



Long-term Care Forum

Care of the Psychiatric Patient in the Nursing Home: Challenges and Opportunities

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Inside Interview

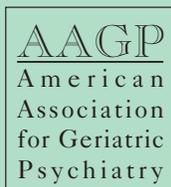
Poor Delivery of Geriatric Mental Health Services in the Long-term Care Setting: Implications for the Shaping of Public Policy and Nursing Home Regulations
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Lori A. Daiello, PharmD, BCPP

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Introduction

Nursing home residents with psychiatric disorders deserve to enjoy the full spectrum of therapeutic options that are available to their counterparts living in the community. These therapeutic options, the “tools” of the geriatric psychiatrist, include a broad range of traditional and novel psychotropic medications, in addition to well-recognized non-pharmacologic interventions such as psychotherapy.

In this issue of *Long-term Care Forum*, Gary Kennedy, MD, of Albert Einstein College of Medicine, describes how the inappropriate use of psychiatry’s therapeutic tools in nursing homes during the late 1980s ultimately prompted government interventions, engendering a strict regulatory climate that persists today. William Reichman, MD, Past-President of the Geriatric Mental Health Foundation and Past-President of the American Association for Geriatric Psychiatry (AAGP), provides an overview of the impact of poor psychiatric care on the nursing home milieu. He emphasizes the need for an increased on-site presence of geriatric psychiatrists, together with a therapeutic strategy that recognizes and values the contributions of a devoted and well-trained nursing staff.

Finally, from a different perspective, Lori Daiello, PharmD, BCPP, member of the American Society of Consultant Pharmacists Board of Directors, examines the various clinical “consequences” that may arise from the use of psychopharmacologic tools. She details the types of clinical problems that can occur whenever psychoactive medications are used, even in an appropriate manner, in the high-risk nursing home population.

Historically, when confronted with the extraordinarily high prevalence of mental health disorders among nursing home residents, America’s long-term care facilities have not always responded with appropriate, efficacious, and compassionate psychotherapeutic interventions. When psychiatry’s tools are used inappropriately—or when they are not used at all—there is a significant impact on the morbidity and mortality of nursing home residents, as well as an obvious deterioration in the “caring” milieu that should be the hallmark of any true nursing facility. Conversely, when psychiatry’s tools are used appropriately, the nursing home setting has the potential to epitomize the delivery of medically appropriate, efficacious, and compassionate neuropsychiatric care. The discussion of these issues attempts to aid the reader in achieving these goals.

Jacobo E. Mintzer, MD

*Professor of Psychiatry and Neurology
Medical University of South Carolina
Charleston, South Carolina*

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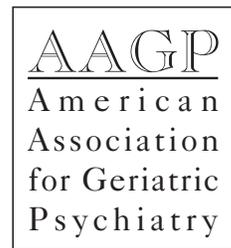
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Vice Dean
New Jersey Medical School
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Newark, New Jersey

Lori A. Daiello, PharmD, BCPP

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Purpose and Overview

The apparent disparity in therapeutic options available to psychiatric patients in nursing homes compared with psychiatric patients living in the community can have a significant impact on the morbidity and mortality of nursing home patients and result in a deterioration of psychiatric care provided. The formation of a therapeutic strategy, derived from an educated perspective on government intervention, careful consideration of psychopharmacologic agents and the consequences of their use, and the contributions of well-trained staff, is essential to the provision of appropriate neuropsychiatric care in the nursing home.

Learning Objectives

After reading this journal, participants should be able to:

- Discuss the evolution and current status of public policy and government regulations with respect to the delivery of mental health services in the long-term care (LTC) setting
- List common adverse drug events (ADEs) and clinical consequences of various classes of psychotherapeutic agents currently used in the nursing home population
- Identify various preventive strategies to help limit the risk for ADEs in the nursing home environment
- Discuss the ways in which poor psychiatric care not only poses a potential threat to the health and well-being of nursing home residents, but also negatively affects the job satisfaction and performance of nursing home personnel
- Identify employment and reimbursement issues that influence the on-site presence of geriatric psychiatrists in LTC facilities
- Describe strategies to improve the delivery of mental health services in nursing homes through educational initiatives, recruitment, financial incentives, and other appropriate interventions

Poor Delivery of Geriatric Mental Health Services in the Long-term Care Setting: Implications for the Shaping of Public Policy and Nursing Home Regulations

An Interview With Gary J. Kennedy, MD

*Professor of Psychiatry and Behavioral Sciences
Albert Einstein College of Medicine
Director
Division of Geriatric Psychiatry
Montefiore Medical Center
Bronx, New York*

We want to reform, not refuse, mental health services in the nursing home.

Gary J. Kennedy, MD, is Professor of Psychiatry and Behavioral Sciences at Albert Einstein College of Medicine. He is also Director of the Division of Geriatric Psychiatry and the Psychogeriatric Fellowship Training Program at Montefiore Medical Center, Bronx, New York.

In this interview, Dr. Kennedy discusses the evolution and current status of public policy and government regulations with respect to the delivery of mental health services in the long-term care (LTC) setting. He also addresses the controversial findings of a recent report published by the US Department of Health and Human Services Office of Inspector General (OIG) regarding Medicare reimbursement of “questionable” or “medically unnecessary” psychiatric services in nursing homes. Finally, he suggests specific strategies to improve the delivery of psychiatric care in the LTC setting through modifications of the current OIG assessment methodology, together with a more accurate definition of the types of therapeutic interventions or therapeutic tools deemed appropriate for nursing home residents with dementia.

Origins of Intense Government Regulation

LTC Forum: Historically, how has public opinion affected public policy in the area of LTC?

Dr. Kennedy: A reason why mental health service in nursing homes has been problematic derives from the way in which the American public views nursing home care. Of all the various types of health services provided in this country, perhaps the only service more stigmatized than nursing home care is the care rendered in state hospitals to psychiatric patients. Historically, nursing home care has been “the kind of care that we all want to avoid.” The nursing home setting has been considered a less-than-desirable environment by patients, their families, and even physicians who, in many cases, have viewed nursing home practice as an area with little prestige. Thus, from the outset, there are significant negatives that tend to skew the public’s perspective of LTC facilities, and this often affects public policy.

LTC Forum: How did the current regulatory climate evolve with respect to mental health services in LTC facilities?

Dr. Kennedy: Currently, nursing homes operate with a greater regulatory burden than any other health care facility. This regulatory burden developed as a consequence of what the federal government recognized as inadequate or inappropriate psychiatric care in nursing homes.

This poor psychiatric care, itself, was a consequence of the rapid demographic and socioeconomic changes that fueled the development of a true nursing home “industry” in the late twentieth century. These radical changes resulted in an explosion of patients suffering from psychiatric disorders in that setting, a growth that evolved without adequate development of specific psychiatric therapeutic interventions in the nursing home setting. From a historic perspective, initially LTC was a small cottage industry conducted largely by philanthropic and religious organizations that ministered to less fortunate individuals. These organizations provided care in either “old age homes” or nursing homes for people who were physically and economically disadvantaged, and who lacked other means of support in the family or community. Since this was a minority of individuals, the patient population was small and the industry was not considered profitable. At the other end of the spectrum, a few old age homes operated strictly for profit, and these did quite well. Assisted living facilities, the present-day counterpart to these old age homes, originated as “for profit” centers rather than as “public expense” care facilities, which is how many nursing homes operate today.

In the 1960s, however, Medicare legislation was passed, followed by Medicaid legislation, which served as a great stimulus for a new, highly profitable nursing home “industry.” Each nursing home became a franchise, because

Medicaid provided for LTC at federal expense. With time, some state hospital systems began to transinstitutionalize older psychiatric patients from the state hospitals, where the state shouldered 100% of the economic burden, to Medicaid-paid nursing homes, where the financial burden was split 50/50 with the federal government. (Medicaid is a joint federal and state program that provides services, including nursing home care, for the economically disadvantaged. The cost of these services is split between the government and the state; however, the decision on how to spend the funds is made by the state.) As a result, state hospitals, which previously had been important sites for care of the most severely disabled persons with dementia, saw their patient numbers plummet overnight. This saved the state legislatures a great deal of money while fueling the growth of private LTC facilities at increased federal expense.

