



Bridging Acute and Long Term Care with a Behavioral Health Perspective

[Joseph M. Casciani, PhD](#)

Bridging Acute and Long Term Care with a Behavioral Health Perspective

Presentation to the San Diego and Imperial County
Learning and Action Network

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San Diego, California

Bridging Acute and Long Term Care with a Behavioral Health Perspective

Joseph M. Casciani, PhD

Background

- Clinical psychologist, licensed in four states, with 30-year specialty in geropsychology
- Consultant and Contractor for Calif. Dept. of Aging and Dept. of Mental Health 1983-1986 to develop Curriculum for Nursing Home Training
- Co-Founder and Exec. Officer of Multi-state Mental Health Group Practice for Nursing Homes, 1990-2007
- President, Psychologists in Long Term Care, 2008-2010
- Board Member, Council of Professional Geropsychology Training Programs, 2007-2012
- Chief Executive, CoHealth Institute – formed 2007 to promote behavioral health training and consulting in the care of older adults – website is www.concepthc.com
- Chief Executive, CoHealth Care Group – formed 2008 to provide behavioral health services to LTC facilities – currently contracted with 70 facilities throughout southern California, and north Texas
- Author, *Handbook of Health and Behavior: Psychological Treatment Strategies for the Nursing Home Patient*



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Welcome

Today's presentation focuses on optimal behavioral approaches with older adult patients who are transitioning from acute care to long term care settings. Behavioral health approaches are important considering the multiple risk issues in this age group, including cognitive impairment, depression and anxiety disorders, personality disorders, resistance to care, missing information, and other barriers to care.

These approaches include assigning patients to treatment tracks based on their level of functioning to individualize their care, triaging patients into severity of need for APM reduction, and non-drug interventions that are as effective as anti-psychotic medications.

Key Learning Objectives

After completing this program, you will better understand the:

- Major transition problems impacting patients transitioning from acute to LTC
- Criteria for assigning patients to 3 different treatment tracks to implement a milieu treatment program
- General principles of preventing and managing problem behaviors
- Criteria for when psychotropics are definitely needed, and when alternate approaches should be considered

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Presentation Outline

- High risk transition problems from acute care to long term care
- Treatment tracks and how they foster milieu programs
- Criteria for when psychotropic medications are needed and when alternate approaches should be considered
- General principles of preventing and managing problem behaviors

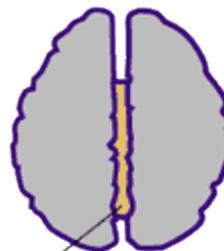
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The Split Brain Experiments – Dr. Roger Sperry

left brain – analytical & verbal tasks

right brain – space perception & concepts



Corpus callosum

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Behavioral Health Issues during Transitions

Effective care transition is the well-executed and smooth movement of a patient between different formal and informal healthcare providers, over the course of an acute illness. Every change from provider or setting is another care transition.

Lumetra Quality Improvement Organization, Care Transitions Conference 2007



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High Risk Transition Problems

- Dementia and Delirium
- Depression, Anxiety or Adjustment Disorder
- Personality Disorders
- Sensory Deficits
- Resistance to Care
- Uninformed and Unprepared on Management of their Care –
Low Health Literacy
- Cultural and Language Barriers
- Lack of Self-care Mindset

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Patient Capabilities Checklist

- I have been involved in decisions about my discharge
- I understand where I am going, why, and what will happen there
- My doctor and nurse have answered my most important questions

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Individualizing Patient Care

Treatment Tracks take into Account:

- Level of Cognitive Functioning
- Psychological and Adjustment Disorders
- Sensory Deficits
- Attitudes toward Caregivers and Resistance
- Awareness of Disability and Decline
- Capacity for Understanding Reasons for Hospital Admission and Discharge, and Admission to SNF

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Why are Treatment Tracks Important?



