Overview

- Background on MH problems in NHs
- Florida NH studies conducted by USF
- CMS initiative to reduce anti-psychotic meds
- Non-psychopharmacological interventions
- Resources

Literature Review

- Deinstitutionalization led to transinstitutionalization of older pts from state hospitals to NHs
- Few living options for those frail with SMI
- NHs as psychiatric institutions – few trained MH professionals on staff
- Limited MH treatment i.e., psychoactive meds by default
Side effects – psychoactive meds

- Anti-depressants linked to falls in older adults
- Anti-psychotics (traditional & atypical) associated with greater mortality in AD residents – led to ‘black box’ warnings
- Sedative drug use related to mortality, cognitive impairment, and balance problems
- Total psychoactive drug load increases risk of hospitalization for NH residents

OBRA – 87 Improve MH treatment of NH residents

1. MH screening for those with SMI(PASRR)
2. Guidelines for use of restraints & psychoactive med usage
3. Encouragement of non-pharmacotherapy
   - OBRA intent not fully realized –
     - Lower # of inapp SMI admits; restraints less
     - Anti-psychotic usage reduced – recent ‘black box’ warnings have helped
     - Anti-depressant usage increased

MH problems in NHs

- Most NH residents have some MH problems
- Depression (40%); Anxiety (3.5-20%); SMI (10%); Dementia (50%) with behavior problems (59%)
- 3 types of NH residents with MH problems:
  - SMI
  - Adjustment problems (anxiety/depression)
  - Dementia with behavior problems/agitation
- Need very different interventions – not one size fits all – require training & professionals
FLORIDA NH STUDIES
FUNDED BY AHCA –
WITH ASSISTANCE FROM FLORIDA HEALTH CARE ASSOCIATION

Study 1 SMI in Florida NHs
Funded by Florida Agency for Health Care Administration

Study 1 - Study Design
- Qualitative study to determine how the mental health needs of SMI residents (Schizophrenia; Bipolar Disorder; MAD etc.) are addressed
- Interviews with 88 stakeholders in 4 high & 4 low citation NHs (Med Dir, Admin, Resident, Family)
- Surveys of 206 NH administrative staff members
- Focus groups in 2 regular NHs & 2 psychiatry specialty NHs
Study 1 - Results
- 9% of NH residents have SMI
- Placement of older adults with SMI is a significant problem
- NH staff particularly concerned about young, male, aggressive SMI residents and the safety of frail elderly residents
- High quality NHs more likely to monitor MH problems & to recognize need for MH services

Study 1 - Conclusions
- Most SMI pts triaged into community settings – positive development related to PASRR
- Those who are admitted carry a secondary SMI diagnosis – don’t receive PASRR2 screening
- Remain off the ‘radar screen’ of most NH staff
- NHs therefore may not plan adequately for their MH needs – physical needs emphasized
- NH staff recognize the need for more mental health training in this area

Study 2

Funded by Florida Agency for Health Care Administration
Study 2 - Design
- All newly admitted Florida NH residents (N=947) over one-year period
- Secondary data analysis - Medicaid & OSCAR
- What mental health (MH) services were provided within 3 months of NH admission?

Study 2 - Results
- 71% received at least 1 psychoactive med
- More than 15% were taking 4 or more meds
- Most of those treated with meds had not received psychopharmacological treatment (64%) nor a dx (71%) prior to hospitalization leading to NHP
- Only 12% received broadly defined 'billable' non-psychopharmacological care

Study 2 - Conclusion
- Major mental health intervention in NHs is psychoactive medication
- Do psych co-morbidities justify such usage?
- Is OBRA-87 intent realized?
- Why are NH residents being prescribed so many psych meds in NHs?
Study 3
Funded by Florida Agency for Health Care Administration

Study 3 – Design
- Reviewed records of residents (n=73) in 7 NHs admitted between 1/1/09 - 6/30/09 who had been residents for at least 3 months
  - Justification based on diagnosis or stated rationale
  - Conducted 6 focus groups in 5 NHs addressing use of psychoactive meds

