

**BEHAVIORAL HEALTH,
MDS N & O
CMS CHANGES 2017**

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**BEHAVIORAL
HEALTH
SERVICES**

PHASE 2 IMPLEMENTATION



BEHAVIORAL HEALTH SERVICES

BEHAVIORAL HEALTH SERVICES §483.40

(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population



BEHAVIORAL HEALTH SERVICES §483.40

in accordance with 483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

(2) Implementing non-pharmacological interventions.



BEHAVIORAL HEALTH SERVICES §483.40

(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.



BEHAVIORAL HEALTH SERVICES

(c) If rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, are required in the resident's comprehensive plan of care, the facility must—

(1) Provide the required services, including specialized rehabilitation services as required in §483.65; or

(2) Obtain the required services from an outside resource (in accordance with 483.70(g) of this part) from a Medicare and/or Medicaid provider of specialized rehabilitative services.

BEHAVIORAL HEALTH SERVICES

Phase 3

Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/ or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to 483.70(e)



BEHAVIORAL HEALTH SERVICES

"In the United States, it is estimated that approximately 26.4 percent of the population suffers from a diagnosable mental disorder.¹ These disorders – which can include serious mental illnesses, substance use disorders, and depression – are associated with poor health outcomes, increased costs, and premature death.² Although general behavioral health disorders are widespread, the burden of serious mental illness is concentrated in about six percent of the population.³ In addition, many people suffer from more than one mental disorder at any given time; nearly half of those suffering from one mental illness meet the criteria for at least two more.⁴ By 2020, behavioral health disorders are expected to surpass all physical diseases as the leading cause of disability worldwide.

Source: Behavioral Health Phase II, Draft Technical Report for Comment, June 30, 2013, National Quality Forum

WHY BEHAVIORAL HEALTH MANAGEMENT IN LONG-TERM CARE?

- \$\$\$
- Consumer-acceptance/popularity
- Cheaper to keep people in their homes than in nursing home (think Money Follows Person)
- This population of need is getting younger and have nowhere to go but to YOU!

CMS says, we gotta do better!

BEHAVIORAL HEALTH SERVICES

Intent

The intent of this regulation is that the resident receives care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning.

Interpretive Guidelines

"Mental and psychosocial adjustment difficulties" refer to problems residents have in adapting to changes in life's circumstances. The former focuses on internal thought processes; the latter, on the external manifestations of these thought patterns

Characterized by overwhelming sense of loss

- of one's capabilities;
- of family and friends;
- of the ability to continue to pursue activities and hobbies;
- and of one's possessions.

A resident with a mental adjustment disorder will have a sad or anxious mood, or a behavioral symptom such as aggression.

BEHAVIORAL HEALTH SERVICES

Other manifestations of mental and psychosocial adjustment difficulties may, over a period of time, include:

- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

WHY ARE WE SURPRISED?



KNOW YOUR DEMENTIA TRAINING PROGRAM!

- Best Friends Approach
- Hand-in-Hand
- Alzheimer's Association
- QIPMO



DEMENTIA AND MENTAL HEALTH

- 24.3 M people have dementia today
- 4.6 M new cases every year
- # of people affected will double every 20 yrs to 81.8M by 2040
- Most in developing countries (71% by 2040)

Source: Global Perspectives on Interdisciplinary Leadership in Aging, Dementia & Mental Health: GPN, Kathleen C. Buckwalter, PhD, RN, FAAN, presentation July 2017 NHCNE Conference

DEMENTIA AND MENTAL HEALTH

- 14% attributed to neuropsych disorders
- (depression, common mental disorders, alcohol and substance abuse disorders and psychosis).
- Important cause of LT disability/dependency
- Lower levels of public awareness of MH probs of old age, challenges of travel and transport: rural areas

Source: Global Perspectives on Interdisciplinary Leadership in Aging, Dementia & Mental Health: GPN, Kathleen C. Buckwalter, PhD, RN, FAAN, presentation July 2017 NHCNE Conference

REALITY CHECK

- No home is "immune" to these issues
- No home "doesn't take people like that."
- No home should go without training for their staff.

EVERYBODY has issues...we just don't all wear them on our sleeves!



