MODEL NURSING HOME PROGRAMS

PROMOTING MENTAL HEALTH OF RESIDENTS

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This article draws upon the proceedings of a national invitation conference held in Washington D.C. in December 1993 as reported in a policy brief *Achieving Mental Health Care for Nursing Home Residents: Overcoming Barriers to Mental Health Care* by Nancy Emerson Lombardo and Herbert Weiss with Gail K. Robinson and Barry S. Fogel, available for $5.45 from the Hebrew Rehabilitation Center for Aged, Research and Training Institute at 617-325-8000 x 391 or fax 617-327-7639 (Attn. Romanna). The policy brief is also in press: Emerson Lombardo, N.B., Fogel B., Robinson, G. and Weiss H., Achieving Mental Health of Nursing Home Residents, *Journal of Mental Health and Aging*, spring, 1996.

Although in general mental health care for nursing home residents is woefully inadequate, innovative mental health programs do exist in some nursing homes. These model programs sometimes receive research or demonstration funds from an array of federal and state agencies, and occasionally from private groups like the Robert Wood Johnson Foundation. According to mental health experts, most model programs are supported by the facilities themselves, drawing upon endowments, gifts or revenue from private pay patients. We know of no model program supported by routine Medicaid revenues alone, although there might be some in existence.

Here are examples of model mental health programs in operation throughout the nation:

PSYCHO-GERIATRIC UNITS, INTERDISCIPLINARY TEAMS AND TRAINING PROGRAMS

The U.S. Department of Veterans' Affairs (DVA) has undertaken a major effort to improve mental health by introducing psychogeriatric units in its 131 DVA nursing homes. Of the 13,500 residents in these facilities, about 21 percent have a primary diagnosis of dementia and 72 percent have a primary or associated diagnosis of a mental illness.

In response to care demands of this group, in the early 1990s the department sponsored a series of national training conferences to teach 70 teams—composed of psychologists, physicians, psychiatrists, nurses, social workers and nursing assistants—strategies for caring for residents with mental illness. The conferences focused on teaching attendees to conduct comprehensive mental health assessments and how to develop a social and physical environment that would be supportive of the mental health needs of DVA residents with mental illness. The DVA plans to sponsor more training conferences in the future when funding becomes available. A manual was produced to document this training effort.

Of particular note, psychiatrists and psychologists attending these conferences had to commit to continued regular participation in their facility treatment team process. Today, there is an increased involvement of psychiatrists and psychologists in interdisciplinary teams that provide assessments and care planning for residents in DVA facilities.

In addition, significant environmental modifications have been made to DVA facilities to help nursing staff care for residents with more difficult behavioral symptoms. For example, over 40 facilities now have enclosed, secure outdoor and indoor wandering areas and use colors for cueing and orientation.

Finally, 15 special psychogeriatric units are now in operation in DVA nursing homes to care for elderly veterans with mental disorders and associated behavioral symptoms. The environment is tailored to, and facility staff trained to care for, this type of patient.

MOBILE PSYCHOGERIATRIC TEAM

Nursing homes in rural areas are sometimes served through model state-sponsored mental health intervention teams. For instance, in southern Maine, a mobile psychogeriatric team consisting of a psychiatrist, a psychiatric nurse and a clinical social worker provide support upon request to nursing and residential care facilities to treat mentally ill or behaviorally disturbed individuals. In operation for over a year, the team provides assessments, treatment services, medication reviews, and works with staff on the development of care plans. The team also offers training to 23 nursing and 28 residential facilities in the program's catchment area. The program's goal of prevention keeps residents from reaching a psychiatric crisis situation and reduces admissions to the acute hospital setting.

The program works because reimbursement barriers to mental health services are removed since nursing homes are not required to pay for the ongoing services. Funding comes from Medicaid and state dollars.

PASARR SCREENING AGENCY WORKS CLOSELY WITH HEALTH DEPARTMENT

Many states have set up systems to use PASARR Level II Screening results to establish treatment plans to improve the mental health care of residents. In Indiana, for example, the PASARR screening agency sends the Indiana Department of Health a list, by nursing facility, of all residents or prospective admissions who receive Level II Screening and are judged to be appropriate for facility admission or continued stay and are in need of mental health services.

In this model program, surveyors spot check records of residents to verify that they are receiving the State Mental Health authority's recommended mental health services. If residents don't receive the recommended services, then additional records of PASARR program (Level II) residents in the facilities are reviewed during the survey. Facilities may be cited for deficiencies when they are not providing the appropriate services noted in residents' treatment plans, and they must develop a plan of correction.