Suddenly, the nursing home industry mushroomed, with a very high profit profile and very little regulation. Basically, the only requirement for charging a Medicaid daily rate was to have a population of Medicaid residents. Unfortunately, the nursing home industry failed to recognize the substantial mental health needs of the patients comprising this unique population. As Smyer et al noted, although more than three quarters of residents with a mental disorder resided at a nursing home that provided counseling, less than one fifth actually received any mental health services within the year.¹ Contrary to the needs of these patients, the burgeoning LTC industry became saturated with facilities that were designed to house and care for cognitively intact residents.² Almost every critical parameter of design and daily operation—building architecture, staff training, patient activities, availability of consulting physicians—was geared toward patients who could cooperate with their care. Quite soon, nursing home proprietors, administrators, and staff found that they were mired in a health care system the resources of which did not match the mental health needs of its patients. For some nursing homes, the responsibility to provide appropriate, and often expensive, mental health services was secondary to the need to generate profits. Predictably, poor psychiatric care—even outright fraud and abuse—was the result.

Symptoms of Poor Psychiatric Care

LTC Forum: Specifically, what were some of the manifestations of poor psychiatric care that prompted public concern and regulatory action?

Dr. Kennedy: One issue was the improper diagnosis of up to two thirds of nursing home residents with psychiatric disorders^{3,4}; a second issue was the misuse of psychotropic drugs. According to studies published in the 1980s, psychotropic drugs were routinely prescribed for a large percentage of nursing home patients without benefit of a psychiatric consultation.⁵ Based on the National Nursing Home Survey pretest, in 51% of cases, prescribing of psychotropic drugs was judged inappropriate on the basis of lack of mental disorder diagnosis, a dosage problem, or an inappropriate drug.⁶

Also at this time, such patient advocacy groups as the National Citizen's Coalition for Nursing Home Reform and the Alzheimer's Association began to focus public attention on the improper use of psychotropic medications as “chemical

restraints,” drugs used to control the behavior of nursing home residents simply for the convenience of staff. The improper use of physical restraints, including the full array of chairs, cuffs, vests, belts, and other devices that could lead to physical injuries, functional decline, and emotional desolation, was a concern as well. Nonetheless, restraints of either form, chemical or physical, often provided a simple solution to behavioral problems in a health care system the resources of which were grossly mismatched with the mental health needs of its patients. Finally, a landmark report from the Institute of Medicine (1986) focused public attention on the overprescription of antipsychotic drugs and the underprescription of antidepressants in nursing home patients with affective disorders.

Fiscal Concerns

LTC Forum: Were these clinical issues the primary impetus for the passage of specific nursing home regulations as part of the 1987 Omnibus Budget Reconciliation Act (OBRA 1987)?

Dr. Kennedy: Clinical issues were only part of the reasons for the regulations imposed by OBRA 1987. Another important driving force was purely financial—fiscal concerns that the federal government was being compelled to pay for inappropriate, inadequate, or even inhumane nursing home care. The basic issue was that states were inappropriately placing patients with psychiatric problems in Medicaid-certified nursing homes. These patients, who were either mentally ill or mentally retarded, were being housed at increased federal expense in facilities that were ill equipped to treat them. In most cases, these patients did not receive the active psychiatric treatment and ancillary mental health services that they required. The federal government, however, had continued to pay for this poor level of care.

OBRA 1987: A New Era of Scrutiny and Regulation

LTC Forum: What were some of the regulatory changes initiated by OBRA 1987?

Dr. Kennedy: OBRA 1987 included the federal Nursing Home Reform Amendments, which directed the Health Care Financing Administration (HCFA), now known as the Center for Medicare and Medicaid Services, or CMS, to issue regulations (HCFA 1991) and interpretive guidelines (HCFA 1992) that provided for government oversight of almost all aspects of nursing home care, including licensure, record keeping, equipment, nursing services, rehabilitation, and pharmacy services. To enforce the new OBRA-based regulations, states were directed to conduct periodic surveys of LTC facilities and to impose penalties for noncompliance.

OBRA 1987 also contained provisions that worked against the states' inappropriate placement of psychiatric patients in nursing homes. The legislation recognized that the states had “dumped” psychiatric patients in nursing homes, that these institutions were never structured to provide mental health services, and *that this had been done at federal expense*. In essence, the regulations enacted as a result of OBRA 1987 told the states, “You can't do this; you've got to take these patients back. If a

person has a mental disorder diagnosis, they [sic] can't go to a nursing home."

LTC Forum: What was the immediate impact of OBRA 1987 on the mental health community?

Dr. Kennedy: The Alzheimer's Association reacted strongly to this new government stance, because a diagnosis of dementia has a psychiatric diagnostic code in addition to a neurologic one. For the Alzheimer's Association, it became apparent that some individuals with Alzheimer's disease would be denied the nursing home care that they deserved, as a result of OBRA 1987. Organized psychiatry reacted vehemently to OBRA 1987 as well, because it was perceived as discriminatory legislation that targeted patients with mental disorders. In effect, OBRA 1987 was telling the mental health community, "You can't provide a certain level of nursing home care to someone with a mental disorder, even if [he or she is] severely disabled by it."

In summary, OBRA 1987 turned out to be a cumbersome piece of legislation that was initially interpreted as anti-mental health. So there was a lot of repair work to be done.

Fine-Tuning OBRA to Meet Patient Needs

LTC Forum: How did "repair work" begin on OBRA 1987?

Dr. Kennedy: Eventually, the combined efforts of patient advocacy groups and organized psychiatry resulted in considerable revisions of the original OBRA 1987 legislation. The upshot of their efforts was the institution of a set of screening procedures known as PASARR (Preadmission Screening and Annual Resident Review). The purpose of PASARR was to identify those patients with psychiatric disorders who required acute psychiatric care, and to ensure that these patients were not placed in nursing homes. However, under PASARR, patients with a primary diagnosis of dementia (with or without psychiatric complications or comorbid psychiatric illness) would remain eligible for nursing home care. So, rather than keeping persons with mental illnesses out of nursing homes, PASARR operated to identify the circumstances under which they could get in.

OBRA 1987: Effects on Patient Care

LTC Forum: With respect to patient care, how did OBRA 1987 affect the inappropriate use of psychoactive drugs?

Dr. Kennedy: OBRA 1987 took the perspective that use of a psychotropic medication in the LTC setting indicated a less than ideal quality of care. Subsequent language in the federal registry said that a psychotropic medication, specifically an antipsychotic, would be considered a "chemical restraint" unless the chart (and the physician's order) specifically indicated that the medication was being given for psychosis. This entailed specific documentation that had never before been considered.

In addition, OBRA-based regulations specified a list of acceptable indications and dose limits for various psychotropic medications, as well as requirements for monitoring adverse events. Nursing homes also needed to adhere to time frames for attempting dose reductions and drug withdrawal.

Since the mid-1990s, the HCFA has monitored the effect of these regulations. According to a 1998 HCFA report, the use of psychotherapeutic medications increased from 21.7% in 1991 to

46.1% in 1997.⁷ However, the tracking of prescribing trends within specific drug categories reveals that the use of antipsychotic medications has actually decreased by 59.8%, while the use of antidepressants has doubled. Much of this change has been the result of improved professional education and advances in scientific knowledge. Since the advent of OBRA 1987, many new psychotropic medications have become available, particularly antidepressants, that have improved tolerability and safety profiles compared with older drugs.

LTC Forum: More than a decade has passed since the enactment of OBRA 1987. In your opinion, what did this legislation accomplish?

Dr. Kennedy: The actual OBRA 1987 legislation and legislative language did succeed in shifting the focus of the LTC industry toward the patient's "well-being." In other words, it was no longer sufficient to be merely custodial. However, as a recent editorial in the *American Journal of Geriatric Psychiatry* points out, OBRA 1987's "punitive regulatory practices [highlight] potential cases of fraud and abuse instead of fostering comprehensive, patient-centered quality improvement."⁸

OIG Focus in the New Millennium

LTC Forum: Where do we stand today in the process of regulation, review, and reform?

Dr. Kennedy: Right now, fiscal issues are again an important focus. Currently, the OIG is targeting the issue of Medicare reimbursement for what it has called "medically unnecessary" or "questionable" psychiatric services in nursing homes. Medically unnecessary psychiatric services, according to the OIG, include:

- Services provided to patients whose cognitive limitations make them unable to benefit from psychiatric intervention (eg, those with advanced dementia, severe agitation, delusions, or paranoia)⁹
- Services of inappropriate frequency or duration
- Services that do not appear to stabilize or improve patients' conditions (eg, the intervention is not maintaining stability, preventing further decline, ameliorating behavioral disturbances, or relieving distressing symptoms)⁹

Questionable psychiatric services, according to the OIG, include those services with incomplete documentation. Other services are considered questionable because of a patient's cognitive function.