With different treatment approaches we are better able to:

- Individualize the care and our interactions with each patient
- Help each patient adjust to their placement, their reason for placement, and their possible discharge or possible long term care
- Recognize the residual strengths each resident has and how to build on these strengths in all of our care giving interactions
- Create milieu that tailors all of the interactions and care according to the patient's capacity and reasons for placement

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Assign Patients to Treatment Track



There are 3 tracks along a continuum from the most alert, capable and coherent (Track A) to the least (Track C). Use both objective and subjective criteria to assign patients to a treatment track.

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Assign Patients to Track



Track A Criteria

Patients assigned to Track A would exhibit the following characteristics:

- Alert, coherent, capable of interacting meaningfully
 - Can explain why s/he is placed in facility
 - Can communicate coherently (complete sentences), communication is meaningful, though may be illogical
 - Oriented to place and person
 - Capable of at least 3 ADL's
 - Capable of sustained mental concentration, AEB can say months of year backward

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Assign Patients to Track



Track B Criteria

Patients assigned to Track B would exhibit the following characteristics:

- Can be expected to improve with treatment, or move to lower level track
 - Has little understanding of reason for placement
 - May be delusional or disoriented, but responds to reorientation
 - Communication is meaningful, but may be disorganized or illogical
 - Oriented to person
 - Capable of minimal sustained concentration, AEB can say days of week backward, or count backward from 20 to 1

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Assign Patients to Track



Track C Criteria

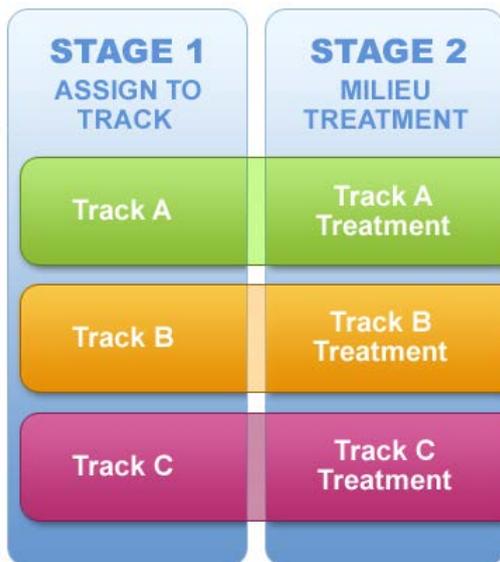
Patients assigned to Track C would exhibit the following characteristics:

- Low functioning, not expected to improve
 - Disoriented to time, place and possibly person
 - Communication is incoherent, disorganized, and generally not meaningful
 - May not be able to communicate own needs
 - Incapable of most ADL's

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Implement Milieu Treatment

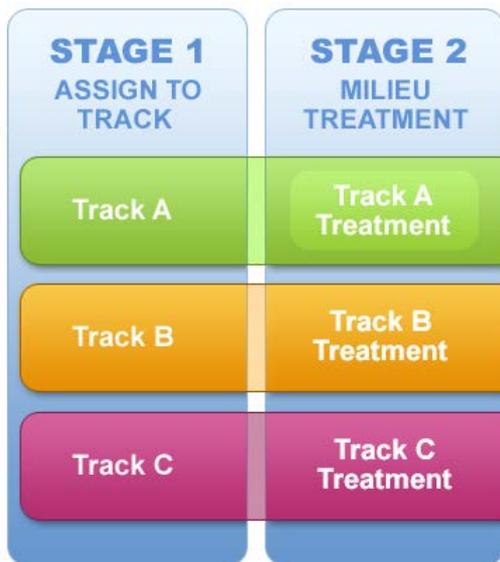


Milieu treatment is implemented according to the track assigned. The focus of treatment for each track is designed to incorporate the patient's individual treatment needs and their capacity to benefit from this treatment.

