General Workgroup Notes
Caring for Residents with Challenging Behaviors Workgroup
February 25, 2004

The organization and effort of the "Caring for residents with challenging behaviors workgroup" has started with great success and has received statements of support from state and national organizations. We appreciate this recognition and remain enthusiastic as we make strides together.

The goal of the February 25th meeting was to have the individual committees meet and develop strategies along with timelines. This goal was achieved. It was established that the location of future meetings will vary. A schedule follows below.

Meeting Schedule:

Policies, Regulations, and Legislative Action Committee:
March 10, 2004 9:00 a.m. Location: CAHCF headquarters in East Hartford

Training Committee:
March 18th, 2004 @ 9:00 a.m. Location: CAHCF headquarters in East Hartford

Care and Case Discussion Committee:
March 19th, 2004 @ 9:00 a.m. Location: Institute of Living - Donnelly Bldg. Hartford

Workgroup next meeting:
April 30th, 2004 @ 9:00 a.m. - 12:00 noon. Location to be announced

General Group Comments:

The CT Public Health Code discusses reporting of incidents but reporting has a lot to do with clinical judgement. Perhaps more information to the individuals making these reports will facilitate a hands-on approach to care-giving across providers as opposed to the current focus on liability avoidance. A hands-on approach would encourage onsite interventions to address underlying causes of behaviors which may more often be treatable. This would bring Connecticut closer to the Federal requirement which focuses more on the onsite interventions the facility offers to a resident rather than the reporting and "deporting" of residents.

Regarding Mandated Reporting and Zero Tolerance, the CT Public Health code dictates what is to be reported and done under specifically outlined circumstances. Perhaps some clarification on this could be requested or provided by this workgroup.

The group also discussed the possibility of including in the DPH annual survey, the examination of care plans of individuals with Level II to ensure needs are being met. This workgroup will examine the possibility of this recommendation further. To assist

with this process CMS may be able to share added insight into the Federal expectation and practices in other states with the CT DPH surveyors.

The workgroup was presented a copy of the Colorado mental health waiver brought by Paul Miller from CMS who encourages our group to apply for a similar waiver in Connecticut. One potential barrier this workgroup will have to examine is the Institute for Mental Disease (IMD) issue which may pose a barrier in CT if a Nursing Facility cares for a population over 50% which has a diagnosis of mental illness.

Training Committee - Summary of Work:

The group's immediate training focus will be on hands-on caregivers in the facility. This primary education goal will be achieved through the development of two major tools:

I. Training modules for individuals working toward certification / licensure in this field.
   A) The CT Certified Nurses Assistant training curriculum requires an additional 25 hours of education.
   B) Nursing School curriculum also does not include a lot of training in behavioral management.

II. Training modules that can be provided to professionals currently working in CT's nursing facilities.
   A) Combined sensitivity training, Assessment and Re-Assessment
   B) Medical professional outreach module to offer clinical test interventions that may be provided onsite thereby offering the least restrictive interventions to de-escalate behaviors.

Tasks for upcoming meeting:

- Research into current training modules.
- Identify current entities providing training
- Level II: Revision and Training
- Incorporating providers in committee

Policies, Regulations, and Legislative Action Committee:

This group has taken a more broad-based approach and hopes to target policy needs through examining systemic problems. Tasks this group has set for the next meeting include:

- Looking at groups of individuals, such as people with Dementia, to discuss alternatives in handling care needs.
- Review of other states' models, such as the Colorado model and any potential risks that may be involved to the public and providers.
- Review of State and Federal regulations addressing reporting and the internal dispute process
- Review of the W10 form and its effectiveness.
- Discuss the development of a pilot to study risk and liability as well as willingness of industry to take on challenging cases. Explore the notion of an alternative approach to regulation that will foster a more complete dialogue on alternatives and best practices between oversight and providers.

- See also see attached notes by Maggie Ewald.

Care and Case Study Committee:

The focus on this date was to look at the applicability and lack thereof of current systems and resources that could have helped in past cases and remain relevant to current trends. This group will be working on:

- Recommendations and plans of action
- Accessing and sharing regulations across provider settings to allow for a better understanding of care issues across providers.
- Development of continuing care practices; use of the medical director or related staff to liaison with the hospital for better communication.
- Researching alternative settings and barriers to access, for individuals who may not need to be in a nursing facility.
- Examine the better use of crisis mobile centers
- Create a CT checklist based on the one offered by the Federal Guidelines which emphasizes onsite interventions.
- Care planning between providers as a more inclusive interdisciplinary team.
- Please also see attached notes provided by Bob Burke.

