# THE REPORT

## Background

A significant problem exists within CT's health care system, one that affects the health, safety, and quality of life of individuals who need nursing home care. Multifaceted, the problem springs from a misalignment of regulations, reimbursement, and policy that impacts nursing homes and hospitals.

Specifically, there is a growing concern around the care of nursing home residents who display challenging behaviors, sometimes viewed as " problem," "disruptive," or "unacceptable" behaviors. In most cases, these behaviors indicate distress from the residents' point of view, but for some, they may reflect life-long personality traits. Regardless, much of this concern has been generated by rare, but highly publicized, incidents in nursing homes involving residents displaying challenging behaviors. However, other recurring issues within the state's health care system are raising questions about its approach to caring for persons with such behaviors. These issues include the following:

(1) The transfer of nursing home residents with challenging behaviors to acute care hospitals and in some situations, the nursing home's refusal or inability to readmit the resident back into their facilities. Some reasons noted for this refusal or inability to readmit include the following:

- The facility belief that they are not able to provide ongoing safety.
- Regulatory intolerance for using restraints more commonly used in the hospital setting.
- The fear that if further incidents occur resulting in resident or staff harm, the facility will be cited by the state for failure to protect.
- Insufficient reimbursement rates.

(2) Reports of some nursing homes refusing to admit anyone with a history of challenging behaviors, even after the person has improved or has stabilized.

Both of these situations can cause unnecessarily traumatic, protracted, and expensive hospital stays which then creates pressure to transfer these individuals to state hospitals, despite the fact most do not have a serious and persistent mental illness, but rather a diagnosis of dementia.

(3) The lack of clarity regarding the type of care being delivered in some nursing homes operating locked special care units, known as "behavior" or "dementia" units. Currently, no uniform standards exist to guide the development and practice of such units, and research on their benefits is inconclusive. This raises questions about both the purpose of the units and the nature of the services provided.

(4) The increasing number of adults with psychiatric disabilities under the age of 65 who are being evaluated for admission to nursing homes which most likely reflects insufficient supported housing options and community-based services.

On a systemic level, the issues impeding the delivery of optimum care for nursing home residents with challenging behaviors are complex. Multiple factors, including staffing levels, staff education and training, definition of job roles, the facility's organizational structure, reimbursement, hospital practices, and regulatory pressures all have a bearing on the ability of nursing homes to provide care for these individuals. The fact that some nursing homes are reluctant to care for residents with challenging behaviors indicates CT and the long-term care industry must begin to address not only the assessment and treatment needs of residents, but also the capacity of nursing homes and their staff take to care of them.

Continuing the current approach does a disservice to both residents and staff. Instead, the system must acknowledge the special needs of residents with challenging behaviors and assure that staff receives the training required to care for this fragile population. Challenging behaviors, if left untreated, diminish the quality of life of the involved individuals and their peers, create stressful work environments for staff, are extremely upsetting to families, and can result in costly transfers to hospitals.

In response to the concern around caring for nursing home residents with challenging behaviors, the Office of the State Long-Term Care Ombudsman convened The CT Workgroup on Challenging Behaviors (Workgroup). The Workgroup is comprised of professionals representing state and federal government, nursing homes, researchers, academia, hospitals, and advocacy groups to examine this issue, its ramifications, and possible solutions. The Policy and Regulations Committee, one of three committees making up the Workgroup, produced this document in order to educate CT policymakers and key stakeholders in the state's health care system. The intent is to formulate recommendations that promote a healthy, integrated, and safe environment for residents and staff in long-term care facilities; recommendations that assure appropriate care for persons with challenging behaviors and that keep in mind limited state resources.

It is important to note that little data is actually collected related to challenging behaviors in CT nursing homes. However, because challenging behaviors are known to be a pervasive issue in nursing homes (Brodaty, Draper, Saab, Low, Richards, Paton, and Lie, 2001; Beck, Frank, Chumbler, O'Sullivan, Vogelpohl, Rasin, Walls, and Baldwin, 1998; Landreville, Bordes, Dicaire, and Verreault, 1998; Spector and Jackson, 1994; Cohen-Mansfield, Marx, and Werner, 1992) and because behavioral interventions are considered the most promising treatment strategy (Burgio and Stevens, 1999), the topic has been widely researched. Therefore, this document will not only discuss the data specific to CT, but also will present

information from an extensive literature review on factors related to caring for nursing home residents with challenging behaviors.

**Connecticut Data**

In July, 2001, "A Report on Violence in Nursing Homes" was issued by the Department of Mental Health and Addiction Services in collaboration with the Department of Social Services and the Department of Public Health, the two nursing home associations, the CT Hospital Association, the Institute of Living/Hartford Hospital, and other key stakeholders. In response to the public's perception that violence in nursing homes was extensive and most often perpetrated by residents with mental illness, the report indicated that the violence most often seen in nursing homes involves aggressive behaviors such as shoving, slapping, hitting, grabbing, and inappropriate touching, and the perpetrators are generally residents with a diagnosis of dementia, not those with chronic mental illness.