Study 3 – Chart Review
Results (Positive)
- All residents on meds have a signed MD order
- 89% of residents on meds have a psych dx*
- Nearly 3/4ths on meds have at least one note justifying psychoactive med prescription
- 80% of those residents who had a medication added/dropped had prior behavioral monitoring
- >90% had note re a behavior meriting attention
- >60% had 1+ note re monitoring of side-effects
- 50% receive additional MH consultation*
Study 3 - Chart Review Results (Concerns)

- No PASRR 2's – SMI or MR dx on admission, or significant change should trigger PASRR 2 – but dementia specifically excluded
- Over 85% of NH residents are on psychiatric meds within 3 months of admission
- 19% of NH residents on 4 or more meds
- OBRA says – non-psychopharm strategies should come first – yet just over half receive

Study 3 - Focus Group Results

- Nurses view themselves as resident advocates
- Residents admitted on too many meds from hospital (84% of residents are admitted from hospital & 84% of these were on meds)
- Innovative non-psychopharm programs
- Better communication between staff members & more education would help staff evaluate resident behavior problems & intervene appropriately
- Use of meds due to lack of MH assessment?

Study 3 - Conclusions

- MH problems of NH residents are being addressed – much improvement from past!
- But we need to make sure that they are receiving optimal MH treatment
Where do we intervene?

NH residents on a psychoactive medication trajectory
40% on meds prior to hospitalization; 68% after hospitalization; 85% after 3 months of admission

Who is responsible? Should we intervene? Where?
- At the community level
- At the hospital level
- At the NH admission level*
- At the NH treatment team level

Study 4


Funded by Florida Agency for Health Care Administration

Study 4 - Design & Findings – Pilot study

**Question:** Does administration of a MH assessment to incoming NH residents change their psychoactive medication utilization pattern?

If so, is the change indicative of better care?

**Methods:** n=23 with assessment; n=25 without assessment. Non-random assignment in 4 NHs

**Results:** Residents who received MH assessments less likely to begin taking psychoactives & sedatives after 1 month
Conclusions re psychoactive med usage in NHs

- PASRR only for SMI – not for the majority of residents with MH problems
- Expertise gap in MH for NH staff & professionals
- Studies using Beers criteria suggest larger issue of poor general NH med usage & combo of meds
- Psych over-medication - big societal problem
- Fed rules & reimbursement – roadblocks to better care – PASRR creates odious requirements

PASRR – (Positives)

- PASRR1 requires screening for those suspected of SMI & DO – attempt to triage to ‘less restrictive environment’ if PASRR2 is positive
- Research suggests some success in eliminating ‘inappropriate’ NH placement when possible
- Requires NH to set up a comprehensive MH treatment plan to address SMI needs – need for meaningful activities & nonpharm approaches
- For those screened positive, it assures that the SMI problems are not “swept under the rug” in NH

PASRR - (Negatives)

- PASRR only for SMI – not for the majority of residents with MH problems, not those with dementia or acute adjustment problems
- Triaging to ALFs – is this an improvement? – lack of MH regulations in ALFs but consistent with Recovery movement principles allowing choice
- Those with SMI prefer more freedom; families and clinicians prefer more supervision
- Fed rules & reimbursement – PASRR creates odious requirements – roadblocks to better care?
MAJOR PASRR QUESTION

- Are NHs equipped to follow the letter AND spirit of the SMI regulations to provide optimal care to SMI residents?
- NH staff need more training, especially in understanding how the behavior problems and/or psychotic symptoms of SMI residents may differ from those with dementia.
- There are two groups of researchers who are working to develop just such a training module for NH staff.

Recommendations – MH care is better but not optimal

- Refine pro guidelines for psychoactive med use.
- Front-line staff education – meds not only answer – need to be competent in dementia care.
- Financial incentives for trained geriatric MH professionals to consult in NHs on difficult cases.
- QI reviews should promote interdisciplinary care & non-psychotherapeutical options.
- Need a summit with federal & state agencies & NH stakeholder groups & residents & families.

