HEALTHY MINDS FOR A HEALTHY NEW YORK

Transitioning Nursing Home Residents with Mental Illness to the Community

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Overview

- Prevalence of nursing home residents with mental illness
- Determining resident mental health need
- Special considerations for transitioning people with mental illness to the community:
  - MH evaluations, proper diagnosis and treatment
  - Dealing with lack of insight and denial
  - Housing concerns, Peer Specialists
  - Meaningful Activity
  - Medication considerations
- Mental health literacy training for Transition Specialists

Olmstead v. L.C. and E.W.

In 1999, the Supreme Court ruled in Olmstead v. L.C. and E.W. that, under the Americans with Disabilities Act, states can be required to place Medicaid-funded patients in their least restrictive settings, e.g., those with mental disabilities in community settings rather than in institutions such as nursing homes.

Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women were voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where they were confined for treatment in a psychiatric unit. Although their treatment professionals eventually concluded that each of the women could be cared for appropriately in a community-based program, the women remained institutionalized at GRH.

How Prevalent is Mental Illness in Nursing Homes?

- Nursing homes have become the de facto mental institution for many persons with mental illness.
- Over 500,000 persons with mental illness (excluding dementia) reside in US nursing homes on a given day, which dwarfs the 51,000 individuals in beds at psychiatric hospitals.
- Nearly 49% of nursing home residents have a diagnosis of depression.
- 19% (N = 187,478) were admitted with mental illnesses other than dementia.
- A high proportion of nursing home residents have a significant mental disorder, with estimates ranging from 65% to 91%

Mental Illness Prevalence at Admission in NY Nursing Homes

	Total new NH admissions	Of N, Cases with Mental Illness			
	(N)	n_{narrow}	%	n_{broad}	%
U.S.	1,150,734	31,335	2.7	315,003	27.4
NY	79,022	2,041	**2.6**	18,635	**23.6**

Mental illness based upon the diagnosis fields in the MDS assessment at admission

1. Schizophrenia
2. Bipolar Disorder
3. Depression
4. Anxiety

Narrow Definition = Just Schizophrenia and Bipolar disorders
Broad Definition = All four diagnosis

This trend has contributed to a growing percentage of younger people living in Nursing Homes

- The average age across all new nursing home admissions in 2005 was 77, with 14% of individuals below age 65. By comparison, the average age at first admission for individuals with schizophrenia or bipolar disorder was 62.
- 21-65 y.o.a in LTC grew from 11.1% in 1999 to 13.6 % in 2008.
- Today, about 15% of nursing home residents are under 65.

What Is a Mental Disorder?

A **mental disorder** or **mental illness** is a diagnosable illness that:

- Affects a person's thinking, emotional state, and behavior
- Disrupts the person's ability to
  - Work
  - Carry out daily activities
  - Engage in satisfying relationships

Serious Mental Illness (as defined by OMH)