Additionally, the report made an important distinction between a diagnosis of dementia and a diagnosis of mental illness. Dementia is a neurological condition characterized by a global and progressive decline in intellectual functioning, most commonly caused by Alzheimer's disease. While individuals with dementia may develop psychiatric symptoms, this diagnosis is not considered to be a primary mental illness. Mental illness includes diagnoses such as schizophrenia, bipolar disorder, and major depression, and in most cases does not involve cognitive impairment.

As stated previously, there is a trend among CT nursing homes to refuse admission altogether, or discharge emergently to hospitals and refuse readmission when individuals have displayed challenging behaviors, particularly the aggressive behaviors. According to the Office of the State Long-Term Care Ombudsman, between 1999 and 2003, the third most frequent complaint made to the program had to do with discharge or eviction of residents from nursing homes. Data does not

include specifics around the circumstances of these discharges or evictions. However, based on the Ombudsman Program's experience, many of these residents had dementia and displayed aggressive behaviors that nursing home staff felt unable to prevent or manage safely.

In reviewing incident reports submitted by nursing homes to the CT Department of Public Health (DPH) Division of Health Systems Regulation between September and December 2003, it appeared that on a monthly basis, approximately 33% involved resident-to-resident abuse (DPH, 2004). Diagnostic information and details of the abuse were not collected in a way that could be easily reported.

A study of 477 residents in dementia programs in 17 CT nursing homes revealed that 41% engaged in aggressive behaviors such as hitting, kicking, pushing, throwing things, and making verbal or sexual advances at least once a week to several times a day (Braceland Center for Mental Health and Aging, 2004). The Braceland Center also obtained data from 308 nursing staff members from these same facilities regarding resident-to-*staff* verbal or physical aggression. Nursing staff reported that in a given month, during approximately 85% of their work time, they experienced residents insulting or swearing at them, or residents hitting, grabbing, pushing, or trying to hurt them in some way.

**Literature Review**

Some behaviors are challenging because they are of such intensity, duration, or frequency that the physical safety of the person displaying the behavior or others is placed in serious jeopardy (Watts, 2001). Examples include aggressive behaviors, particularly physically striking out at other residents or staff, as well as verbal communications or interactions that are threatening to others and inappropriate sexual behaviors. Other less overtly dangerous behaviors which indicate distress include wandering, screaming, and resistance to care.

While many professionals believe that residents with serious mental illnesses are prone to challenging behaviors, in fact, these behaviors are most often

associated with dementing illnesses such as Alzheimer's disease (O'Brien, Shomphe, and Caro, 2000; Allen-Burge, Stevens, and Burgio, 1999; Beck et al, 1998). Additionally, there is anecdotal evidence that an increased acuity level among nursing home residents may be a factor in the prevalence of disruptive behaviors given their close association with disability and impairment (Jackson, Spector, and Rabins, 1997).

***Why It is Important to Address the Issue Now***

There are at least three reasons why it is important now to address the long-term care of nursing home residents with challenging behaviors, including the needs of staff caring for them. First, regardless of clinical conditions, challenging behaviors are common among the nursing home population (Brazil, Hasler, McAiney, Sturdy-Smith, and Tettman, 2003; Burgio, Stevens, Burgio, Roth, Paul, and Gerstle, 2002; Landreville et al.; Jackson et al., 1997; Kolanowski, Taylor, and Strumpf, 1994) with estimates ranging from 64% to 83% (Sutor, Rummans, and Smith, 2001; Allen-Burge, Stevens, and Burgio, 1999) to as high as 90% (Boucher, 1999).

Additionally, among nursing home residents, the estimated prevalence of dementia and mental illnesses is extensive, ranging from 65.3% to 94% (Brazil et al., 2003; Cody, Beck, and Svarstad, 2002). Eighty-nine per cent of older people with serious mental illness who are institutionalized reside in nursing homes (Kanapaux, 2004).

According to data from the Centers for Medicare and Medicaid (CMS) for the quarter ending March 31, 2004, approximately 36.4 % of CT nursing home residents have varying degrees of depression, less than 10% have a serious and persistent mental illness such as schizophrenia and bipolar disorder[1], and 51% have a diagnosis of Alzheimer's or other dementia. Given these figures, it would seem

[1] The Department of Mental Health and Addiction Services' (DMHAS) OBRA data base indicates that 8% to 9% of CT nursing home residents have a serious mental illness which includes mental disorders that lead to chronic disability, essentially diagnoses of schizophrenia, delusional (paranoid) disorder, psychotic disorders not elsewhere classified, bipolar disorder, and major depression. It would appear that the number of CT nursing home residents with mental illness might be under-reported to DMHAS.

that nursing homes are a primary source of residential care for persons with mental disorders.

