BEHAVIORAL
HEALTH SOLUTIONS

Severe Mental Illness and Behavioral Health

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Presented by: Kristina Kovacs, PhD
Chief Clinical Officer/Co-founder

Brandon Chuman, PsyD
Chief of Neuropsychology

Overview

- **Fact vs. Myth**
- **Causes of Mental illness**
- **Mood disorders**
- **What are psychiatric disorders?**
- **Schizophrenia/Schizoaffective disorder**
- **Bipolar disorder**
- **How do we work with these?**
  - Systems level
  - Bedside level
- **How do we document?**

Fact vs. Myth: Which is it?

- People with mental illness are weak or dangerous.
- Mental illness is a choice, and people should just “snap out of it.”
- People with mental illness cannot live fulfilling, productive lives.
- Talking about mental illness makes it worse.

What Are Psychiatric Disorders?

Conditions that affect a person's thinking, mood, and behavior — often impacting daily life and relationships.

THINKING
disorganized thoughts, difficulty concentrating, confusion

MOOD
sadness, anxiety, irritability, mood swings

BEHAVIOR
withdrawal, aggression, impulsivity, changes in activity

- **Causes:** biological, psychological, environmental
- **Duration:** acute or chronic
- **Diagnosis:** clinical evaluation (DSM-5, ICD-10)

Depression • Bipolar Disorder • PTSD • Schizophrenia • Dementia • Borderline Personality Disorder

Mental Illness- Mood Disorders

BEHAVIORAL HEALTH PROGRAMS

Mood Disorders

DEPRESSION

- Multiple types of depression
  - Major depressive disorder (MDD)
  - Depressive DO, due to another medical condition
- (MDD) Lasts >2 weeks
- Depressed mood most of the day, diminished interest or pleasure, weight loss/gain, insomnia or hypersomnia, agitation, fatigue, worthlessness, diminished ability to think or concentrate, recurrent thoughts of death
- Residents may not get out of bed, reply with monotone speech, avoid eye contact, refuse socializing, skip meals
- Impairment in social, occupational functioning

(American Psychiatric Association [APA], 2022)

Mood Disorders

ANXIETY

- Excessive anxiety and worry >6 months
- Difficulty controlling worry
  - Restlessness
  - Easily fatigued
  - Difficulty concentrating
  - Irritability
  - Muscle tension
  - Sleep disturbance
    - Residents may ask questions repeatedly/frequently, appear tense and restless, shifting in their chair/bed, have difficulty sleeping
- Cause significant difficulty in occupational, social functioning

(American Psychiatric Association [APA], 2022)

Mood Disorders

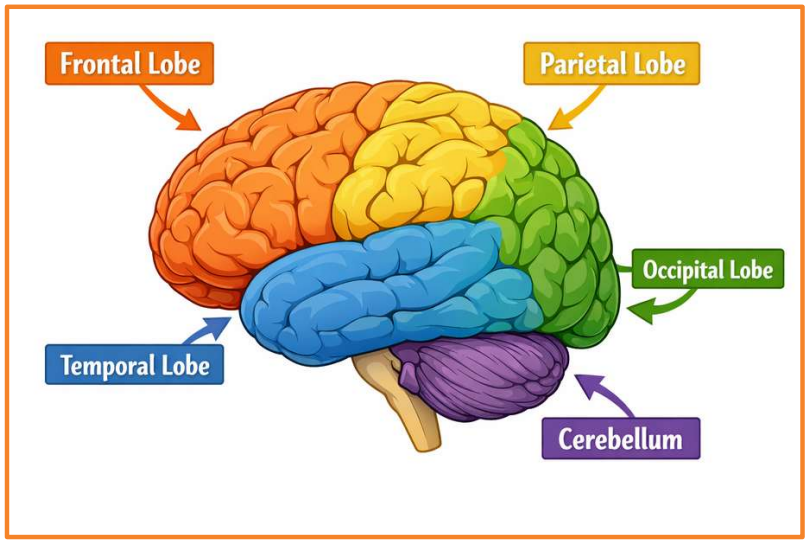
- Put yourself in the resident's position:
  - Away from friends, family, familiarity
  - Around many new people, sights, smells, noises
  - Dealing with possible loss of physical, emotional, cognitive functioning
  - No privacy, no end in sight, no choice

"I don't get it-WHY are they Anxious/Depressed!?"

