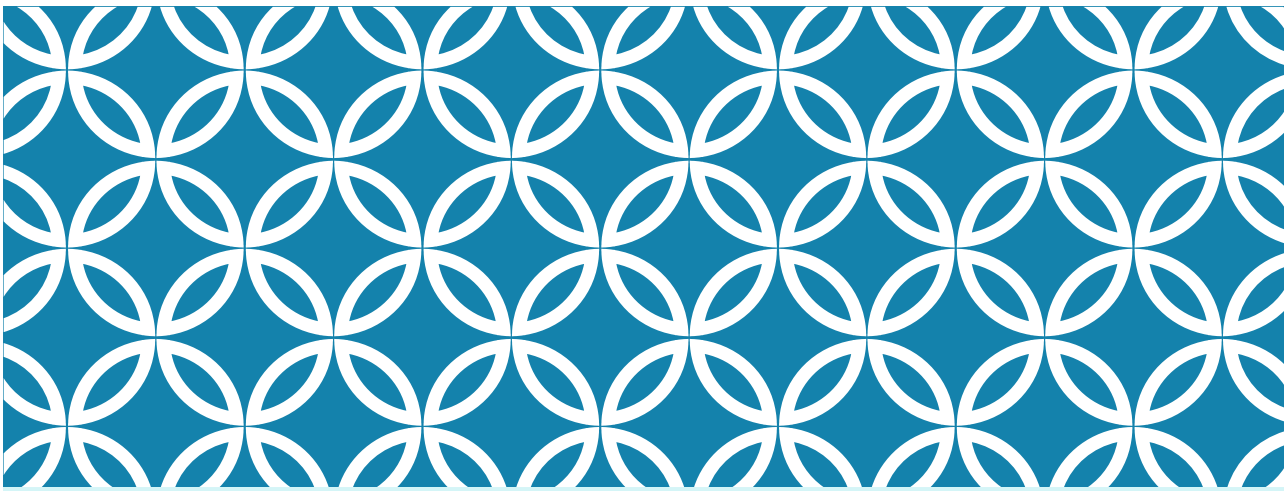

FINDING YOUR BEHAVIORAL PRACTICES TO REDUCE PSYCHOTROPIC MEDICATION USE

Chelsea Daum, BSW
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Kari Sodman-Orth, BS, CNA

LEARNER OBJECTIVES

List three psychotropic medication classifications

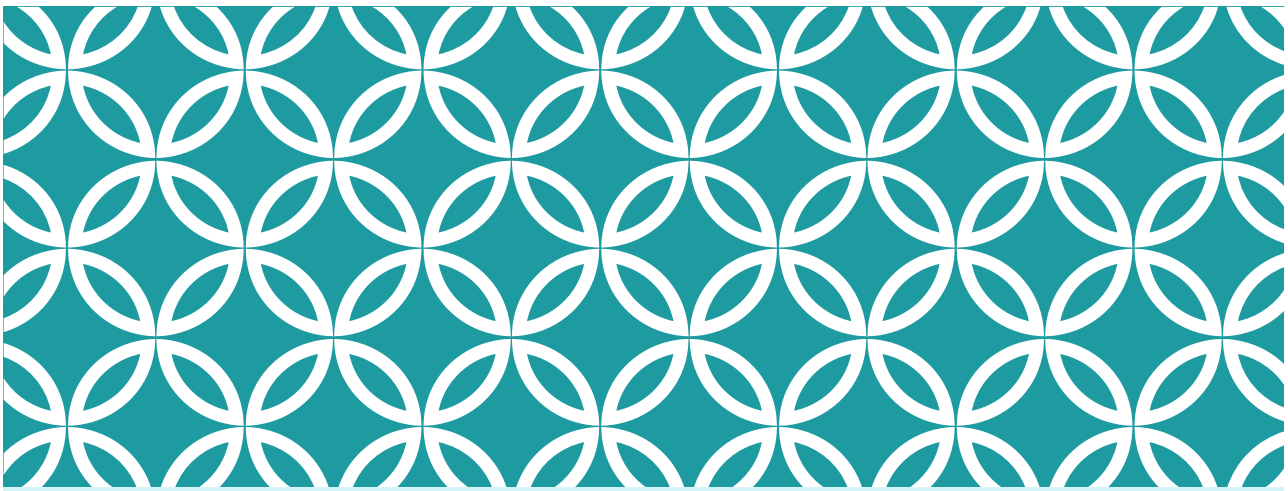
Explain How Behavioral Interventions are Person Centered

Describe How to Prioritize to Conduct Meaningful Gradual Dose Reductions

Create a behavior management program

FIND **YOUR** BEHAVIORAL PRACTICES -

Today we provide an overview of behavioral information. Every patient, resident, social worker, nurse, and nursing assistant is unique.



