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Caring for Patients with Mental Health Conditions:

A Toolkit for Home Health Clinicians

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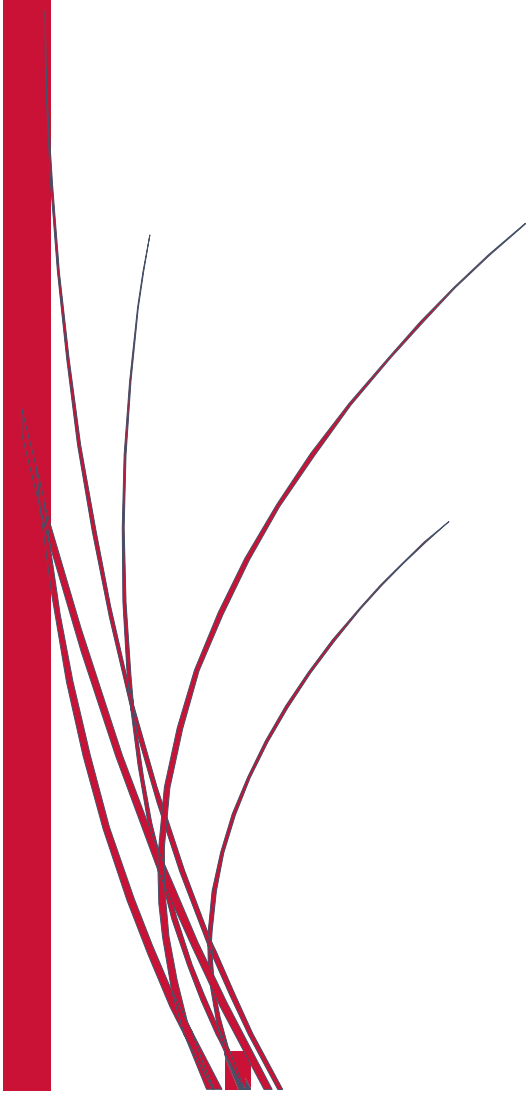

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About the Authors

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Additional Resources

Chronic Illness and Mental Health 2 pg:
https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/nih-15- mh-8015 151898.pdf

Depression Basics (what, causes, s/s, etc) 6 pg:
https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/nih-15-mh-8015 151898.pdf

Older Adult s and Depression 6 pg:
https://www.nimh.nih.gov/health/publications/older-adults-and-depression/gf-16-7697 153371.pdf

Generalized Anxiety Disorder 8 Pg:
https://www.nimh.nih.gov/health/publications/generalized-anxiety-

disorder-gad/generalized-anxiety-disorder 124169.pdf

Mental Health First Aid (website): https://www.mentalhealthfirstaid.org/

Forgetfulness: Knowing When To Ask For Help (cg resource):
https://www.wrpioneers.org/wp- content/uploads/2015/09/forgetfulness 0.pdf

Alzheimer's Association: Living With Alzheimer's - For Caregivers - Early Stage Tips (pdf workbook) 17 pg:
https://www.alz.org/documents custom/early-stage-caregiver-tips.pdf

Staying Safe (patient safety tips for caregivers):
https://www.alz.org/national/documents/brochure stayingsafe.pdf

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The purpose of this toolkit is to provide home care physical therapists with resources to provide optimal care for patients with mental health conditions that may impact safety and impede implementation and success of the plan of care. The mental health conditions to be addressed are cognitive impairment (delirium, dementia, depression with dementia and pain with dementia), depression, and anxiety.

Dementia is classified as a *syndrome*, a collection of symptoms with many causes. According to the 2017 Alzheimer's Facts and Figures: "The characteristic symptoms of dementia are difficulties with memory, language, problem-solving and other cognitive skills that affect a person's ability to perform everyday activities." It is believed that nearly 14% of the population over the age of 71 has a form of dementia. The most common type of dementia is Alzheimer's Dementia, representing nearly 5.3 million Americans over the age of 65 and about 200,000 under the age of 65. Other forms of dementia include Dementia with Lewy-Bodies, Vascular Dementia, Mixed-Dementia, Frontotemporal Lobar Degeneration, and other neurological conditions that have associated cognitive impacts such as Parkinson's Disease and Normal Pressure Hydrocephalus. Dementia is the only disease in the top ten of causal mortality that "cannot be prevented, slowed, or cured."

Depression in older adults is believed to impact about 5% of the population, however that number for those receiving home health care may be as high as 13.5% according to the Centers for Disease Control & Prevention (CDC). Symptoms of depression in older adults may include loss of energy, difficulty concentrating and remembering details, insomnia or excessive sleeping, feelings of hopelessness or pessimism. Many health care providers overlook depression in older adults assuming it may be normal for the current situation (someone who is ill or experiencing loss) but any significant change in interest or enthusiasm for everyday events should be screened to see if intervention is appropriate.