In January and February 2000, the OIG studied the medical records of 274 different beneficiaries in 251 different nursing homes for the first 6 months of 1999. From a 1% sample of the National Claims History File, a national stratified random sample of 450 line items was chosen. The study sample included 5 of the top 7 codes for nursing home psychiatric services that corresponded to individual psychotherapy, group psychotherapy, and psychological testing. Those 7 codes accounted for more than 90% of all Medicare Part B nursing home psychiatric payments in 1998, and were considered by the OIG to be "among the most problematic."⁹

In the report of this study, which was published in 2001, the OIG determined that 27% of all Medicare psychiatric services in

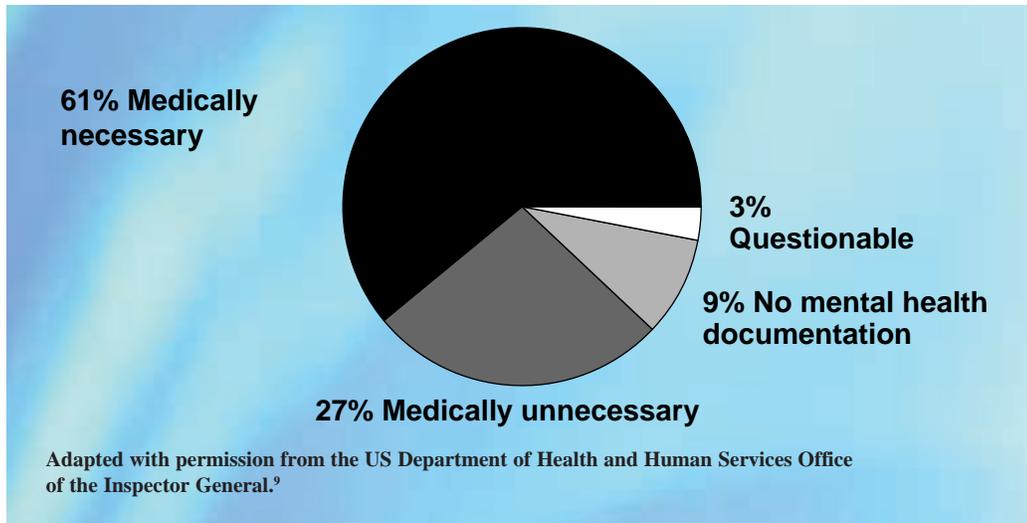


Figure 1. Over one third of Medicare payments for psychiatric services in nursing homes are inappropriate.

nursing facilities were medically unnecessary, while 3% were questionable (see Figure 1).⁹ An additional 9% of mental health services were found to have no psychiatric documentation in the patient's nursing home record.⁹

LTC Forum: In your opinion, what are some limitations of this OIG report?

Dr. Kennedy: The current OIG report was based on chart reviews, not on interviews with nursing home staff. Also, the sample was not very representative: it was not large enough, and it did not take into account variability by geographic region. Additionally, definitions were difficult because they were not based on standards of practice developed by mental health specialists.

Finally, the OIG report did not detail the proportion of inappropriate or medically unnecessary services with respect to billing code, provider type (physician, psychologist, social worker), or procedure (psychological testing, psychotherapy, medical assessment, and treatment). This shortcoming was recently addressed in a joint response to the OIG report that was published by the American Association for Geriatric Psychiatry (AAGP) and the Council on Aging of the American Psychiatric Association (CoA/APA).¹⁰

LTC Forum: What is your opinion of the OIG's overall findings?

Dr. Kennedy: The OIG's 2001 report seems like overkill. I say this because, as the AAGP-CoA/APA statement asserts, patients with psychiatric disorders in nursing homes represent "a population in great need."¹⁰ Currently, mental health services are not delivered in nursing homes to anywhere near the extent to which they should be. Clearly, there is excess disability and suffering that probably could be reduced by increasing and improving mental health services in the nursing home, not by working to reduce these services.

One of the other problems—and this is part of the regulatory environment with Medicare reimbursing for specific mental services—is that clinicians, by regulation, cannot be reimbursed for psychotherapy for a patient who has dementia. In other words, if a patient carries a diagnosis of dementia, whether it is

end-stage dementia or the very earliest stages of dementia, Medicare will not pay for that individual's psychotherapy.

In addition, regulators have a very limited view of psychotherapy options. They view psychotherapy as monolithic insight-oriented psychotherapy. They do not regard group therapy, behavior modification therapy, or cognitive behavioral therapy as psychotherapy.

Some Solutions: Better Codes and a New Look at Outcomes

LTC Forum: What solutions do you suggest?

Dr. Kennedy: Some of the Medicare intervention codes that were cited as being quasifraudulent or unjustified were psychotherapy codes for services administered to persons with dementia. Among other issues, the OIG is concerned that LTC facilities are billing the government for services that normally should be provided to patients with dementia out of the daily rate for the nursing home. Typically, these would include group and activity services, music, and recreational therapies. The OIG is concerned that nursing homes have psychologists and social workers provide those services in a group setting and then bill these services as psychotherapy. Clearly, this is wrong, and a nursing home should not be able to do it. However, to say that every psychotherapy intervention for a patient with dementia cannot be justified—that's wrong, as well.

One solution would be to develop better codes that would allow for expanded psychotherapeutic interventions for a person with dementia. Obviously, if the person is so severely demented that he or she no longer has any verbal output—is unable to communicate, unable to understand, unable to express himself or herself—then a verbal therapy is of no benefit. However, there may be something that clinicians can do with the staff to assist that person. We need improved ways of identifying the circumstances under which a specific psychotherapeutic intervention, whether it is behavior modification or working with the staff, will be reimbursed by Medicare. These interventions should include therapies that are not insight-oriented, even interventions that involve interaction with staff members who care for the patient.

LTC Forum: Would you suggest that we need more appropriate studies, with designs that better reflect the reality of the nursing home setting?

Dr. Kennedy: Definitely. We need studies that focus on novel types of outcomes. It may be that the “favorable” outcome we are seeking is actually better staff morale and satisfaction, rather than standard measures of how the patient benefits. For example, the real benefit of psychotherapy may be measured in terms of increased interaction between the nursing staff and a patient, or by a more satisfying interaction. Typically, we do not think in those terms. We think that if the patient is not obviously better by standard measures, then the intervention is not beneficial. But if the family or the staff is better, I would argue that the intervention has actually improved quality of life for everyone involved.

So yes, we do need more and better scientific studies. However, public policy does not always follow science. In fact, it generally does not follow science. It usually follows one legislative person with a constituent, or a parent with a burning interest, who can mobilize people to put new legislation in action.

The Future: Increased Advocacy for an Underserved Population

LTC Forum: Are you suggesting that increased patient advocacy would again spur reform?

Dr. Kennedy: An advocate is needed for this particular issue just as clearly as one is needed for a type of cancer or a type of infectious disease. The majority of our patients cannot advocate for themselves. Take the case of children’s mental health services. The children do not vote. They do not lobby. But a mark of the quality of our concern for one another is the care we provide for those who cannot protect themselves. The Alzheimer’s Association, interestingly enough, has been a “pro nursing home” advocate in the sense that they recognize LTC facilities as places of respite care, and they believe this situation may be the best medicine for the patient and family in some instances.

Unfortunately, advocacy groups are still confronted with an array of stigmas and challenges unique to the mental health arena. First of all, they must try to awaken public interest in the problems of patients who live in a doubly stigmatized environment—nursing homes that provide psychiatric care. Also, we are not discussing a “cure.” Today, a large segment of the public still thinks that mental health therapies are ineffective. In fact, there are still persons who believe that mental illness is just a matter of character: a person is “weak-willed.” That is the reason for his or her depression or anxiety. So we have a lot of things going against us as we try and improve mental health services.

LTC Forum: Are you optimistic about future prospects for improving mental health services in nursing homes?

Dr. Kennedy: In the past, the upshot of mobilizing organized psychiatry and psychology, together with the patient advocacy groups, was an improvement in psychiatric services in nursing homes. The fraud that followed the growth of the nursing home “industry,” basically a blank check to nursing homes through Medicaid, resulted in a heavy regulatory burden without necessarily reforming the quality-of-care practices. OBRA 1987 was meant to be a major reform, but initially it operated to prevent the delivery of mental health services in nursing homes. It was the advocacy groups, consumer groups, and the mental health professionals who mobilized to reverse the situation. Thus, paradoxically, OBRA 1987 eventually resulted in an improvement in psychiatric services in nursing homes.