CMS nationwide NH initiative

- Reduce anti-psychotic med usage by 15% by 12/12.
- Over half of residents have dementia - at least half exhibit some behavior problems.
- Initiative has now been broadened to include the mission of giving better dementia care, improving behavioral health, reducing # of medications, lowering dosages & tapering when stable.
- What resident needs are not being met?
Disruptive Behaviors
- Aggression
- Anxiety & Agitation
- Catastrophic reactions
- Crying, Screaming, Yelling
- Repetitive questions
- Suspiciousness, Paranoia

ASCP Report - Psychopharmacology for PWDs
- 25% of NH residents receive anti-psychotic meds
- No meds have been approved by FDA for the management of behavior problems for PWDs
- Back box warnings for atypical and traditional anti-psychotic meds for those with dementia
- Meds should only be used in emergency situations
- Meds should only be used after non-pharmacological approaches have been tried

Treatment
DVA Meta-analysis of non-pharmacological interventions (2011)
- Evidence to support behavioral interventions:
  - Functional analysis of specific behaviors, CBT
  - Token economies
  - Habit training
  - Progressive muscle relaxation
  - Communication training
- Not enough evidence for validation therapy, acupuncture, aromatherapy, music therapy, massage, exercise, pet therapy – may have promise
Effective Treatment of Behavior Problems Include:

- Problem-solving approach: Antecedent-Behavior-Consequences – “training family or staff to carefully observe problem behaviors, identify antecedents, and modify physical environment, schedule or interpersonal interactions”
- Strategies to increase positive behaviors such as pleasant events and exercise
- Multicomponent programs that include environmental mods & staff education in ADL’s


Treatment (cont.)

STAR-VA – Karlin & Teri

- A trained MH provider consults with NH staff to implement interventions for difficult cases
- ABC approach - Identify & change antecedents and consequences of problem behaviors
- Increase pleasant events
- Promote effective communication
- Create realistic expectations for PWDs
- Reduces disruptive behavior & symptoms such as depression & anxiety – but labor intensive

CMS Partnership

- Promotes a multi-dimensional approach that involves family in decision-making
- 3 R’s to improve dementia care
- Rethink approach to dementia care
- Reconnect with residents via person-centered care practices
- Restore good health & quality of life
Nursing Home Quality Measures

- Measure: Percentage of Long-Stay Residents Who are Receiving Antipsychotic Medication
- Measure: Percentage of Short-Stay Patients Who Have Antipsychotic Started – Incidence
- Monitor: Staff compliance with dementia policies, staff training & competency in care, how MDs respond to pharmacists
- Engage family, medical director & pharmacist
- Surveyors are looking for a systematic process to be evident to reduce anti-psychotic meds and for that process to be individualized for every resident based on a thorough assessment, targeting specific behaviors noted in care plan

CMS regional proposals to Prevent behavior problems

- Grass Roots effort with different stakeholders
- Pharmacist regularly monitor meds regimen
- Interdisciplinary meetings – assess & monitor bio-psycho-social needs
- Person-centered care - include families
- Culture change – more flexibility re NH rules
- Staff training to prevent & manage problems
- MH consultants re more difficult situations
- Use low med NHs as exemplars

Outcomes as of 2nd quarter 2014

- 17.1 overall reduction in antipsychotic medication usage
- Wisconsin – ranked 8th in progress – 19.1% reduction
- Wide variability between states (10.9% - 31.4%) reductions
- Tremendous variability within individual NHs
Models of Disruptive Behavior – not mutually exclusive
- Kunik - Focus on mutative factors(depression/pain/UTI)
- Antecedent-Behav-Consequences CARES; DICE
- Volicer - understimulation-overstimulation
- Algase & Teri - Need-Driven Dementia-Compromised Behavior Model (NDB)
- Progressively lowered stress threshold
- Lawton – match between person & environment
- Validation approach e.g. Naomi Feil – change our behavior to accommodate residents’ reality