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Implement Milieu Treatment



Track A: Focus of Treatment

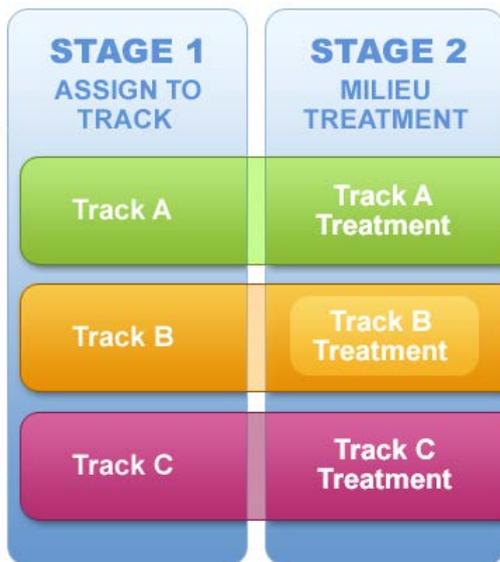
With patients assigned to Track A:

- Communicate goals of placement and treatment and what is required for discharge
- Identify residual strengths and resources
- Maintain as much independence and self-care as possible
- Increase opportunities for socialization
- Emphasize anger management, socialization, communication, re-motivation

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Implement Milieu Treatment



Track B: Focus of Treatment

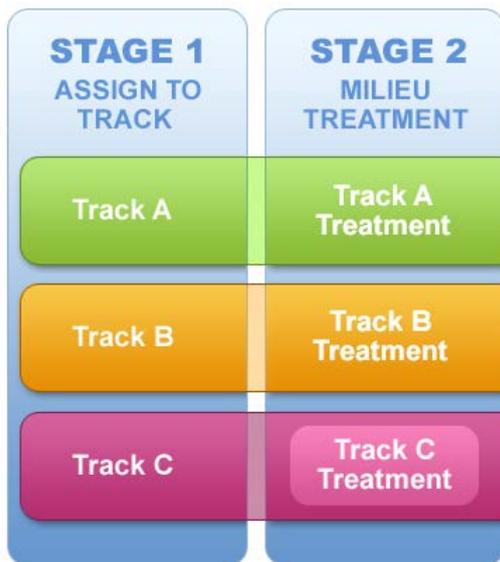
With patients assigned to Track B, the goal is to provide education and structure to move the patients to a higher level:

- Focus on reality orientation; educate as to why placement is needed, and placement and treatment goals
- Outline a daily schedule and encourage interaction and activities
- Improve skills in communication and self-care
- Increase sense of control and mastery over environment, increase frustration tolerance

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Implement Milieu Treatment



Track C: Focus of Treatment

With patients assigned to Track C, the treatment is much more structured and focused on the patient's losses:

- Focus on adjusting to structure and placement
- Reduce expectations
- Focus on feelings of safety and security, daily schedule, routine
- Avoid taxing patient's limited memory and learning capacity
- Identify any possible excess deficits that are treatable (e.g., vision or hearing)

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Track A Criteria & Focus of Milieu Treatment

Tailor the milieu treatment to the individual's residual strengths and placement goals.

CRITERIA	FOCUS OF TREATMENT
Can explain why s/he is placed in facility 	Why placement is needed and what is required for discharge
Can communicate coherently (communication is meaningful, though may be illogical) 	Maintaining as much independence and self-care as possible
Oriented to place and person 	Identifying residual strengths and resources
Capable of at least 3 ADL's 	Increase opportunities for socialization
MDS Score, Section C: 11 to 15; MMSE > 21 	Treatment focusing on anger management, socialization, communication, re-motivation

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Track B Criteria & Focus of Milieu Treatment

Tailor the milieu treatment to the individual's residual strengths and to increase capabilities.

CRITERIA	FOCUS OF TREATMENT
Has little understanding of reason for placement	Reality orientation; why placement is needed
Communication is meaningful but may be disorganized or illogical	Educate about placement and benefits of placement, and what the treatment goals are
Oriented at least x1 (to person); MMSE score 17 to 21; MDS 7 to 10	Involvement in activities; Improve skills in communication and self-care
Capable of minimal sustained concentration, AEB saying days of week backward, or counting backward from 20 to 1	Increase sense of control and mastery over environment, decision-making skills, and increased frustration tolerance

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Track C Criteria & Focus of Milieu Treatment

Tailor the milieu treatment to reality orientation and to foster safety and security.