Delirium is considered an acute decline in cognitive function often associated with major surgery, infection, sepsis, under-treated pain and polypharmacy. It may occur in as many as 50% of hospitalized older adults, making it a significant concern for home health clinicians. Unlike dementia that has a slow onset, delirium often has a rapid onset but may also fluctuate across a 24-hour period. It is possible to have delirium on top of an existing diagnosis of dementia.

The challenge for home health providers is that there is significant overlap in the presentations of these three conditions. Accurate history taking, medical review and assessment is required to help differentiate the possible cause of cognitive changes in the older adults. This is of course complicated if the person receiving care cannot easily communicate the information accurately and may not have another representative available during your visit. It may be further complicated by an individual or family who is unwilling to acknowledge that cognitive changes may be occurring due to fear for loss of identity, the risk of institutionalization and the stigma associated with mental and cognitive health issues.

The clinical decision tree on Page 12 was designed to help aid the clinician in determining if cognitive and mental health safety needs further assessment or intervention. The toolslisted here are appropriate to use for the home health patient but are not an exhaustive list of all the possible screening tools. Further testing and referral for medical work up may need to occur simultaneous with initiation of the physical therapy Plan of Care.

The mental health safety checklist also includes some additional questions for safety concerns with possible interventions. Assessment should include root cause analysis of behavioral and psychological symptoms of dementia (wandering, pacing, agitation) to help determine how these may be mediated with non-pharmacological interventions. Additional considerations such as sleep health are increasingly being better understood for the impact they have on daily function along with general engagement and physical activity. This list is not all-inclusive and there can be other factors that influence the plan of care, however these areas are among the more common issues for families in helping to provide care for a loved one with cognitive or mental health issues.

Mental Health Safety Checklist

Answering "YES" to any of the following questions indicates possible triggers for inappropriate behaviors for persons with cognitive impairment/dementia. Follow the algorithm as a decision making aide to maximize patient safety.

		Interventions
Is current support system insufficient to provide for patient needs, safety, mental stimulation and physical activity?	Yes	Provide patient/caregiver education, referral - MSS, community resources/services, ****
Is the physical environment a potential trigger? (Sound, space, surfaces, temperature, safety	Yes	Provide education on environmental triggers like noise (volume, TV/violence, music) lighting, floor surfaces, clutter, oven use, etc.
Medication Review - are all meds unnecessary for the diagnoses and dosed inappropriately?	Yes	Discuss concerns with physician for unnecessary medications or inappropriate dosing (Use Beers Criteria, where applicable)
Are there any signs of discomfort/pain? (consider Painad)	Yes	Address pain with non-pharm or refer for assessment of pain/appropriate meds
Any issues with sleep pattern?	Yes	Explore night environment (light, noise, temperature), consider melatonin (via physician), increasing daytime physical activity and engagement, educate caregiver for self-care
Any other signs of distress/behavioral expressions? (For example: wandering, pacing, verbalizations of fear/lost, bored)	Yes	Root cause analysis of distress (pain, boredom, etc)
History of depression, signs of undiagnosed current condition? (Consider use of Cornell Scale for Depression in Dementia)	Yes	Discuss concerns with physician, MSW, Psychologist/Psychiatrist

To properly address mental health conditions, it is important to understand the difference between delirium and dementia. Many clinicians use the terms interchangeably, which is unfortunate as delirium is an acute mental status change that is often life-threatening and requires medical attention whereas, dementia is a slow and chronic progression of cognitive loss.

The following key terms provide simple definitions of delirium, dementia and depression.

KEY TERMS

- **Delirium:** acute global brain failure with fluctuations in attentiveness and disorientation. Sx are generally acute and may fluctuate across the day.
- **Dementia:** a group of disorders of the brain that result in decline in functioning, primarily associated with memory deficit. Additional features include sensorimotor changes, verbal fluency changes and difficulty in planning and other executive functions. Sx are usually gradual and developing.
- **Depression:** mood disorder that affects how you think and handle

There are many screening tools for delirium, dementia, depression, anxiety, and pain. The graphic below contains a sampling of commonly used tools and is not by any means an exhaustive list.