Second, demographic changes related to aging, Alzheimer's, and nursing home admissions will most likely increase the prevalence of challenging behaviors. The geriatric population is expected to grow dramatically due to the aging of the baby-boom generation. In CT alone, between 1995 and 2020, the number of citizens age 65 and older will increase by 35%, whereas CT's total population will increase only by 9% (State of CT Office of Policy and Management, 1995).

With the number of elderly people increasing, the number of those developing Alzheimer's disease will also increase as Alzheimer's is linked to advancing age (Radebaugh, Buckholtz, and Khachaturian, 1996; Ryden, Bossenmaier, and McLachlan, 1991). By 2030, it is estimated that the number of Americans with Alzheimer's could rise to 7.7 million and by 2050, to 16 million (Eastman, 2004). There's the additional concern about the numbers of younger people at risk for developing dementia as a result of other conditions, such as substance abuse, traumatic brain injury, and HIV/AIDS. As the younger population ages, the sequelae of these conditions most likely will increase as well.

Among people who live to age 65, an estimated 20% to 50% will eventually reside in a nursing home (Sutor et al., 1995; German, Rovner, Burton, Brant, and Clark, 1992), and regardless of a person's physical disabilities, research has shown that problems with mood, behavior, or cognition are often contributing factors in nursing home admissions (Whall and Kolanowski, 2002; Emerson Lombardo, Fogel, Robinson, and Weiss, 1996). In fact, behavioral symptoms, particularly when associated with a diagnosis of dementia, often predict institutionalization (Opie, Doyle, and O'Connor, 2002; Kolanowski, Litaker, and Baumann, 2002; Morgan and Stewart, 1997; Carlson, Fleming, Smith, and Evans, 1995; Class, Schneider, and Farlow, 1997; Algase, Beck, Kolanowski, and Whall, 1996; Cohen-Mansfield, 1995).

Third, regulations associated with the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1991 shifted the paradigm of nursing home care from a medical/custodial model to one that is more therapeutic/rehabilitative. The regulations mandate that nursing homes assist residents in attaining their highest practicable level of functioning which requires a more active treatment model than custodial care.

Most importantly, the regulations limit the use of physical and chemical restraints, instead recommending the use of behavioral interventions (Burgio et al., 2002). In fact, in a set of proposed rules for nurses' aide training published in the Federal Register in March 1990, it was recommended that nurses' aides be taught to use "behavior management by reinforcing appropriate behavior and reducing or eliminating inappropriate behavior" (Burgio and Bourgeois, 1992). It is generally thought that greater reliance on behavioral and environmental interventions is associated with higher quality of life in nursing homes (Burgio and Stevens, 1999).

Therefore, given that many nursing home residents are already affected by challenging behaviors and that their numbers will increase, as well as the fact nursing homes are expected to provide more than custodial care, it seems clear the development of strategies to deal with challenging behaviors should take priority in improving the care and treatment of this vulnerable population. Research has demonstrated that behavioral management, when implemented by trained staff and integrated into individualized resident care planning, can enhance the quality of the living and working environment of nursing homes (Hughes and Medina-Walpole, 2000; Carlson et al., 1995; Burgio and Bourgeois, 1992).

***Current Thinking on the Causes and Management of Challenging Behaviors***

Because a high percentage of nursing home residents with dementia display challenging behaviors, most of the research centers on their care needs. There is little research on challenging behaviors in nondemented nursing home residents. However, the literature documents a trend in dementia care that can be considered

wholistic and seems applicable as well to individuals without dementia. The trend revolves around four central ideas: (1) Behaviors are need-driven and are a way to communicate unmet needs (Whall and Kolanowski, 2002; Algase et al., 1996); (2) Behavior must be understood in the context of a person's life and his/her interaction with the environment, including physical surroundings, nursing home staff, and other residents (Low, Draper, and Brodaty, 2004; Whall and Kolanowski, 2002; Burgio et al., 2002; Sutor et al., 2001) with an increasing recognition of the importance of adapting the environment to individual needs (Morgan and Stewart, 1997; Kitwood and Bredin, 1992); (3) Staff providing the direct care (i.e., nurses' aides) have the most frequent contact with residents and offer the greatest potential for affecting resident behavior, either beneficially or detrimentally (Burgio and Burgio, 1990); and (4) Staff education and training in behavioral management strategies is essential to minimizing what are viewed as behavioral problems in nursing homes (Reichmann, 2004; Brazil et al., 2003; Cody, Beck, and Svarstad, 2002; Chartock, Nevins, Rzetelny, and Gilberto, 1988). Staff also need education and training about dementia and mental illnesses (Lyketsos, 2004; Bridges-Parlet, Knopman, and Thompson, 1994).