CRITERIA	FOCUS OF TREATMENT
Disoriented x3 (time, place, person)	Focus on adjusting to structure and placement, and reality orientation
Communication is incoherent, disorganized, generally not meaningful	Reduce expectations to a level equal to capacity; do not over-estimate pt's ability to comprehend
May not be able to communicate own needs	Focus on feelings of safety, security, and keeping anxiety level low
MMSE score of 16 or less; MDS score of 0 to 6	Do not tax patient's limited memory and learning capacity
Incapable of most ADL's	Identify possible excess deficits that are treatable (e.g., vision or hearing)

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Which Patients need Psychotropic Medications?

Triage all patients on anti-psychotic medications into one of three groups, depending on the medical necessity of the medication.

The three groups are:

- Definite Need (DN) for meds
- Attempt to Reduce (ATR)
- Definitely Reduce or Discontinue (DR/D)

Source: University of Iowa Geriatric Education Center,

<https://www.healthcare.uiowa.edu/IGEC/IAAdapt>



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Triage Patients Into Groups 1

Group 1: Criteria for “Definite Need”

Continue APM's if target symptoms pose a danger to the patient or to other patients, such as:

- Aggressive behaviors exhibited during caregiving
- Hallucinations that are destructive, pose a risk, or are unsettling to the patient
- Delusional thinking that is disruptive to the care of the patient, to other patients, staff or visitors



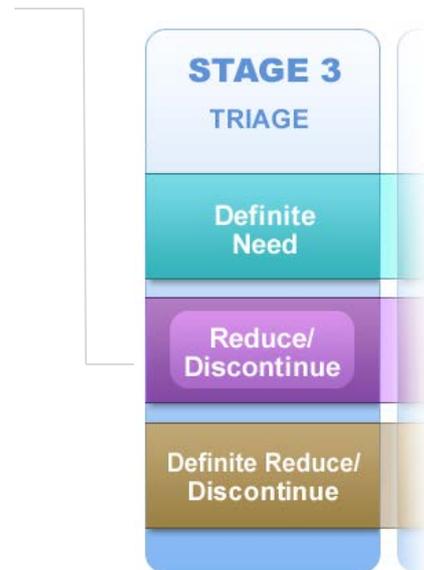
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Triage Patients Into Group 2

Group 2: Criteria for “Attempt to Reduce”

- Rule out “treatable” causes of behavior problems:
 - Physical** - pain, hunger, constipation, fatigue, insomnia, infection, dehydration, medication side effects, or sensory losses
 - Psychological** - worry and distress, fear, anxiety, depression, impaired speech and communication, boredom, or catastrophic thinking
 - Environmental Stressors** - over or under stimulation, lack of structure and routine, or inconsistency in schedules and caregiving
- If target behavior is not changing as a result of the APM, consider discontinuing the medications and monitor patient to see if there are some non-drug interventions for target behaviors



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Triage Patients Into Group 3

Group 3: Criteria for “Definitely Reduce or Discontinue”

- Decrease and discontinue APM’s for:
 - Wandering and restlessness
 - Not being social
 - Poor self care
 - Non-aggressive, uncooperative behaviors
 - Nervousness and fidgeting
 - Mild anxiety and worry
 - Mild memory impairment



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Recommendations on Non-Drug Interventions

For patients assigned to the “Reduce / Discontinue” group based on triage criteria, the staff play an important role in a patient achieving behavior changes.

When applying non-drug interventions for target behaviors:

- Focus on one behavior at a time
- Identify possible triggers or consequences of target behaviors that reinforce those behaviors
- Reduce or eliminate possible triggers
- Consider what patient is communicating through behaviors
- Communicate effectively during caregiving



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Signs and Symptoms of Dementia

Dementia is a cluster of symptoms that results in a global loss of intellectual or cognitive abilities. Symptoms include:

- Memory loss
- Loss of comprehension and difficulty dealing with complex statements
- Loss of general information
- Emotional changes, lability, unpredictability
- Loss of inhibition and impulse control
- Hallucinations
- Loss of orientation
- Poor judgment
- Irritability, low frustration tolerance
- Loss of initiative
- Verbal changes and difficulty with communication

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General Principles of Prevention

Many problem behaviors can be avoided by applying general principles of prevention.