Mood Disorders

DEPRESSION/ANXIETY ANATOMY-NOT INCLUSIVE

- **Depression:** frontal lobe, parietal lobe, thalamus, and temporal lobes, the hippocampus and amygdala
- **Anxiety:** amygdala and hippocampus



Severe Mental Illness

BEHAVIORAL HEALTH PROGRAMS

Schizophrenia/Schizoaffective Disorder

- Typical behaviors:
  - Positive Symptoms
    - Delusions
    - Hallucinations
      - Auditory
      - Visual
    - Thinking disorders (tangentiality)
  - Negative symptoms
    - Loss of functioning, disorganized
    - Personal, social, occupational

Schizophrenia	
Diagnosis	• ≥2 of the following (at least 1 symptom from 1-3) 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Disorganized or catatonic behavior 5. Negative symptoms (eg, apathy, flat affect) • Continuous impairment ≥6 months • Significant functional decline
Treatment	• Antipsychotic medication • Adjunctive psychosocial interventions (eg, social skills training, cognitive-behavioral therapy, family intervention)

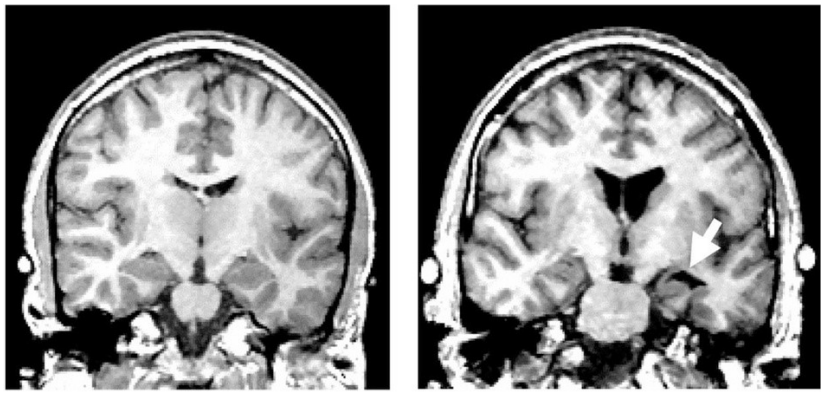
Schizophrenia/Schizoaffective Disorder

- **Schizophrenia (0.3%-0.7%)**
  - Mid-early 20s-men; late 20s-women
  - Chronic >6 months
  - Positive and negative symptoms
  - Impaired judgment, illogical thinking
- **Schizoaffective disorder**
  - Delusions/Hallucinations with mood episode (depression or mania)
  - Less common

(American Psychiatric Association [APA], 2022).

Severe Mental Illness

SCHIZOPHRENIA ANATOMY



- Reduced Grey matter volume (processes information)
- Reduced White Matter (transmit information)
- Smaller hippocampus and amygdala (emotions and memory)
- Neurotransmitters Serotonin (-mood stabilization), Dopamine (+Hallucinations, -cognitive symptoms, glutamate (-psychosis)

Walking in Their Shoes

PUT YOURSELF IN THE RESIDENTS' SHOES FOR A MINUTE:

- You are a 34-year-old who has a history of homelessness, schizophrenia, and substance use. You have been at the facility for 5 days and your behaviors are yelling, refusing medications and care.

WEAR THEIR SHOES:

- What is it like to be schizophrenic?
- What are you adjusting to?
- Are you withdrawing? In pain? Scared?

When was the last time you had a hug?