I hope that the OIG report will have the same paradoxical effect. Although the OIG’s initial assessment may be wrong, it can provide seed for important revisions in public policy. I hope that it will spur a movement by consumers and mental health professionals to counter the OIG’s perspective with a much better set of regulations and practices.

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Quality of Psychiatric Services in the Nursing Home: Impact on Patients, Staff, and the Nursing Home Milieu

William E. Reichman, MD

Associate Professor of Psychiatry

Vice Dean

New Jersey Medical School

University of Medicine and Dentistry of New Jersey

Newark, New Jersey

With the advent of the new millennium, there is evidence that US nursing homes are experiencing an even greater influx of patients with psychiatric illnesses than was documented in the 1990s.

William E. Reichman, MD, is Associate Professor of Psychiatry and Vice Dean of the New Jersey Medical School at the University of Medicine and Dentistry of New Jersey (UMDNJ). He is a Past-President of the American Association for Geriatric Psychiatry (AAGP) and recently served as President of the Geriatric Mental Health Foundation. Dr. Reichman has written extensively on a variety of topics pertaining to geriatric mental health and Alzheimer's disease, including dementia care and models of geropsychiatric service delivery.

In the following article, Dr. Reichman follows up on our previous conversation with Dr. Kennedy, focusing on the rarely discussed notion of inadequate psychiatric care in the nursing home milieu. He emphasizes that poor psychiatric care not only poses a potential threat to the health and well-being of nursing home residents, but may also negatively affect the job satisfaction and performance of nursing home personnel. He suggests strategies to improve the delivery of mental health services in long-term care (LTC) through an increased on-site presence of psychiatric specialists, as well as through educational initiatives, recruitment, financial incentives, and novel research into appropriate interventions.

Mental Health Services and the LTC Milieu: The Current Situation

In spite of substantial evidence that nursing home residents have a great need for psychiatric services, relatively few studies have focused on how LTC facilities are currently endeavoring to meet that need, especially in nonpharmacologic ways. In general, published studies document the shortcomings of the current LTC system with respect to either the quality or quantity of psychiatric services rendered. For example, according to a survey of New York State nursing facility administrators, only 40% of facilities in the state had daily physician presence.¹ In LTC facilities where a physician *is* available, his or her clinical expertise may not always be appropriate to the patients' mental health needs. In the New York State study mentioned above, most medical directors were trained in either family medicine (42%) or internal medicine (55%), and 73% of them did not have a certificate of added qualification in geriatrics.¹

Support for this observation comes from studies such as those conducted by Podgorski et al, who reported that among LTC patients, "primary care physicians did not record a mental disorder in 29% of residents who were found to have one on psychiatric examination."² The clinical shortcomings of nonpsychiatric physicians are further documented in work published by Borson and colleagues, in which a survey of 899 nursing directors suggested that "certain categories of staff (registered nurses, social workers, and activities therapists) may be substantially more effective in managing disruptive residents' behaviors than are...nonpsychiatric physicians, who write the majority of orders for psychotropic drug therapy for nursing home patients."³

When Smyer et al reviewed data from the Institutional Population Component of the National Medical Expenditure Survey, they found that psychiatric treatment rates were low in all types of facilities, although rates in not-for-profit and government facilities were slightly higher than those in for-profit facilities.⁴ In another study published by Reichman et al, a 6-state survey of nursing directors documented that rural nursing homes and small-capacity nursing homes (fewer than 100 beds) were especially underserved by psychiatrists. (see Table 1)⁵

Even when psychiatric services are provided at a level that is consistent with patient needs, there is a danger that other factors in the nursing home milieu may operate to exert a negative influence on patient care, including mental health care. For example, according to a 1999 Office of Inspector General (OIG) report, inadequate staffing levels are "one of the major problems in

Table 1**Frequency of Consultation by a Psychiatrist as a Function of Nursing Home Location and Size, %**

Frequency	Location ^a			Size ^b		
	Rural	Suburban	Urban	Small (≤100 Beds)	Medium (101-300 Beds)	Large (300+ Beds)
Never	27.5	10.0	6.5	21.7	10.7	4.6
<Once per month	27.5	20.0	17.9	31.3	17.3	2.3
Once per month	26.7	29.9	32.9	27.2	32.7	13.6
Once per week	15.5	25.9	29.7	13.7	29.1	27.3
>Once per week	2.8	14.3	13.0	6.1	10.3	52.3

^aMantel-Haenszel χ^2 [1]=64.4; $P<.001$.

^bMantel-Haenszel χ^2 [1]=93.2; $P<.001$.

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nursing homes...staffing shortages lead to chronic quality of care problems.”⁶ In LTC facilities, the turnover rate for certified nurses’ aides (CNAs) ranges from 40% to 75%.⁷ Because CNAs comprise 43% of nursing personnel and provide 90% of nursing care,⁸ it is not surprising that nursing home residents are among the first to feel the impact of staffing shifts and shortages. As Mesirov et al observed in 1998, a high turnover rate for CNAs interrupts continuity of care, severs relationships with nursing home residents “who do not respond well to change,” and produces a sense of loss that “can result in increased confusion, anger, and sadness.”⁸ Accordingly, patients who are confused, angry, or sad because of turnover-related caregiver loss will be incapable of responding optimally to psychotherapeutic interventions, even in LTC facilities where psychiatric consultation is considered adequate.

Improving Mental Health Services in LTC: Beginning With Existing Tools

In their capacity as caregivers, psychiatrists and nursing staff have the potential to function as powerful “tools” in the psychotherapeutic armamentarium. It is obvious, however, that their value tends to be either ignored or underestimated in the present LTC system. Logically, improving the system might begin by increasing the availability of psychiatric consultation in nursing homes and taking measures to ameliorate high turnover rates among nursing personnel.

With respect to the first point, establishing a formal contract between consultant and nursing home might be an effective incentive. Evidence for this is provided in the 6-state survey of nursing directors already described. According to this survey, psychiatrists who practiced under contract with a nursing home were twice as likely to be judged as providing “adequate”

services as those who practiced under a fee-for-service arrangement.⁵ In addition, the presence of a formal contract also increased the frequency of on-site psychiatric consultation, especially for weekly or “greater than once per week” patient contact. (see Table 2)⁵

In addition to the presence of a formal contract for psychiatric services, it also would be prudent to ensure equitable monetary compensation to psychiatrists for valuable therapeutic services that are labor-intensive but poorly reimbursed. These services include nonpharmacologic patient management, staff support,

Table 2**Frequency of Consultation by a Psychiatrist as a Function of Financial Arrangement, %**

Frequency	Type of Financial Arrangement ^a	
	Formal Contract	Fee-for-Service
Never	3.3	9.1
<Once per month	13.1	26.4
Once per month	36.1	32.0
Once per week	30.3	23.0
>Once per week	17.2	9.5

^aWilcoxon rank-sum statistic, $S_{(1)}=91,735$; $\chi^2=28.12$ ($P<.001$).

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staff stress reduction, and conflict resolution.⁵ In facilities where these services are readily available, one might anticipate an improvement in the therapeutic milieu, a reduction in staff turnover, and a higher level of satisfaction among patients and families.

Historically, appropriate and efficacious pharmacologic treatment often has been underestimated as a tool for improving the therapeutic milieu. With more appropriate pharmacologic treatments, the nursing home setting becomes more hospitable to everyone — patients, staff, and visiting families. As patients receive better treatment, staff will see more manageable behaviors without the worry of side effects that increase patient morbidity and impede social interaction.

Specifically, for many patients with psychosis or behavioral problems related to dementia, the atypical antipsychotics have proven to be safe and efficacious. For example, in a study by Katz and colleagues, risperidone was found to be superior to placebo in treating elderly patients whose psychotic or behavioral symptoms were due to Alzheimer's disease (AD), vascular dementia, or mixed dementia.⁹ After 12 weeks of risperidone therapy (0.5-2 mg/d), patients showed significant reductions in Behavioral Pathology in the Alzheimer's Disease rating scale (BEHAVE-AD) total scores as well as in the psychosis and aggressiveness subscale scores. In this study, the most common side effects were extrapyramidal symptoms (EPS), somnolence, and mild peripheral edema. However, the frequency of EPS in patients treated with risperidone 1 mg/d was not significantly greater than in patients treated with placebo.

