Mental Health Care & Crisis Planning For Nursing Facilities

PRESENTED BY:

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Objectives

- Implementing recommendations from the PASRR Level II evaluation in the care plan
- Description of a behavior support plan and a crisis plan
- How to create a behavior support plan and a crisis plan

Care Planning and PASRR

Services or supports that a resident requires due to mental illness, intellectual disability or related condition that supplements the typical scope of services that a nursing facility provides are described under the recommendation section on the PASRR determination sheet and within the evaluation report.

Care Planning with PASRR

Assessments that are completed:

- Psychosocial Assessment
- Psychiatric Assessment/History
- Behavioral Assessment
- Level of Functioning
- Medical History
- Physical Assessment
- Mental Status Examination
- Affective Behavioral Observations
- PASRR Evaluation Report
- Conclusions

Sections within the Level II Evaluation that gives direction in the care planning process:

- Assessment and implementation of **behavioral support** plan
- **Medication** therapy and monitoring services
- Provision of a **structured environment**.
- Implementation of **ADL program** to increase independence and self determination
- **Crisis Intervention** Services
- Development of **Personal Support** networks
- Plan for **discharge** and transition to less restrictive environment by application/referral to appropriate community resources

PASRR Determination Sheet

Section II: Determination

1. Has a serious mental illness as defined by PASRR:	Yes (A)
2. Has a substantiated dementia or related condition:	No
3. Needs specialized psychiatric services which can only be provided in an inpatient psychiatric setting:	No
4. Has ID/DD/RC as defined by PASRR:	Yes (C-Has RC other than MI)
5. Needs specialized developmental disability services:	No
6. Needs Nursing Facility level of services:	Yes
7. Recommended for short term NF stay: New DA124s: No	Yes
8. Needs rehabilitative services of a lesser intensity which can be provided by the nursing facility:	Yes

Recommended Services

Behavioral Support Plan — Medication Therapy
Structured Environment — Crisis Intervention Services
Personal Support Network — Discharge Planning

Section III: Recommendations

1. Secured Placement:	No
2. Alternative Services:	No
Assessor: Wilson, Carol A.	Credentials: RN, QMHP

NF Applying to: Undecided Nursing Facility

Short Term NF Recommendations

Nursing Facility MUST initiate discharge planning to evaluate appropriateness of move to less restrictive setting including referrals to community service providers including DMH/DD Regional office as applicable.

REVIEWED

- This is the current format of the determination sheet. We are currently reviewing this and a new format will be released soon. The new from might look different but it will still have the same information.
- #1 is identifying the individual meets the criteria be identified as requiring a Level II.
- # 6 Is showing their basic needs can be met in a NF.
- # 7 shows this person is recommended for a short term stay and will not require an update on the evaluation if they are still needing to continue to stay in the NF. More details are at the bottom of this and within the evaluation report. Some determinations may be time limited and require a new Level I application.
- Recommended Services are listed and can be explained more on the evaluation report. These services are required to be addressed in the individuals care plan.

PASRR Evaluation

25. If admitted to an NF, the individual needs or continues to need the following supports and services.

☒ A. Assessment and implementation of **behavioral support** plan

☒ Monitoring of behavioral symptoms

☒ Provision of behavioral supports

Identify and describe behaviors to be addressed in the NF plan of care:

has poor coping skills and will bang her head and face on the wall and bite herself when she is overwhelmed. Sometimes is able to calm herself down by taking deep breaths, as well as with help from staff. Talk to when she is upset and encourage her to take deep breaths.

SECTION X: PASRR Level II Evaluation Report (continued)

☒ B. **Medication** therapy and monitoring services

☒ Psychiatric follow up to prescribe and manage medications

☒ Medication set up/administration by staff and monitoring for compliance with prescribed medication

☒ Monitoring of interaction or adverse effects (AIMS, etc)

☐ Monitoring of therapeutic effect in managing mental health symptoms including labs as indicated

☐ Address, report, and implement plan to manage patient refusals/noncompliance (including cheeking, hoarding, etc.)

☐ Provide education/training in drug therapy management

☒ Pharmaceutical services/medication review

☐ Other: _____

Requires ongoing medical management and review.

☒ C. Provision of a **structured environment**.