Bipolar Disorder

TYPE 1 AND TYPE 2

Bipolar Disorder

- Bipolar I disorder (1.5%; 20-30yo):
  - Manic Episode
    - Elevated, expansive, or irritable mood, activity or energy, >1 week
    - Inflated self esteem, decreased need for sleep, more talkative, flight of ideas, distractible, increased activity, involvement in consequential activities such as spending, rapid shifts in mood.
    - Severe enough to cause impairment in social, occupational functioning

(American Psychiatric Association [APA], 2022).

Bipolar Disorder

- Bipolar I disorder:
  - Major depressive episode
    - Depressed mood most of the day, diminished interest or pleasure, weight loss/gain, insomnia or hypersomnia, agitation, fatigue, worthlessness, diminished ability to think or concentrate, recurrent thoughts of death
    - Impairment in social, occupational functioning

(American Psychiatric Association [APA], 2022).

Bipolar Disorder

- Bipolar II disorder:
  - Hypomanic Episode
    - Elevated, expansive, or irritable mood, activity or energy, 4 consecutive days, heightened creativity and impulsiveness
    - Inflated self-esteem, decreased need for sleep, more talkative, flight of ideas, distractible, increased activity, involvement in consequential activities such as spending.
    - Not severe enough to cause impairment in social, occupational functioning

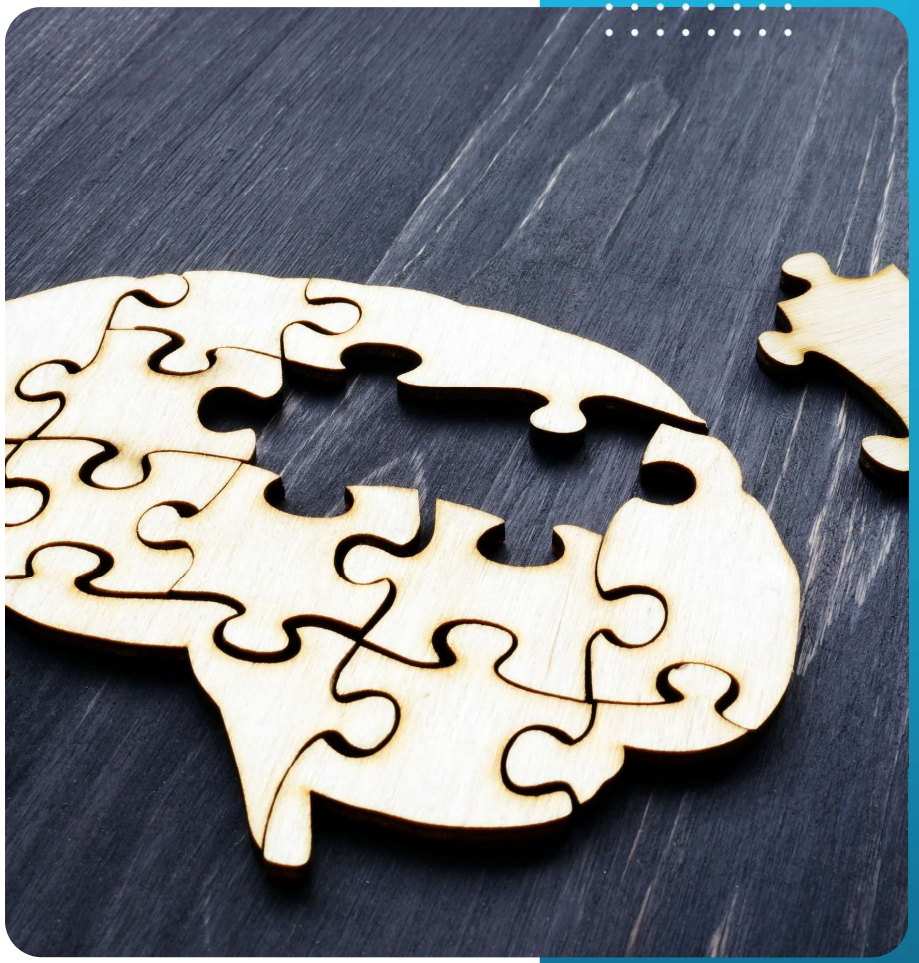
(American Psychiatric Association [APA], 2022).

