Long Term Care Coordinating Council: Behavioral Health Work Group

11/09/20

1:00-2:30pm

Meeting Facilitator: Susie Smith (Co-chair).

Attendees: Alicia English, Benson Nadell, Christine Roppo, Scott Haitsuka, Michelle Roberts, Scott Arai, Dan Kelly, Nora Martín-White, Peggy Cmiel, Alexander Jackson (co-chair).

Not in attendance: Nicole Bohn; Dr. Fiona McDonald; Bernadette Navarro-Simeon; Christine Ng; Gloria Wong; Brett Andrews; Dr. Marcy Adelman; Anne Fischer; Allegra Fortunati; Susan Gonzalez; Courtney Gray; Jesus Guillen; Deborah Kaplan; David Knego; Dr. Ingrid Lin; Jennifer McAtee; Norman Manglona; Lisa Rosene; Dr. Michi Yukawa; Eric Zigman.

I. Introductions: Welcome new Members!

a. Alicia English, behavioral health manager at SFHP (previously PACE program for older adults)
b. Benson Nadell, director of ombudsman program from Felton
c. Christine Roppo, director of social services at jewish home/rehab center in excelsior
d. Peggy Cmiel, director of nursing at jewish home

II. Scope update and initial progress (Dan and Nora)

a. Scope review: what are the gaps in access to mental health services for assisted living residents and IHSS recipients?
    i. We originally considered studying the spectrum, from IHSS to ARFS/RCFEs to SNFs
    ii. **We propose narrowing the focus to SNFs, and possibly IHSS**
    iii. (We can potentially revisit ARFs & RCFEs in a Phase 2)
    iv. Telehealth provides opportunities and challenges (training/staff, capacity, privacy, physical access)
    v. How might we get access to focus group, survey of SNF population, lit review?
b. Administrative data match update:
    i. Challenges with data availability and capacity
    ii. We recommend including general data summaries, but focusing our primary research efforts on stakeholder interviews, surveys, and focus groups
c. Stakeholder interviews update and initial themes
    i. Isolation prevalent in all assisted living environments, but especially in SNFs
    ii. Disparity in access across the spectrum of community services to congregate care, varies tremendously, including in regards to telehealth, Wi-Fi access, devices
    iii. Social connectivity as element of mental health in addition to more severe diagnoses or conditions like depression or cognitive impairment

iv. Expanded definition of mental health vs behavioral health only
v. What is actually traditionally billable, what do we want to be billable in the "New Normal"? Trauma, severe isolation
    1. For services not traditionally billable, some new ftags in CMS for trauma-related issues, surveyors at CDPH
vi. Trauma-informed care important but so many SNFs have transitioned to post-acute care, no families visiting
vii. ILRC buys tech for people with disabilities and conducts 1:1 assessment; can call and do it over the phone

d. What has the Jewish Home experience been like? (Christine Roppo, Peggy Cmiel)
    i. 370 beds, primarily long term care with a rehab arm. We made decision to open COVID+ unit.
    ii. We meet the client/resident where they are
    iii. We work with some contracted psychologists who visit in person to meet with some of our residents; only one doing telephonic visits
    iv. We have been providing telephonic and video support to connect family members
        1. Challenges include residents' sensory deficits (cognition, visual), confusion about the video call
        2. We need to make it easier and include more **adaptive technology**, to address dexterity problems and issues
        3. A real person is always preferable, but supplement with technology when needed
    v. Challenge to add extra layer of mental health support during the pandemic
    vi. Have you seen a spike in acuity since pandemic?
        1. We have not necessarily noticed a difference
        2. We conduct a mood assessment every quarter; we will compare scores from this year to last year to compare negative outcomes
    vii. As part of the COVID+ unit, we bought 50 iPads for purpose of telemedicine
        1. We don't use very often for telemedicine but do use them for social visits and families
        2. We've been surprised by how labor intensive it is on staff
        3. Some residents cognitively don't quite understand that the person they are FaceTiming isn't in the room;
        4. No one can do it independently
        5. We try to give people privacy but they often need 1:1 support to use the device
        6. 330:50 right now, that is not enough iPads
    viii. Not enough social engagement given COVID realities; residents often suffer more from that even than from not seeing family
        1. Frustrated by lack of technology availability in other activities besides telemedicine or 1:1 family calls (e.g. bingo on tech)
        2. Volunteers to help the tech part when it's possible and safe
        3. Very limited outdoor visitation