A FEW COMMENTS BEFORE WE BEGIN

"No comment is also a comment."
Ehsan Sehgal

WHY DIAGNOSES "MATTER"

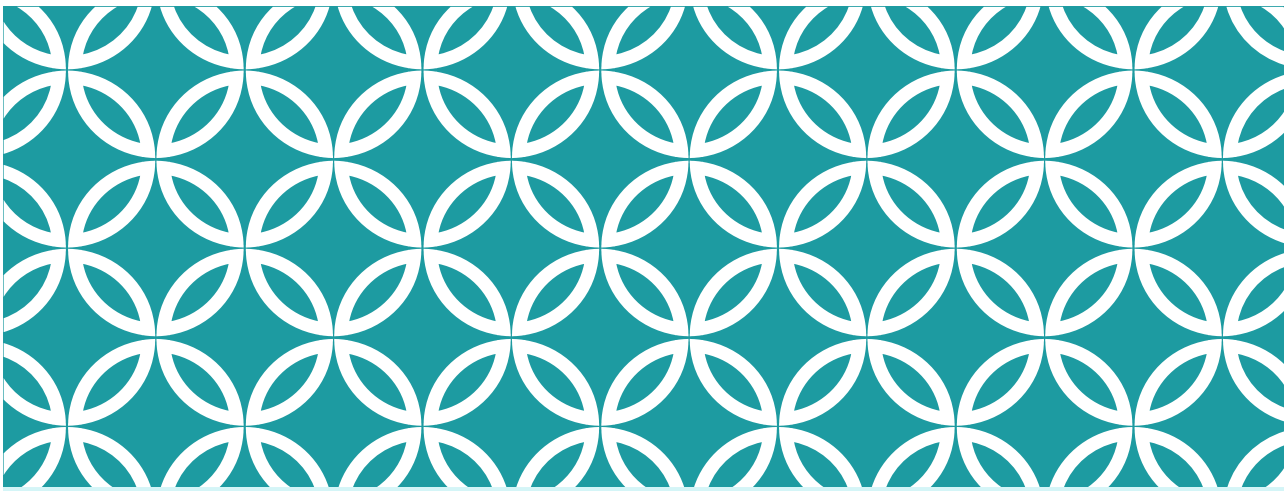
- The State Operations Manual (SOM) states (F605 Respect & Dignity – Right to be free from physical or chemical restraints), *"When any medication restricts the resident's movement or cognition, or sedates or subdues the resident, and is not an accepted standard of practice for a resident's medical or psychiatric condition, the medication may be a chemical restraint. Even if use of the medication follows accepted standards of practice, it may be a chemical restraint if there was a less restrictive alternative treatment that could have been given that would meet the resident's needs and preferences or if the medical symptom justifying its use has subsided. The facility is accountable for the process to meet the minimum requirements of the regulation including appropriate assessment, care planning by the interdisciplinary team, and documentation of the medical symptoms and use of a less restrictive alternative for the least amount of time possible and provide ongoing re-evaluation."*
- IN SUMMARY….The diagnosis and condition being treated must be addressed by the medication classification AND the minimum dose possible for therapeutic efficacy AND the least amount of time AND GDRs must happen (unless contraindicated).
- REMEMBER – Diagnosis alone is NOT "proof" of needing the medication (even when the diagnosis matches the medication class).

EXAMPLES OF SURVEY CONCERNS

- No brainer = heightened awareness regarding schizophrenia
- "PSYCHOTIC DEPRESSION" obtained IN THE HOSPITAL and an antipsychotic medication was ordered
- IF psychotic depression IS a REAL diagnosis, YOUR TEAM is responsible for finding the psychiatric evaluation determining this course of treatment AND YOUR TEAM is responsible for GRADUAL DOSE REDUCTION even IF the diagnosis is accurate
- "DEMENTIA WITH PSYCHOTIC FEATURES" – a couple things – forms of dementia result in psychotic like features AND simply having a psychotic feature that is not harmful or impacting the person or others negatively may not require an antipsychotic medication
- **As an FYI: MOST people with a psychotic condition are identified by their 30s, not in their 80s.**

HAVE A PLAN…

- CARE PLANNING IS the key to continuity of care – teach your staff to document to the care plan (and revise as needed)
- New admission, no one knows about a history – write an action plan or PIP with the timeline and information you'll gather over the next 30 days
- Observing a resident for gradual dose reduction and documenting target symptoms and interventions
- TRYING behavioral interventions
- PREPARE THE STAFF FOR "RESIDUAL" behaviors even if the psychotropic medication was NOT needed or being used off label



LIST THREE PSYCHOTROPIC MEDICATION CLASSIFICATIONS

"Behind every fine doctor, there is always a nurse." Unknown

F758 SAYS….

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, **but are not limited to**, drugs in the following categories:

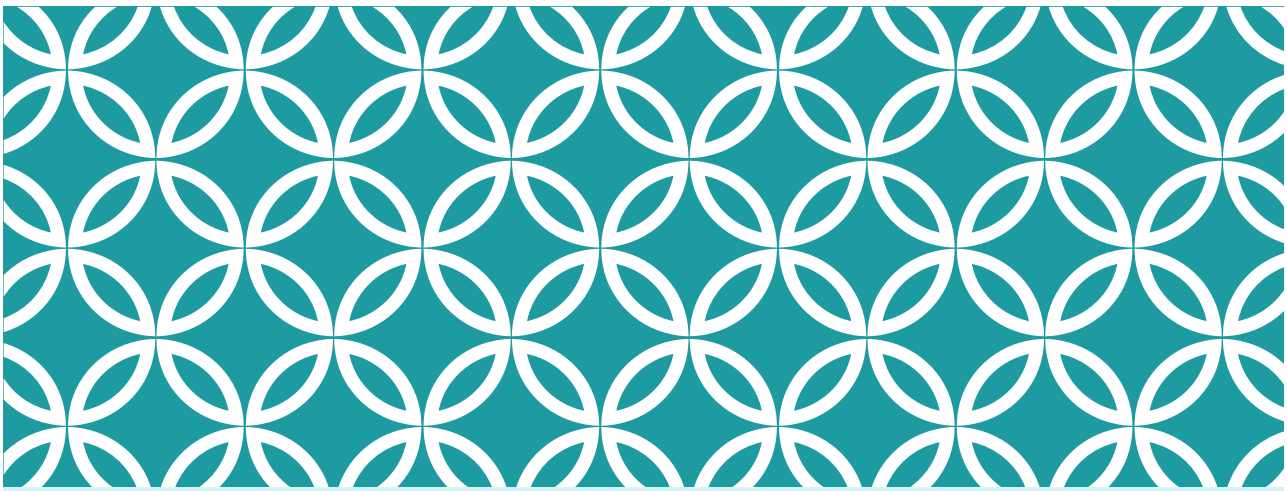
(i) Anti-psychotic;

(ii) Anti-depressant;

(iii) Anti-anxiety; and

(iv) Hypnotic.