We look forward to another productive session!

Please do not forget to RSVP for meetings to enable rotating site hosts to make arrangements. We can be contacted at LTCOP@po.state.ct.us

Policy, Regulations and Legislative Actions Committee
"Caring for Residents with Challenging Behaviors"
Minutes of Meeting February 25, 2004

Group discussion follows:

- Lack of definition/monitoring of specialized units/dementia units; keypad vs locked (literal lock and key)units. purpose/ intent of segregation; achieving balance/support of "wandering behavior" and concept of least restrictive environment; JAHCO no longer certifies specialized units; number of locked/ secured units in State unknown

- Identify existing research related to working with residents presenting challenging behaviors (i.e. recent JAMA article regarding resident to resident violence and previous studies undertaken by the Braceland Center several years previously)

- Consideration that any risk assessment be applied to all residents rather than any target population; disconnect regarding risk/liability issues experienced by providers/ conservators and impact on residents presenting challenging behaviors

- Identification of Care Plan and actual delivery/follow through as critical piece in work with individual residents; Use of screening tool in care plan; Level II evaluation; on site clinical judgement; observation/frequency of behavior; determination of triggers and what interventions have/have not worked in past; PAS/RR

- Units where residents and staff able to progress through stages of dementia (unit for all stages of Progressive diseases) vs units specialized for certain stages of a dementia/diagnosis; Bazelon Center supports mainstreaming; issues of acute/episodic behaviors vs chronic/progressive behavior

- Identify best practices (i.e. environmental support through lighting, sound)

- Tennessee model for Alzheimers/dementia unit; Colorado model (21-64 yrs)

- Need for Public Education regarding:
  - -risk assessment
  - -stabilizing staff/training
  - -regulation with regard to facility risk aversion

- Facilities no longer trust quality/uniformity/reliability of W-10 information; need for standardized definitions/language/"tags"; adequacy/quality of information shared between facilities (Nursing homes, hospitals, psychiatric

and/or geriatric units) being questioned; DONs left to document everything which might constitute inappropriate behavior

- Disconnect between mandated reporting; industry concern with OBRA survey deficiencies, plan of correction, penalization; review history; streamline process

- Difficulty in predicting danger to oneself and/or others; when to discharge back to facility; failure to readmit; consider extension of 15 day bed hold in light of time needed for medications to be evaluated

- Consideration of existing resources: Qualidigm; mental health mobile crisis teams; improve existing reporting process; improve yet standardize W-10 process; review "best facilities"/types of complaints: regional sponsorship/approach to Breaking the Bonds; Healthcare Administrators Association; Medical Director to serve as liaison between ERs and/or Psych units

- Consider pilot regulation/negotiation/arbitration body/process, similar to internal dispute negotiations in MA

Workgroup members agreed to follow up on a number of issues:

Jan Van Tassel:	Colorado HCBS waiver
Carol Lee Hall:	Specialized unit certification
Rick Brown:	MA IDR (Internal DisputeNegotiation) Survey waiver JAMA article
Mag Morelli:	W-10 form
Gene Hickey:	Braceland Center Behavioral Studies
Marilyn Denny:	Comparison of Federal/State statutes

CARING FOR RESIDENTS WITH CHALLENGING BEHAVIORS

"Care and Case Discussion Committee" Meeting Minutes

Rocky Hill Marriott

February 25, 2004 9am – 12noon

Committee Members Present:

Teresa Cusano, CT OMB, facilitator
Valerie Bryan, CT DPH
Michael Michalski, Reg Omb
Laurel Woods, MedOptions
Lynne MacLean, Apple Health Care
Nancy March, IOL
Bob Burke, Athena Health Care, Recorder

Discussion:

The Care and Case Committee initial discussions focused on the following topics:

