Project 3.a.v: Behavioral Interventions Paradigm (BIP) in Nursing Homes

**Domain 3: Clinical Improvement Projects**

**Problem Statement:**
Forty percent of Skilled Nursing Facility (SNF) residents in the FLPPS region have a behavioral health diagnosis as compared to 32% statewide. The percentage of SNF residents with depression and/or anxiety symptoms have increased. Readmissions to acute care beds following admission to a SNF account for 16% of all Medicaid readmissions. Many patients in long term care have behavioral health issues as a primary disease or as the result of other ongoing chronic diseases. Despite the prevalence of such problems within the SNF, staff may have inadequate formal training to manage these problems or rely on medication to manage these patients. These patients are a significant cause of avoidable admissions and readmissions to hospitals from SNFs.

**Summary Statement:**
This program provides a pathway to avoid hospital transfers and to ensure better care for the SNF patient with these diagnoses. Interventions that rely on increased training of traditional care staff to identify and address behavioral health concerns have been found to be effective management tools. Resources from other evidence based SNF initiatives to reduce avoidable hospital admissions, e.g., INTERACT, may be integrated into this program.

**Objective:**
To reduce transfer of patients from a SNF facility to an acute care hospital by early intervention strategies to stabilize patients with behavioral health issues before crisis levels occur.

**Core Components and Deliverables:**

- Implement the Behavioral Interventions Paradigm (BIP) Model in Nursing Homes using SNF skilled nurse practitioners (NP) and psychiatric Social Workers to provide early assessment, reassessment, intervention, and care coordination for at risk residents to reduce the risk of crisis requiring transfer to higher level of care.
- Augment skills of the clinical and non-clinical staff in identifying & managing behavioral health issues.
- Enhanced environmental and holistic interventions to promote the mental health of SNF residents.
- EHRs or other technical platforms used in the treatment and tracking of all patients engaged in this project.
- Assignment of NP with BH training to coordinate care with interdisciplinary team.
- Engagement of key partners in protocol development and service delivery.
- Development of a medication reconciliation and reduction program.
- Telehealth services where access to psych specialists is limited.
FLPPS Design Elements:
- Employ early assessment, reassessment and intervention strategies with NPs and psychiatric social workers to stabilize patients with behavioral health issues before crisis levels occur.
- Modify facilities, as needed, to ensure adequate recreation and holistic interventions can be carried out.
- Implementation of a medication reduction and reconciliation process across all partnering SNFs within the PPS.
- Build an education & training infrastructure to facilitate education and training for SNF clinical and non-clinical staff using local, online and web-based training.
- Use EHR and other documentation to develop algorithms that identify patients in need of intervention before a crisis requiring a transfer occurs.
- Improve access to psychiatric expertise along with enhanced mental health care at our SNFs.

Target Populations:
- SNFs that do not have access to consistent and effective psychiatric expertise (most of them).
- SNFs with high rates of acute psychiatric hospitalizations for their residents.
- Patients across all SNFs in the PPS.

Assets:
- Expertise and resources across the PPS in the successful implementation of the INTERACT Model, in the use of Telehealth and Telementoring.
- A PPS-wide willingness and ability to share expertise, best practices and provide leadership as needed.
- Broad-based partnerships with partners that have had to do more with less that will help us to think differently and pave the way for innovation.

Challenges:
- Availability of Psychiatric providers especially those with geriatric expertise.
- IT variability and variability in data-tracking resources.
- Communication especially around transitions with acute services.
- Behavior change of the workforce and sustainability of these changes.
- Finding adequate time & space for training across the SNF workforce.

Last revised: 5/7/15