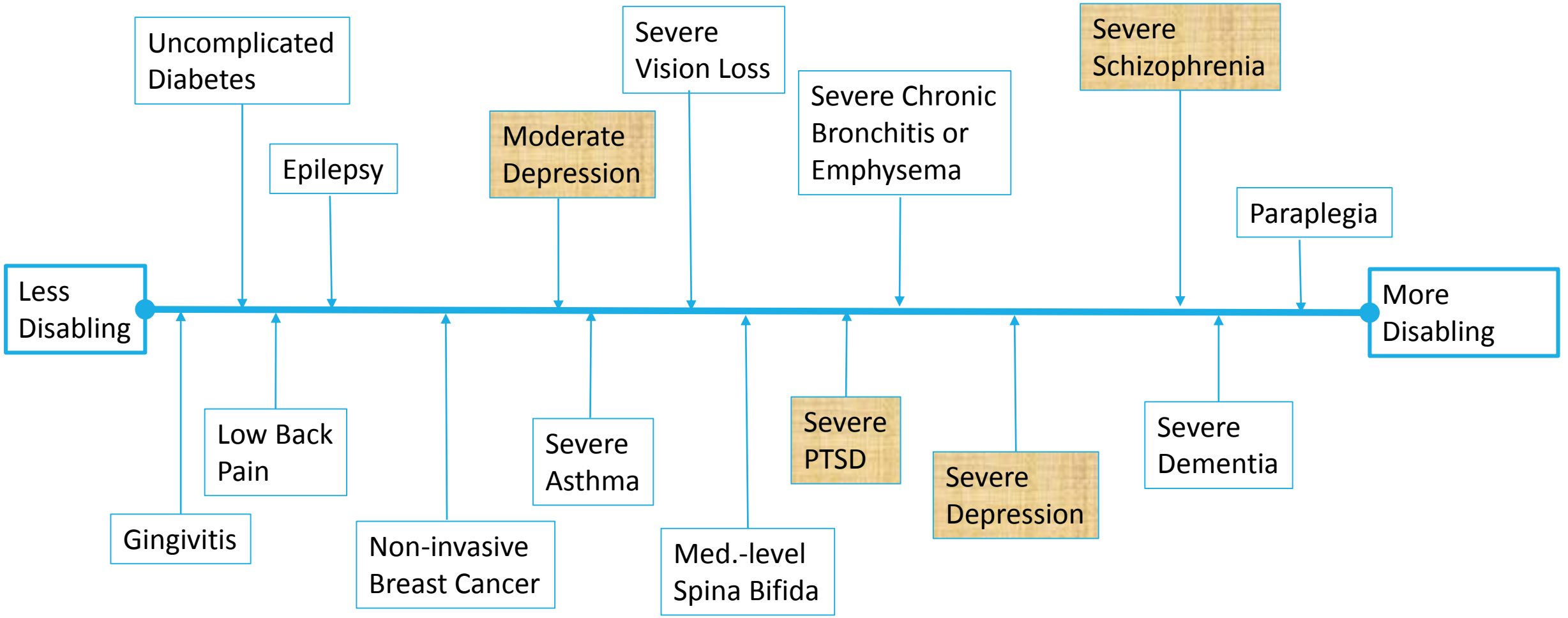
1. **Meets the criteria for a DSM-V** The individual is 18 years of age or older and currently **meets the criteria for a DSM-V (or any subsequent edition) psychiatric diagnosis** other than alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD-CM psychiatric categories and codes that do not have an equivalent in DSM-V or (any subsequent edition) are also included mental illness diagnoses. **AND**

2. **Is Disabled:** SSI or SSDI due to Mental Illness The individual is currently enrolled in SSI/SSDI due to a designated mental illness. **OR**

3. **Extended Impairment in Functioning due to Mental Illness..** Documentation that the individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis: **i.** Marked difficulties in self-care, **ii.** Marked restriction of activities of daily living, **iii.** Marked difficulties in maintaining social functioning **OR**

4. **Reliance on Psychiatric Treatment, Rehabilitation and Supports.** A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports.

The Impact of Psychiatric Disabilities



** Depression is the leading cause of chronic disability in the United States for people between the ages of 15 to 44.*

Incentives Exist to Inappropriately place and maintain people with MI in the Nursing Home

IMD Exclusion: Federal Medicaid funding can not be used for inpatient psychiatric care for individuals 21-65 years of age in mental health/substance abuse treatment facilities larger than 16 beds.

Nursing Home Payment Structure: For extensive physical need & multiple ADL deficits, there is no additional payment for the presence of behavioral problems. Payment rules may incentivize the admission of less physically disabled persons with mental illness, particularly if treatments are not expensive.

As a result…

Mental illness is one, and sometimes the decisive, factor contributing to placement in nursing homes.

Pre-Admission Screening and Resident Review (PASRR)

- The PASRR system is the primary mechanism by which individuals with mental illness in nursing facilities are monitored.
- Congress created the PASRR program under OBRA 1987 to help assure that people with SMI or mental retardation would not be inappropriately placed in nursing homes, where they would not receive the care or specialized services needed.
- 10 NYCRR 415.26 requires a SCREEN to be completed prior to admission to a RHCF. Federal Regulations 42 CFR Part 483, Subpart C.
- The intent of PASRR is to ensure that all NF applicants are:
  - ✓ thoroughly evaluated,
  - ✓ that they are placed in nursing facilities only when appropriate, and
  - ✓ that they receive all necessary services while they are there.

PASRR Level I and Level II Screens

Level I screen will determine whether an individual might have MI and/or ID.