- There is an evident need within nursing home settings that staff and supervisors within facilities need training in the identification of specific target behaviors in documenting an Inter-Agency Referral Report (W-10) when preparing for the transfer of a resident to an acute care setting. It was the impressions of the committee that too often residents in need of an emergency psychiatric evaluation are sent with accompanying documents that lack adequate descriptions of the presenting symptoms, which the receiving setting would need in order to adequately assess and stabilize the patient. (This point was later reiterated by the Training Committee which they had included in their recommendations)

- There is presently evidence that nursing home facilities and the acute care settings that they utilize for emergency evaluation of aggressive or potentially harmful resident behaviors do not have mutual respect and understanding for the resources and capabilities available or lacking in their respective organizations. It was the impression of the committee that if Nursing Home and Hospital Administrators were to develop inter-agency relationships and dialogue prior to problem or crisis development, the nursing home residents needing access to thorough and comprehensive assessments of acute conditions would receive such without the potential trauma of possibly unnecessary inter-agency transport.

- It was the impressions of the committee that "Best Practice" Standards must be developed which could assist in the assessment and treatment of challenging behaviors presented by nursing home residents in order to reduce the potential for any unnecessary emergency transport of a resident. The committee suggests the development of a clinical assessment "checklist" for licensed nursing home staff to utilize in their screening of whether an immediate emergency evaluation would be necessary for the resident.

- It was the impression of the committee that there is evidence that available resources (community and facility based) are not always being utilized for consultation or guidance in conditions in which residents are being transported for emergency evaluations. Examples discussed included:
  - facility based social workers (some of whom are Licensed Clinical Social Workers) who are required by OBRA regulations to respond to psychosocial conditions, and
  - DMHAS LMHA Mobile Crisis Assessment Teams for facilities that may not have 24 hour contracted psychiatric consultation available.

Recommendations:

The Care and Case Discussion Committee has made the following recommendations for future work and development by the Committee:

1. A forum or process must be developed for the sharing of Regulations, Statutes, and Standards between the different agencies and settings that must assess and treat challenging behaviors that may be presented by nursing home residents. Practitioners in hospital or nursing home settings should become familiar with the capabilities or restrictions affecting each others services, as this might serve as a guide in their development of aftercare recommendations.

2. The Committee shall endeavor to access all applicable Statutes and Regulations of hospitals (general and psychiatric) and nursing homes, in order to prevent contradicting or conflicting with existing standards in the development and proposal of "Best Practice" Standards.

3. On-site evaluations should be conducted by nursing home clinical representatives when individuals whose conditions include evidence of challenging behaviors are awaiting admission or re-admission to nursing homes. It is recommended that this be included in "Best Practice" Standards, not only to prevent inappropriate nursing home placement, but also to ensure that the necessary resources are in place at the nursing home to meet the individuals needs.

4. Practitioners in the acute care settings should share with colleagues in the nursing home settings some of the assessment tools that are presently used in acute psychiatric care, in order for nursing home professionals to maximize their crisis assessment capabilities.

5. In cases in which there is conflicting perceptions between hospital staff and nursing home staff as to the patient/resident's clinical condition, treatment and disposition needs, the nursing home Medical Director shall collaborate with the hospital physician in order to determine the optimal clinical methodology and disposition recommended for the individual patient/resident.

6. Training of Hospital Psychiatric and ED Staff regarding Nursing Home Residents Rights should be provided for clarification of a nursing home's limitations regarding behavioral management and medication administration, which are sometimes included in hospital aftercare recommendations, but not able to be carried out by nursing home caregivers.

7. A "Best Practice" checklist will be developed by which nursing home licensed staff will be able to more comprehensively assess a resident's presenting symptoms in order to ascertain whether or not the presenting symptom requires immediate and/or emergent psychiatric evaluation.

8. A letter to the Commissioner of the CT Dept of Mental Health and Addiction Services will be sent by the CT LTCOP to ascertain which LMHAs throughout the state have Mobile Crisis Intervention Services which may be referred to by facilities that are without contracted psychiatric consultation services available.

The "Care and Case Discussion" Committee's next meeting has been scheduled for Friday March 19th from 9a – 12noon at the Institute of Living (Donnelly Bldg).

The next "Caring for Residents with Challenging Behaviors" Work Group Meeting has been scheduled for Friday April 30th from 9a – 12 noon at the offices of Hartford Legal Assistance /Asylum Ave.

Respectfully Submitted,
Robert Burke, LCSW