Screening Tools

Delirium:
- Confusion Assessment Method

Cognition/Dementia:
- Mini-Cog

Depression:
- Cornell Scale for Depression in Dementia
- PHQ9
- PHQ2

Pain:
- Painad

Anxiety:
- Hamilton Anxiety Rating Scale (HAM-A)

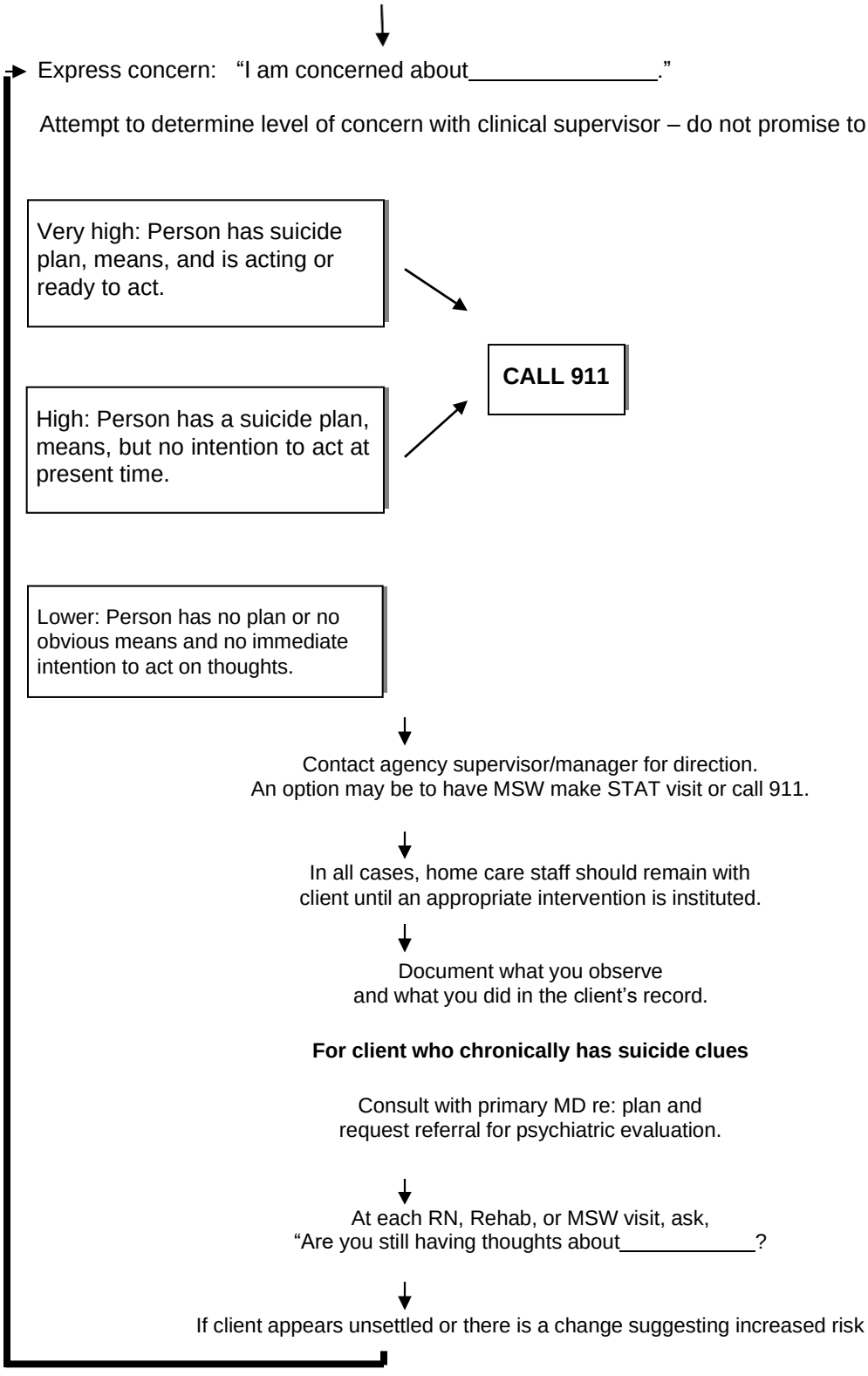
Clinicians work with older adults who may have chronic, progressive diseases, or experience life changing events that result in suicidal ideations or actual suicide attempts. Being able to triage suicide risk in the older population is important to ensuring patient safety. The following suicide protocol is provided to triage patients into risk categories and guide the clinician in how to handle these difficult situations. The national suicide hotline is a resource that is recommended for all clinicians to have available and provide routinely to patients, caregivers and patients' representatives.

In the home health practice setting, the OASIS data set contains several items that specifically address a patient's neurological, emotional, and behavioral status. The answers to these items should be supported by the screening tools listed above, as appropriate:

- M1700 Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
- M1710 When Confused (Reported or Observed within the Last 14 Days)
- M1720 When Anxious (Reported or Observed within the Last 14 Days)
- M1730 Depression Screen Has the patient been screened for depression, using a standardized, validated depression screening tool? (PHQ-2)
- M1740 Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed)
- M1745 Frequency of Disruptive Behavior Symptoms (Reported or Observed)

Suicide Prevention Protocol Flowchart

New observation of suicide clues



Unfortunately, elder abuse and neglect are commonly encountered when working with an older adult with cognitive impairment. The regulations on mandatory reporting are state specific and due diligence is required to ensure compliance with these regulations. Be sure to check with federal and state agencies and the agency policy and procedure manual regarding the handling of suspected abuse or neglect. Reports go to Adult Protective service (APS) agencies that are responsible for the safety of older adults, similar to reports for child abuse to Child Protective Services (CPS). Resources on APS are available in the table below.