Mental Illness

BIPOLAR DISORDER ANATOMY

- Dopamine- reward, motivation, pleasure, activity level
  - Too much = Mania
  - Too little = Depression

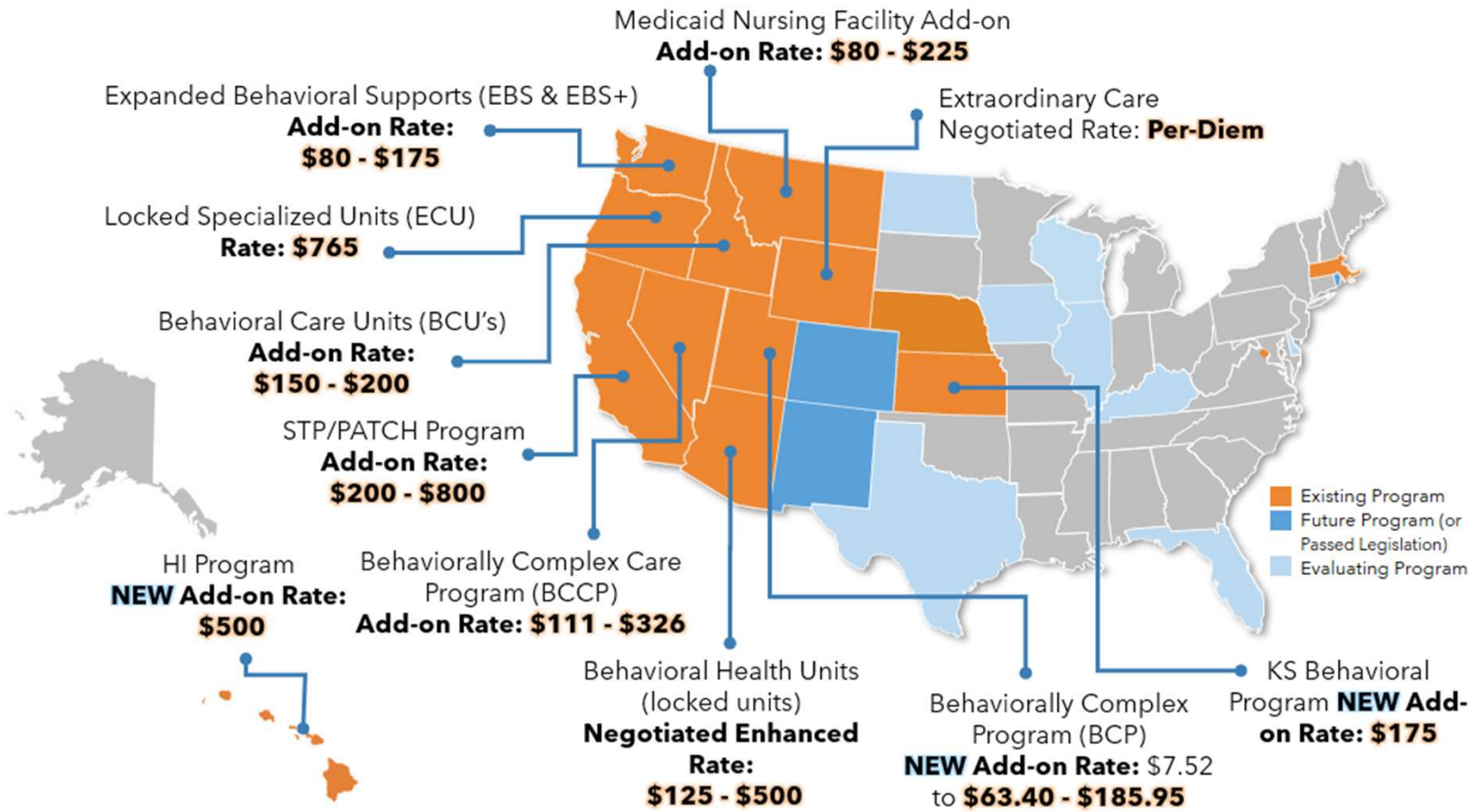
- Serotonin - Affects mood stabilization, well-being, and happiness, imbalances can cause mood instability.