(A properly designed Level I instrument will therefore produce a number of false positives. Residents expected to stay in the NH less than 30 days are exempt from preadmission screening requirements)

If an individual "tests positive" at Level I,

- the subsequent **Level II screen will**:
  - Confirm or disconfirm the results of the Level I screen, and
  - For individuals who have MI or ID, determine where they should be placed – whether in a NF or in the community – and identify the set of services they require to maintain and improve their functioning.

NOTE: Medicaid funding will not be available when required Level II PASRR evaluations have not been conducted or when the individual has been admitted to the RHCF despite a Level II placement recommendation determining the individual is not appropriate for RHCF placement.

The Four "D's" of PASRR
(according to the Federal definition of MI for PASRR)

Diagnosis or suspicion of a major mental illness such as schizophrenia, bipolar disorder, major depression, or an anxiety disorder such as OCD.

Dementia (absence of): If dementia is also present (co-morbid with) MI, it cannot be the primary diagnosis. The individual's MI must be more serious than their dementia.

Duration (well-defined): Intensive psychiatric treatment for MI must have taken place within the last two (2) years.

Disability level: functional limitations in major life activities within the past 3 to 6 months. Need not have received treatment. Focus is on Severity and recency of impairment, not hospitalization or treatment history.

The Importance of PASRR Level II

PASRR Level II must not merely rubber stamp the outcome of the Level I. Rather it must "look behind" the diagnosis of record to identify the "true" diagnosis.

The Level II must include the following elements:

- **History and physical:** (H&P), performed by a physician;
- **Functional assessment**: including ADLs and IADLs;
- **History of medication and drug use**;
- **Assessment of IQ:** (for PASRR/ID) performed by a PhD psychologist, **or**
- **Assessment of psychiatric history:** performed by a qualified assessor (e.g., a psychiatrist, a psychiatric social worker, or a nurse with substantial psychiatric experience).

*Level II evaluators cannot be employed in any way by a nursing facility.

*Admitting individuals for levels of MI/ID that do not rise to NF level of care would constitute a severe violation of the Supreme Court's Olmstead decision.

PASRR Reviews

A resident review (RR) is triggered: **significant change in status and that change has a material impact on their functioning as it relates to their MI/ID status.**

A significant change is a decline or improvement in a resident's status that:

- Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; is not 'self-limiting' (for declines only);
- Impacts more than one area of the resident's health status; and
- Requires interdisciplinary review and/or revision of the health care plan

***Referrals for a Level II evaluation must be made as soon as the significant change is evident.**

What's So Important About PASRR?

- ✓ **Accountability** of the Nursing Home for Proper MI Screening and Evaluation
- ✓ **Accuracy** in understanding mental health status and changes in condition
- ✓ **Access** to appropriate Mental Health services both in the NH and the Community

Predictors of Community Discharge

- Psychosocial variables (i.e., depression, mental health diagnosis, social engagement), and most diseases do not predict community discharge.
- Having a support person who is positive toward discharge has the greatest positive effect.
- Having a support person positive to discharge increases the odds of success by 381%.

Consider adding a Peer Specialist to the team…

- A Peer Specialist is an individual with lived mental health recovery experience who has been trained and certified to help their peers gain hope and move forward in their own recovery.
- Certified Recovery Peer Advocates (OASAS approved certification)

Barriers to Successful Transition: Lack of Insight (Anosognosia) vs. Denial

Lack if Insight affects 50% of people with schizophrenia, and 40% of people with bipolar disorder and may also be present in people with dementia:

- A complete psychiatric evaluation may be needed to rule out lack of sight.
- Proper, managed and consistent medication therapy may be required to improve lack of insight

Barriers to Successful Transition: Lack of Insight (Anosognosia) vs. Denial

Denial: can present with any diagnosis of mental illness and is most likely rooted in stigma.

- Start dialogues, not debates: if the individual doesn't agree she or he has an illness, talk about it; find out why. Listen without trying to change them or their mind. Forget the power struggle. Focus on building trust and rapport
- Work to reduce stigma by helping to establish a disease model way of thinking about MI
- Enlist the help of a mental health peer (contact with people who have lived experience is the most effective means of reducing stigma)

Note Here About Mental Health First Aid

Barriers to Successful Transition: Appropriate Housing

Isolation vs. Autonomy

People with mental illnesses who live in community-based housing prefer the autonomy of their own private or semi-private unit with key access and the ability to come and go as they please.