Adult Protective Services

- Must check HIPAA rules and Abuse reporting rules (state law)
- Mandated Reporting (state specific rules)
  - Resource for all US states regulations
- Forms of elder abuse:
  - Neglect (intentional and unintentional)
  - Physical, sexual or emotional Abuse
  - Financial abuse or exploitation

The Beers Criteria developed by Dr Mark Beers and maintained by the American Geriatrics Society (AGS) contain a list of medications that are potentially inappropriate for the older adult due the increased risk for adverse effects. Many of the drugs on the 2015 Beers Criteria are known to cause delirium and are considered potentially inappropriate medications. Several drug classes (with drug examples) are highlighted here for the practicing physical therapist to incorporate medication review into the review of systems and be aware of the effects the drugs, both intended and side effects to report back to the prescriber.

Beers Criteria

- List of potentially inappropriate medications to be avoided in older adults.
  - Avoid in general
  - Avoid based on diseases and syndromes
- List of select drugs that should be avoided
  - Or have their dose adjusted based on the individual's kidney function and select drug-drug interactions documented to be associated with harms in older adults.
- The 2015 AGS Beers Criteria are applicable to all older adults with the exclusion of those in palliative and hospice care.
- Resources

Beers Criteria 2015 Drugs that cause delirium

Table 2. Potentially Inappropriate Medications – partial list		
Organ System/Therapeutic Category (partial list)	Rationale	Recommendation
Anti-cholinergics 1st Gen. Antihistamines diphenhydramine (Benadryl)	Confusion, dry mouth, constipation, memory loss, increased risk of falling	Avoid
Benzodiazepine Short Acting Alprazolam (Xanax) Lorazepam	Cognitive Impairment, delirium, falls, fractures and motor vehicle accidents	Avoid
Long Acting Clonazapam Diazepam	May be appropriate for seizure disorder	Avoid

Beers Criteria 2015 Drugs that cause delirium

Table 2. Potentially Inappropriate Medications – partial list		
Organ System/Therapeutic Category	Rationale	Recommendation
Antipsychotics, first- (conventional) and second- (atypical) generation	Increased risk of cerebrovascular accident (stroke) and greater rate of cognitive decline and mortality in persons with dementia Avoid antipsychotics for behavioral problems of dementia or delirium unless nonpharmacological options (e.g., behavioral interventions) have failed or are not possible and the older adult is threatening substantial harm to self or others	Avoid, except for schizophrenia, bipolar disorder, or short-term use as antiemetic during chemotherapy

Beers Criteria 2015 Drugs that cause delirium

Table 2. Potentially Inappropriate Medications – partial list		
Organ System/Therapeutic Category	Rationale	Recommendation
Antidepressants, alone or in combination Amitriptyline Amoxapine Clomipramine Desipramine Doxepin >6 mg/d Imipramine Nortriptyline Paroxetine Protriptyline Trimipramine	Highly anticholinergic, sedating, and cause orthostatic hypotension; safety profile of low dose doxepin (≤6 mg/d) comparable with that of placebo	Avoid

MENTAL HEALTH DECISION TREE

Signs/Symptoms of Cognitive/Mental Health issues and/or behaviors* (CI)

YES

Is the current treatment plan effectively addressing these issues?

NO

YES

*Signs/Symptoms:
Confusion, Change in judgment,
Hallucinations/Delusions
Altered Memory, Loss of interest
Lethargy/Aggression

**See Mental Health Safety Checklist

Complete Cognitive Screen
Assess other possible causes
Delirium, Normal Pressure Hydrocephalus, Depression/Anxiety

Delirium due to recent:
Hospitalization
UTI or dehydration
Infection
Med change or initiation

Normal Pressure Hydrocephalus:
Gait change + Incontinence?

Signs/Symptoms Untreated Depression/Anxiety?

Proceed with PT**
Continue to monitor

Based on clinical findings:

- Contact MD to share findings for further workup
- Advise urgent medical care visit
- Initiate 911 call for EMS to assess patient

There are many interventions available to include in the care of people with dementia, depression, and anxiety. Cognitive behavioral therapy is one approach that has been shown to be effective in reducing inappropriate behaviors and encouraging appropriate behaviors.