***(1) Behavior as Communication***

Researchers strongly assert that all behaviors have meaning and can be understood; that they represent a way of communicating unmet needs (Whall and Kolanowski, 2002; Camp, Cohen-Mansfield, and Capezuti, 2002; Watts, 2001; Morrison, Ramsey, and Synder, 2000; Hughes and Medina-Walpole, 2000; Morgan and Stewart, 1997; Emerson Lombardo et al., 1996; Carlson, et al., 1995; Stevenson, 1991). With respect to dementia, communication becomes overtly behavioral because of the loss of cognitive abilities (Kolanowski, Litaker, and Baumann, 2002). For example, a young child is not considered a behavioral problem when communicating hunger, pain, or fear by crying. A person with dementia may have the same limitations and respond in

the same way. Morgan and Stewart (1997) put it simply by stating "Stop asking how to manage behaviors and start asking how to understand and meet needs." The most common needs are for physical and social stimulation, and relief from discomfort and pain (Camp et al., 2002). Additionally, undiagnosed medical issues including delirium, anxiety, sleep disturbances, and depression are markers of behavioral disturbances (Hughes and Medina-Walpole, 2000) as well as urinary and respiratory infections, fecal impaction, silent myocardial infarction, transient ischemic attacks, gastrointestinal bleeding, onset of diabetes, and hypothyroidism (Boucher, 1999). The goal of treatment, therefore, is to uncover and address the unmet needs.

***(2) Person-Environment Interaction***

If anything, the environment is viewed as a significant factor in the way behaviors manifest themselves in nursing home residents. At a 1993 invitational conference of 130 mental health and aging experts, many believed the environment of the typical nursing home exacerbates problem behaviors; that is, an environment that is not supportive can accentuate whatever frailty residents have – physical illness, mental illness, or both (Emerson Lombardo et al., 1996). Archibald (1999) went so far as to say the social environment (i.e., the day-to-day habitual and spontaneous human interactions inherent in any facility), is more the problem in nursing homes, not the resident displaying the behaviors. And McGrew (1999) points out that the facility's social environment has just as much impact on the psychosocial well-being of residents as the programmatic environment (i.e., specific psychotherapeutic or psychopharmacological interventions).

Using the perspective of person-environment interaction, behavior is considered a response to, or an attempt to cope with, the environment in which people find themselves (Kolanowski et al., 1994). With respect to long-term care institutions, Kolanowski et al. described the environment as a

system, involving the facility's physical characteristics, organizational climate (i.e., style of management, staffing levels and attitudes, etc.), and the psychosocial milieu. This system interacts with the individual's personal system which includes his/her lifelong habits and personality as well as current physical and mental conditions. The interaction between these two systems results in behavior, either positive or negative, depending on how well the person is functioning, and how demanding the environment is. Therefore, to understand challenging behaviors, one must understand both the personal and environmental contexts of the behavior. It may not be possible to alter the resident's personal characteristics, but it may be possible to alter the environmental factors, thereby effecting more positive interactions and outcomes.

***(3) Behavior of Nursing Staff Affects Resident Behavior***

According to the literature, nursing staff represents a major environmental factor for nursing home residents (Burgio et al., 2002; Burgio and Stevens, 1999). Studies conducted by Burgio et al. (2002) and Burgio and Burgio (1990) reported that the behaviors of nursing staff, especially nurses' aides who are responsible for 80% to 90% of the care provided residents, can influence the occurrence of challenging behaviors in residents – particularly in the way they communicate with residents and how they respond to them when a behavior problem occurs. Staff behavior can exacerbate residents' behavioral symptoms or actually reinforce inappropriate behaviors (Sutor et al., 2001; Spore, Smyer, and Cohn, 1991; Chartok et al., 1988). Watts (2001) takes this idea one step further by referring to the Theory of Social Constructionism which asserts that language, both verbal and nonverbal, is the means by which the social community is created. Nursing homes represent social communities of residents, staff, families, and other visitors. Thus, the behavior found challenging by nursing home staff is in

effect, co-constructed, or co-created, by people in the facility communicating with each other. This theoretical position may help to understand the roots of behaviors on three levels: (1) Behavior is a way of communicating needs; (2) Staff's *own* communication within the facility is important; and (3) Staff contribute to the *patterns* of communication within the facility.

