

VOP Statewide Conference Call Minutes

Weds, June 20, 2016; 2:00 – 2:50 PM

Hosts: Sarah Hinzman, VOP Coordinator; Jennifer Golle, Local Long-Term Care Ombudsman

Topic: *What happens when a person a mental health diagnosis needs facility based care?*

Attendance:

Christine Powers, Ridgecrest Village - Davenport

Gregg Durlam, Sunny View Care Center - Ankeny

Jerry Hampton, Lamoni Specialty Care and Southern Hills Specialty Care (Osceola)

Jill Leimkuehler, Northbrook Manor, Cedar Rapids

Kay Cota, Embassy Healthcare Community, Sergeant Bluff

Ken Marlin, Monticello N&R

Maggie Elliott, Iowa City Rehab

Pam Pickar, Heritage Residence, New Hampton

Sandy Grant, Anamosa Care Center

Shannon Snyder, AmeriCorps VISTA - VOP

Terry Hornbuckle, Wesley Park Centre - Newton

Tricia Scieszinski, Fountain West – West Des Moines

Someone in the community having a severe mental health crisis and they do not recognize that they need help. What can you do? If services are not working or not available...

- Mental health commitment
 - At the county courthouse, two people sign a form stating the person is in an acute psychotic status or is a harm to themselves or others. That form goes to a judge who may issue an order for Sheriff to pick that person up. The Sherriff would take them to the mental health unit at the hospital.
- Hospital
 - At the hospital they will have a hearing. The patient is given an attorney and mental health advocate (judicial advocate). Their role is to represent the interest of the patient through the court process and they can communicate between the judge and patient but the mental health advocate is not legally representing them. If strict criteria are met, the patient may be placed on a 72-hour hold to monitor and complete assessments. There may be another hold.
 - It may be determined they need some supervision and need to go to a facility. It can be difficult in Iowa for a resident with mental health history (behaviors, aggression, hypersexual—anything the facility seems as a threat or unable to manage) to be placed in a facility.
- PASSR – Pre Admission Screening and Resident Review

Typically while in the hospital, professionals contracted by ASCEND Corporation complete a PASSR assessment of the resident to determine what their needs are—they could be assessed as a Level I or Level II. Level II occurs where there is a mental health or disability diagnosis. The assessor writes recommendations such as need for therapy or a psychiatrist, be treated for substance abuse, etc. PASSR may be approved for a period of time (30, 60 days, etc.). The

PASSR is sent to a facility and they can determine whether or not to accept the resident. PASSR's goal is to get them out and into a lower level of care ASAP. The federal Olmstead decision created the trend to have these folks served in the community rather than an institution. The plus side of PASSR is that the resident can get more services. The down side is that a facility may feel that they cannot accommodate the PASSR requirements—and they don't get an incentive for doing so. A lot of PASSR Level II's don't get accepted. If they don't need full blown nursing care, Level II's could go to a residential care facility.

Trends in Facilities

Diagnoses, medication, and treatment

- Residents in facilities may have mental health conditions or may be experiencing similar symptoms as a result of dementia.
- Many residents in nursing facilities are on antidepressants.
- Goal to reduce antipsychotic medication: These were overused in the past. We see less folks with dementia or depression on these kinds of medications. Facilities are tracked as to percent of residents on these medications with the goal to reduce. Some residents do need them. If you're observing a problem that seems to be coming from a medication or could be made better with medication, please bring it up to staff.
- Telehealth and shortage of psychiatrists: Telehealth is getting mixed reviews. A psychiatrist via telehealth may be in another state—they have a TV screen appointment. The ideal scenario is that a psychiatrist can actually come to the facility. Some facilities do have that option but the majority does not. Sometimes it's a nurse practitioner prescribing medication.
- Pharmacists: Pharmacists will conduct a med review periodically to see if there are any complex issues. They should attempt a gradual dose reduction of mood medications and have the facility observe how person does—it may completely throw them off. That needs to be reported and noted in the chart as a failed reduction so it doesn't happen again. Relay to POC as an observation if you notice any mood changes.
- Minimum Data Set (MDS-3): MDS (version 3) is a long assessment done for all residents as a requirement of Medicaid system. There is a behavior and mental health portion. If says that if a resident is able to communicate, staff should ask them questions about mood and health. If residents are persistently upset or anxious (observed) but they say no to the question at the time they may not get services they probably need. Residents with mood issues shouldn't be left to suffer.