Similarly, Street et al demonstrated the effectiveness of low-dose olanzapine (5 mg and 10 mg/d) compared with placebo in AD patients with psychosis and behavioral symptoms, specifically agitation and aggression.¹⁰ Importantly, this low-dose therapy produced no significant cognitive impairment, increased EPS, or central anticholinergic effects when compared with placebo. Moreover, olanzapine-treated patients showed a significant reduction in Occupational Disruptiveness score, a measure of the impact of patients' symptoms on the caregiver.

Furthermore, in a recent placebo-controlled, multicenter study comparing quetiapine, haloperidol, and placebo in Alzheimer's disease patients, Tariot and colleagues observed no difference between treatment arms with regard to psychosis. However, a difference in the Brief Psychiatric Rating Scale (BPRS) agitation subscale was observed suggesting possible effects of antipsychotic therapy on agitation.¹¹ Of special relevance is the benign safety profile of quetiapine as compared with haloperidol.

Increasingly, attention has been directed to other pharmacologic interventions that might be helpful to treat behavioral, cognitive, and functional decline in dementia. Cholinesterase inhibitors represent one such intervention for patients in LTC facilities.

In a 6-month, placebo-controlled, multicenter nursing home study, Tariot and colleagues demonstrated that donepezil use maintained or improved cognition and overall dementia severity compared to placebo in residents with AD.¹² In separate 1-year, placebo-controlled studies of AD patients, Winbald and colleagues demonstrated that donepezil can exert beneficial effects on AD patients' performance of activities of daily living,¹³ while Mohs et al documented a 38% reduction in the risk of functional decline.¹⁴ In addition, a recent poster presentation by Etemad at the annual meeting of the American Neurological Association revealed that a 26-week trial of the cholinesterase inhibitor rivastigmine was found to curb disruptive behavior in AD patients and reduce the need for other psychotropic medications.¹⁵

Looking Toward the Future: A Call to Action

As more Americans enter their senior years, the first decades of this new millennium will see an increased demand for nursing homes, including their psychiatric services. The present system of LTC does not seem to have used existing psychotherapeutic interventions to maximal advantage when addressing the substantial mental health needs of nursing home residents. And the trend toward inadequate care is likely to continue unless mental health professionals mount a concerted effort to reverse it. Logically, geriatric psychiatrists are the most qualified to spearhead this effort, since these physicians, in the words of the AAGP, "have the full range of knowledge and clinical skills required to address the biological, psychological, and social aspects of mental disorders of late life and are uniquely

qualified to integrate these complex factors in the assessment and management of geriatric mental health problems."¹⁶

Any effort to increase the direct involvement of geriatric psychiatrists in the administration and therapeutic milieu of the nursing home should begin with physicians in training. In order to recruit young physicians into the specialty of geriatric psychiatry, they should be exposed to medicine as practiced in the nursing home environment while they are still medical students and residents. It is hoped that these young physicians will soon appreciate how intellectually stimulating, and emotionally rewarding, and, at times, how much fun it is to take care of geriatric patients.

Nursing home administrators must be made aware of the advantages of having a geriatric psychiatrist readily available on-site in their facilities, not only as a consultant but as an integral member of a permanent mental health team. The continuing presence of a geriatric psychiatrist would prove to be a great asset to LTC facilities, not only in addressing residents' psychiatric symptoms and behavioral issues, but also in developing strategies to aid nursing staff in coping with the demands of elder care. LTC facilities should consider establishing relation-

Among the geriatric population, perhaps even more than in other age groups, efficacious therapeutic interventions for psychiatric illness can have a significant impact on patient morbidity, mortality, and overall quality of life...the positive effects are often dramatic.

ships with geriatric psychiatrists in order to increase their on-site presence. As part of a strategy to decrease staff stress and turnover, the psychiatrist also should be fairly reimbursed for rendering such nontraditional services as staff education, staff support, and the implementation of nonpharmacologic interventions. Under arrangements where services are billed to Medicare, there must be more consistent reimbursement policies by regional Medicare intermediaries.

In addition to increasing the availability of on-site psychiatric specialists in LTC facilities, better training of all nursing home staff should be provided. An interdisciplinary team approach might be helpful, such as the one employed by Reuben's group in the management of behavioral disturbances among geriatric patients in a transitional care unit (TCU).¹⁷ In this study, a Behavior Management Program used an interdisciplinary Behavior Team consisting of both psychiatric and nonpsychiatric physicians, geriatric nurse practitioners, geriatric clinical nurse specialists, a recreation therapist, a speech pathologist, and a geriatric TCU pharmacist. Six months of care by the Behavior Team was accompanied by a reduction in behavioral episodes among TCU residents, together with an improvement in the use of nonpharmacologic interventions in behavior management. In addition, the Behavior Management Program promoted professional education and camaraderie among staff, and created a

productive liaison between TCU and the psychiatry services.¹⁷ The investigators have suggested that further studies be undertaken to test the validity of their findings in other clinical settings, including LTC facilities.¹⁷

Once an LTC facility has succeeded in assembling a well-trained, clinically astute, and caring staff, every effort must be made to retain these individuals. What incentives should be provided to foster staff retention? In addition to offering an attractive salary and employee benefits, employers also must create an attractive working environment and provide opportunities for professional development and growth. Nursing home residents comprise a unique and very interesting patient population. To care for them successfully can be a very rewarding experience, personally as well as professionally.

Finally, more federally funded research is needed with respect to the types of psychiatric interventions that are most likely to be efficacious and safe in the LTC setting. Although several psychotropic drug studies are available, much more information than this is needed, such as information concerning nonpharmacologic interventions, staffing stress and turnover, and the dynamics of staff-patient interaction. More information also is needed concerning the complex psychosocial factors that will create a milieu of optimal care in LTC facilities.

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Clinical Consequences of the Inappropriate Use of Psychotropic Medications in Nursing Homes: Implications and Prevention of Adverse Drug Events

Lori A. Daiello, PharmD, BCPP

Geriatric Psychopharmacology Specialist

President

Pharmacotherapy Solutions

Orlando, Florida

Nursing home residents represent a special population whose risk for ADEs is even greater than that of the community-dwelling geriatric population

Lori A. Daiello, PharmD, BCPP, is President of Pharmacotherapy Solutions, a firm that provides advanced psychopharmacology and pharmacotherapy consultations for long-term care (LTC) facilities, as well as educational programs and project development in geriatric psychopharmacology for professional and lay audiences. Dr. Daiello has served as Chairperson of the Educational Advisory Committee of the American Society of Consultant Pharmacists (ASCP). She also has served on the Ohio Department of Mental Health LTC Behavioral Task Force. Additionally, she has been a member of the Scientific Advisory Committee on Psychiatric Services in Long-Term Care (American Association for Geriatric Psychiatry [AAGP], American Medical Directors Association [AMDA], ASCP), and an advisor to the State of Florida Panel for the Study of End-of-Life Care.

In the following discussion, Dr. Daiello provides an overview of the clinical impact of adverse drug events (ADEs) due to use of psychotropic medications in the LTC setting, and highlights specific types of ADEs that arise as “consequences” of such use. In so doing, Dr. Daiello examines various classes of psychotherapeutic agents. She emphasizes that nursing home residents represent a unique population at risk for ADEs, with special characteristics and needs that are different from the community-dwelling elderly. Finally, she suggests various preventive strategies to help limit the risk for ADEs in the nursing home environment.

Incidence of ADEs in the LTC Setting

Overall, the geriatric population possesses inherent high-risk characteristics that may significantly increase the risk for ADEs, including psychiatric ADEs. These high-risk characteristics may include multiple medical comorbidity, use of complex drug regimens, presence of episodic acute illness, and the frailty of old age. Among all elderly individuals, nursing home residents represent a special population, whose risk for ADEs is even greater than that of the community-dwelling geriatric population. This stems from the fact that nursing home residents tend to be “frailer” than the community-dwelling elderly and have a relatively high incidence of chronic disease and functional disability. In addition, 20% of all nursing home residents take at least 10 medications daily, with the average resident taking 6.¹

Recently, several important studies have examined the problem of ADEs in the nursing home population. In one 12-month study, Gurwitz and colleagues reported an incidence of 1.89 ADEs per 100 resident-months in a large, community-based nursing home cohort.² During 28,839 nursing home resident-months of observation, investigators described 546 ADEs and 188 potential ADEs, of which 1 was fatal, 31 (6%) life-threatening, 206 (38%) serious, and 308 (56%) significant. Overall, more than half of all ADEs were judged to be preventable. Among psychoactive medications, antipsychotics were associated with the highest incidence of ADEs (23%); antidepressants and sedatives/hypnotics were associated with lower incidences (13%).