Working with MI and SMI

- A systems approach
- An individual approach

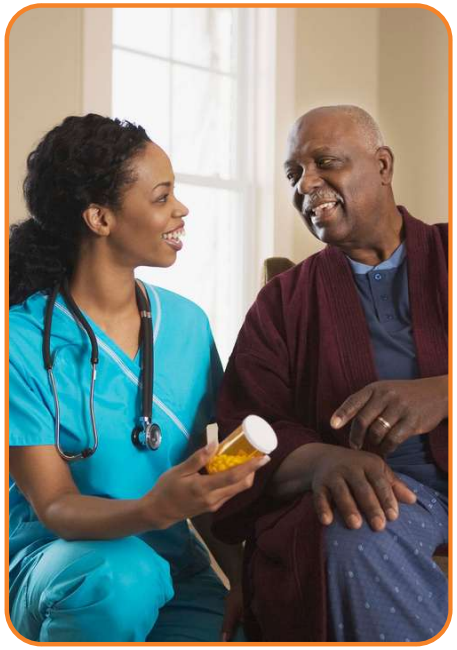
Existing National Programs



Developing Value-Based Programs

IN SKILLED NURSING FACILITIES

- ✓ Allows SNFs to better partner with acute hospitals to address difficult to discharge patients
- ✓ Provides funding to increase resources to behaviorally complex patients
- ✓ Increases staff retention through additional funding, training, and staff resources
- ✓ Reduces acute transfers and decreases acute length of stay
- ✓ Reduces out of state placements
- ✓ Helps to stabilize patients in the lowest care setting
- ✓ Overall savings to the healthcare system



Purpose of Programs

TRANSFORMING BEHAVIORAL HEALTH FUNDING INTO MEASURABLE OUTCOMES

Enable nursing facilities to safely admit and retain patients with significant behavioral complexities by funding an LTC behavioral health add-on. The add-on closes the resource gap that drives avoidable prolonged acute stays, reduces "difficult-to-discharge" bottlenecks, and stabilizes high-utilizers in the post-acute setting.

How the Add-On Works:

- **Target population:** Hospitalized patients with behavioral complexities awaiting LTC placement and current LTC residents at risk of cycling back to acute care.
- **Payment:** A per-diem behavioral add-on paid to participating nursing facilities to underwrite on-site, wraparound behavioral health services and staff education.
- **Outcome focus:** Faster transitions from acute to LTC, fewer returns to acute, improved quality of life (QoL), and reduced reliance on high-risk psychotropics.

Industry Trends

UNDERSTANDING BEHAVIORAL HEALTH & FACILITY TRENDS

1. **Younger demographics** entering facilities due to SUD and conditions

2. **Increased demand:** for behavioral health services due to the psychological effects of COVID-19, such as social isolation, trauma, and stress

3. **Complex patient populations** with co-occurring mental and physical health conditions, such as homelessness, substance abuse disorder, dementia, and diseases.

