Behavioral Health Taskforce
Geriatric Subcommittee

**Date:** Thursday, December 1, 2011

1. **Present:** Judy Carroll, Melissa Gale, Representative Bernie Hunhoff, Senator Jean Hunhoff, Amy Iversen-Pollreisz, Jeremy Johnson, Marilyn Kinsman, Kim Malsam-Rysdon, Representative Nick Moser, Shawn Nills, Ken Senger, LuAnn Seversen, Dr. Ramesh Somepalli, Dr. Tom Stanage, Steve VandeKop, Pam VanMeeteren, Dr. Vicki Walker, Ginger Wells

2. Welcome and Overview- The meeting began with an overview by Kim Malsam-Rysdon of the transition of behavioral health services to the Department of Social Services. The goal of the change is to meet behavioral health needs across the state more effectively. As part of the transition, a Behavioral Health Taskforce was formed by Governor Daugaard, and is being led by Lt. Governor Michels. The Taskforce is composed of a group of multidisciplinary stakeholders to review mental health services and create a framework for moving behavioral health services forward. This includes a review of relevant statutes. The Geriatric Subcommittee is a result of the work of the Behavioral Health Taskforce as the need for geriatric psychiatric services across the state has been identified as a concern.

3. Guiding Principles and Goals – Amy Iversen-Pollreisz followed the overview with a presentation of guiding principles of the Behavioral Health Taskforce which are:
    - Services are provided through the “no wrong door” approach
    - Services focus on individualized recovery/resiliency driven outcomes
    - Services are person-centered/family-driven
    - People are served in the least restrictive environment appropriate for their care and safety
    - People are served with dignity and respect in a culturally responsible manner
    - Services are available and accessible statewide
    - Communities are involved and invested in service delivery

The goal areas of the Behavioral Health Taskforce are as follows:

1) Increase access to services
2) Build capacity of local communities
3) Develop a statewide strategic behavioral health prevention plan

4) Define the role of HSC.

4. Hospital Overview – Pam VanMeeteren provided an overview of the services provided at the Human Services Center, as well as trends with admission and census. The Adult Acute Program area is the unit designated for all adult psychiatric admissions at HSC. The number of acute admissions to HSC has increased significantly over the past several years. Acute services recorded an increase of 140 admissions between FY 2010 and 2011. The increased admission numbers are creating capacity issues at HSC. In order to be able to care for persons in psychiatric crisis under an involuntary commitment, it has been necessary to restrict voluntary admissions at times. The service population that HSC is noting an increase in need for care is geriatric persons in need of behavioral health services. The admissions are frequently coming to HSC with notice that the referral facility will not accept the patient back. As a result, approximately 20% of our acute beds are filled with persons whose need is long term placement, but not necessarily long-term psychiatric treatment.

5. Definition of Problem and Trends – Pam VanMeeteren expanded on the concerns with the increased number of geriatric admissions coming from community nursing facilities. Many of these referrals have not had previous mental health issues until developing dementia in their senior years. Senior admissions are coming to HSC through the involuntary commitment process often without the knowledge of their families. While HSC can often assist in the treatment and management of behaviors associated with dementia, the primary concern is the inability of HSC to discharge geriatric patients back to a less restrictive environment. This is creating concerns with capacity and appropriate environment of care at HSC. The following key points were presented:
   - 10% of admissions to HSC Adult Services during FY2011 were age 65 years or older
   - 20% of admissions to HSC during FY 2011 were age 55 years or older
   - 61 patients were admitted to HSC in FY 2011 from community nursing home facilities. Of those 61 patients, 28 patients remain at HSC and five of the 61 patients expired at HSC with palliative care orders.
   - The average length of stay for persons age 65 and older admitted to Acute Services is 90.6 days. Average length of stay for the program is 13.8 days.
   - Currently, Adult Services has a census of 46 patients. Of those patients, 14 need placement in nursing homes or assisted livings. Eleven of the fourteen patients have a primary diagnosis of dementia. Eight of the eleven patients with dementia are first time admits to HSC.