In a second study, which attempted to identify specific risk factors for ADEs among nursing home residents, Field and colleagues documented 226 preventable ADEs in 2916 study subjects over a 12-month period.³ Independent risk factors included being a new resident (admitted within 2 months of the ADE), having a score of 5 or higher on the Charlson comorbidity index, and receiving 5 or more regularly scheduled medications. Specific medications that correlated with a high risk for ADEs included anti-infectives/antibiotics (odds ratio [OR] 4.0; 95% confidence interval [CI], 2.5-6.2), antipsychotics (OR, 3.2; CI, 2.1-4.9), and antidepressants (OR, 1.5; CI, 1.1-2.3).

Although this research provides some clinically useful information for the practicing geropsychiatrist, it only begins to delineate the scope of the

problem concerning ADEs and their risk factors in the LTC setting. Within the current body of medical literature, knowledge of ADEs among nursing home residents is relatively limited. This clinical reality exists, although federal regulations mandate stringent and continuous monitoring for ADEs in Medicare-funded LTC facilities.

In daily practice, psychiatrists who treat nursing home patients routinely face the challenge of selecting efficacious psychoactive medications that not only relieve distress and alleviate symptoms, but are also pharmacologically appropriate to the patient's overall medical condition. The goal is to provide good psychiatric treatment that complements nonpsychiatric medical therapy while limiting the risk for any adverse events that may negatively impact quality of life (QOL), overall morbidity, or (in rare cases) mortality.

Every psychoactive medication carries its own "laundry list" of potential side effects. However, for the geriatric clinician who cares for a unique patient population in a specialized setting, laundry lists may be less helpful than an approach that emphasizes the broader clinical picture. Since this issue of *Long-term Care Forum* emphasizes "consequences," the problem of ADEs will be discussed from a clinical perspective, one that reflects the real-life impact of psychiatric and psychomotor side effects on the daily life of nursing home residents.

Falls and Fractures

Of all the potential ADEs associated with psychotropic drug use in the elderly, falls and fractures, specifically femoral fractures, seem to carry the most immediate increased risk of morbidity and mortality. These ADEs are not necessarily life-threatening in the short-term. However, they have a greater impact on long-term survival and QOL in the LTC population than the population at large because of the increased morbidity in the LTC population after a fall-related fracture and the ensuing difficulty with rehabilitation. Hannan and colleagues studied this point in 571 elderly patients who were hospitalized for a hip fracture.⁴ Looking at mortality and locomotion, investigators examined patients 6 months posthospitalization and found that overall mortality was 13.5% for the total patient population (nursing home residents plus community-dwelling subjects). Among the subgroup of nursing home residents, however, mortality was almost 24%, with the rate of "adverse outcome" (defined as either mortality or needing total assistance to ambulate) at approximately 54%.⁴ In this study, dementia was found to be a significant risk factor for mortality, a finding that reinforces the earlier work of Morrison and Siu.⁵ These investigators placed the 6-month mortality rate at 55% for elderly patients with both end-stage dementia and hip fracture. When Thapa attempted to remove dementia as a confounding factor in a study of falls in nursing home residents,

additional independent risk factors for falls emerged, including the use of psychotropic drugs. These medications nearly doubled the risk for recurrent falls.⁶

In the literature, agents in the benzodiazepine class of psychotropic medications have been most often associated with falls, primarily because of their sedative properties. For this reason, geriatric clinicians in the nursing home setting tend to be cautious in prescribing agents from this drug class, especially the long-acting agents with a half-life of 24 hours or more (diazepam, chlorthalidone, clorazepate, flurazepam).

In a recent study by Ray and colleagues, the rate of falls increased 44% among nursing home residents who used any form of benzodiazepine.⁷ Among specific benzodiazepine classes, there was a correspondence between fall rate and drug elimination half-life; the adjusted rate ratio for the long-acting drugs (diazepam, chlorthalidone, clorazepate) was 1.73 compared with 1.15 for the short-acting drugs (temazepam, oxazepam,

triazolam). The intermediate-acting benzodiazepines (lorazepam, alprazolam, clonazepam, estazolam), which accounted for the majority (74.1%) of benzodiazepines used in the study population, had an adjusted rate ratio of 1.45. For all benzodiazepine classes, the rate of falls was dose-dependent, and it was greatest within the first 7 days after the medication was started. Importantly, although the overall risk for falls was least among patients who used the short-acting drugs, the use of these medications (which are often prescribed as hypnotics) doubled the risk for nighttime falls, possibly due to impaired psychomotor function. (see Figure 1)⁷

Next in line to the benzodiazepines, agents in the antipsychotic and tricyclic antidepressant drug classes are commonly associated with falls and fractures in nursing homes. Like the benzodiazepines, these drugs increase the risk for falls because of their sedative properties, with an effect on gait and balance. In addition, they also may trigger orthostatic changes, with a resultant decrease in blood pressure. In an article published in the *New England Journal of Medicine*, Thapa et al indicated that epidemiologic studies have linked the use of tricyclic antidepressants to a 50% to 200% increased risk for falls among residents of LTC facilities.⁸ In their own retrospective study of nearly 2500 nursing home residents, these investigators confirmed that new users of tricyclic antidepressants did, in fact, have a fall rate during therapy that was twice that of nonusers of antidepressants.⁸ These findings are consistent with results from a 40-study meta-analysis performed by Leipzig, which revealed that antidepressants (primarily tricyclics) carried the highest risk for falls among all psychotropic medications used in persons aged 60 and older living in the nursing home setting.⁹

Historically, the desire to prevent falls and fractures in their elderly patients prompted many clinicians to prescribe

Investigators have documented an increased rate of falls among nursing home patients who were new users of SSRIs. This increased risk was dose-dependent, and it persisted throughout the period of SSRI therapy.

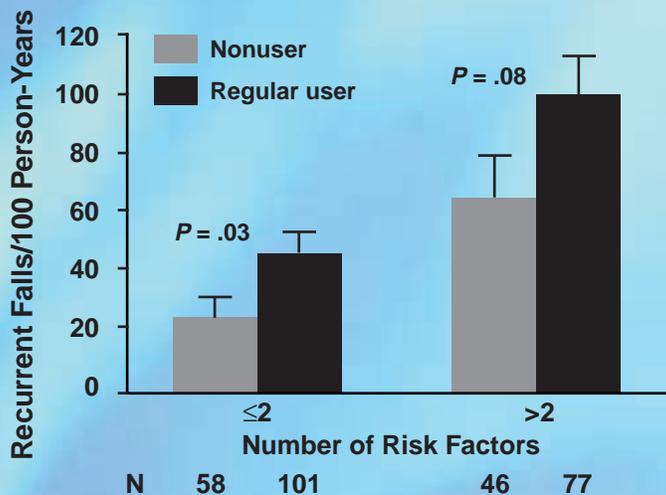


Figure 1. Rate of current falls among nonusers and regular users of psychotropic drugs by number of significant fall risk factors present in 282 ambulatory residents of 12 Tennessee nursing homes, 1991-1992. Numbers below bars denote the number of study residents in each group. *P* values denote test for differences in rates of recurrent falls between psychotropic drug users and nonusers. Reprinted with permission from Oxford University press.⁶

selective serotonin reuptake inhibitors (SSRIs) as an alternative to tricyclic antidepressants. The rationale behind this treatment choice has been the proven efficacy of the SSRIs, coupled with their relative lack of adverse psychomotor and autonomic effects. Unfortunately, mounting evidence suggests that the use of SSRIs in the LTC setting may increase the risk for consequences—including falls and fractures—that are different from those seen elsewhere. For example, in their 1998 study, Thapa et al documented an 80% increase in the rate of falls among nursing home patients who were new users of SSRIs compared to nonusers. This increased risk for falls was dose-dependent, and it persisted throughout the period of SSRI therapy.⁸ It also persisted when the authors controlled for factors such as functional status, medical illness, cognitive impairment, and concomitant medications.