CHECKLIST FOR READINESS

MAKE IT ABOUT **THEM**...get them personally-empowered

I. Create opportunities

- self-governance;
- systematic orientation programs for staff AND residents;
- arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices;
- maintaining contact with friends and family

CHECKLIST FOR READINESS

2. Educate staff

Attend trainings, do in-services, talk to your psychiatrist/psychologist or community counseling agency about training staff on different psych diagnosis...many have different triggers and require different responses

- *Appropriate treatment for mental adjustment difficulties may include crisis intervention services; individual, group or family psychotherapy, drug therapy and training in monitoring of drug therapy and other rehabilitative services. (See §483.24.)*

CHECKLIST FOR READINESS

3. Evaluate safety

Look closely at placement and population in your home.

Whatever the diagnosis, it often comes down to personality. A 99-year-old Alzheimer's resident and a 42 year-old alcoholic/bipolar resident might get along fine but are they safe together if the alcoholic is manic and the resident with Alzheimer's suddenly likes to pinch people? Look at history and root cause analysis.

Look at safety for your staff and your professional liabilities.

CHECKLIST FOR READINESS

4. Think PERSONAL...what triggers them and what works for them??

NONPHARMACOLOGICAL INTERVENTIONS

NONPHARMACOLOGICAL INTERVENTIONS

NONPHARMACOLOGICAL INTERVENTIONS

5. CARE PLAN!!!



NONPHARMACOLOGICAL OPTIONS










SECTION N

MEDICATIONS

Section N		Medications
N0300. Injections		
<input type="checkbox"/>	Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0410, Medications Received	
N0350. Insulin		
<input type="checkbox"/>	A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days	
<input type="checkbox"/>	B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days	
N0410. Medications Received		
Indicate the number of DAYS the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days		
<input type="checkbox"/>	A. Antipsychotic	
<input type="checkbox"/>	B. Antianxiety	
<input type="checkbox"/>	C. Antidepressant	
<input type="checkbox"/>	D. Hypnotic	
<input type="checkbox"/>	E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)	
<input type="checkbox"/>	F. Antibiotic	
<input type="checkbox"/>	G. Diuretic	
<input type="checkbox"/>	H. Opioid	

CODING SECTION N-N0300: INJECTIONS

N0350 - Insulin

Insulin **Insulin Injections** Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days.

Insulin **Insulin for Insulin** Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days.

- Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by injection.
- Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by injection.
- Insulin injections are counted in this item as well as in Item N0350.
- For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.
- If an antigen or vaccination is provided on one day, and another vaccine is provided on the next day, the number of days the resident received injections would be **coded as 2 days**.
- If two injections were administered on the same day, the number of days the resident received injections would be **coded as 1 day**.
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values **does not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days can be counted and coded.


N0300 - Injections

Injections Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. **IPD → Skip to N0450 Medications Received**

PSYCHOTROPIC MEDICATION

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



Part of Phase I Drug Regimen Review (F428)

PHASE 2

- Patients do not receive psychotropic drugs pursuant to a PRN order unless diagnosis supports and condition is in the medical record, and;
- PRN orders for psychotropic **are limited to 14 days** unless physician documents in the medical record the rational for continuation.

PHASE 2

Facilities must ensure that

- residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record.
- residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs
- residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.

PHASE 2 PHARMACIST RESPONSIBILITIES

Pharmacist must report any irregularities to the attending physician and the facility's medical director and DON, and these reports must be acted upon. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document her/his rationale in the medical record.

N0450. Antipsychotic Medication Review	
Enter Code	<input type="checkbox"/>
A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent? 0. No - Antipsychotics were not received → Skip to O0100, Special Treatments, Procedures, and Programs 1. Yes - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted? 2. Yes - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted? 3. Yes - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?	
Enter Code	<input type="checkbox"/>
B. Has a gradual dose reduction (GDR) been attempted? 0. No → Skip to N0450D, Physician documented GDR as clinically contraindicated 1. Yes → Continue to N0450C, Date of last attempted GDR	
C. Date of last attempted GDR: [] [] - [] [] - [] [] [] Month Day Year	
N0450 continued on next page	
Section N Medications	
N0450. Antipsychotic Medication Review - Continued	
Enter Code	<input type="checkbox"/>
D. Physician documented GDR as clinically contraindicated 0. No - GDR has not been documented by a physician as clinically contraindicated → Skip to O0100, Special Treatments, Procedures, and Programs 1. Yes - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated	
E. Date physician documented GDR as clinically contraindicated: [] [] [] - [] [] [] - [] [] [] Month Day Year	