YOU CAN'T GET THERE BY DOING WHAT YOU'VE ALWAYS DONE
Measure what matters – look at FACTS, benchmarks, person centered needs and more☺



BEHAVIORAL INTERVENTIONS **ARE** PERSON CENTERED

Begin at the very beginning

BEHAVIORAL INTERVENTIONS ARE PERSON CENTERED

- ***Behaviors are responses to unmet needs!***
- ***"Non-pharmacological intervention"*** *refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being.*
- Behavioral interventions are not "one size fits all"
- Interventions are most effective when they mean something to the person
  - Talking about farming with a farmer
  - Making bread (or moving dough around) with the person who loved to bake
  - Typing or using an old calculator for a former secretary or bookkeeper
- WHAT MAKES THE PERSON TICK?

NON-PHARMACOLOGICAL INTERVENTIONS

Behaviors are RESPONSES to unmet needs. First ask if:

Are they hungry/thirsty?

Are they in pain?

Do they have bathroom or positioning needs?

Do they need to move?

Are they lonely?

Are they bored?

You might need to try them all or try them all at the same time, trial and error

NON-PHARMACOLOGICAL INTERVENTIONS CONT'D

Touch-hold hands, sit with, brush hair, fidgets

Distract-walk, snack, hand massage, crafts

Personal needs-offer help with restroom, snacks or drinks

For SOME residents-baby dolls, robotic animals, busy boxes, busy blankets, SAD lamps, weighted blanket, pet therapy, aromatherapy, sunlight

SLEEP-sleep in or go to bed earlier, nap

F758 PSYCHOTROPIC MEDICATIONS

"Behavioral interventions" *are individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial well-being.*

- The State Operations Manual (SOM) repeatedly describes the need and importance of person centered "behavioral interventions"
- GRADUAL DOSE REDUCTION IS A CRITICAL COMPONENT of F758 (and F757)

CMS SAYS (STATE OPERATIONS MANUAL)

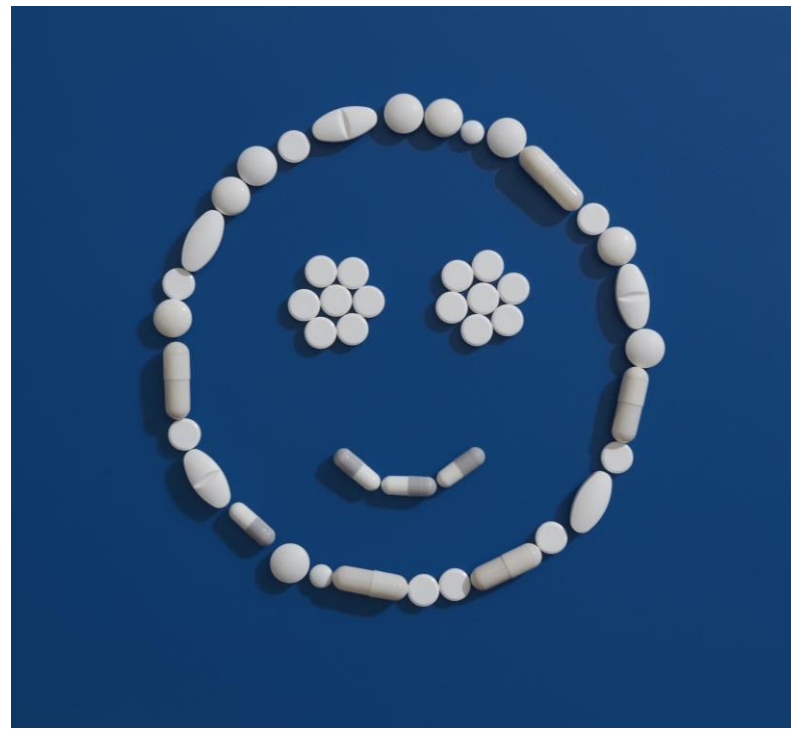
Categories of medications affecting brain activity include antihistamines, anti-cholinergic medications and central nervous system agents used to treat conditions such as seizures, mood disorders, pseudobulbar affect, and muscle spasms or stiffness.