***(4) Nursing Staff Education and Training***

It has been stated earlier in this document, but it is important to note again that, in 1990, the Health Care Financing Administration (now known as the Center for Medicare and Medicaid Services, or CMS), recommended that nursing staff receive training in and utilize behavioral management strategies over the use of pharmacological interventions. However, studies have found that nursing home staff receive very little formal education and training in mental health and dementia (Lyketsos, 2004; McGrew, 1999; Hagen and Sayers, 1995; Emerson Lombardo, 1994: Chartok et al., 1988), or in behavior management strategies (Cody, Beck, and Svarstad, 2002; Lennox 2002; Brazil et al., 2003; Emerson Lombardo et al., 1996; Burgio and Bourgeois, 1992). In a survey of 13 nursing homes, McGrew (1999) found the lack of mental health education and training as a major barrier to staff trying to respond to the mental health needs of residents. Burgio and Bourgeois cited a survey of 89 nursing homes where it was found that 54% of staff acknowledged using behavior management procedures, but only 16% had received any formal training in their use. Another survey of 101 geriatric nurses in 5 long-term care facilities conducted by Burgio and Bourgeois found that the nurses were not sure they had received sufficient training to manage clinically significant behavioral problems displayed by their elderly residents. In a Canadian study of how well staff manages resident behaviors in 15 long-term care facilities, the second most common

need cited by staff was the need for increasing their competencies in behavioral management, the first need being increased staffing levels (Brazil et al., 2003). Researchers who have concentrated on methods of educating and training nurses' aides about managing challenging behaviors have found that formal on-the-job training is essential for them to perform new skills on nursing units (Stevens, Burgio, Bailey, Burgio, Paul. Capilouto, Nicovich, and Hale, 1998; Burgio and Scilley, 1994, Burgio and Burgio, 1990). However, in order to maintain skills over time, their studies suggest that there must also be a formal system of supervision and feedback, including the use of motivational incentives. Additional research conducted by Stevens et al. concluded that attempts to implement behavior management procedures without training *and* a motivational system of supervision and feedback result in few positive resident outcomes and contribute to staff burnout, poor moral, and high staff turnover. Burgio and Stevens (1999) particularly note that supervisory deficiencies are a major stumbling block in the long-term application of therapeutic skills. In nursing homes, supervisory capabilities are the responsibility of registered nurses and licensed practical nurses, most of who lack sufficient training in supervisory techniques. Consequently, in many nursing homes, there may exist a management structure that is inadequate to support innovative training and intervention programs.

***Interventions Specific to Nondemented Nursing Home Residents***

As mentioned previously, there is a dearth of research on nondemented nursing home residents who may display challenging behaviors. Existing research appears to concentrate on persons with mental illness who are treated on either inpatient hospital psychiatric or medical-surgical units.

Aside from determining whether behaviors are the result of acute psychiatric symptoms requiring pharmacological treatment, such as delusions or

hallucinations, concepts around how to address behavioral issues among persons *without* dementia in hospital settings seem similar to those applied to persons *with* dementia residing in nursing homes. For example, earlier, it was pointed out that behavior represents communication of unmet needs. Morrison, Ramsey, and Synder (2000) suggest looking beyond psychiatric labels and trying to understand the underlying emotional needs the individual's behavioral symptoms might represent. In this way, the person may seem more like you and me, thereby less threatening and intimidating. Another example is the effect the environment, especially staff behavior, may have on exacerbating or reinforcing a resident's negative behavior (Morrison et al., 2000; Morrison, 1994).

As in dementia care, interventions begin with determining what the individual feels is needed and they may include those mentioned previously: physical and social stimulation, and relief from discomfort or pain. For psychiatric inpatients, one of the most common needs is the need for control and it can be expressed through anger, aggression, or even violence (Morrison, 1994; 1992). In nursing home residents under the age of 60, more than likely there is a struggle with dependency issues which compounds the anger and frustration (Richter, 1989). Studies have found that people can become aggressive and violent when they perceive themselves to be powerless, but using force to control them can be an encouragement for more aggressive behavior (Burgio and Bourgeois, 1992; Stevenson, 1991).

However, nursing home residents who are not cognitively impaired must be held accountable for their behaviors and the expectation needs to be clearly communicated to them (Distasio, 1994). Instead of focusing on rules and using a confrontational approach, Morrison et al. (2000) suggest finding ways to empower the individual, encouraging participation in his/her own care, making his/her own decisions as much as possible. Nursing home staff must remember that involving the resident in developing his/her own care plan and being informed of any changes

that may affect his/her well-being, is their right under OBRA 1987 (42 CFR 483.10)

To address challenging behaviors displayed by a resident who is cognitively intact, the resident's care plan might include what Morrison et al. refer to as a "negotiated contract." A negotiated contract between a resident and nursing staff represents a mutually cooperative effort in reducing the possibility of unacceptable behaviors. It outlines detailed information about the unacceptable behaviors, the appropriate behaviors, the consequences for breaking the contract, and the nurse's contribution to care. An important part of nursing staff's contribution is to encourage and reward the resident when he/she is independent, when he/she has positive interactions with others, and when he/she behaves in an acceptable manner (Cawood, 2002).

