Behavioral Health:
Compliance, Ethics, and Advocacy

Barbara Speedling, QOL Specialist
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CMS Final Rule
Trauma-Informed Care

• Expanded regulatory requirements for the care of residents with behavioral health needs;
• New regulatory requirements for assessment and treatment for PTSD, substance, and alcohol addiction;
• Heightened expectations in quality of life for residents with complicated psychosocial needs.
Behavioral Health
New Federal Regulations

§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

(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 wellbeing 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

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

• 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

• 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
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Trauma-informed care

Interpretive Guidelines:

“Mental and psychosocial adjustment difficulties” refer to problems residents have in adapting to changes in life’s circumstances. The former focuses on internal thought processes; the latter, on the external manifestations of these thought patterns.
Coordination includes:

• (1) Incorporating the recommendations from the PASRR level II determination and the PAARR evaluation report into a resident’s assessment, care planning, and transitions of care.

• (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.
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.
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?
Drug Abuse and Mental Health Issues

A 2011 study by the Substance Abuse and Mental Health Services Administration found:

- Baby Boomers who came of age in the ‘60s and ‘70s when drug experimentation was pervasive, are far more likely to use illicit drugs;
- Among adults 50-59, current illicit drug use increased to 6.3 percent in 2011 from 2.7 percent in 2002;
- The most commonly abused drugs were opiates, cocaine and marijuana.
Drug Abuse and Mental Health Issues

2010: An estimated six to eight million older Americans – almost 20 % of the elderly population – had one or more substance abuse or mental health disorders.

2030: Adults 65 and older is projected to increase to 73 million from 40 million between 2010 and 2030.

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
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

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
Symptoms of Addiction in the Elderly

- Changes in eating habits
- Wanting to stay alone much of the time
- Failing to bathe or keep clean
- Having trouble concentrating
- Difficulty staying in touch with family or friends
- Lack of interest in usual activities

http://www.oasas.ny.gov/admed/fyi/fyiindepth-elderly.cfm
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 mentally ill is lacking; care of residents with dementia is weak in many environments

• Staff lack basic understanding of symptoms and how this impacts all aspects of function

• Assessment procedures often fail to distinguish symptoms from behaviors
SYSTEM FAILURES

• Assessments often fail to identify the antecedents to behavior
• Communication between disciplines is weak in tracking behavioral patterns and implementing appropriate intervention
• Coordination of Level II services is lacking
• Medication is the often the preferred intervention
• Little consideration is given to how boredom and a lack of meaningful activity impact behavior and function
ASSESSMENT AND PERSON CENTERED CARE
Assessment:
Understanding the Individual

Who is the person behind the behavior?

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

• Impact of neurodegenerative disease, mental illness, and stress on behavioral health and social functioning;

• Assessment of symptoms and behavioral triggers;
Assessment

• The importance of distinguishing between signs and symptoms of dementia/mental illness/brain injury, personality, and responses triggered by environment or circumstance.
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
Program Development

• Improving the interdisciplinary assessment process;
  – Expand the focus of the psychosocial assessment;
  – Involve the primary CNA in the initial assessment process;
  – Develop a care partnership with the resident and family; and
  – Improve the efficiency of interdisciplinary communication.
Program Development

• Coordination of psychosocial services and PASRR recommendations;
  – Ensure PASRR Level I Screens are received on all new admissions, unless the exception applies;
  – Maintain a current roster of residents with Level II recommendations;
  – Ensure Level II recommendations are incorporated into the CCP; and
  – Track resident with MD/ID/DD for significant change.
Program Development

Developing care strategies:

– Dementia care
– Mental Disorders and Special Needs
– Substance use and opioid addiction
– Create contemporary evaluation tools
– Develop a partnership with other care providers;
– Improve interdisciplinary coordination of care; and
– Expand therapeutic activity programming to include self-help, life skills, and pre-vocational programming.
Barbara Speedling
Quality of Life Specialist
917.754.6282
Bspeedling@aol.com
www.innovationsforqualityliving.com

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