4. **Staffing challenges** due to the nursing shortage, staff turnover, burnout, and lack of education and training on behavioral health issues

5. **Regulatory changes** that require SNFs to provide behavioral health services as part of the comprehensive person-centered care plan, and to monitor and report the quality of those services

Patient Demographics

UNDERSTANDING BEHAVIORAL HEALTH & FACILITY TRENDS

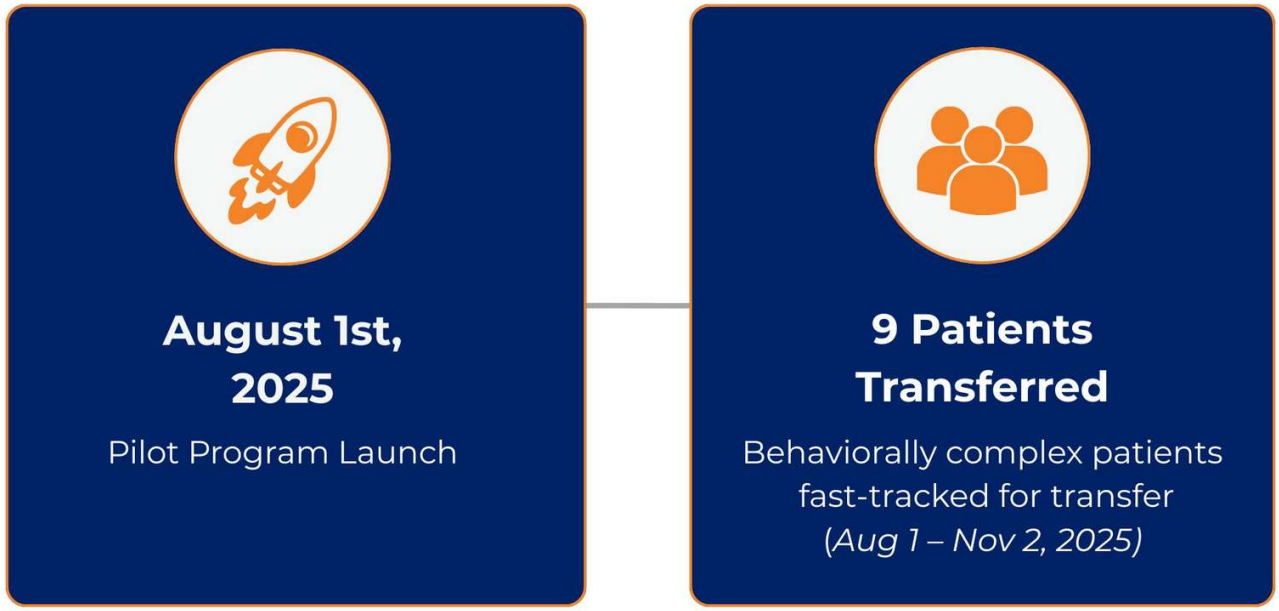
- **Rising Prevalence of Dementia:**
  - With the increasing median age of nursing facility residents, there's a notable surge in the prevalence of dementia at later stages.
  - Residents aged over 85 face a 50/50 chance of developing Alzheimer's disease, underlining the need for specialized care.
- **Impact of State Inpatient Facility Closures:**
  - The closure of state inpatient facilities has led to a shift in the landscape, with nursing facilities now catering to a diverse range of patients, including the Chronically Mentally Ill (CMI).
- **Rehabilitation Trends:**
  - Conditions like traumatic brain injury, stroke, and other rehabilitative needs are increasingly being addressed in long-term care (LTC) facilities rather than hospital-based settings, reflecting a shift in the delivery of specialized care.
- **Psychiatric Disorders on the Rise:**
  - Recent studies illuminate a concerning trend, indicating that over 70% of residents in LTC facilities grapple with various psychiatric disorders or disturbances that demand specialized treatment.
  - A comprehensive study published in the Journal of Long-Term Care revealed that more than 51% of LTC facility residents are prescribed psychoactive medications, emphasizing the critical role of mental health care in these settings.