It's important to realize that there is no one-size-fits-all solution for depression, anxiety, or other mood disorders. Talk therapy treatments like Cognitive Behavioral Therapy (CBT) are effective and recommended as a first-line treatment for these conditions. The purpose of CBT is to help the patient reduce or eliminate the behavior and thinking patterns that are contributing to his or her suffering and to replace dysfunctional patterns of behavior and thought with patterns that promote health and well-being. Cognitive Behavioral Therapy helps the patient change his negative thought patterns, emotions, with resulting changes in behavior. If your patient can change just one of these things, he will have a much greater chance of changing the other two. Home care clinicians don't have to be trained or directly involved in this type of treatment to understand that behavior change is an important part of the process. Therapists can and should be involved in behavior change and can work with their patients to develop a plan to meet those goals. One obvious example is to improve gait, mobility, and safety so that they can resume community activities again and improve their social life. Understanding how these things work together will help home care clinicians design a plan of care that is more likely to succeed and achieve better outcomes. The British Columbia Medical Journal has information on how to adapt the principles of CBT to the older adult population. These resources are available here: http://www.bcmj.org/articles/cognitive-behavioral-therapy-older-adults.

CBT is used in a variety of settings and by various professionals. A strength of CBT when compared with other similar forms of psychotherapy is its use of manuals that facilitate the effective provision of therapy by professionals whose primary training may not be in psychiatry, psychology, or counseling. These manuals come in individual, group, and self-help formats.

See the appendices for case scenarios.

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Case Scenario: Dementia

Reason for referral: Recent fall without loss of consciousness, unsteady gait
History of Present Illness: Patient has had three falls in the last past 6 months, however 2 in the past week.

Medications: Aricept 10 mg po qd (evening), pravastatin 40 mg po qd (morning), metoprolol 25mg po bid, famotidine 20 mg bid, aspirin 81 mg qd (evening), trazodone 25mg prn, Tylenol 500 mg prn, MOM prn,

Health Condition (ICD-10): Dementia with behavioral disturbance, age-related osteoporosis, h/o major depressive disorder, hypocholesteremia, hypertension, GERD

Body Structures/Body Functions (Impairments): Weakness in LE's, back pain, and impaired balance. Family reports that the patient is more confused over the past few days.

Activities & Participations: ADL's- dressing upper body independently, lower body with supervision due to difficulty standing on 1 leg. Family notes more challenges with her bathing, daughter now assists minimally for shower 3x/week, but they note she is more resistant to getting in the shower and don't know what to do. Grooming – independent with setup. Bed mobility – Supervision with use of bed bar. Transfers – supervision Ambulation – 50 feet x 1 without device and CG x 1 for safety. Gait is slow and steady with decreased step length. Able to ascend/descend 6 steps with 1 rail and CG.

Environmental Factors: Split level home with no steps to enter, bed and half bath on first level, full bath up 2 flights of 6 steps with rail. Home has hardwood floors, wide doorways and clear access throughout the home. Kitchen, DR 6 steps with rail to access.

Personal Factors: 76-year-old female with a college education, former occupation – retired nurse, financially able to meet needs. Divorced, lives with adult daughter and family.

Physical Exam: BP – 126/78 supine; 118/68 standing. 30 second chair stand test – able to complete 5 reps. Timed up and go – 24 seconds. Pain –
patient did not complain of pain when asked.

Mini Cog – 2 points; Confusion Assessment Method (CAM) = (+) acute mental status changes (increased confusion, outbursts), greater distractibility; irrelevant conversation; and appeared lethargic. Positive for features 1, 2, 3 and 4.

Falls review with daughter.
All 3 falls have been during the night. One occurred at 10:45 pm when she was getting herself to bed about 4 months ago. One occurred at around 12:30 am 6 days ago, heard

her calling for help in living room, she was on the floor near the couch. Third fall occurred 11:45 pm 4 days ago in the kitchen, she reported to her daughter that she was hungry and fell while accessing the refrigerator. She is not sleeping well and seems to be getting up to "putter around" more during the nighttime. She used to take long walks during the day while family worked but she is walking less and less these days and with her dementia progressing they are not encouraging her to "go outside" anymore during the day. They are concerned she may need nursing home placement if she continues to fall and/or injures herself.

Homebound status – Needs a person to leave the home, leaving is infrequent and considered a taxing effort. Medical Necessity – Patient is at risk for falling and has had recent falls. Utilize Mental Health Safety Checklist and the Decision tree to guide clinical decision making…Follow the red arrows.

Are there Signs/Symptoms of Cognitive/Mental health Issues and/or behaviors? YES. Patient has known cognitive impairment, but recent behavior changes. No gait changes, no signs of depression or anxiety. Screening for delirium via CAM is (+) indicating delirium superimposed on the cognitive impairment patient already has. Should 911 be called? Should patient go to Urgent Care Center? Should patient's physician be called? In this case, vital signs are stable, so MD should be contacted for further workup.

DEMENTIA DECISION TREE

Signs/Symptoms of Cognitive/Mental Health issues and/or behaviors* (CI)

YES

Is the current treatment plan effectively addressing these issues?