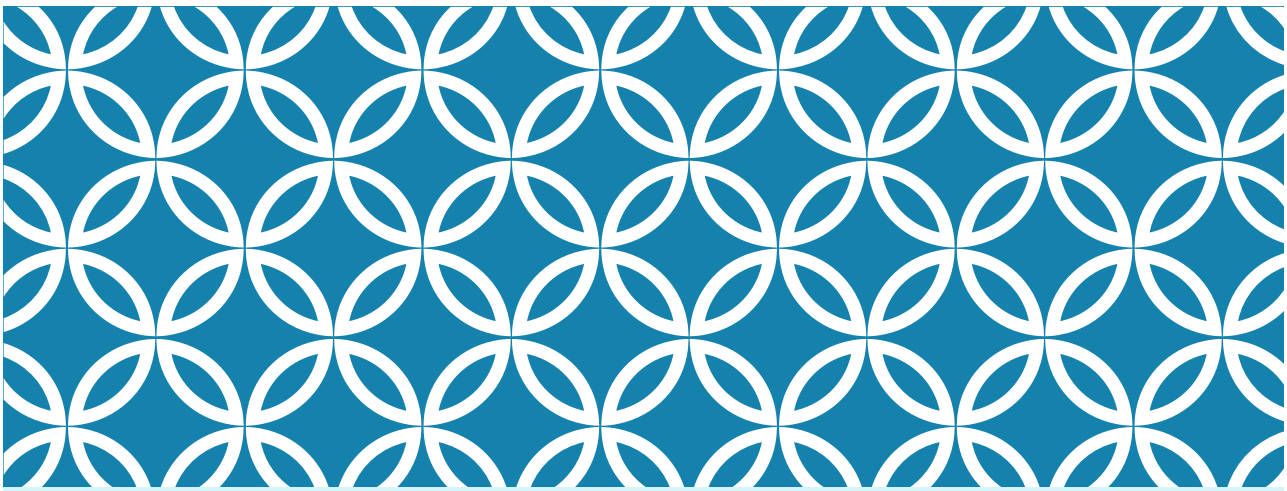
Requirements for psychotropic medications apply to these types of medications when their documented use ***appears to be a substitution*** *for another psychotropic medication rather than the original or approved indication.*

Example: Valproic acid is prescribed and EHR shows no history of seizures. Documentation supports valproic acid is being used to treat agitation or other expressions of distress. Use of valproic acid should be consistent with the psychotropic medication requirements.

OKAY, OKAY, STOP TALKING ABOUT OFF LABEL USE OF MEDICATIONS!

We get it coming and going – knowing how to evaluate resident options to support the resident is a WIN-WIN!





CREATE A BEHAVIORAL MANAGEMENT PROGRAM

This might start with employee education….

RESIDUAL "BEHAVIORS"

- Educate the team to EXPECT "residual behaviors"
- This means – behavioral symptoms WILL (most likely) exhibit EVEN if the medication was not, and is not, treating an actual diagnosis.
- WHY? Let's look at case examples
- Imagine a person is diagnosed with ADHD and receives ADHD medication. Suddenly the psychiatrist decides the person has Bipolar II disorder –
  - The gradual dose reduction of the ADHD medication, with or without, the addition of medication for Bipolar II will cause behavioral symptoms – brain fog, fatigue, irritability, emotional dysregulation
- Betty was diagnosed at 85 with psychotic depression and put on Zyprexa, which she's taken for 2 years. Zyprexa flattened her affect AND contributed to weight gain.
  - Betty experiences crying, lethargy, and irritability as the gradual dose reduction occurs
  - She may even hit out at staff – use behavioral symptom management to help her

WHAT IS "BEHAVIORAL" MANAGEMENT?

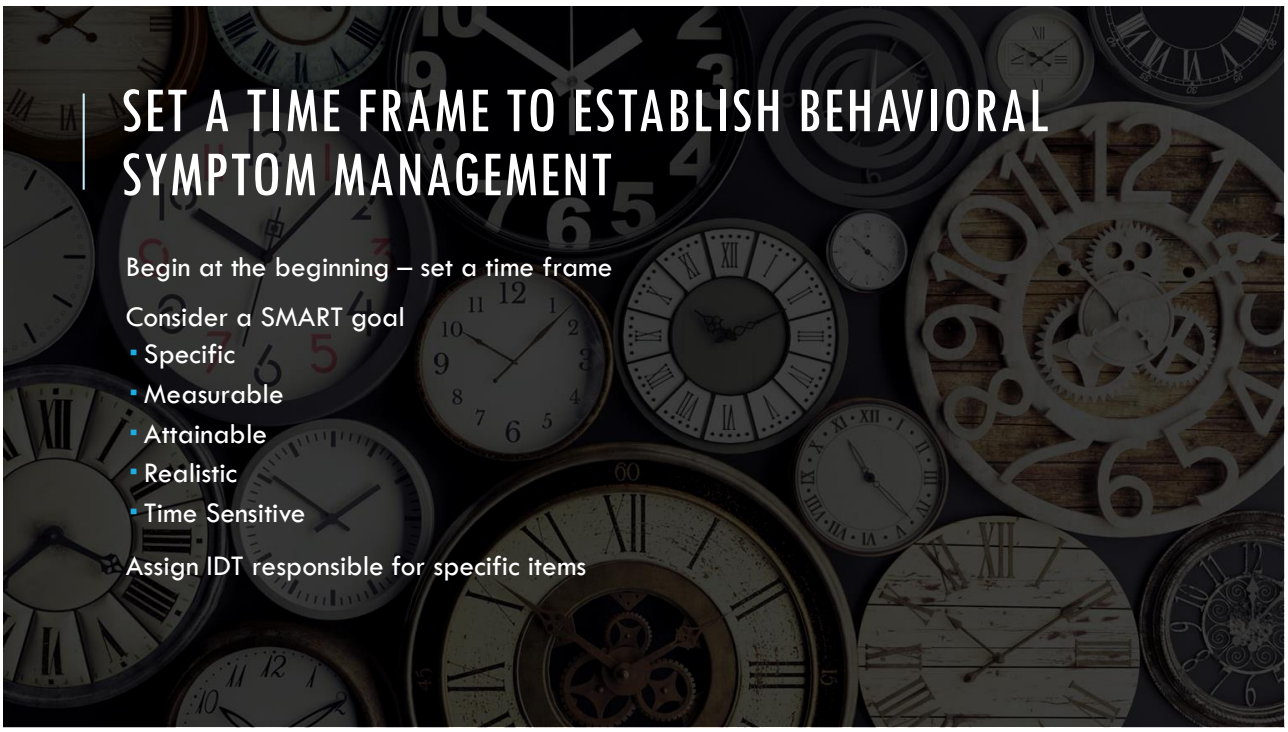
- Meeting the person where he/she is to support behaviors that are not distressing or harmful to self or others
- Supporting residents and staff in creating a calm milieu
- Using innovation and flexibility to meet resident needs
  - Let a night owl sleep later
  - Let a snacker have a basket of snacks in room
  - Use white, pink, brown noise machines
  - Use LED Lumen lights (check for pacemaker prohibitions)
  - Of course – life like baby dolls
  - Put a red light in the bathroom/room for the resident who gets up a lot at night