Services Core to BH Management & Stabilization

INTEGRATING CARE, EDUCATION, AND CRISIS SUPPORT FOR BETTER OUTCOMES

- **Specialized staff training & education:** Engaging in-person training plus online platform approved by multiple states to meeting behavioral health training mandates covering topics such as trauma-informed care, de-escalation, root-cause analysis, and documentation best practices, with ongoing coaching to sustain skills.
- **Psychiatric assessment & medication management:** Evaluation and longitudinal med management overseen by psychiatrists, aligned with person-centered goals.
- **Individualized, person-centered behavioral plans:** Practical, facility-embedded care plans that integrate into daily routines and IDT processes.
- **Non-pharmacological interventions:** Structured talk therapy, behavioral activation, and 1:1 psychosocial activities to reduce agitation and improve engagement.
- **Weekly rounding & case conferencing:** Collaborative rounding with facility teams to monitor progress, adjust interventions, and prevent crises.
- **Rapid crisis support:** Immediate consults to prevent escalation, ED transfer, or involuntary discharge.

UNM Genesis Pilot



Meadows/NMBHI Pilot

Working with Working with MI/SMI

- **Behavioral intervention**
  - e.g. relaxation, go for walk, encouragement-positive speech
- **Socialization**
  - e.g. friends, family, activities
- **Communication**
  - Building trust with the resident , active listening and non-judgemental speech, redirecting focus
  - Knowing the residents likes/dislikes = Person Centered Care
  - Empathy goes a long way
- **Medical care**
  - e.g.. control of medication, call care worker

Working with MI/SMI

Cognitive interventions

- e.g.. TV, music, crosswords, activities

Environmental

- Structured, calm environments

Working with MI/SMI

- Supporting residents with behavioral health needs starts with careful observation and an open mind.
- Many symptoms that look like mental illness may actually be caused by underlying medical conditions, such as vision problems, thyroid issues, or delirium.
- Care Tip:
  - Stay calm and **avoid reacting emotionally**
  - Approach from the **front**, use clear language, short close-ended sentences
  - **Speak softly** and use a soothing tone
  - **Redirect gently** to a quieter activity or setting
  - Use **biographical statements:** If resident was a Farmer, ask questions like "I read you used to be a farmer, what was your favorite thing to grow?"
  - Reduce environmental **triggers like noise or crowding**

Working with and Documenting MI/SMI

ABCOF MODEL

- A – Antecedent: What happened right before the behavior?
- B – Behavior: What the resident did—observable actions and statements.
- C – Consequence / Intervention: What staff did in response.
- O – Outcome: How the resident responded afterward and for how long.
- F – Follow-Up: What needs to happen next, including notifications or care plan updates.

Documenting Psychosis

- Use objective language, include dates, times, details of behaviors, document interventions and outcomes, and maintain confidentiality.
- The resident was observed speaking to themselves during breakfast repeating: “I know, they said that.” Attempted to redirect patients focus with resident’s favorite food (pancakes). Resident unable to redirect. Informed SS and charge nurse about observations.

Documenting Mood Disorders

- A 64-year-old resident has a history of depression, stays in bed most days, is generally sad appearing, and doesn't interact with anyone.
- How do you document this? Focus on what they say, do (or don't), your observations.

- For example:
  - The resident reported feeling "sad today." She reported that she missed her kids and wanted to go home. The resident was encouraged to attend activities and social gathering beginning later in the day. She refused but was able to discuss her favorite memories from when she went to Scotland, which appeared to improve her mood slightly. Informed case manager of intervention.

Documenting Behaviors

- Mr. Wilson, a 76-year-old resident, has recently shown noticeable changes. Staff report that he often repeats the same questions, becomes easily confused during daily activities, and sometimes gets lost in familiar areas of the facility. When asked, Mr. Wilson does not seem aware of his memory problems. His daughter shared that these issues have gradually worsened over the past two years.

- At the same time, Mr. Wilson occasionally appears withdrawn and sad. When asked about it, he admits to feeling “down” at times but quickly forgets the conversation and asks the same questions again.

- Based on Mr. Wilson’s symptoms, which condition best explains what he may be experiencing?

THANK YOU

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