☒ Provide for individual personal space

☒ Provide for sensory supports

☒ Maintain environment with low stimulation

☒ Maintain environment with a minimum of visual/auditory distractions

☒ Establish consistent routines

☒ Provide schedule of daily tasks/activities

☒ Provide instructions at the individual's level of understanding

☒ Assess and plan for the level of supervision required to prevent harm to self or others

List needs and rationale as well as level of supervision needed:

Ongoing

☒ E. **Crisis Intervention** Services. Assess and plan for Crisis Intervention that provides emotional support, education, safety planning and case management to handle an immediate crisis. List need or behavior necessitating crisis intervention. Include need for suicide, assault, and elopement precautions.

Given history of self injury and aggression, Crisis Plan should identify clear steps that will be taken to support individual during a crisis situation, specify who to contact for assistance, how staff should work together with individual during the crisis, as well as identify when the physician, emergency medical services and /or law enforcement should be contacted. Facility may also wish to utilize DMH Behavioral Health Crisis Hotline: https://dmh.mo.gov/mentalillness/progs/acimap.html

☒ F. Development of **Personal Support** networks.

☒ Assess and plan for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc.

☒ Assess, plan, and develop appropriate personal support network through community and social connections.

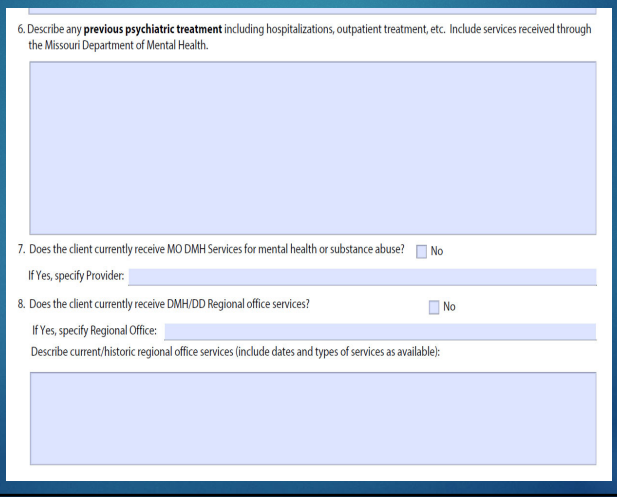
likes to listen to country music - Taylor Swift and Luke Bryan. She also likes to watch movies, draw, color. Encourage interaction with staff and others.

☒ G. Assess and plan for **discharge**, transition to less restrictive environment by application/referral to appropriate community resources. Facility/staff to make referral and assist with application for resources and/or services. Describe and specify:

Facility social sevices director will monitor progress and work with guardian on transitioning to a less restrictive level of care with the appropriate services in place, when it is felt that is ready and has an accepting facility. NF social services should coordinate discharge planning with DD support coordinator to facilitate return to community living situation and identify necessary community supports and services. Recommend application for DD waiver services.

PASRR Evaluation and Previous Treatment

In the evaluation section III, these questions address current and previous DMH services



6. Describe any **previous psychiatric treatment** including hospitalizations, outpatient treatment, etc. Include services received through the Missouri Department of Mental Health.

7. Does the client currently receive MO DMH Services for mental health or substance abuse? ☐ No

If Yes, specify Provider:

8. Does the client currently receive DMH/DD Regional office services? ☐ No

If Yes, specify Regional Office:

Describe current/historic regional office services (include dates and types of services as available):

Care Planning

- Create an environment and atmosphere conducive to mental and psychosocial well-being.
- Care should be person-centered and reflect the resident's goals for care.
- The direct care staff should communicate in a manner that the resident understands and in a way that promotes mental and psychosocial well-being.
- Residents require meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community.
- Include specifics about how the resident communicates best in care plan.
  - Get eye contact before giving instructions.
  - Speak slowly and clearly Use as few words as possible in explanations.
  - Assist the individual with the beginning steps to tasks.
  - Give directions in a variety of ways to increase the individual's understanding.
  - Model the appropriate action or response for the individual.
  - Recognize the individual's indications that he/she needs assistance.
  - Offer assistance, then wait for that offer to be accepted.
  - Be patient. Be prepared to repeat things more than once.