Indiana's process links together the

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mental health system, the public health system and the aging network to effectively implement the PASARR program to achieve the optimal results for residents with mental illness. The state's payment system encourages nursing homes to seek mental health services for residents. With a physician's order a facility may obtain mental health services from a qualified Medicaid provider who then bills the Medicaid program directly for reimbursement. This approach removes the financial disincentives for the facility to obtain services.

In a move to reduce healthcare regulations, the Clinton Administration has called for regulatory reforms that would eliminate the annual reassessment of mentally ill or retarded residents. Provider groups and state mental health programs support the President's proposal because resident reassessments are already required by general nursing facility regulation. But some have expressed concern that totally repealing the PASARR mandate would be a serious blow for residents who need mental health services. The apparent basis of concern is that without the mandate in PASARR, problems identified might not be addressed, and the improvements that have come in identification of mental illness and of service needs during preadmission screening and in provision of community-based services for those not admitted, would be lost.

FACILITY CREATES MENTAL HEALTH DEPARTMENT

One of the oldest model mental health programs in a nursing facility was established by the Benedictine Nursing Center in Mt. Angel, Ore. The facility established a mental health department in 1978, staffed by a psychiatric mental health clinical specialist, and this department is still in operation today. For the past four years, the Oregon-based 130 bed nursing facility has been restraint-free.

The part-time director reviews psychotropic medications to ensure appropriateness of drug, dosage and time of administration. During drug review, the director brings her nursing perspective into the problem-solving process and develops nursing interventions that can be used in addition to or in place of medications. In addition, she works closely with facility staff to develop alternative interventions and ways of addressing different behavioral symptoms. For instance, staff might provide residents with walkman headphones so they can focus on music they like. Physical touch can also be used to provide reassurance.

Over the years, the mental health department and facility staff pioneered the development of communication techniques for use with confused residents and for handling wanderers. Currently the department is increasing staff skills in speaking the "language of dementia." For example, people with dementia may not remember how to sit in a chair. A verbal message combined with a tactile cue such as tapping the back of their knees to show them where to bend can greatly assist them in sitting down.

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THE EDEN ALTERNATIVE

Chase Memorial Nursing Home, an 80-bed skilled nursing facility in upstate New York, has developed one of the newest model programs that some say may revolutionize nursing home care in America. The program was created to reduce loneliness, helplessness and boredom among residents.

The Eden approach emphasizes creating a human habitat that engenders spontaneity and variety to end boredom; provides each resident with companionship of animals or humans to end loneliness; and gives them something to care for to end helplessness. Care is redefined as treatment to include "helping the person grow and contribute." The needs of the resident are made first priority and the nursing home is made part of the community to "break down institutional walls and normalize the human habitat."

The original Eden Alternative brings hundreds of birds—plus dogs, cats, rabbits and even chinchillas, into the facility. Rooms and halls are filled with green hanging plants; residents can plant vegetables and flowers in gardens on the grounds. Children play onsite for several hours most days as part of a daycare program giving residents a chance to mingle with the youngsters. The on-site daycare program allows intergenerational relationships to grow.

Early research findings of the program's effectiveness are promising. Three years after the project began, Eden staff found a 15-percent drop in its death rate compared to a nearby nursing facility that served as a control. Infection rates have also dropped by about 50 percent. And, staff turnover rates plunged by 26 percent, saving the facility the cost of recruitment and training of nursing assistants, about $2,000 per individual. The average number of prescriptions per resident has decreased to 3.01, the national average is 5.6. Medication cost is less than 56 percent of the U.S. average. Because of these appealing results, at least two states, Missouri and New York, and several individual nursing homes are initiating demonstrations adopting the Eden concept.

Other nursing homes, like the Eden Alternative and the Barkin innovations in California, are establishing programs that emphasize creating meaningful experiences; they are recognizing the "spirituality" or "spiritual needs" of residents

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including those with dementia. "Spirituality" here relates to meaning, value, and purpose for human beings and is not necessarily related to "religion."

Further, several conferees pointed out the importance of family involvement in planning and implementing care to people with mental disorders including dementia. The Hebrew Rehabilitation Center for Aged in Boston is currently testing a family-staff partnership program with clearly delineated options for constructive family participation in assessment, care planning, activities, assistance with personal care and suggestions for "successful" visiting in special care units in eight nursing homes in New England.

Nontraditional model mental health programs are increasing across the nation to provide stimulation to residents with mental illness and dementia. Arts, music, culture, and religious programming can be innovative approaches to addressing mental health problems in nursing homes. For example, residents with Alzheimer's who learned hymns, prayers and religious rituals in childhood have stored the information in long-term memory even though they forget recent events. These early memories can be very comforting as dementia progresses.

But whatever progress has been made, experts agree that progress is slow and that good mental health care in nursing homes is still the exception rather than the rule.

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