STAFF AND BEHAVIORS

- Start with staff…
- What does staff need to be supported and take care of their needs?
- Mentality = "What's in it for me?" (WIIFM)
- Power struggles – why disagree with a person with dementia or psychosis?
- "Reality orientation" – only for the stage when a person still responds to orientation?
- Reframe, reframe, reframe
  - Think CAREFULLY before directing, "Treat the residents like you'd treat your family."
  - Give direction based on person centered approaches in language the staff can understand and USE

MORE PROCESS, LESS PRODUCT

- MUSIC
- "PHOTO ALBUMS" – copies of family pictures, labeled and laminated into an album
- Tactile
  - Folding
  - Cutting
  - Smelling
  - Touching
- Daily/rote behaviors
  - Making bread, cookies (PROCESS, no one cares how they turn out)
  - Washing dishes
  - Polishing silver
  - Sorting
  - Exercise (in minute long intervals)


SET A TIME FRAME TO ESTABLISH BEHAVIORAL SYMPTOM MANAGEMENT
Begin at the beginning – set a time frame
Consider a SMART goal
Specific
Measurable
Attainable
Realistic
Time Sensitive
Assign IDT responsible for specific items

WHERE TO BEGIN? PRIORITIZE

WORK WITH RESIDENTS and RESPONSIBLE PARTIES WHO ARE INTERESTED in BEHAVIORAL INTERVENTIONS FIRST (if you have any – a lot of times THEY like the medications because the resident started using them at home)

1st Use the CASPER QM Indicator Report

- Identifies those assessed as having "behaviors"
- Layer this with psychotropic medication use
- Layer with depression/anxiety
- Layer with dementia

- You might have a different way to PRIORITIZE

WHERE TO BEGIN? PRIORITIZE

2nd Determine, using the CASPER QM Indicator Report, if you have a SYSTEMIC problem with Behavior Management or ISOLATED

- This will frame how you write the Performance Improvement Project (PIP)

3rd Use the identified CRITICAL ELEMENT PATHWAYS to ask critical questions and understand the regulatory process

- This will further frame the Performance Improvement Project (PIP)

BEHAVIORAL PIP (PERFORMANCE IMPROVEMENT PROJECT)

- WHAT's the identified problem?
- Who will work on it?
- What are the actual goals? To hit benchmarks? Improve Behavioral Interventions & GDR?
- Determine BENCHMARKs (hint: EXTERNAL sources establish BENCHMARKs)
- What resources are needed?
- What are the time frames?
- How will outcomes be evaluated?
- How will the work tie into QAPI for ongoing excellence?
- Does this tie into the Facility Assessment?

THE ACTUAL BEHAVIOR MANAGEMENT PROGRAM

Behavior management based on Assessment, ROOT CAUSE and CONTRIBUTIVE FACTORS

PERSON-CENTERED

Staff Centered

Train staff (live and meaningful)

- "What's in it for ME?" (Asks the staff)
- Give them tools to effectively cope

STAFF TRAINING -

Several Ftags tie into training including facility assessment, training requirements, care plans, psychosocial well-being, etc., etc.

Develop/purchase/attend an INTERESTING and MEANINGFUL training

- Focus on the ADULT LEARNER
- Evidence-based training
- Person centered
- Teach/identify empathy
- Monitor effectiveness of care plan
- "Behavioral Health" education is the regulatory language

THE ESSENCE OF BEHAVIOR MANAGEMENT

Does our staff have the tools, the training and the support to provide good behavior management?

Start low and slow – 1-2 residents

- Find behavioral interventions
- Meet with staff and start implementing the interventions

THE REGULATORY SIDE OF BEHAVIORAL SYMPTOM MANAGEMENT

Consistent Caregivers

Meaningful Activities

Diversional Activities (adult coloring, puzzles, music, books)

And so on….

CASE STUDY – CONSTANT SCREAMING/YELLING

Suzi yelled and screamed consistently. "Help me, help me." Her care plans stated when she was alert and oriented, she knowingly yelled to disturb other people. *This became a rote behavior.*

The team tried:

- Weighted blanket (must have physician order – place/remove per order)
- Light lamp (verify if it can be used if resident has a pacemaker)
- White noise
- Mechanical kitty
- Music and headphones
- Picture in light
- Sound proofing panels
- Pulling her door ajar
- Massage by Restorative
- Pet visits

CASE STUDY – CONSTANT SCREAMING/YELLING

What worked?

Can you guess?

Let's discuss…..