Person-Centered Environment

- Some individuals are more able to take responsibility for themselves than others, and providers must establish a baseline of engagement, health literacy, and decision-making abilities before diving into a complicated care plan. Clearly define the roles of the care team. Educate them about their responsibility and accountability for their own health. Provide them access to their data. Adhere to HIPPA guidelines to foster better relationships and to assist the individual with feeling more secure in knowing they have privacy.
- PASRR assessments may include recommendations for a structured environment, structured socialization, and/ or the development of a personal support network.
- Meaningful activities and a well-developed support systems diminish tendencies towards isolation and withdrawal, lower stress and depression, and improve physical and mental wellness. Individuals also tend to have positive interactions, cope better with life and the transition to long term care when they experience a sense of connection and belonging.

Person-Centered Activities of Daily Living, Recreation and Socialization

- Establish consistent routines.
- Allow the individual to check in each morning with a designated person.
- Inform and remind of activities for the day.
- Provide a written or photo schedule of the day.
- Schedule preferred activities throughout the day as possible.
- Notify the individual of any changes in the schedule as early as possible.
- Allow the individual input into the daily schedule.
- Allow time at the beginning of each activity to help the individual organize.
- Give the individual a preferred responsibility at the beginning of the new activity.
- Provide assigned tasks in small segments or in a step-by-step manner.
- Provide the individual with additional time when needed.

Ideas for Sensory Supports

- Use seat cushions/device or adaptive equipment for better positioning.
- Provide foot stools or supports.
- Provide “fidget”/“weighted” items.
- Provide programs and sensory ideas such as Minds in Motion, Yoga and Brain Gym.
  - https://www.pinterest.com/mbirdlowry/minds-in-motion-and-sensory-ideas/
- Provide low lighting/color lighting.
- Provide stress reduction items (balls, etc.).
- Use a “white noise” or sound machine.
- Provide headphones.
- Maintain comfortable room temperature.
- Use night light to avoid shadows that distorts vision.
- Avoid sunlight or brightness that distorts vision.
- Provide sensory for vision impaired individual:
  - 63 Best Sensory for Blind and Visually Impaired ideas | sensory, sensory activities, activities (pinterest.com)
  - 110 School - Minds in Motion and Sensory ideas | motor planning, activities, core stability (pinterest.com)
  - Providing Students with Visual Impairments with Sensory Input - Teaching Students with Visual Impairments (teachingvisuallyimpaired.com)

Person-Centered Goals

- Person-centered care, is defined by the World Health Organization as “empowering people to take charge of their own health rather than being passive recipients of services.” This care strategy is based on the belief that patient views, input, and experiences can help improve overall health outcomes.
- Person-centered planning is a process for selecting and organizing the services and supports that an older adult or person with a disability may need. Most important, it is a process that is directed by the person who receives the support.
- Individuals are going to be more motivated to work towards things that are most important to them.
- Including the resident or anyone the resident wants included in the creation of the goals is going to provide the best outcomes in achieving the goals.
- The PASRR evaluations do not currently address individual goals but can still be a very useful tool in the creation of goals.

keep in mind resident dignity, autonomy, privacy, socialization, independence, choice, and safety

How PASRR Can Assist in Person-Centered Care

Intent of change in condition- To ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting, when a significant change in their status occurs.

A nursing facility must notify the Department of Mental Health, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for a resident review.

Change in Condition

- A significant change for the purposes of PASRR may or may not trigger a significant change in status for the MDS. Level II evaluations and recommendations are independent from the requirements of a Level I screening. Therefore, level II changes in condition have different criteria and a different process separate from the change in status.
- This is not required if a Level II screening was completed and the individual did not meet the criteria of having the qualifying diagnosis for Level II purposes. Level II requirements no longer apply to these individuals.
- If an individual receives a new mental health diagnosis and was previously identified as not have a qualifying diagnosis, a Level I will be required and COMRU will refer for a Level II.
- Examples of changes can be found on the DMH website and on the new updated form also found on the DMH website.

Change in Condition Cont.

To notify DMH of a change in condition, providers can access the Notification to DMH for Change in Condition and Resident Review Referral Form:
https://dmh.mo.gov/media/45581/download

Please complete the referral form and email to: DMHNotifications@dmh.mo.gov.

Considerations For Increased Mental Illness Symptoms or Undesired Behaviors

If expressions or indications of distress, lack of improvement or decline in resident functioning are identified by the facility- they should be documented in the resident's record and steps taken to determine the underlying cause of the negative outcome.

In these instances, a significant change notification should be made by the facility to DMH for a determination of whether or not a PASRR – Level II reevaluation needs to be completed.