At the same time, they also often prefer community, and isolation can be counter-therapeutic for recovery.

Safe, decent, and affordable housing is a cornerstone of recovery from mental illness. Most people want permanent, integrated housing that is not bundled with support services (housing as housing)

Housing Options for People with Mental Illness

Licensed Community Residences

<u>Traditional CR Model:</u>

- Congregate, transitional living
- Up to 24 beds
- 16 or less is MA funded
- Rehabilitation goals
- Not available with MA – HCBS
- Available statewide, less so in NYC

<u>CR /SRO:</u>

- 25-80 beds
- Less services than traditional CR
- No shared bedrooms
- Is available with MA – HCBS
- Available is certain regions of New York

Housing Options for People with Mental Illness

Treatment Apartments

- Congregate setting
- Medicaid funded and Compatible with HCBS programs
- Focus on 14 restorative services (e.g. medication mgt, ADLs, etc.)
- 2-3 persons per apartment

Scattered-Site Supported Housing:

- Located in rented apartments scattered throughout the community
- Services by providers as needed by the recipient to ensure housing stability.
- High level of independence, lower level of “community”

Housing Options for People with Mental Illness

Supported Single-Room-Occupancy (SP-SRO)

- Combines long-term to permanent housing with some on-site services
- Housing case management only

Mixed-Use/Income Housing:

- The most integrated congregate housing model
- Affordable housing units mixed with OMH–funded capital units
- Front-desk or security staff are on-site 24 hours per day.

NYS OMH Supported Housing Guidelines
https://www.omh.ny.gov/omhweb/adults/SupportedHousing/supported_housing_guidelines.pdf

Barriers to Successful Transition and Meaningful Activities (such as employment and volunteering)

Consider programs such as Medicaid Buy-in to preserve Medicaid eligibility for those who wish to work.

Medicaid Buy-In Program

- Be a resident of New York State;
- Be at least 16 years of age (coverage up to 65 years of age);
- Have a disability as defined by the Social Security Administration;
- Be engaged in paid work (includes part-time and full-time work);
- Gross income can be up to $61,332/ $82,236 (couple); and
- Have non-exempt resources not over the Medicaid resource level of $20,000 (1-person) and $30,000 (2-person).

Barriers to Successful Transition: Meaningful Activities

Encourage self-help and wellness skills such as:

- Support groups
- Family, faith and friends and other consistent socialization and supports
- Wellness action plans (WRAP)
- Specialized mental health training for caregivers
- Consider the use of mental health Peer support

Barriers to Successful Transition: Medication Considerations

- Psychotropic medications are sometimes overused in order to keep residents with problem behaviors such as wandering or combativeness subdued or “under control.”
- CMS Five-Star Quality Rating System for Nursing Homes can create the opposite problem of under-medicating.
- In anticipating a move from the NH to the Community, or in order to obtain a clear picture of a resident’s desire to live in the community, residents should be evaluated by psychiatry to determine whether psychotropic medications play a role in:
  a. obscuring the resident’s wishes;
  b. confound a transition OR
  c. whether a residents pre-existing medication regime has been changed in a manner that destabilizes the individual’s recovery.

Building Mental Health Literacy using Mental Health First Aid

What is Mental Health First Aid?

It’s the help offered to a person developing a mental health problem (i.e., depressive, anxiety, and/or psychotic disorders, which may occur with substance abuse), or experiencing a mental health crisis (i.e., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior). The first aid is given until appropriate treatment and support are received or until the crisis resolves.

An 8-hour training program that certifies Mental Health First Aiders for 3 years.

The “ABCs (CAB)” of Mental Health First Aid

Mental Health First Aid Action Plan

Assess for the risk of suicide or harm

Listen nonjudegmentally

Give reassurance and information

Encourage appropriate professional help

Encourage self-help and other support strategies

Mental Health First Aid

Evidence-based, Peer-reviewed studies published in Australia

These studies show that individuals trained in the program:

- **Grow their knowledge** of signs, symptoms and risk factors of mental illnesses and addictions.
- Can **identify multiple types of professional and self-help** resources for individuals with a mental illness or addiction.
- **Increase their confidence** in and likelihood to help an individual in distress.
- Show **increased mental wellness** themselves.
- **Stigma reduction:** studies also show that the program reduces the social distance created by negative attitudes and perceptions of individuals with mental illnesses.