Long Term Care Coordinating Council: Behavioral Health Work Group

5/10/21

2:30-3:30pm

Attendees: Michelle Roberts, Susie Smith, Carley Clemons, Alicia English, Arielle PIastunovich, Alexander Jackson, Nora Martin-White, Scott Arai, Lisa Rosene, Cathy Spensley

1. **Annoucements**
    a. **Lisa Rosene**: open skilled nursing facilities homes for those who are served by GGRC – GGRC case managers currently taking intakes for 5 open beds
2. **Project Update and Thursday LTCCC presentation preview (Carley)**
    a. **Findings include:** impact of pandemic on LTC residents; resident needs exceed caregiving staff capacity; pandemic as an opportunity for improvement
    b. **Recommendations**
        i. **Improve status quo:**
            1. Improve caregiving staff ratios
            2. MC/Medicare reimbursement rates
            3. Decreased reliance on psychotropic medications alone
            4. Increased presence for registered nurses in SNFs
            5. Addressing staff turnover
        ii. **Standardize person-centered care**
        iii. **Advocate for safe resumption of social engagement activities**
        iv. **Promote evidence-based on-site therapeutic practices**
            1. Telephonic outreach
            2. Life review groups
            3. Group, individual, staff therapy (GIST)
            4. Behavioral Health Activities Intervention (BE-ACTIV)
        v. Train caregiving staff on mental health and trauma informed care
        vi. Ensure tele-connectivity for all residents who are able to benefit
    c. **Group questions and feedback**
        i. Lots of generalizability to SNFs in other jurisdictions
        ii. Some interventions/evidence based practices are also generalizable to other contexts
3. **Action Steps (Susie)**
    a. LTCCC full council presentation in May for formal adoption
    b. Incorporate recommendations into LTCCC policy agenda; endorse a letter to the State with report & recommendations
    c. Socialize report with the State, Governor's office/Master Plan on Aging, CDA, SF State delegation, CCC, Mayor's Office, Board of Supervisors)
    d. Incorporate report findings and recommendations into the local Master Plan and Local Policy Playbook
    e. Support any state/federal bills which address status quo issues (staffing, digital divide)

f. Pursue pilots/partners/funding to plan and launch:
    i. evidence-based on-site therapeutic practices (recommendation #4)
    ii. training of staff (recommendation #5); could take model from DCYF, SFDPH for trauma-informed care
    iii. digital divide (recommendation #6)
g. Identify ways to support safe resumption of social engagement activities (e.g. new health guidance and CCC oversight) (recommendation #3)
h. **How to continue/reconfigure LTCCCC BH workgroup?**
    i. Benson: Ombudsmen is submitting an RFP through DAS-SFHSA (via the Older American Act) to address some of these issues; nursing criteria mentioning quality of life; UCLA loneliness scale should be treated with as much seriousness as geriatric depression scale
        1. Activities (choice and preference)
        2. Eating (choice and preference)
        3. Some residents want more little brothers contact, bypassing clinical
    ii. Susie: all workgroup members should help socialize report
        1. Benson: share with Anna Chodos, some of the UCSF doctors
    iii. Lisa: DDS downsizing funds; facilities can make applications to DDS to get funds to bring them into compliance with rules (AB962 – how the homes are set up; adult facilities). If any federal money flowing to DSS or DDS for facilities to bring themselves into compliance with current rule
i. **How to transition this workgroup? Are members interested in looking at pieces of different recommendations? Spinoff groups?**
    i. Benson: Reviving continuity of care research question: case management when someone is placed in SNF, they lose that community-based case management, it becomes interrupted
    ii. Benson: Reviving homeless and behavioral health systems change issue: homeless and placed in SNF, challenge in managing behaviors with limited resources in the facilities; problematic to provide care plan with individuals
    iii. Scott: interested in the next steps to implement trauma-informed care training. Helping staff and caregivers will help clients, but many caregivers do not have time to do the training. How do we put together training that meets the needs of staff and is realistic; what steps can we do in the interim? Getting funding to expand capacity
    iv. Cathy: even starting small will make a difference. For example, in board and care homes, when we brought in a group activity/therapy with an outside resource even 1x/month, it would make a difference. (Alameda County willing to pay our staff to go into SNFs.) This doesn't need to be a huge amount of funding; we could start small as a pilot and embed teams that are already out there. The consultation is key. Our psychologist is really motivated to form a relationship as a consultant with SNFs.
        1. We can also apply the report findings to other populations like board and care.