Considerations For Increase in Mental Illness Symptoms or Undesired Behaviors

- Adjust the Care planning
- Create a crisis safety plan or update current one
- Create a Positive Behavior Intervention Plan
- Identify the activities associated with the event
- Identify environments associated with the event
- Possible Medications adjustment needed (consult psychiatrist)
- Need for adjustment in supervision
- Need staff training (see resources for training assistances)
- Might need to access the Behavioral Health Crisis Line
- Review PASRR Level II Evaluations/Reevaluations

What Is A Positive Intervention Plan?

- It is a written proactive plan that is part of an individual's person center planning and includes strategies to help reduce or prevent the likelihood of challenging or inappropriate behaviors from occurring. For some individual's, simple interventions such as reducing the noise level or providing a quiet environment may make a difference. For others, a more formal plan may be needed to address the behavior.
- Needed when an individual's behavior negatively impacts his or her quality of life or that of others, the person center planning team should consider the use of positive behavior interventions, strategies, and supports to address the problem.

Positive Intervention/Support Plan

- The team should consider ways to help the individual learn positive behavioral skills as well as other necessary coping skills. A positive behavior intervention plan is developed by the person center planning team with information gathered from the:
  - Individual, Family/Friends, Medical and Nursing staff, Other staff who know the individual well, Others who are important to the individual
- Gather evaluation information including an assessment of the behavior through observation and collection of data. The information is reviewed to determine the reason for a behavior and the times and situations in which it is most likely to occur. This can be done by a short collection of data. Document who, what, when, and where to find patterns to help identify possible causes for the behavior.
- An intervention plan should include specific steps to assist the individual to learn new behavioral and coping skills. It should include:
  - Environmental changes to reduce or eliminate challenging behaviors
  - Strategies for teaching new skills to replace challenging behaviors
  - Skills training to increase individual understanding of positive behavior strategies
  - Supports that will be provided to help the individual practice the new strategies across different settings within the facility.

What Is A Crisis Plan?

- A plan that includes a safety assessment and suggested strategies to help everyone understand how to respond to reduce the likelihood of a crisis situation.
- A crisis plan is an action plan that is needed when an individual maybe at risk of harm to self or others.
- An individual's crisis plan should be developed by individuals knowledgeable about the individual.
- Crisis plans should be individualized and reviewed regularly.
- One of the most effective ways of averting a crisis is to address the problem before it fully emerges. These warning signs include personal situations, thoughts, moods, or behaviors and serve as a reminder to retrieve and follow the Safety Plan.
- The planning team should consider all facility policies and procedures for responding to an individual who is experiencing a crisis. If an individual's actions are viewed as a violation of the facility's policies, the planning team may consider if the individual's crisis warrants a reassessment for significant change in condition submitted to DMH.
- It is not always possible to prevent a crisis, so sometimes the goal of a crisis plan is to manage the situation well or to keep people from getting hurt. The goal should focus on the person in crisis and how on the caregivers handling the situation.

A Crisis Plan Allows Individuals to:

- Clearly state treatment preferences, including treatments to use and those not to use; medications to use and those not to use; preferences for hospitals; and preferences for doctors and other mental health professionals.
- Decide who can act on their behalf, by designating a trusted person (sometimes referred to as "healthcare agent," "proxy," or "health care power of attorney") as a decision-maker on their behalf.
- Identify whom to notify in the event of a mental health crisis.
- Share the plan with others, including doctors, other members of the care team, and family and friends if desired by the individual.

Crisis Plan Should Include

- Defines what an individual's crisis looks like.
  - Ask questions like "What does it look like when you are doing well?" "What does it look like when your symptoms are starting to increase?"
- It includes clear steps that will be taken to support the individual during a crisis including
  - knowing who to contact for assistance
    - Ask: "Is there anyone that can help you during a crisis?" friend's or family sometimes know what to say to assist individuals when in crisis. "Would you like to speak with a mental health professional by phone, text or in person?" contact ACI
  - how to work together with the individual during the crisis
    - Ask: "Is there any activity that assist you during a crisis?" What would you like your care team to do in the event of a crisis?"
  - how to determine when the crisis is over
    - Ask: "How will people around you know when you are starting to stabilize?" "Is there anything specific you do or say that may tell someone you are doing better"
- A crisis plan also identifies when the physician, emergency medical services and /or law enforcement should be contacted.

