

Draft Proposal
Care Integration Team
January 26, 2006

The Connecticut Workgroup on Challenging Behaviors has identified a serious problem in the care of nursing home residents in Connecticut. In brief, when a resident with dementia or a psychiatric illness develops certain behaviors they may be subjected to a series of emergency room visits, acute hospitalizations and multiple nursing home placements, often in a series of different nursing facilities. The Workgroup believes that this pattern is fostered by a constellation of issues including conflicting legal, regulatory and financial factors, and great variations in the missions, expertise and resources of the different facilities. The result is that certain residents are harmed by being deprived of timely access to appropriate care, shifted from one facility to another, or hospitalized unnecessarily. This issue is discussed in more detail in the Workgroup's January 2005 position paper. To date, efforts to address this problem have focused on regulatory enforcement or enhancement of services within particular institutions or levels of care. This approach is necessary but not sufficient to address the well-being of affected nursing home residents.

The Workgroup proposes a model of intervention that is resident focused and will cut across institutions and episodes of care. The intent is to directly connect appropriate resources and expertise to the planning and delivery of care to people with challenging behaviors. The Workgroup believes that this longitudinal, individually-oriented service will provide more appropriate and targeted interventions, create incentives for facilities to accept and work with such individuals, enhance the expertise of the facilities and prevent unnecessary emergency room visits and acute hospitalizations.

The Care Integration Team would consist of licensed mental health clinicians with expertise in treating behavioral disturbances associated with dementia and mental illness. Once a resident is identified by a facility as having behaviors that could lead to the pattern of placements described above, the (Office of the Long Term Care Ombudsman? Or the organization selected to house the CIT – see below) would assign the Team to work with and on behalf of the individual. Interventions would include, but not be limited to, a thorough diagnostic assessment leading to a behavior management plan. The team would then work with the facility caring for the individual so that the facility's front line staff can implement the plan. Should the behaviors continue or escalate, the team would get reinvolved with staff and the resident to make any modifications to the care. In those situations where a resident must move to a different facility the Team would follow the resident and continue to serve as a resource.

In addition to the obvious benefits to the resident, and a reduction in placements and hospitalizations, team involvement also provides facilities with ad hoc in service training on coping with challenging behaviors. Finally, the model allows for development of a

data base on the longitudinal course of individuals with challenging behaviors, the interventions that are employed and their effectiveness.

We propose a Pilot Test of the Care Integration Team, limited to one region in CT. An RFP will be broadcast to (who?? What type of orgs?) to create a Care Integration Team, as described above. The region for the Pilot Test will be determined based on which organization's proposal is chosen. In each case, individual team members with expertise regarding the individual in need of evaluation and treatment will be drawn from a larger pool of available team members.

A research evaluation of the feasibility and success of the program will be conducted in concert with the Pilot CIT program.