- Current census on Geriatric Services is 58 residents. 79% of residents have a primary diagnosis of some form of dementia. Seven of the 58 residents could be placed in Community Nursing home without the need for psychiatric services if placement can be found.
- Currently the Geriatric Program waiting list has ten patients referred from Acute Services and three patients referred from Psych Rehab Services

6. Explanation of Current Admission Process – Judy Carroll, HSC Admissions Officer, explained the current process for admission of all geriatric patients. It was noted that the process for admission and unit is the same for all adults regardless of age. Assignments are made on a rotational basis, so there is a mixture of ages and diagnosis of adult patients on all acute units. It was also noted that admissions arrive at all times of the days and sometimes geriatric persons are admitted late at night.

7. Explanation of Geriatric Services – Jeremy Johnson, Geriatric Social Worker, explained the nursing facility. He clarified that the expectations for assessment and treatment at HSC were the same as those for all licensed nursing facilities. HSC meets the federal and state licensure expectations in regards to all aspects of care including medication administration, restraint and seclusion, and patient rights.

8. Case presentation – Dr. Vicki Walker provided the group with a couple of examples of admissions to HSC where the primary problem was medical in nature. The behaviors that were exhibited by patients were a result of treatable medical issues, and once the medical issues were resolved, the behaviors improved. However, in both examples, placement back to the community has not occurred due to the initial behavior concern and in the other case the inability to get an MD to assume patient care following discharge.

9. Tours – The group was divided into three groups for brief tours of the admissions area, the acute units, and the geriatric units with overviews provided by Julie Kuchta, Adult Services Program Manager; Jeremy Johnson, Geriatric Social Worker; and Judy Carroll, HSC Admissions Officer. Questions and discussion followed the tour.

10. Geriatric Behavioral Health Delivery Models
    - Lewis and Clark Behavioral Health Services – Dr. Tom Stanage, Executive Director, provided a historical overview of the efforts and work done by Lewis and Clark Behavioral Health Services several years ago when HSC decreased the number of geriatric units from six to three. Lewis and Clark continues to provide psychiatric consultation

and behavioral support to several nursing facilities in Southeast South Dakota.

- Canistota Good Samaritan Nursing Facility – Ginger Wells, Administrator, presented to the group the experience of the Good Samaritan facility in creating a behavioral health focused program. The nursing facility worked in collaboration with the Department of Social Services and the Human Services Center to developing training, staffing and criteria for the program. DSS was able to provide add-on pay for persons who meet the criteria when Medicaid is the primary payor for a resident. The program has been very successful in the community and has assisted with discharges from HSC for persons with behavioral issues as a result of a mental illness.
- Benedictine Healthcare, Parkston – Melissa Gale, LPC/Behavioral Health Specialist, presented her work in nursing facilities around the Parkston area. She has implemented behavioral health services into the local medical clinic. One of her projects, pertinent to this discussion, is addressing the management of geriatric "problem behaviors" in local nursing homes. She did this by providing education to medical providers and nursing home staff and administration. She has emphasized the need for early involvement of the physician to evaluate and treat medical conditions that might be triggering the issues. She has also helped staff to look at alternate ways of engaging the patient and family to minimize behaviors. The sessions have been well received by the audience. She has also been available when specific problems arise to help review the case and options for management. This approach has been very successful at decreasing the number of referrals to HSC.

11. Discussion followed. The issue of reimbursement for additional services and staffing was discussed. Concern was expressed regarding the creation of services that would add to the burden of cost to private payers. Due to time restraints, Marilyn Kinsman, Director of the Division of Adult Services and Aging, was unable to present information on Medicaid add-on pay options that may assist with additional costs. Marilyn will present at the next subcommittee meeting. In addition, members discussed the need to deepen the understanding of the community dynamics that are leading to increased referrals and refusal to re-admit patients. This understanding is necessary in order to evaluate how best to offer support to community nursing homes, thereby reducing admissions to HSC and increasing the return of patients to their home community after an admission to HSC.

12. Further discussion of the admission of elderly individuals followed. The consensus of the group was that there needs to be capacity created at HSC that would allow for the admission of geriatric residents directly to a geriatric unit or specialized acute geriatric unit.

13. Further Action: A second meeting of this committee will be scheduled in late February or March. Items for presentation and discussion at the next meeting include an overview of regulations that impact geriatric psychiatric care, staffing trends and patterns at HSC and community facilities, Medicaid add -on pay options, review of geropsych services in nursing facilities in surrounding states, and information regarding nursing facility vacancy and capacity in South Dakota.

14. The meeting was adjourned at 4:20pm