Access Crisis Intervention (ACI)

(ACI) provides access to services for individuals experiencing a behavioral health crisis. ACI will provide an opportunity for individuals to receive necessary behavioral health crisis services in an effort to reduce unnecessary interventions such as hospitalization or detentions. By calling the ACI hotline, individuals have access to behavioral health crisis services that are free and available to both youth and adults.

- All calls are strictly confidential.
- ACI hotlines are staffed 24 hours a day, seven days a week by behavioral health professionals who are available to provide assistance.
- The mental health professionals will talk with you about your crisis and help you determine what further help is needed, for example, a telephone conversation to provide understanding and support, a face-to-face intervention, an appointment the next day with a mental health professional, or perhaps an alternative service that best meets your needs. They may give you other resources or services within your community to provide you with ongoing care following your crisis. If crisis is not resolved by phone they can send a crisis response team.

ACI 24 hour Hotline Numbers

Access Crisis Intervention | dmh.mo.gov

What is 988?

- In July of 2022, 988 became the national three-digit dialing code for the National Suicide Prevention Lifeline (NSPL), replacing the current phone number of 1-800-273-TALK (8255).
- Connect individuals in crisis with a mental health professional to address immediate needs
- Assure 24/7 availability and rapid access to crisis services via call, chat, or text
- Reduce health care spending with more cost-effective early intervention
- Reduce use of law enforcement, public health, and other safety resources
- Meet the growing need for crisis intervention at scale
- When should you call?
  - When you or someone you know is in need of crisis support for mental health.

What Happens When Someone Dials 988?

1. The caller will hear an automated greeting message that will prompt them to select an option (Lifeline, Veterans Crisis Line, or Spanish Network).
2. Once the caller makes a selection, music plays while the call is quickly routed to a trained crisis specialist.
3. The call is answered by a crisis specialist.
4. The crisis specialist will listen to the caller, work to understand the problem the caller is experiencing, provide support, and collaborate with the caller on ways to help them feel better.
5. The crisis specialist will connect that person to local resources and supports or dispatch a mobile crisis response team if a higher level of care is needed.

How to Contact Crisis Services

- The toll-free **Access Crisis Intervention (ACI) Hotline** for your region
- **988** Replaces the 1-800 National Suicide Prevention Lifeline
- 911 for emergency services
- **Other crisis hotlines**
- The **Crisis Text Line**, Text MOSAFE to 741741
- The **Veteran's Crisis Line**, text 838255

CRISIS TEXT LINE

Veterans Crisis Line
1-800-273-8255 PRESS 1

Training Resources

- Behavior Health training
  - https://www.mimh.edu/mental-health-first-aid/
- Developmental Disabilities training
  - Positive Supports | dmh.mo.gov
  - Tools of Choice | dmh.mo.gov
  - Tiered Supports | dmh.mo.gov
- Trauma Informed Care training
  - Trauma Informed Care | dmh.mo.gov
  - https://modmh.thinkific.com/
  - Trauma Informed Treatment Models | dmh.mo.gov

Other Resources

- More information from DMH about PASRR: ***https://dmh.mo.gov/dev-disabilities/programs/pasrr-level-ii-assessments***
- More information from DMH about ACI: Access Crisis Intervention | dmh.mo.gov
- Positive Behavior Intervention and Crisis Plans | dmh.mo.gov
- Therapy Aide, worksheets and Tools: https://www.therapistaid.com/
- Person-Centered Care Planning: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/qmp/care-planning-dementia.pdf
- Guide For Assessing Changes in Behavior in Residents of Long Term Care Facilities and....Getting Help When Needed: https://pogoe.org/sites/default/files/ABC-SuppMat.pdfhttps://www.maine.gov/dhhs/samhs/mentalhealth/mh-system/olderpersons/guide/GuideTT.pdf
- Managing Difficult Behaviors in Dementia, By Linda Conti, RN, CHPN, Today's Geriatric Medicine: Managing Difficult Behaviors in Dementia (todaysgeriatricmedicine.com)
- PASRR Technical Assistance: https://www.pasrrassist.org
- Missouri Suicide Prevention Network | Jefferson City, MO | MOSPN

MSPN
Missouri Suicide Prevention Network

Questions and Contact Information

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Missouri Department of MENTAL HEALTH