***Workplace Violence***

In health care organizations, the emergence of workplace violence is associated with patient, staff, situational, and environmental factors and in many instances can be predicted (Distasio, 1994). Workplace violence can be defined broadly as a "fatality, an assault, an aggressive act of hitting, kicking, pushing, scratching, sexual act or attempt, with or without a weapon, or any other such physical or verbal attacks directed to the worker by a patient, client, relative, co-worker, customer, or work-associated individual, which arises during or as a result of the performance of duties and which results in death, physical injury, or mental harm (Simonowitz, 1995).

Nurses' aides endure more incidences of physical violence than any other institutional-based caregiver (Brunk, 1997), resulting in high physical, emotional, and financial costs to them (Simonowitz, 1995). For example, Simonowitz describes the effects of suffering assault as including physical injury and partial or total disability, fear, anxiety, sleeplessness, self-doubt, depression, irritability, disturbed relationships with family and peers, decreased ability to function

effectively in the workplace, increased absenteeism, and post traumatic stress syndrome. Victimized workers may choose to leave the field if they see violence occurring on a regular basis, or perceive that management lacks concern and commitment to prevent violence. This can contribute to the high staff turnover often seen in nursing homes which in turn detrimentally affects the well-being of residents who might act out distress related to changing caregivers.

As a prevention strategy, adoption of risk management procedures in nursing homes would most likely reduce injuries and accidents, allowing facilities to respond positively to unexpected events to prevent their recurrence (Cody et al., 2002). In fact, the Occupational Safety and Health Administration (OSHA) advises every organization to make prevention of violence a high priority, instituting measures to protect staff and clients (OSHA, 2004). OSHA identifies five components of an effective safety and health program to prevent workplace violence:

a) Management commitment and employee involvement;
b) Worksite analysis;
c) Hazard prevention and control;
d) Safety and health training; and
e) Recordkeeping and program evaluation.

While not every incident of violence can be prevented, many can be, and the severity of injuries sustained by employees can be reduced. Additionally, effective safety and health programs improve both morale and productivity, at the same time, reducing workers' compensation costs.

***Special Care Units***

Within nursing homes, special care units (SCUs) are thought to be one solution for the care of persons with dementia (Gerdner and Buckwalter, 1996; Sloane, Lindeman, Phillips, Moritz, and Koch, 1995; Holmes, Teresi, Weiner, Monaco, Ronch, and Vickers, 1990), especially for persons with challenging behaviors. While SCUs were defined by the Health Care Financing Administration, now CMS, as units

with a specific number of beds identified and dedicated for residents with specific needs or diagnoses, they are not defined further for purposes of reimbursement or licensure (Banaszak-Holl, Zinn, and Mor, 1996). While 26 states have set standards guiding the development and practice of SCUs (Alzheimer Association, 2000), CT has not done so. As a result, in CT, SCUs tend to be heterogeneous, varying in format from specially designed, free-standing facilities staffed with highly trained employees, to facilities which simply close off a wing, segregating the confused, or those with behavioral problems, from the frail.

Often, the differentiation between a SCU and an integrated unit is quite vague and there is some concern SCUs merely represent a marketing ploy by facilities targeting a vulnerable population (Gerdner and Buckwalter, 1996; Mor et al., 1995-1996; Holmes et al., 1990). Consequently, the Alzheimer's Association recommends disclosure laws that make clear to consumers the characteristics and services that distinguish a SCU from a non-SCU (Alzheimer's Association, 2000).

Because SCUs are so varied in their milieu (i.e., differences in unit size, type of facility, the residents served, including age and level of illness, therapeutic approach, etc.), it is difficult to conduct research on the effectiveness of SCUs. Therefore, little data exist examining the characteristics of residents on SCUs or of the effects that may be associated with placement in such units (Holmes et al. (1990).

Holmes et al. conducted a 6-month follow-up study of SCU and non-SCU residents in four institutions where the SCU was defined "as a segregated unit for demented patients, in which structural modifications have been made reflecting the treatment, social, and safety needs of these patients, and in which special programs are conducted by specially trained staff." Essentially, the SCUs in his sample were designed to care for the more cognitively, behaviorally disturbed person who required more one-on-one, intensive care. His findings suggest that for cognitively-impaired residents, there were neither deleterious nor beneficial effects

associated with SCU residence. However, the findings might be different on units targeting less demented individuals receiving special "rehabilitative" services. Holmes et al. also cited a study done in 1987 involving 32 residents of a SCU over a 12-month period and the findings suggested positive outcomes.

