medications;

Non-pharmacological Interventions

- Improving sleep hygiene;
- Accommodating the resident's behavior and needs by supporting and encouraging activities reminiscent of lifelong work or activity patterns;
- Using massage, hot/warm or cold compresses to address a resident's pain or discomfort; and
- Enhancing the dining experience.

101 ACTIVITIES ANYONE CAN DO

1. Listen to music
2. Make homemade lemonade
3. Count trading cards
4. Clip Coupons
5. Sort poker chips
6. Rake leaves
7. Write a poem together
8. Make a fresh fruit salad…

Source: Alzheimer's Association Web Site – www.alz.org

Activities for a New Age

- Diversify therapeutic activity offerings to include education, self-help, and support programs;
- Collaborate with community addiction services;
- Promote positive self-esteem through meaningful socialization and therapeutic activity;
- Collaborate with community vocational services organizations in discharge planning;
- Foster opportunities for volunteerism.

Steps to Creating a Livable Environment

- Evaluate Relationships
- Evaluate the Environment
- Educate Everyone
- Structure the Environment
- Consider the ***Boredom Factor***
- Increase Pleasure

Becoming The Change You Want To See

Changing the nature of relationships is the best foundation for changing the way the organization achieves its goals.

- Demonstrate respect
- Educate equally
- Give everyone a voice in addressing challenges
- Be prepared to try, try again
- Acknowledge a job well done
- Express your gratitude

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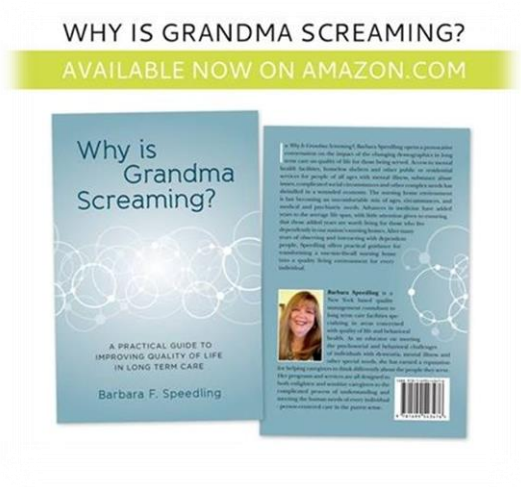

Innovations for Quality Living

Creating Meaningful, Satisfying Lives One Person at a Time