Running through all these principles is a patient-centered approach, which means knowing the person in front of us, their needs and preferences, their likes and dislikes, and their family, history and background.

- Consistency
- Reduce expectations
- Personal approaches
- Provide structure and routine
- Simple language and communication
- Reality orientation
- Engage in activities
- Reduce unnecessary stimulation



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Prevention Principles

Non-drug interventions can reduce the potential of problem behaviors.

- Be “patient centered” - know the patient’s needs, preferences, background, likes and dislikes, functioning level, triggers that might cause irritably
- Check your attitude in caregiving
- Develop a “prosthetic environment” to support a patient whose cognitive functioning is not expected to improve with treatment
- Do not over-estimate a patient’s capacity to understand
- Use consistency in routines, caregivers, room assignments, meals, etc. because change is difficult for patients with cognitive loss
- Learn what the patient is communicating through behavior
- Reinforce and praise for desirable, expected behaviors and attempts to change
- Speak with patients in area that is free from distraction



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Prevention Principles (cont'd)

Non-drug interventions can reduce the potential of problem behaviors.

- Use distraction and re-direction when behavior becomes disruptive or argumentative
- Watch for precursors of escalating problem behavior
- Recognize, acknowledge and respect the patient's feelings
- Avoid criticizing
- Recognize and support patient's ability to stay calm
- Do not take behavior problems personally



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Interventions and Management Techniques for Common Behavioral Problems

Anxiety

Resisting Care

Verbal Aggression

Manipulative Behaviors

Wandering

Disruptive Vocalizations

Paranoia, Delusions, and Suspiciousness

Sexual Behavior Problems



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Anxiety Symptoms

There are a number of clinical signs and symptoms associated with anxiety, including:

- Loss of eye contact
- Reports uneasiness, fear, worry, dread, loneliness
- Repetitive movements, wringing hands, clenched fists
- Increased motor activity – restlessness, pacing
- Repetitive sounds, crying, complaining
- With intact residents, may be a reaction to illness, separation or abandonment by family, and reduced ability to function independently

Let's look at some techniques and caregiving approaches for preventing and/or effectively managing behavioral symptoms associated with anxiety.

more...

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Anxiety Prevention

- Be flexible in the way you give care
- Make sure clothing and personal care items are easy to use
- Provide consistency in caregiving style
- Explain what will be happening before you start caregiving task
- Schedule a predictable routine each day
- Schedule periods of physical activity to release excess energy
- Provide times for rest each day

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Management Techniques

- Comfort and reassure safety and security of patient
- Use distraction if appropriate to diffuse situations
- Provide comfort through touch, holding patient's hand, backrub
- Make sure person is using needed visual or hearing aids
- Break down a complex task into individual steps
- Give as much control as possible to promote feelings of power and mastery over his/her environment
- Give rewards and appreciation when appropriate and when requests are followed and/or tasks are finished
- Do not force when patient is not cooperating – leave and return when resident has calmed down

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Resisting Care

When patients are uncooperative or resisting care, the ideal approach is prevention.

Prevention

- Let the staff member with best relationship give care
- Display patience, explain your task from the start, proceed slowly in all care
- Avoid situations, activities, and/or tasks that are known triggers
- Let the patient use remaining skills as much as possible in their own self-care
- Use another staff member to keep the patient focused or distracted
- Do not overwhelm the patient with demands

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Resisting Care – Management Techniques



Dressing

- Limit the choices patient has to make
- Lay out clothes in order in which they are put on
- Simplify clothing and closures when possible – elastic waistbands, slipover blouses, hook-and-loop fasteners, and slip-ons



Eating

- Serve foods that are familiar and reflect cultural and personal eating habits
- Use finger foods that patient can pick up easily
- Remove noise and other activities that can be distracting or interfere with meal times

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Resisting Care – Management Techniques (continued)



Bathing

- Create a feeling of privacy – e.g., wrap a towel around patient's shoulders while washing lower body
- Make sure gender of caregiver is agreeable to the patient
- Undress the patient only when entering shower or tub, not ahead of time
- Do not argue with patient about need for bathing or the temperature of the water; if the patient is resistant, stop and try again later