NO

YES

*Signs/Symptoms:
Confusion, Change in judgment,
Hallucinations/Delusions
Altered Memory, Loss of interest
Lethargy/Aggression

**See Mental Health Safety Checklist

Complete Cognitive Screen
Assess other possible causes
Delirium, Normal Pressure Hydrocephalus, Depression/Anxiety

CAM = positive
Mini-Cog = 2 points

No changes in gait or incontinence.

No signs of depression or anxiety.

Proceed with PT**
Continue to monitor

Delirium due to recent:
Hospitalization
UTI or dehydration
Infection
Med change or initiation

Normal Pressure Hydrocephalus:
Gait change + Incontinence?

Signs/Symptoms Untreated Depression/Anxiety?

Based on clinical findings:

- Contact MD to share findings for further workup
- Advise urgent medical care visit
- Initiate 911 call for EMS to assess patient

Case Scenario: Depression

Reason for referral: Recent fall, difficulty with getting in and out of home.

History of Present Illness: Patient was found on the floor in her bedroom by adult daughter. Patient was taken to MD for follow up. No fractures noted on x-ray. + contusion on L buttock.

Medications: Metoprolol, Prozac, levothyroxine, atorvastatin

Health Condition (ICD-10): Hypertension, depression, hypothyroidism, high cholesterol

Body Structures/Body Functions (Impairments): Generalized weakness, nervous system disorder.

Activities & Participations: ADL's- dressing upper body independent with setup, lower body with supervision once clothes were set up. Bathing – currently sponge baths at sink with min assistance. Grooming – independent with setup. Bed mobility – Supervision with use of bed bar. Transfers – sit to stand with contact guard x 1. Ambulation – 75 feet x 2 with supervision x 1 for safety. Gait is slow with shuffling steps noted. Ascending/descending steps with contact guard due to weakness and increased risk of falling. Patient reports limiting outdoor activities stating, "I don't feel up to going out." Daughter reports, "My mom has been staying in bed more and more. She also doesn't have much of an appetite."

Environmental Factors: Two floor mother/daughter home with 2 steps no hand rails to enter, bed and bath on first level, daughter lives with spouse on second floor. Home has hardwood floors throughout. Daughter is patient's primary caregiver. Daughter works full time approximately 20 minutes away from home and is available by phone during the day. Daughter assists patient before going to work and during nights/weekends.

Currently homebound due to need for assistance to leave the home; leaving is infrequent and requires considerable and taxing effort.

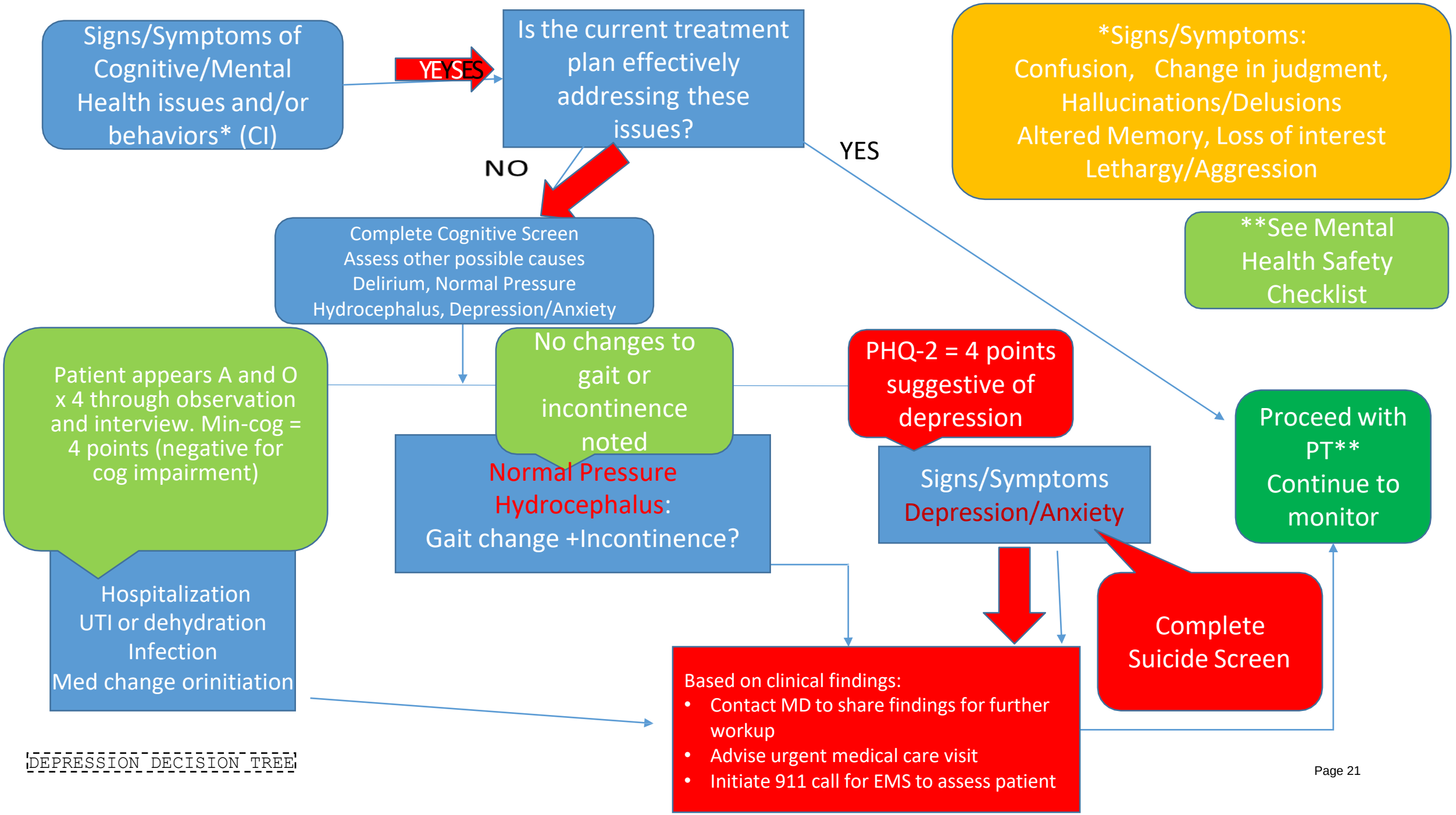
Personal Factors: 66-year-old female with a college education, former occupation – receptionist, financially able to meet needs. Spouse recently passed away 2 months ago.