If SSRIs do, in fact, increase the risk for falls among nursing home residents, how is this “consequence” explained in light of the traditional pharmacologic safety profile of these medications? Are SSRIs less “safe” in the LTC setting because their pharmacology is substantially different in this patient population? Probably not. As Thapa et al suggest, the explanation may lie in factors that are unique to the LTC patient population and nursing home setting.⁸ The investigators hypothesize that some major change in the health status of an LTC patient, such as medical deterioration, a worsening neurologic picture, or depression itself, may occur near the onset of antidepressant therapy. They suggest that the change in health status, not the initiation of antidepressant therapy, may trigger deterioration and disability, resulting in an increased risk for falls.⁸

As an alternative hypothesis, Slaughter and colleagues have suggested that it actually may be the clinical efficacy of SSRIs in the nursing home population that paradoxically increases the risk for falls in this group.¹⁰ These investigators assert that the SSRI-induced resolution of depression among nursing home residents promotes an increase in patient activity, and it is this increased activity that raises the risk for falls.

Medication-Induced Cognitive Impairment and Decreased Functional Status in Nursing Home Residents

In the LTC setting, cognitive impairment has important implications, not only for patients, but for the nursing home staff, residents, and visiting family members as well. With respect to the patient, cognitive impairment increases the risk for falls, fosters dependency in activities of daily living, and may significantly impair the ability to communicate. While the medical implications of repeated falls may be obvious, very little information in the literature examines the consequences of increased dependency and impaired communication in this patient population. Logically, the cognitively impaired patient would be expected to be a poor self-advocate, ill-equipped to report potentially life-threatening medical symptoms to the physician and staff. The cognitively impaired patient also might be expected to experience significant alterations in the quality of social interactions with staff, fellow residents, and visitors. This may lead to increased isolation, loneliness, and despair—all of which represent potential psychosocial consequences of cognitive impairment, although none is traditionally addressed as an ADE in the pharmacologic sense.

Among the psychoactive medications that may cause cognitive impairment, those in the benzodiazepine class (the primary [and largest] category of drugs) are again likely to be problematic. Agents in this class also have been associated with diminished overall functioning in elderly patients, especially in those with hypertension and other medical comorbidities.¹¹

Agents in two other important drug classes, the sedating antipsychotics and the tricyclic antidepressants, also can impair cognition and diminish functional status, especially at higher doses. Even low doses of potent anticholinergic drugs may produce acute delirium or an unexpected cognitive and

functional decline that is puzzling and worrisome to staff and family. Confronted with new or worsening symptoms, the consulting psychiatrist can conduct a complete medication review, which can be a valuable tool in differentiating reversible versus disease-related sources of decline. The consulting pharmacist also may provide substantial assistance with medication-related issues.

Movement Disorders: Extrapyraxidal Symptoms and Tardive Dyskinesia

Among the LTC population, extrapyramidal symptoms (EPS) and tardive dyskinesia (TD) can be a significant source of psychosocial and functional impairment. The effects of these ADEs on gait and balance also may increase the risk for falls and fractures, with an attendant increase in morbidity and mortality. Additionally, the impact of TD on the mechanics of chewing and swallowing may impair eating, resulting in weight loss and overall nutritional decline.¹²

Historically, the “conventional” antipsychotic drugs such as haloperidol and thioridazine have been associated with high rates of neuroleptic-induced parkinsonism (NIP), especially when used to treat cognitively impaired elderly patients. For example, in one prospective study of patients with behavioral symptoms related to Alzheimer’s disease (AD), low doses of typical antipsychotics were associated with a 66.7% incidence of NIP after 9 months of therapy.¹³ Likewise, the risk for TD is extremely high with these medications, with one study showing TD rates of 25% in 261 formerly drug-naïve subjects after 1 year, and 34% after 2 years.¹⁴ After 3 years of low-dose exposure to typical antipsychotics, more than half (53%) of all patients showed TD symptoms.

As a group, the newer “atypical” antipsychotics (eg, risperidone, olanzapine, and quetiapine) have a relatively low risk for EPS and TD. Consequently, these medications have largely supplanted the typical antipsychotics as first-line therapy for psychoses and AD-related behavioral problems in the elderly. Support for this therapeutic shift is based on the results of many studies, particularly those of Jeste and colleagues. In 1999, for example, Jeste et al published results from a 9-month study demonstrating a significantly lower risk of TD in matched groups of older outpatients (older than 45 years) treated with risperidone compared with those treated with haloperidol.¹⁵ In a later study, investigators found that the 1-year cumulative incidence of emergent persistent TD in elderly institutionalized patients with mixed dementia who had received a mean dose of 0.96 mg risperidone per day was 2.6%.¹⁶ A similar low-risk TD profile also has been demonstrated for olanzapine (6-week trial)¹⁷ and quetiapine (52-week open-label trial).¹⁸

For risperidone, De Deyn and colleagues have demonstrated a 15% incidence of EPS-like symptoms in elderly patients who had been treated with 12 weeks of the agent (mean dose 1.1 mg/d), compared with a 22% incidence in patients who had received haloperidol (mean dose 1.2 mg/d).¹⁹ In addition, Katz et al have suggested that the risk for risperidone-related EPS symptoms may be dose-dependent.²⁰ More adverse events were reported by patients receiving 2 mg/d of risperidone than 1 mg/d. For this reason, a risperidone dose of 1.0 mg/d may be a prudent therapeutic choice when treating behavioral symptoms in cognitively impaired elderly patients.²⁰

The EPS profile for olanzapine (dosage range 5-15 mg/d) appears to be similar to that of placebo, according to Street’s 6-week double-blind study in patients with AD.¹⁷ For quetiapine, preliminary research and clinical experience suggest that EPS incidence is also low. In an unpublished placebo-controlled trial of quetiapine versus haloperidol versus placebo in nursing home patients with dementia-related behaviors, quetiapine-

treated patients experienced less total EPS than patients who received placebo ($P<.001$) or haloperidol ($P<.001$).²¹ However, both agents showed an advantage over placebo in agitation score. Unfortunately, neither agent appeared more efficacious than placebo on Brief Psychiatric Rating Scale (BPRS) total or Neuropsychiatric Inventory (NPI-3) measurements.²²

Cognitive impairment increases the risk for falls, fosters dependency in activities of daily living, and may significantly impair the ability to communicate.

Limiting the Risk for ADEs: Strategies for the Clinician

Psychotropic-related ADEs, as well as their many clinical consequences, can represent a major source of morbidity and mortality within the nursing home population. Unfortunately, for the geriatric psychiatrist who practices in the LTC setting, the total avoidance of all ADEs may be an unrealistic goal, especially in a clinical climate of multiple practitioners, high staff turnover, poor staff training, and high-risk patients. It is realistic, however, to limit the risk for ADEs by adopting a strategy that couples prudent psychotropic prescribing with a savvy utilization of all on-site tools that are available in the nursing home.

A Strategic Approach to Avoiding ADEs

- *Follow accepted guidelines regarding the prescription of psychotherapeutic medications.* Prudent prescribing begins with a recognition of those medications that are either generally contraindicated in the LTC population, or are considered potentially “inappropriate” for a specific patient because of comorbid medical conditions, potential drug-drug interactions, or altered pharmacokinetics due to age or organ failure. Since 1991, the Beers Criteria have served as a prescribing guideline for geriatric specialists.²³ These criteria, which were revised in 1997, also have been modified and included

in the federal nursing home regulations as a guide to surveyors in identifying potential ADEs for a variety of drug classes.

- *Aggressively monitor efficacy parameters, routine laboratory values, and functional status.* In its 1997 Position Statement on Psychotherapeutic Medication in the Nursing Home, the AAGP emphasized that, for LTC patients, “all treatments with psychotherapeutic medications must be considered to be therapeutic trials.”²⁴ In the elderly, the effects of aging and comorbid illnesses may significantly alter the pharmacologic properties of a medication, resulting in “significant interindividual variability in the rates of drug metabolism and sensitivity to drug effects.”²⁴ As a rule, treatment with a psychotherapeutic medication always should begin with a low dose in elderly patients, followed by careful monitoring for efficacy and ADEs.
- *Consider routine attempts at drug withdrawal.* The Nursing Home Reform Amendments of OBRA 1987 recommends periodic trials of psychoactive drug discontinuation when these drugs are used to treat dementia-related behavioral symptoms in residents of LTC facilities. As multiple studies have shown, when psychotropic medications have been prescribed for behavioral symptoms in LTC residents, drug discontinuation may be possible without a resurfacing of behavioral disturbances. However, as Cohen-Mansfield and colleagues have emphasized in their recent study of psychotropic drug withdrawal, a psychiatrist’s attempts at changing the status quo may meet with considerable resistance from patient care team members, who have “a great deal of faith in the utility of these drugs.”²⁵
- *When possible, use nonpharmacologic interventions.* This is particularly important with respect to falls and fractures.