CASE STUDY – HENRIK THE YELLER

Henrik was constantly yelling and screaming. He used a big merry walker and walked all day long. Everyone felt burned out.

A Social Worker would take him to her office:

- She gave him (cooled) coffee
- She rubbed his hands and face
- He cried when she did this…

She showed the staff…

What do you think happened?

BEHAVIOR TRACKING - REALISTIC

ASSESSMENT of the RESIDENT and the "BEHAVIORS"

Simple

Accurate

Person Centered

BEHAVIOR TRACKING - REALISTIC

Use the staff's language (as long as it's respectful)

Tie it into the POC if able

Use the "alerts" from RCAs

- Don't have to be entered into the clinical record
- Provides daily data/feedback

BEHAVIOR TRACKING - REGULATORY

Refer to CMS 20067 Behavioral-Emotional Critical Element Pathway

What are the resident's assessed needs?

What does the PASARR say?

Are you meeting resident needs?

Physician Orders in place and make sense?

- Would a logical and rationale person understand your workflow?

DO SOMETHING WITH THE TRACKED BEHAVIORS

This is where most facilities fail

People do a great job prioritizing, assessing, care planning….

Then do NOTHING with the behavior tracking

WHY?

KEEP IT SIMPLE

Track behaviors in the most-simple way possible

This means:

- Easy to read
- Easy access for direct line staff
- Easy access to TALLY and EVALUATE the behaviors by the Behavior Management Team

BEHAVIOR TRACKING – OUTCOME/EVALUATION

Establish realistic interventions

Tie the interventions to the behaviors

Get AHEAD of behaviors if able

BEHAVIOR MANAGEMENT MEETINGS

YOUR facility practice will direct WHEN

Resident needs will direct FREQUENCY

Best when part of a standard habit, practice and routine at YOUR facility

- Team approach
- Get buy in by being visible, helpful and supportive

Do a Behavior Huddle when behaviors are problematic, be boots on the ground

- Ask the resident for feedback as applicable

BEHAVIOR MANAGEMENT MEETING

DO, DIRECT, DECIDE

Document work and OUTCOMES (decisions)

Quarterly (or more frequent) summary of findings to QAPI

THE BEHAVIORAL CARE PLAN AND BEHAVIOR NOTES

Refer to regulations and critical element pathways for regulatory standards

Write in “plain English”

Use direct quotes

Avoid words like “inappropriate” and “appropriate” – they are subjective

Avoid labeling, DESCRIBE the Behaviors

What are the ACTUAL BEHAVIORAL INTERVENTIONS to reduce behavioral symptoms?

BEHAVIORAL CARE PLANS

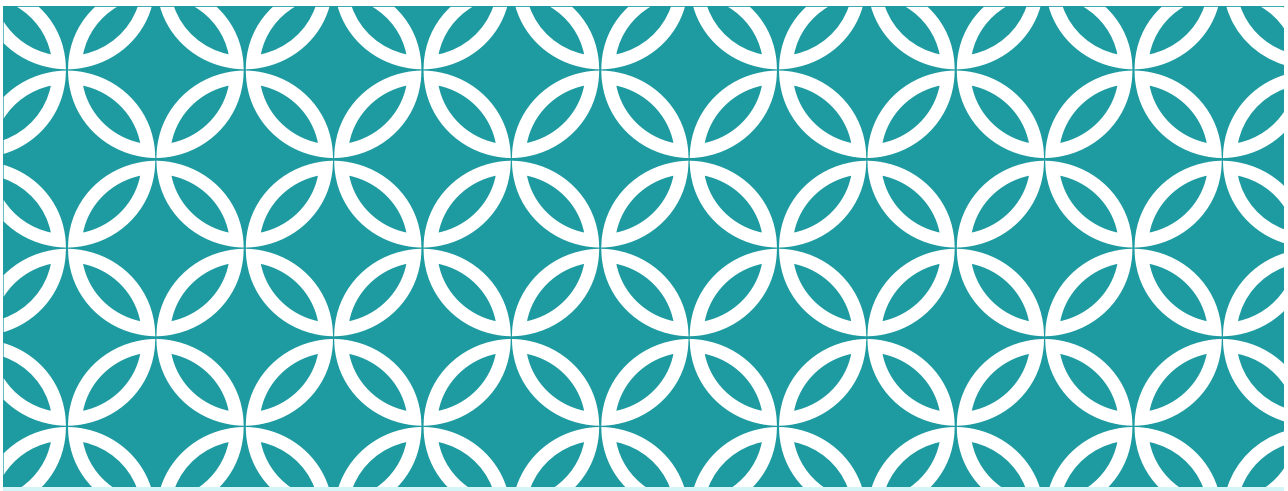
Short term care plans – more medically oriented, more acute oriented

Long-stay – should be interesting and tell us something meaningful about the resident

NEED to be updated….

Change approaches, change GOALS, change problem statement

If you have PCC - DOCUMENT TO THE CARE PLAN!