Physical Exam: BP – 104/66 supine; 100/64 standing, HR – 110 bpm at rest, 110 bpm with activity, RR – 20 at rest, 24 with activity. Appears A and O x 4 at time of visit.

30 second chair stand test – unable to complete as patient needed assist to stand. Gait Speed – 0.8 m/sec. 2 Minute Step Test (2MST) – 57 reps. Rate of Perceived Exertion following 2MST – 5/10, Pain
– patient did not complain of pain when asked.

PHQ2 – 4 points.
Mini-Cog – 4 points.

Using the decision tree provided, Is this patient appropriate for physical therapy services? Yes/No. If no, what is the appropriate course of action to take? Complete suicide screen and contact MD for further workup. Vitals are stable. Physical Therapy is appropriate depending on patient willingness to participate.



DEPRESSION DECISION TREE

Case Scenario: Anxiety

Reason for referral: Difficulty performing ADLs due to shortness of breath and inability to ascend/descend stairs. No reported falls within past year.

History of Present Illness: Patient hospitalized for shortness of breath was discharged from hospital with referral for physical therapy to improve ADLs, gait and stair negotiation. Unable to climb stairs due to anxiety related to SOB and fear of falling.

Medications: Boniva 150 mg PO monthly; Prednisolone 5 mg PO 1 tablet daily; Advair (salmeterol/fluticasone) 50 mcg/250mcg PO 1 actuation every 12 hours; albuterol 2.5 mg (nebulizer) twice to three times per day as needed for bronchospasm. Metoprolol 25mg PO bid, Prozac 20mp PO daily, Xanax .025mg every 8-12 hours as needed for anxiety no more than 3 tablets per day, Tylenol 500 mg 1-2 tablets every 6 hours as needed for pain, no more than 8 tablets per day.

Health Condition (ICD-10): COPD, Anxiety, hypertension, osteoporosis

Body Structures/Body Functions (Impairments): Generalized weakness, shortness of breath, excessive kyphosis, nervous system disorder.

Activities & Participations: ADL's- dressing upper body moderate assistance due to SOB with activity, lower body with moderate assistance with SOB with activity and anxiety with reaching down towards feet. Bathing – not able – currently sponge baths at sink with mod assistance. Grooming – independent with setup. Bed mobility – Supervision with use of bed bar. Transfers – sit to stand with contact guard x 1 using FWW and erratic breathing pattern, complaints of nervousness. Ambulation – 50 feet x 1 with FWW and Min assist x 1 for safety and encouragement to perform needs VC for breathing pattern and relaxation reminders as patient reports feeling nervous. Gait is slow and steady, decreased step length and apprehension noted. Unable to ascend/descend steps at present.

Homebound due to need for a person and device to leave home; leaving is infrequent and requires considerable and taxing effort.

Environmental Factors: Split level home with 3 steps with one hand rail to enter, bed and half bath on first level, full bath up 2 flights of 6 steps with rail. Home has hardwood floors, and clear access throughout the home with FWW. Kitchen, DR 6 steps with rail to access.

Personal Factors: 66-year-old female with a college education, former occupation – receptionist, financially able to meet needs. Lives with spouse. Adult daughter and son live nearby and are available as needed, nights and weekends.

