Comprehensive Therapy Specialists, LLC.

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*

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Behavioral Health Evaluation

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.

Start Date	Medication Name, Dose, & Directions for Use	Indication for Use	Last Change in Therapy	Dose Change Successful?
			Date: ☐ Increase ☐ Decrease	☐ Yes ☐ No
			Date: ☐ Increase ☐ Decrease	☐ Yes ☐ No
			Date: ☐ Increase ☐ Decrease	☐ Yes ☐ No
			Date: ☐ Increase ☐ Decrease	☐ Yes ☐ No
			Date: ☐ Increase ☐ Decrease	☐ Yes ☐ No
			Date: ☐ Increase ☐ Decrease	☐ Yes ☐ No

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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.)

Targeted Behavior(s)	**Frequency of Targeted Behavior(s)** *(Indicate Appropriate Description)*	**Care Plan Last Updated (Date)**	**PRN Medication Administered for Targeted Behavior(s)**
	☐ Isolated (1 time event) ☐ Rarely (< weekly) ☐ Occasionally (1-2x / week) ☐ Frequently (3+ / week) ☐ Daily	__ / __ / ____	Month:______ Times: ______ Month:______ Times: ______ Month:______ Times: ______
	☐ Isolated (1 time event) ☐ Rarely (< weekly) ☐ Occasionally (1-2x / week) ☐ Frequently (3+ / week) ☐ Daily	__ / __ / ____	Month:______ Times: ______ Month:______ Times: ______ Month:______ Times: ______
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	☐ Isolated (1 time event) ☐ Rarely (< weekly) ☐ Occasionally (1-2x / week) ☐ Frequently (3+ / week) ☐ Daily	__ / __ / ____	Month:______ Times: ______ Month:______ Times: ______ Month:______ Times: ______
	☐ Isolated (1 time event) ☐ Rarely (< weekly) ☐ Occasionally (1-2x / week) ☐ Frequently (3+ / week) ☐ Daily	__ / __ / ____	Month:______ Times: ______ Month:______ Times: ______ Month:______ Times: ______

C. What Non-Pharmacological measures/techniques have been attempted to manage the targeted behavior(s), and which are most effective for this particular resident?

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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

Most Recent BIMS	**Most Recent PHQ9**
Result:_____ Date: ___/___/____	Result:_____ Date: ___/___/____
Result:_____ Date: ___/___/____	Result:_____ Date: ___/___/____

F. Is the resident currently being followed by Psychological Services?

- ☐ Yes, Date last seen: ___/___/_____
- ☐ No

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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)* ☐ No	Comments:

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

☐ Yes *(please explain)* ☐ No	Comments:

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?

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

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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:*

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

Prescriber Rationale for Disagreement:

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Behavioral Health Evaluation

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:*

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

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)***

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

Prescriber Rationale for Disagreement:

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Contact with questions:

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