CODING SECTION N

- Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used
- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used
- Include any of these medications given to the resident by any route (e.g., PO, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.
- Combination medications should be coded in all categories/pharmacologic classes that constitute the combination. For example, if the resident receives a single tablet that combines an antipsychotic and an antidepressant, then **both** antipsychotic and antidepressant categories should be coded.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not categorized as hypnotic medications.
- During the first year in which a resident on a psychoactive medication is admitted, or after the nursing home has initiated such medication, nursing home staff should attempt to taper the medication or perform gradual dose reduction (GDR) as long as it is not medically contraindicated.
- Residents who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior
- Herbal and alternative medicine products should not be counted as medications

N0450: GDR


- The term physician also includes physician assistant, nurse practitioner, or clinical nurse specialist.
- Do not include Gradual Dose Reductions that occurred prior to admission to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission to the facility)
- Physician documentation indicating dose reduction attempts are clinically contraindicated must include the clinical rationale for why an attempted dose reduction is inadvisable. This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life
- Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated
- Do not count an antipsychotic medication taper performed for the purpose of switching the resident from one antipsychotic medication to another as a GDR in this section.
- In cases where a resident is or was receiving multiple antipsychotic medications on a routine basis, and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C, Date of last attempted GDR.
- If multiple dose reductions have been attempted since admission/entry or reentry or the prior OBRA assessment, record the date of the most recent reduction attempt in N0450C, Date of last attempted GDR.

OPIOIDS

- Additional class has been included:
- **N0410H, Opioid:** Record the number of days an opioid medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- Opioid medications can be an effective intervention in a resident's pain management plan, but also carry risks such as overuse and constipation. A thorough assessment and root-cause analysis of the resident's pain should be conducted prior to initiation of an opioid medication and re-evaluation of the resident's pain, side effects, and medication use and plan should be ongoing.
- Additional information on psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)** (or subsequent editions) (<http://www.psychiatry.org/practice/dsm><https://www.psychiatry.org/psychiatrists/practice/dsm>)

SECTION 0

ISOLATION



- Isolation—new guidelines
<http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>
<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

VACCINES

- The CDC has evaluated **inactivated influenza vaccine** co-administration with the **pneumococcal vaccine** systematically among adults. It is safe to give these two vaccinations simultaneously. If the influenza vaccine and pneumococcal vaccine will be given to the resident at the same time, **they should be administered at different sites** (CDC, 2009). If the resident has had both upper extremities amputated or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.
- “Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
- If a resident has received one pneumococcal vaccination and it has been less than one year since the resident received the vaccination, he/she is not yet eligible for the second pneumococcal vaccination; therefore, O0300A is coded 1, yes, indicating the resident’s pneumococcal vaccination is up to date.
- NEW RECOMMENDATIONS:
https://www.cdc.gov/mmwr/volumes/66/rr/rr6602a1.htm?s_cid=rr6602a1_w

THERAPIES

- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.
- *Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.*

PHYSICIAN ORDERS AND VISITS

- O600 Physician visits and O700 Physician visits both are captured in the last 14 days.
- In the new version of the manual it states: **CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.** Missouri does not require this but other states may do so.

RESOURCES

1. Alzheimer's Association www.alz.org
2. Behavioral Health Phase II, Draft Technical Report for Comment, June 30, 2013, National Quality Forum
3. Best Friends Approach <http://bestfriends.healthprogress.com/health-professions-press-homepage/best-friends-institute/>
4. CMS <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2.pdf>
5. Experience Life/ Blue Mind <https://experiencelife.com/article/blue-mind/>
6. Global Perspectives on Interdisciplinary Leadership in Aging, Dementia & Mental Health: GPN, Kathleen C. Buckwalter, PhD, RN, FAAN, presentation July 2017 NHCNE Conference
7. Hand in Hand https://ahca.myflorida.com/MCHQ/Field_Ops/Training/Other_Training/CMS_Hand_in_Hand_Toolkit.pdf
8. Music and Memory <https://musicandmemory.org/>
9. National Geographic <http://www.nationalgeographic.com/healing-soldiers/>
10. QIPMO www.nursinghomethelp.org