Research conducted by Van Haitsma, Lawton, and Kleban (2000) has revealed that environmental segregation alone, without extra staffing, activities, and the targeting and tailoring of programs to residents, can have a negative effect on the cognitively impaired. They point out that while there is controversy over what criteria are necessary to constitute a SCU, the three most important aspects of special care are augmented staffing, staff training, and specialized programs. Additional criteria include: (1) Physically separated unit with controlled access; (2) Physical environment designed for the cognitively impaired; (3) Specified criteria for admission and discharge; and (4) A designated unit director. A unit of this kind may be more costly to operate than traditional care and providers may request additional reimbursement.

***Costs Related to Challenging Behaviors***

Overall, it is likely that disruptive behavior contributes to an increase in the cost of care. For example, in an analysis of the costs of caring for nursing home residents in Massachusetts, the cost of caring for a resident with dementia was shown to be higher than caring for a resident without dementia. Behavioral problems were a distinct and measurable factor contributing to the increase (O'Brien, Shomphe, and Caro, 2000). The higher cost of a disruptive resident may reflect the need for additional supervision, and cost may further increase if other residents become disturbed and nursing staff experience higher amounts of stress (Spector and Jackson, 1994).

There is some concern that what may discourage nursing homes from admitting persons with dementia is the payment methodology by which they are reimbursed. Controversy exists over the accuracy of case-mix reimbursement

systems that tie payment rates to a resident's estimated cost of care, some believing that the cost of high quality or even adequate dementia care is underestimated (Emerson Lombardo et al., 1996). According to Jackson et al. (1997), estimates developed as part of case-mix reimbursement studies indicate that individuals with behavioral problems require more supervision and interventions.

Schnelle, Ouslander, and Cruise (1997) question whether nursing homes have sufficient resources for the consistent application of an active treatment model. However, to consider augmenting funding for the care of nursing home residents with mental impairments, professional standards are needed that specify and mandate adequate levels of psychosocial care for this population (Rohrer, Buckwalter, and Russell, 1989). Regulatory mechanisms that require documentation of access to and receipt of psychosocial interventions are also needed. Increased reimbursement should be based on evidence of quality provision of needed psychosocial services.

***Regulatory Factors***

Current regulatory practices may function as barriers to implementing a therapeutic model, that is, a model of active treatment to maximize a resident's functioning. In an article published by Schnelle, Ouslander, and Cruise (1997), it was argued that most nursing home inspection teams focus on paper compliance with regulatory mandates for active treatment rather than on actual implementation of therapeutic practices.

Additionally, because there is a lack of tolerance for safety violations such as aggressive behavior, and also a great concern to protect the rights of other residents, staff is often caught in a "catch 22" situation. They may be reluctant to take the time required to implement behavioral strategies – especially since there is little guidance as to what can be used and the methods to implement and document their use. And they may not want to take the risk for not curtailing

safety violations promptly. Consequently, the most expedient solution in caring for a resident who is particularly aggressive may be to hospitalize him/her, thus initiating the cycle of hospital admission, the refusal to readmit to the facility, and the request for assistance from the state.

**Other Considerations**

- Under Medicare, it is not widely known by psychiatrists and psychologists that behavior management is a reimbursable treatment. However, in CT, psychiatrists and psychologists cannot bill Medicaid for behavior management as a treatment. Reichmann (2004) recommends reimbursement for labor intensive therapeutic services such as nonpharmacologic (behavioral) patient management, staff support, staff stress reduction, and conflict resolution. If these services were readily available, there might be an improvement in the therapeutic milieu, a reduction in staff turnover, and a higher level of satisfaction among patients and families.
- There is a need for the development of quality of care and quality of life measures for nursing home use. If behavioral treatments can affect improvements in these types of measures, it may be possible to use that data to better decide the amount of resources needed by nursing homes (Burgio and Stevens, 1999).
- For better management of residents' challenging behaviors, strategies must be directed towards modifying the infrastructure of nursing homes – particularly reviewing funding formulas for staffing and the development of standards on how nurses' training is designed, implemented and supported (Brazil, 2003).
- A study by Castle and Fogel (1998) of 268 nursing homes in ten states, including CT, examined the degree to which organizational structures affect quality outcomes experienced by nursing home residents with mental disorders. Findings indicated that mental health outcomes (i.e., mood, social

engagement, behavioral problems, cognitive performance, and mortality) are not solely dependent upon residents' characteristics but also on several structural factors. Structural factors included facility charter (for profit versus not-for-profit), whether the facility was a member of a chain, facility size, whether the census included Medicaid recipients, staffing levels, occupancy rates, and whether the facility had a SCU.

- Because of the communal nature of nursing homes, other residents and visitors are as vital a part of the facility's plan to address behavioral disturbances as nursing home staff. Families also need education about mental illness, dementia, regulatory issues, participation in care planning, and communication with nursing staff (Cody et al., 2002).