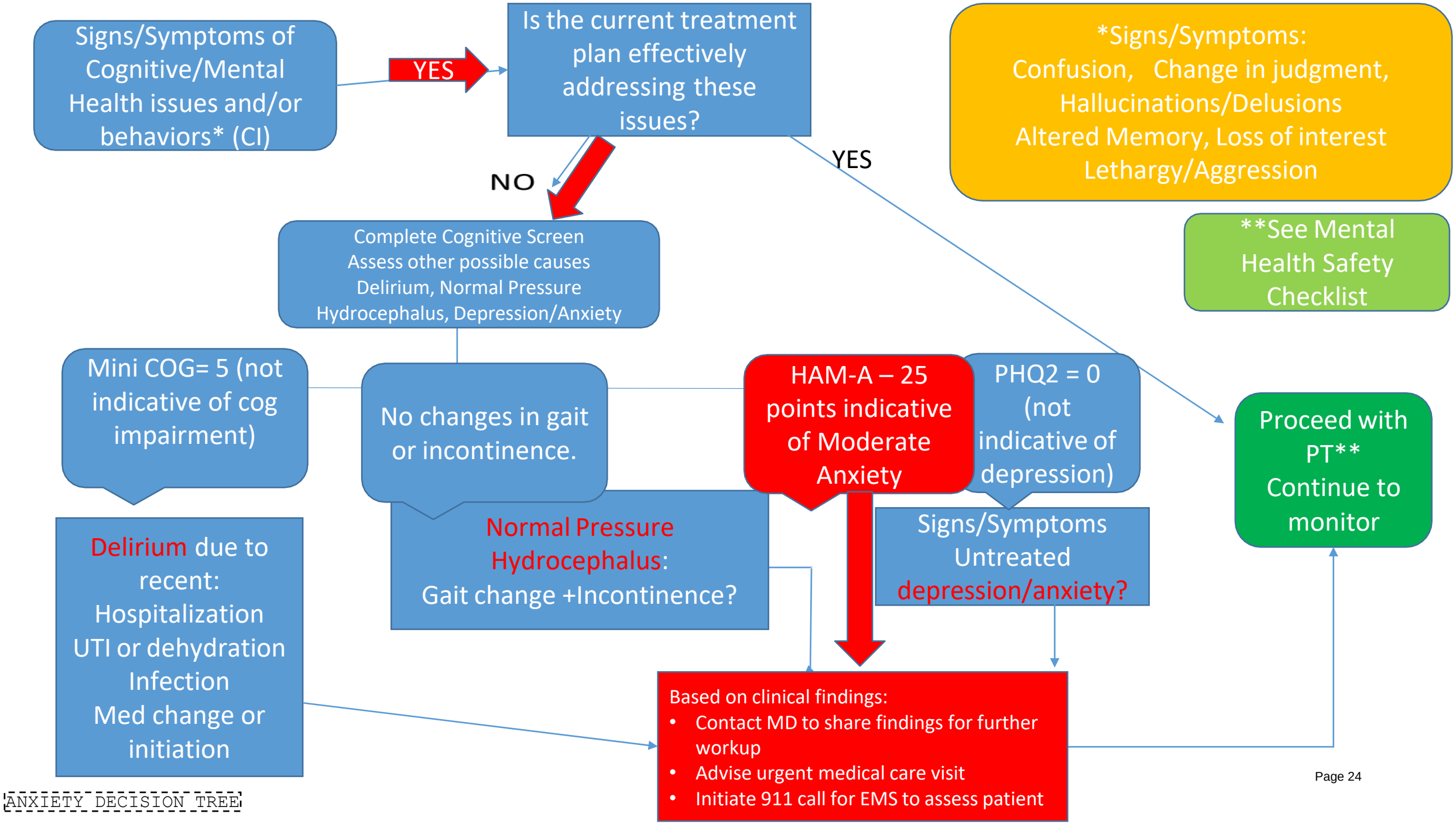
Physical Exam: BP – 116/72 supine; 110/68 standing, HR – 110 bpm at rest, 124 bpm

with activity, RR – 20 at rest, 26 with activity. Excessive use of accessory respiratory muscles noted.

30 second chair stand test – unable to complete as patient needed assist to stand. Gait Speed – 0.9 m/sec. 2 Minute Step Test (2MST) – 7 reps, test was stopped at 32 seconds due to patient request, due to anxiety. Rate of Perceived Exertion following 2MST – 8/10, Pain – patient did not complain of pain when asked.

PHQ-2 = 0; Mini-COG = 5; HAM-A = 25 points

Using the decision tree provided, Is this patient appropriate for physical therapy services? Yes/No. If no, what is the appropriate course of action to take. Decision is patient is appropriate to continue with physical therapy as vital signs are stable, patient is cognitively intact however, anxiety requires further workup. MD should be contacted.



ANXIETY DECISION TREE