4. Clinicians to assess someone's suicidality is best done in person, telehealth not as good

e. Tension between physical health and mental health
    i. What is the data/stories impact of visitation restrictions on mental health? Concerns that SF has started opening up other things but not visitation in assisted living settings
    ii. Jewish Home: Visitation opening up more is frightening to us – especially SNFs – e.g. 350 visitors – hoping that SF continues restrictions for a bit
    iii. **How do you balance risk of physical health vs risk of mental health? How to assess what is best?** Complicated
f. Cathy:
    i. SF Tech Council is compiling all activities that are happening virtually, can share with group
    ii. Nora, Dan, Susie will try to visit a future Tech Council meeting
    iii. Lit review about tech/iPads and those with dementia, cognitive impairment
        1. E.g. Robotic pets at Jewish Home have been quite successful
    iv. Sometimes family members suffering more than the residents re: social isolation
    v. Aging 2.0 and other entities, Center of Longevity
g. Benson
    i. Compassionate burnout
    ii. Balancing social isolation and connectivity (see PowerPoint)
    iii. SNF variability
        1. E.g. one iPad per floor, protocols for using it for 750 residents
        2. Not enough staff to carry iPads
        3. Survey needed of all SNFs to try to find out variability – is there a best way to reach SNFs in one place?
            a. Amy Ovadia, SFN hub coordinator, SFDPH hub that has gotten SNFs together to touch base about COVID
            b. The senior hub; Arielle Piastunovich
            c. Ombudsman focus group
    iv. Pharmacological vs talk therapy, importance of trauma informed practice
        1. Sometimes not reimbursable with protracted sessions (alan sachs)
    v. Virtual peer groups?
        1. Institution tests everyone coming in including volunteers
        2. Citywide volunteer organization as pipeline to SNFs? Little brothers doing telephone work
        3. CANHR

III. Digital Equity (Dan)

a. Governor's solicitation of public comments related to technology needs during the pandemic
    i. Adaptive technology
    ii. Staff support to use technology
    iii. iPads/ TV screens to project video calls
    iv. Tech companies – tech for good departments

v. Senior vitality

IV. Continued discussion: Impact of the COVID-19 crisis on mental health needs of people living in facilities and in the community? (All)

a. Mental health services for people who are homebound (Alicia English)
   i. SFPH primary care at home, keeping an eye on behavioral need, primarily physical but do focus on whole person care
   ii. PHQ9 standard for screening
   iii. SNFs often contract behavioral health services (private companies – e.g. Vericare is a Medicare benefit)
   iv. Jewish home acute psychiatric unit (15 beds)
   v. Long term residents – rehab short term care, who stay longer, and are on psychotropic medication, have IHSS services, can have gap where have complex psychosocial needs
   vi. Transition points in the system**: how do you ensure continuity of care between levels, especially when people get disconnected from community services**
   vii. Many residents get home health; but not sure MSW assessor who is conducting discharge has the level of complex understanding required to refer to appropriate behavioral health services

b. Community behavior health services and telehealth
   i. Alex: 2/3 of services are currently telehealth
      1. Driven by clinical need
      2. Each clinician considers the risk benefit of in-person vs telehealth with each client, weighing physical and mental health needs. If telehealth not sufficient, will conduct services in person as clinically indicated
      3. Primary focus on client need and client safety
      4. We have enough in-person capacity since the pandemic began, there have not been gaps in service
      5. We prioritize those most in need to see in-person, versus those who can be seen by phone/telehealth
      6. No difference in operating hours since pandemic
      7. Most staff do telecommute but scheduled days in clinic (skeletal crew)
   ii. Cathy: all the group activities are missing both in community behavioral services and SNFs
      1. how can we enable that social connection, virtual community;
      2. at this cusp of those 80+ years old who didn't grow up with tech
      3. CTAP and Lighthouse for the Blind as resource. More residents using phone to talk to loved ones, had been using cell phone but if decline in functional ability can use adaptive phone. They send phone out within 2 days.
      4. Stanford Center for Longevity

V. Next Steps

- Everyone: email existing needs assessments/literature/best practices/additional research and stakeholder interview ideas (e.g. PHQ9, MDS)
- Nora: share stakeholder interview questions, SharePoint