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Preventing Verbal Aggression

- Help patient have more privacy and personal space
- Avoid situations that are known to trigger aggressiveness
- Allow other opportunities for patient to be expressive and assertive
- Give as much control and decision-making as possible over all ADL's

Managing Symptoms

- If patient becomes violent, secure patient and restrain as authorized; give simple communication in calm but firm tone
- Do not reason or debate but rather communicate clearly in a calming, reassuring voice

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Preventing Manipulative Behaviors

- Whenever possible, give choices about daily routine, schedule, and overall treatment plan
- Ask patient how much help s/he needs and how much s/he would like to do on her/his own
- Maintain consistency among all caregivers
- Provide information and explanation on all tasks
- Help patient make decisions, take action, and see results

Managing Symptoms

- Set limits on inappropriate requests and demands
- Avoid power struggles
- Provide recognition and rewards for positive, appropriate behaviors

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Recommended Steps to Reduce Difficulties with Wandering Patients

- Provide indoor and outdoor spaces to wander and explore safely
- Limit the number of exits; make exits doors look like something else (i.e., camouflage) or put “STOP” or “DO NOT ENTER” in front of exits
- If wandering into other rooms, determine if lost, searching for toilet, looking for bed to take a nap; put pictures on bathroom door to identify toilet
- Establish routines in schedule and anticipate times of increased activity and re-direct

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Management Techniques for Wandering Patients

- Determine if wandering is drug-induced akathisia, or due to a lack of stimulation, a desire to leave facility, or just imitating others
- Assess physical agitation possibly due to pain, constipation, hunger, thirst, toileting need
- Gently re-direct the patient back to desired area or away from other rooms, verbally distract patient while physically guiding patient back
- If patient does not respond to distraction, stay with patient to ensure safety
- If pressing for discharge, have patient talk about home, who lives there, where s/he grew up, etc.
- Plan for special phone calls with patient when possible
- Beware of risks associated with dead-end hallways

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Disruptive Vocalizations

Determine if attention-seeking, self-stimulation, or due to unmet psychosocial needs (feeling alone, fearful, or abandoned)

Management Techniques

- Anticipate needs and provide attention and reinforce desired behavior when patient is not calling out
- Assure patient's safety but do not provide attention when calling out
- Reward appropriate requests for assistance
- Have family provide a recorded message to decrease loneliness and enhance security
- Provide an alternative means of stimulation (e.g., headset with music) when calling out is used for self-stimulation
- Provide adequate attention and companionship

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Paranoia, Delusions, and Suspiciousness

Manifested as fears of being harmed, in danger, being followed, or personal possessions are being taken. If due to memory and cognitive loss, may be an expression of fears of losing contact.

Management Techniques

- Avoid disagreeing, arguing, or debating
- Respond and validate feelings, reassure patient that s/he is safe and secure
- Use distraction rather than using a logical explanation to counter the delusion
- When accused by the patient, respond in non-defensive manner; develop a non-threatening, trusting relationship; introduce yourself routinely
- Do not speak in a foreign language or in a whisper around the patient

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Sexual Behavior Problems

Sexual Behavior Problems

Manifested as disrobing or removing clothes, inappropriate touching during caregiving, or self-stimulation and masturbation in public

Management Techniques

- Do not over-react, confront, cause humiliation or shame, and avoid non-verbal messages of disapproval
- Respond calmly and firmly, direct patient to stop and inform patient that behavior is not acceptable
- Provide privacy and remove from inappropriate setting and re-direct to patient's own room
- When inappropriate during ADL's (personal care, dressing, bathing), use distraction
- Meet basic needs for touch and warmth; model and demonstrate appropriate touching

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Summary

In today's presentation, we explored:

- Major transition problems that can impact older adults moving from acute to long term care
- The advantages of assigning patients to different treatment tracks, based on their functional level
- General milieu treatment approaches
- Effective non-drug interventions as alternatives to medications



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Thank you.

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