Behavioral Health Evaluation

This document is intended to serve as a template for a behavioral health committee meeting in an extended care facility. The State Operations Manual (SOM), Appendix PP - "Guidance to Surveyors for Long Term Care Facilities" (F309 Quality of Care and F329 Unnecessary Drugs) were the foundation in which this template was created.

Sections of this document include:

Part 1: Pharmacist (Meeting Preparation)
Part 2: Social Services / Nursing (Meeting Preparation)
Part 3: Social Services (Meeting Preparation)
Part 4: Behavioral Health Committee Meeting Documentation
Part 5: Clinical Contraindication Documentation
  - Psychopharmacologic Therapy
  - Sedative / Hypnotic Medications
  - Antipsychotic Medication
**Part 1: Pharmacist (Meeting Preparation)**

**Date:** ______________  **Resident Name:** _______________________________________________________

A. List all medications given to manage behavior(s), stabilize mood, or treat a psychiatric disorder, include indication for use, start date, date of last attempted gradual dose reduction, and result of that reduction.

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Medication Name, Dose, &amp; Directions for Use</th>
<th>Indication for Use</th>
<th>Last Change in Therapy</th>
<th>Dose Change Successful?</th>
</tr>
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**Comments:**
## Part 2: Social Services / Nursing (Meeting Preparation)

Date: _______________  Resident Name: _________________________________________________________

**B. What targeted behavior(s) are being monitored? Is there a care plan in place for each behavior?**

(Please bring behavior log/monitoring for the previous 3 months to Behavioral Health Committee Meeting.)

<table>
<thead>
<tr>
<th>Targeted Behavior(s)</th>
<th>Frequency of Targeted Behavior(s) (Indicate Appropriate Description)</th>
<th>Care Plan Last Updated (Date)</th>
<th>PRN Medication Administered for Targeted Behavior(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Isolated (1 time event)</td>
<td></td>
<td>__ / __ / ____</td>
<td>Month:______ Times: ______</td>
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<tr>
<td>□ Rarely (&lt; weekly)</td>
<td></td>
<td>__ / __ / ____</td>
<td>Month:______ Times: ______</td>
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<tr>
<td>□ Occasionally (1-2x / week)</td>
<td></td>
<td>__ / __ / ____</td>
<td>Month:______ Times: ______</td>
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<tr>
<td>□ Frequently (3+ / week)</td>
<td></td>
<td>__ / __ / ____</td>
<td>Month:______ Times: ______</td>
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<tr>
<td>□ Daily</td>
<td></td>
<td>__ / __ / ____</td>
<td>Month:______ Times: ______</td>
</tr>
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C. What Non-Pharmacological measures/techniques have been attempted to manage the targeted behavior(s), and which are most effective for this particular resident?
**Part 3: Social Services (Meeting Preparation)**

Date: _______________   Resident Name: _________________________________________________________

**D. What is the reason for this review?**

- [ ] Quarterly Review
- [ ] Secondary to a Recent Behavior(s)
- [ ] Secondary to a Change in Condition

**E. Results of Relevant Scales**

<table>
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<tr>
<th>Most Recent BIMS</th>
<th>Most Recent PHQ9</th>
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<tbody>
<tr>
<td>Result:___________ Date: <em><strong>/</strong></em>/____</td>
<td>Result:___________ Date: <em><strong>/</strong></em>/____</td>
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<tr>
<td>Result:___________ Date: <em><strong>/</strong></em>/____</td>
<td>Result:___________ Date: <em><strong>/</strong></em>/____</td>
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**F. Is the resident currently being followed by Psychological Services?**

- [ ] Yes, Date last seen: ___/___/____
- [ ] No
## Part 4: Behavior Health Committee Meeting Documentation

**Date:** ______________  **Resident Name:** __________________________________________________________

### G. Have the resident’s targeted behavior(s) changed since the last evaluation?

- [ ] Improved  
- [ ] Worsened  
- [ ] No Change  

**Comments:**

### H. Do the targeted behavior(s) **represent danger** to self or others?

- [ ] Yes *(please explain)*  
  **Comments:**

- [ ] No  

### I. Have precipitating events to the targeted behavior(s) been identified?

- [ ] Yes *(please explain)*  
  **Comments:**

- [ ] No  

### J. Evaluate if this resident is a candidate for a dose reduction at this time?

- [ ] Yes *(specifically which therapy)*  

- [ ] No *(specifically which therapy)*  
  
  See Page 5 for Clinical Contraindication Documentation

### K. Committee Recommendations?

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| Prescriber Signature/Title | Date | [ ] Agree | [ ] Disagree *(brief rationale for compliance)* |
Part 5: Clinical Contraindication Documentation - Psychopharmacologic Therapy: Twice the First Year (two separate quarters with one month in between attempts), Annually Thereafter

Date: ________________    Resident Name: _________________________________________________________

L. Psychopharmacologic Clinical Contraindication:       Name of Medication: ________________________________

☐ Continued Use in Accordance with Relevant Current Standards of Practice

Rationale: Any attempted dose reduction would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

Additional Rationale:

☐ Target Symptoms Returned/Worsened with Most Recent Dose Reduction within the Facility

Rationale: Any attempted dose reduction would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

Additional Rationale:

☐ Benefit of Therapy Outweighs Risk of Therapy. Adverse Drug Reactions are monitored by facility staff, prescriber, and consultant pharmacist on a routine basis.

☐ Additional Documentation by Prescriber where Appropriate:

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Prescriber Signature/Title Date  □ Agree  □ Disagree (brief rationale for compliance)

Prescriber Rationale for Disagreement:
# Part 5: Clinical Contraindication Documentation - Sedative/Hypnotic Medications: Quarterly

Date: ________________    Resident Name: _________________________________________________________

M. Sedative Hypnotic Clinical Contraindication: Name of Medication: ________________________________

- [ ] Continued Use in Accordance with Relevant Current Standards of Practice
  
  Rationale: Any attempted dose reduction would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

  Additional Rationale:

- [ ] Target Symptoms Returned/Worsened with Most Recent Dose Reduction within the Facility
  
  Rationale: Any attempted dose reduction would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

  Additional Rationale:

- [ ] Benefit of Therapy Outweighs Risk of Therapy. Adverse Drug Reactions are monitored by facility staff, prescriber, and consultant pharmacist on a routine basis.

- [ ] Additional Documentation by Prescriber where Appropriate:

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<td>□ Agree □ Disagree (brief rationale for compliance)</td>
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Prescriber Rationale for Disagreement:

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Part 5: Clinical Contraindication Documentation - Antipsychotic Medication: Twice the First Year (two separate quarters with one month in between attempts), Annually Thereafter

Date: _______________    Resident Name: _________________________________________________________

N. Antipsychotic Clinical Contraindication: Name of Medication: ____________________________________________

- [ ] Continued Use in Accordance with Relevant Current Standards of Practice (Psychiatric Disorder Only)
  Rationale: Any attempted dose reduction would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.
  Additional Rationale:

- [ ] Target Symptoms Returned/Worsened with Most Recent Dose Reduction within the Facility
  Rationale: Any attempted dose reduction would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.
  Additional Rationale:

- [ ] Benefit of Therapy Outweighs Risk of Therapy. Adverse Drug Reactions are monitored by facility staff, prescriber, and consultant pharmacist on a routine basis.

- [ ] Additional Documentation by Prescriber where Appropriate: (Required for Dementia “Only” Therapy)

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Behavioral Health Evaluation

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