CARES: Person Centered + Behavioral Approach
Basic Online Training for all NH staff
- Connect with the Person
- Assess Behavior
- Respond Appropriately
- Evaluate What Works
- Share with Others

CARES (cont.)
- Person-centered approach
- Show that one cares
- Help residents in a sensitive, thoughtful, and respectful way, like one would do for a good friend or family member
- Focus on what residents can do rather than what they can’t
- Add meaning to residents’ lives & celebrate moments of success
C = Connect
- The “C” step is about making a connection with people each time you interact with NH residents.
- It’s about taking time to greet them and doing so in a respectful, friendly, and nonthreatening way.
- It’s about noticing their individualities.
- Making a connection and being perceived as safe is especially important for NH residents.
- If NH residents feel connected to you, they are more likely to listen to you.

A = Assess
- Figure out what might be causing this person to respond in a certain way or become upset.
- If you have had a chance to get to know the person, it will be easier to figure out why he or she is behaving in a certain way.
- When a person becomes upset, there is something or someone that has triggered the reaction. What is the trigger?
- Was it the TV or a harsh roommate?

Assessment Questions
- 1. Does the behavior need a response? Some irritating behaviors are harmless.
- 2. Is this person’s behavior dangerous to himself or herself or other people?
- 3. Is this behavior a change for the person?
- 4. What do you think might have caused this person to behave in this way? Is it because of something in the environment? Is it because of someone? Is there a physical or medical reason?
R = Respond Appropriately

- After you have assessed a person’s behavior, you will need to decide on the best way to respond
- The key is to make your response fit the person and the situation e.g., reduce stimulation while eating; bathe person at another time
- If the person is fearful, think about the best way to make him/her feel safe

Respond Appropriately (cont.)

- It’s important to understand that the ways you respond—the tone of your voice, your body posture, the words you choose—are as important as the response itself
- No matter what kind of response a situation requires, put the dignity of the person first
- Think about who the resident is & what she needs

E = Evaluate what works

- Did the person you are caring for become calmer or happier based on what you said and did? Or, did he or she become more upset?
- Keeping track of what works will help the next time you are in a similar situation with that person.
- What worked one time may not work every time.
- The more time you spend with a person and note what’s working, the more effective you will become.
S = Share with Others

Sharing information helps everyone to do their job better. Sharing successes is a simple way to create a more positive environment.

If the information you need to share is not about a success, the simple act of sharing can foster concern and encourage everyone to work together to reach a goal.

Discussing with family, staff, or even with the person how well a certain response worked promotes consistency.

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CMS

- [CMS one-stop shopping – best overall resource](http://nhqualitycampaign.org)
- [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)
- [http://www.americangeriatrics.org/](http://www.americangeriatrics.org/)

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Resources

- [CMS initiative](http://nhqualitycampaign.org/star_index.asp?controls=dementiaCare)
- [NH assessments & care plans for residents receiving anti-psychotic drugs](https://oig.hhs.gov/oei/reports/oei-07-08-00151.asp)
- [Monitoring progress in reducing anti-psychotic medications](http://www.google.com/search?q=cms+initiative+to+reduce+antipsychotics+&ie=UTF-8&rlz=1T4ADFA_enUS471US471&sourceid=navclient&aq=&oq=CMS+initiative+&gs_l=hp..1.0l4.0.0.6824...........0.7Y-4dTfHM2g&pbx=1)
Resources (cont.)

- [https://www.ascp.com/articles/antipsychotic-medication-use-nursing-facility-residents/ASCP](https://www.ascp.com/articles/antipsychotic-medication-use-nursing-facility-residents/ASCP)

Resources (cont.)

- [www.CaresProgram.com](http://www.caresprogram.com)
  CARES® Online Dementia Care Training
  Health Care Interactive: 952-928-7722
- “Art of caregiving” by Teepa Snow, video series
- [http://cohealthinstitute.litmos.com/online-courses](http://cohealthinstitute.litmos.com/online-courses) Casciani Co-Health Training Program