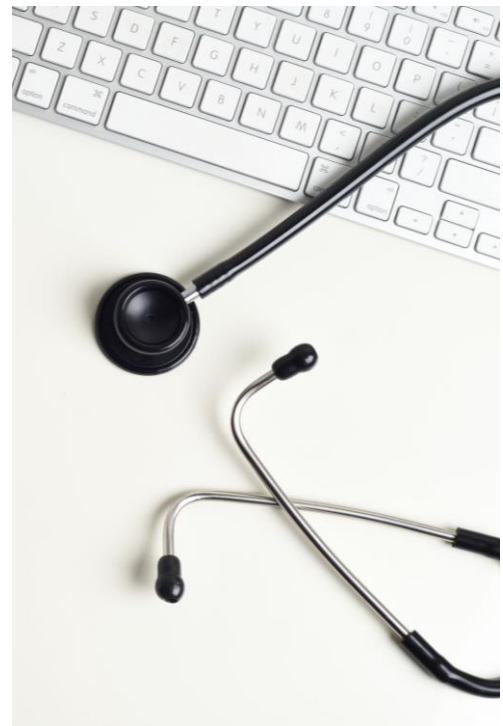


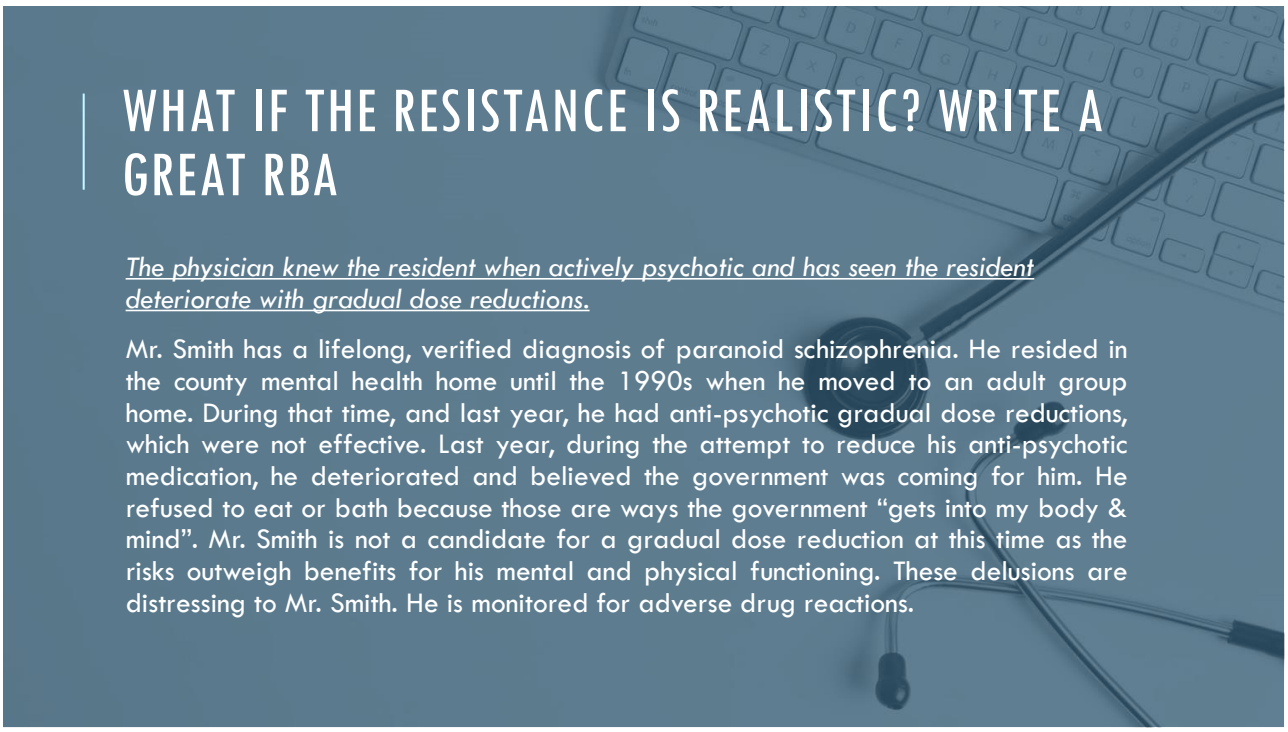
CONDUCT MEANINGFUL GRADUAL DOSE REDUCTION (GDR) PROCESS

Low and slow saves the day -

WHY WOULD A PHYSICIAN BE RESISTANT TO GRADUAL DOSE REDUCTIONS?

1. They get called day & night when staff is not on board for the gradual dose reduction.
2. Licensed nurses call with "justifications" to get the medication reinstated – in absence of the Interdisciplinary Team recommended approaches and actions.
3. *They knew the resident when actively psychotic and have seen the resident deteriorate with gradual dose reductions. (SEE THE NEXT SLIDE.)*
4. The licensed nurses haven't been given tools to understand the use of anti-psychotic or anxiolytic (or other psychotropic medications).





WHAT IF THE RESISTANCE IS REALISTIC? WRITE A GREAT RBA

The physician knew the resident when actively psychotic and has seen the resident deteriorate with gradual dose reductions.

Mr. Smith has a lifelong, verified diagnosis of paranoid schizophrenia. He resided in the county mental health home until the 1990s when he moved to an adult group home. During that time, and last year, he had anti-psychotic gradual dose reductions, which were not effective. Last year, during the attempt to reduce his anti-psychotic medication, he deteriorated and believed the government was coming for him. He refused to eat or bath because those are ways the government "gets into my body & mind". Mr. Smith is not a candidate for a gradual dose reduction at this time as the risks outweigh benefits for his mental and physical functioning. These delusions are distressing to Mr. Smith. He is monitored for adverse drug reactions.

LOGICAL AND RATIONAL FLOW OF INFORMATION

LOW and SLOW – pick a set of residents (or just one)

Prioritize based on DIAGNOSES and Behavioral Symptoms

If the resident has a supporting (VERIFIED) diagnosis, do you need to try a GDR?

- How involved is the physician?
- How did you verify the diagnosis?
- Has a GDR been tried?
- Is the resident experiencing side effects?