Residential care facilities and jail deferment

- Residential Care Facilities (RCFs): Many have been closing across the state. In the state mental health redesign, RCFs were not named as a core service. Mental health regions can decide how to spend their allocation and include RCF payments or not. In northeast Iowa, they've decided not to pay for RCF's but rather treat those folks in an apartment setting. This reduces the amount of beds available for people who need facility based care.

- In some instances, people end up in jail for lack of another option. They may have had a charge or encounter with law enforcement as a result of their mental state. It is not an appropriate discharge to send someone from an RCF to jail, but it does happen.

Returning to the community

- For those enrolled in a Medicaid Managed Care Organization, the MCO Case Manager will follow the PASSR w/goal to return to community
 - As of 4/1/16 all Iowa Medicaid dollars have been privatized to 3 insurance companies to cover most of the folks on Medicaid. Most residents on Medicaid have been assigned a Case Manager (this was not something done previously). Case Manager also develops a care plan for each resident. So far haven't heard any problems with insurance companies wanting people to return to the community, but they have a requirement of 12 returns each year for each company. In Iowa, we have a lower acuity rate so there are folks in some facilities who could be in community with services.
- Some facilities like to keep their beds full. If it's been a long time and the resident has given up their home, the Local Long-Term Care Ombudsman (LTCO) may help. Potential options include:
 - Home and Community Based Services (HCBS)—it's a complicated process. They can't apply for it until they're discharged so it's not easy to get everything set up. LTCO can work on a transition plan.
 - Habilitation services: similar to a waiver program, provides for folks to receive services in their own home. It generally does not provide 24 hour care but assistance with transportation and life skills (cleaning, shopping, cooking).
 - Home health care for in-home nursing services.

Bottom line

- In Iowa, there is a lack of infrastructure to serve folks with mental health needs to the best of our ability. There has been a reduction in mental health beds in hospitals and two mental health institutes closed last year. That's where they go if no facility can handle them. Be an advocate for the whole system whenever you can.

Questions

Marilyn S: Have been working with LTCO on an issue with a resident wanting to move to another facility in another state.

Kay: I have a resident the facility wants to move because they believe he's a danger to others. He's a Vietnam vet with PTSD. On Medicaid so they want him to share a room. Has 24/7 aide. They cannot just turn someone out into the street, can they?

Jennifer: They have to provide a safe and orderly discharge. It becomes tough because the facility has an obligation to protect all the residents—if they're under the threat of being harmed they have to prevent that. What happens a lot is that a facility will take resident to

hospital after an occurrence and then won't accept them back from the hospital. Hospital dumping is looked down upon. There should be an emergency discharge with rights given to appeal—that doesn't always happen. A judge may say the facility has to take them back but that doesn't usually happen. They become the hospital's responsibility. Things to think about: Would they be handled better in a dementia unit? Could meds be adjusted? Can they provide 1 on 1 assistance? Can they prevent other residents from entering that room? Is he to be blamed for acting out if others are entering his room and he perceives it as a problem? This a good one to refer to your LTCO.

Pam P: How successful has that been to treat mental health conditions in the community?

Jennifer: Tough to answer because it's a new process. Historically people who have been in and out of facilities don't stabilize well. If they're chronically mentally ill and they're left alone and don't take meds and get in trouble with law/community it can be a huge challenge. I would like to see the RCFs stay open—I believe we have a place for them. But we definitely have people that can't succeed on their own.

Ken: I can attest that our prisons and jails are becoming more and more like mental health facilities. While they're working hard to adapt, the officers there are not professionally trained for mental health folks. This is an interesting topic. I'm hearing some talk about the other mental health institute's closing.

Jennifer: Talk to your legislators about that.

Jill: How long does the mental health commitment process take?

Jennifer: Not long. Once the form is completed they'll get it before the judge within 24 hours. The Sherriff will go out right away once ruled.

Q: What about folks who are violent?

Jennifer: It's case by case and we help where we can. There are 2-3 nursing facilities for those with persistent mental health needs and they are willing to take the tougher cases.

Jerry: I don't understand managed care and neither do the residents. Who is urging the trend for reducing MH hospital beds?

Jennifer: Individual hospitals, mainly. The Governor proposed the closure of the mental health institutes since they were run by the state.