**Conclusion**

Nursing homes are, and most likely will remain, important sites for the care of individuals with behavioral health needs. And, as the state's population ages and the demand for long-term care services increases, failure to address their needs as well as the needs of nursing staff will result in the escalation of problems related to challenging behaviors. Therefore, the State of CT must develop and implement a systemic approach to meeting the long-term care needs of persons with challenging behaviors, an approach that promotes quality care, avoids costly and unnecessary hospital stays, and assures a safe environment for residents and staff. Accomplishing this goal will require a broad-based collaborative effort, one that addresses staffing and staff education and training, funding, and regulations. Key solutions center on education for health are system managers and nursing home staff, examination of appropriate reimbursement to nursing homes, and alternative placements for individuals who do not need nursing home care.

To this end, under the auspices of the Office of the State Long-Term Care Ombudsman, the CT Workgroup on Challenging Behaviors will take the lead in working with state policymakers to bring about the change necessary to address

the assessment and treatment of nursing home residents with challenging behaviors and the capacity of nursing homes and their staff to care for them. Recommendations that speak to this multifaceted problem are listed below in no particular order of priority.

**Recommendations**

(1) Identify best practices for caring for residents with challenging behaviors being utilized in CT nursing homes. Hold on-going statewide forums to present and share this information.

(2) Develop an assessment tool and collect data on the special care units currently operating in the State of CT with respect to criteria and procedures for admission, transfer, and discharge, the special services provided, and staff levels, training, and supervision.

(3) Require nursing homes operating special care units to fully disclose to state agencies, as mandated by statute (C.G.S. Sections 17b-262 and 19a-512a), as well as the public, the criteria and procedures for admission, transfer, and discharge, the special services provided, and staff levels, training, and supervision for such units.

(4) Upon review of the following efforts:

- Two studies conducted by the Legislative Program Review and Investigations Committee in 2000 and 2001 respectively: *Staffing in Nursing Homes* and *Medicaid Rate Setting for Nursing Homes*;
- The *Final Report of the Ad Hoc Task Force on Nursing Home Costs* issued in 2002; and
- The current U.S. Department on Health and Human Services Nursing Home Quality Initiative wherein the Center for Medicare and Medicaid Services is undertaking an aggressive action plan for nursing home improvements, including improved accuracy of the Medicare payment systems; improved access for those with greatest care

needs; and directing the appropriate level of resources to nursing homes to furnish high quality care, including performance incentives related to quality (USDHH, December 22, 2004);

the CT General Assembly, in consultation with the CT Workgroup on Challenging Behaviors, should examine the reimbursement methodology for long-term care facilities to determine whether it is adequate to cover the cost of staffing, training, and programming required to meet the behavioral health needs of residents.

(5) Pilot a mobile care integration team (CIT) that would travel to nursing homes specifically to work with nursing staff on implementing appropriate interventions with residents with challenging behaviors. The CIT would be interdisciplinary and would not only assist in the assessment of, but also in the development of behavior care plans. The CIT would also be responsible for educating and training staff in behavior management as well as about dementia and mental illness.

(6) Assure that hospital staff and nursing home management receives education about assessment and treatment of individuals with challenging behaviors, including the importance of their role in supporting the efforts of direct care staff.

(7) Assure that programs educating and training practical nurses for licensure and nurses' aides for certification place adequate emphasis on behavior management training, including the understanding of dementia and mental illnesses.

(8) Assure that nursing homes provide regular, ongoing staff education and training in assessment of challenging behaviors, and the understanding of dementia and mental illness. Behavioral interventions for persons with dementia are different from those utilized for persons with serious and persistent mental illness.

(9) While this document does not specifically focus on nursing home residents with mental illness, the next four recommendations would improve the mental health services and placement options provided them: (a) Reinstate Annual Resident Review (ARR), originally mandated under OBRA 1987, but terminated in CT in 1996. Under ARR, nursing home residents identified to have a serious mental illness would be evaluated by qualified mental health professionals (QMHPs) at least annually, and more often as necessary, to assess their psychiatric status. This would allow the QMHPs to consult with nursing home staff about residents' conditions and needs. (b) Request that the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), and the Department of Mental Retardation review the current process of PASRR (Preadmission Screening Resident Review) to assess whether changes would improve the screening and evaluation of nursing home applicants/residents with serious mental illness and/or mental retardation. (c) Request that the Department of Public Health (DPH), under their responsibilities to license and certify CT nursing homes, to review facilities' implementation of the mental health services recommendations specified in PASRR Determination Notices issued to nursing home residents with serious mental illness. (d) DSS and DMHAS should explore the feasibility of implementing a home and community-based services waiver for adults with psychiatric disabilities who reside in, or would otherwise be admitted to, a long-term care facility.