CRITICAL ELEMENT PATHWAY CMS-20082 UNNECESSARY MEDICATIONS, PSYCHOTROPIC MEDICATIONS, AND MEDICATION REGIMEN

See the FULL Critical Element Pathway – this is just a small section…

Demonstrates a system for and documents gradual dose reduction (GDR) for psychotropic medications, **unless contraindicated**.

- Within the first year in which a resident is admitted on a psychotropic medication or after the facility has initiated a psychotropic medication:
  - GDR attempts in two separate quarters - at least one month between attempts.
  - GDR must be attempted annually thereafter unless clinically contraindicated.
  - Non-pharmacological approaches must be attempted & documented instead of using psychotropic medications, along with use of psychotropic medications, **and** while GDR is attempted.

USE A DETOX APPROACH FOR GDRS

Improve pain management

Treat infections more effectively

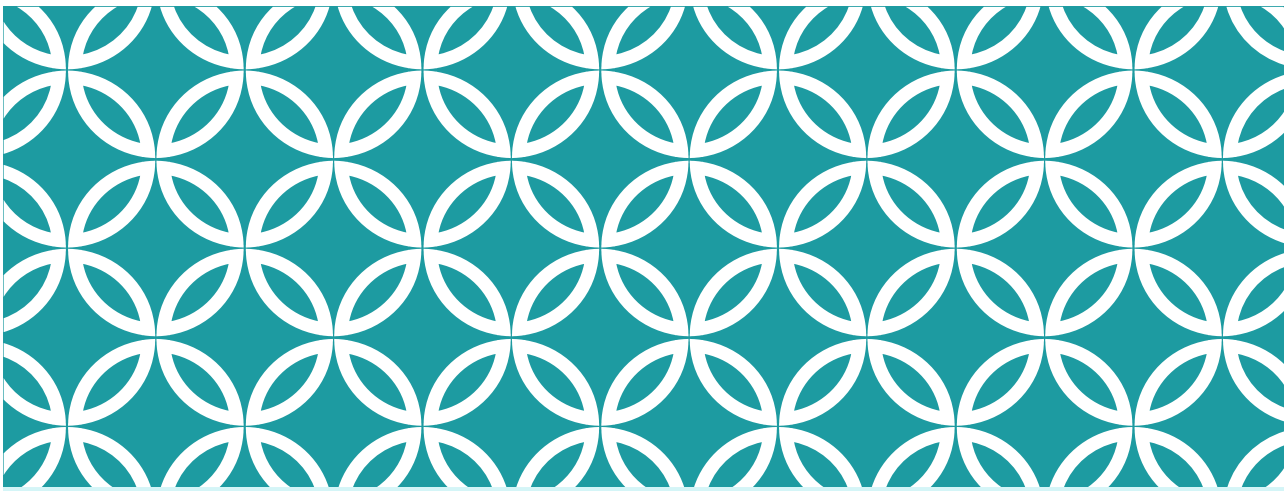
EXPECT “residual behaviors” – this is KEY….

Non-pharmacological interventions

Increase fluids as able

Promote more fiber, fruits, vegetables

Assist with good sleep hygiene



IMPLEMENT A RISK BENEFIT ANALYSIS

Make that "A MEANINGFUL Risk Benefit Analysis"

CRITICAL ELEMENT PATHWAY – SOME AREAS TO ADDRESS

If the practitioner denied a GDR: Did the practitioner provide a risk-benefit statement describing the contraindications for a GDR?

How does the facility ensure a review of medications for GDRs?

If the resident is on a psychotropic medication: When did you attempt to reduce the medication in the last year and what were the results?

How do you monitor staff to ensure they are implementing care planned approaches?

What was the rationale for the practitioner's decisions in managing the resident's medications or medication-related concerns?

How did you involve the resident in decisions regarding medications?

HELP YOUR PRACTITIONERS – SUGGESTIONS FOR A RICH RBA

Is there a **verified*** diagnosis that renders a GDR unnecessary?

If yes, document to that.

If NO, start with the diagnosis and work back

- What are the target behaviors and how does the medication "hit" the target?
- Graph of behaviors over last year with drug dosage in graph
- What are the identified and specific LIKELY adverse drug reactions for THIS resident?
- Labs, vital signs, neurological, mood, behavior evaluations

CONTRAINDICATED WHY – lay it out methodically HOW do the BENEFITS outweigh the risks?

HAVE YOU EVER SEEN THIS FOR RISK BENEFIT ANALYSIS?

"The resident benefits outweigh risk of continued antipsychotic use."

- What do you think?
- Does this fulfill the regulatory requirements?
- Is if person-centered?
- Does it explain the connection to a VERIFIED DIAGNOSIS or to DISTRESSING symptoms?
- Consider creating a template if you have resistant physicians
  - BE PREPARED and PROACTIVE when starting gradual dose reductions

CONTRAINDICATION LANGUAGE AND FRAMING INFORMATION – F758

Medication treats a symptom that is not present due to **treatment** but the disease is still there:

- Schizophrenia, psychosis, psychotic episodes, chronic psychiatric illness
- Neurological disorder - Huntington's, Tourette's

Specific reference for physician's contraindication note within F-tags

SUMMARY

List three psychotropic medication classifications

Explain How Behavioral Interventions are Person Centered

Describe How to Prioritize to Conduct Meaningful Gradual Dose Reductions

Create a behavior management program

QUESTIONS OR COMMENTS?

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If you have questions later, please feel free to contact us!

RESOURCES

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