For LTC patients. “all treatment with psychotherapeutic medications must be considered to be therapeutic trials.”
(AAGP, 1997)

Examples of nonpharmacologic interventions include removal of clutter from floors, adequate lighting, regular toileting, proper footwear, and alarms on beds or chairs to alert the staff that the patient is rising.²⁶

Future Trends: Genomics, Informatics, and a Team Approach

Within the next century, genomic technologies (utilizing manipulation of the genetic material of an organism) should enable physicians to limit ADEs by tailoring pharmacotherapy to fit a patient’s unique DNA variations.²⁷ Until this can be accomplished, however, computer-assisted technologies may serve as useful alternative tools in the prevention of ADEs. Advances in informatics technology can help to improve clinical decision-making and reduce the incidence of ADEs by providing practitioners with rapid access to all pertinent patient data via one central, computerized source. With the aid of a computer, the clinician not only will

be able to monitor parameters of efficacy and eliminate duplicative therapy, but he or she will also be able to detect potential drug-drug interactions and ADEs.²⁸ Currently, financial considerations limit the use of modern data management technologies to cutting-edge health care facilities. In the future, however, these technologies should be more generally available at lower cost to all providers of LTC.

Finally, no discussion on the avoidance of ADEs would be complete without including the valuable contributions that might be made through the use of a truly interdisciplinary team approach to patient care. In particular, the combination of a consultant pharmacist-psychiatrist team or consultant pharmacist-primary care physician team has great potential to maximize the efficacy of all psychopharmacologic therapies while minimizing the risk for ADEs.

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CME Self-Assessment Test

Care of the Psychiatric Patient in the Nursing Home: Challenges and Opportunities

On the answer form (page 19), please circle the letter that corresponds to the single most appropriate answer for each of the following questions. A passing grade of 70% is required to receive credit.

The deadline to receive credit is one calendar year from date of publication.

1. True or false: The current regulatory burden shouldered by LTC facilities with respect to mental health services has its roots in OBRA 1987 legislation. This legislation arose from government concerns over the quality of psychiatric care in the burgeoning LTC “industry” of the late 20th century.
 - a. True
 - b. False
2. Clinical issues that spurred the passage of OBRA 1987 included:
 - a. Improper diagnosis of psychiatric disorders in nursing home residents
 - b. Misuse, inappropriate use, or overprescription of psychotropic drugs in nursing home residents
 - c. Improper use of physical restraints in nursing homes
 - d. All of the above
3. According to a 2001 report published by the OIG, what percentage of all Medicare psychiatric services are “unnecessary” or “questionable”?
 - a. 27% unnecessary, 30% questionable
 - b. 27% unnecessary, 3% questionable
 - c. 10% unnecessary, 5% questionable
 - d. 1% unnecessary, 2% questionable
4. True or False: OBRA 1987 legislation has been an unqualified success in reforming the delivery of mental health services in US nursing homes.
 - a. True
 - b. False
5. In addition to antipsychotics and antidepressants, what other medications correlated with a high risk for ADEs among nursing home residents?
 - a. Anti-infectives/antibiotics
 - b. Diuretics
 - c. Chemotherapeutic agents
 - d. None of the above
6. New research has called into question previous assumptions that the following medications are associated with a relatively low risk for falls and fractures:
 - a. Atypical antipsychotics
 - b. Benzodiazepines
 - c. SSRIs
 - d. Tricyclic antidepressants
7. True or False: Due to their relatively low risk of EPS and TD, the atypical antipsychotics are often used as first-line therapies in elderly patients with psychoses and AD-related behavioral problems.
 - a. True
 - b. False
8. According to the OIG, medically unnecessary psychiatric services include:
 - a. Those that do not maintain stability
 - b. Those that do not prevent further decline
 - c. Those that do not ameliorate behavioral disturbances or relieve distressing symptoms
 - d. All of the above
9. Categories of nursing homes that are especially underserved by psychiatrists include:
 - a. Rural nursing homes
 - b. Nursing homes that have established a formal contract with a psychiatrist
 - c. Small nursing homes (fewer than 100 beds)
 - d. b and c
 - e. a and c
10. To increase the on-site presence of geriatric psychiatrists, LTC facilities might consider:
 - a. Offering opportunities to lecture staff
 - b. Establishing formal contract relationships with geriatric psychiatrists
 - c. Asking psychiatrists to provide nontraditional services that are poorly reimbursed
 - d. None of the above
11. In LTC facilities, high turnover rates for CNAs negatively impact nursing home residents because:
 - a. Traditionally, CNAs comprise almost half of all nursing personnel
 - b. CNAs provide 90% of nursing care
 - c. Continuity of care is interrupted when CNAs leave
 - d. When a caring relationship with a CNA is severed, residents experience a sense of loss
 - e. All of the above
12. Both Dr. Daiello and Dr. Reichman suggest the following as one strategy to improve mental health care in LTC facilities:
 - a. Improved reimbursement for psychiatric services
 - b. An interdisciplinary team approach to patient care
 - c. A repeal of OBRA 1987 legislation
 - d. All of the above
 - e. None of the above

Personal Information

PERSONAL INFORMATION

I certify that I have completed this educational activity and posttest.

Expiration date: June 2003

Name _____ Degree _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Specialty _____

ACTIVITY EVALUATION

Have the activity's educational objectives been met?

Discuss the evolution and current status of public policy and government regulations with respect to the delivery of mental health services in the LTC setting. Yes No

List common ADEs and clinical consequences of various classes of psychotherapeutic agents currently used in the nursing home population. Yes No

Identify various preventive strategies to help limit the risk for ADEs in the nursing home environment. Yes No

Discuss the ways in which poor psychiatric care not only poses a potential threat to the health and well-being of nursing home residents, but also negatively affects the job satisfaction and performance of nursing home personnel. Yes No

Identify employment and reimbursement issues that influence the on-site presence of geriatric psychiatrists in LTC facilities. Yes No

Discuss strategies to improve the delivery of mental health services in nursing homes through educational initiatives, recruitment, financial incentives, and other appropriate interventions. Yes No

Did you find this activity to be fair, balanced, and free of commercial bias? Yes No

Comments: _____

Relevance to your practice:

Very relevant 4 3 2 1 Irrelevant

Amount of knowledge gained:

Great 4 3 2 1 None

Level of material presented:

Too advanced 4 3 2 1 Too simple

Overall evaluation of activity:

Excellent 4 3 2 1 Poor

Effectiveness of this method of presentation

Excellent 4 3 2 1 Poor

Hour(s) spent reading this issue (circle one): 1.0 1.25 1.5

Would you recommend this publication to a colleague?

Yes No

Ideas for future publications and/or your comments:

Care of the Psychiatric Patient in the Nursing Home: Challenges and Opportunities

CME SELF-ASSESSMENT TEST

ANSWER FORM

Please circle the letter that corresponds to the single most appropriate answer and fax the Personal Information and CME Self-Assessment Test Answer Form to the American Association for Geriatric Psychiatry at **301-654-4137** or mail your response to:

American Association for Geriatric Psychiatry
Education Department
7910 Woodmont Ave., Suite 1050
Bethesda, MD 20814

Expiration date: June 2003

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Final Thoughts: An AAGP Perspective

A number of the problems clinicians and such professional organizations as the American Association for Geriatric Psychiatry (AAGP) encounter in nursing homes derive from inappropriate, outdated policies that require the time and effort of many to change. Policy makers with little expertise in geriatric mental health issues further complicate endeavors to implement change, as well as concerns regarding expenditures and reports of fraud and abuse in nursing homes. As Dr. Kennedy has explained, a large, complex, and bureaucratic public health system has a difficult time managing issues such as these, which require careful differentiation.

Nonetheless, changes are possible. On a number of fronts, the AAGP and geriatric psychiatrists are actively addressing the problems associated with nursing homes and inadequate mental health services. However, the AAGP believes shifts in policy and, then, implementation of changes require ties to be built with policy makers for purposes of education and, ultimately, better policy.

The concerted efforts of the AAGP and other groups with similar concerns can and do effect positive change. For instance, early in 2002, when the Centers for Medicare and Medicaid Services (CMS) announced a national consumer quality initiative for nursing facilities to provide specific information to consumers, one of the proposed categories concerning antipsychotic drug use was considered misleading by the AAGP and other professional organizations. Accordingly, the CMS was persuaded to drop the measure from the initiative.

The AAGP also is involved with an ongoing federal regulatory initiative, the initial focus of which was use of “unnecessary drugs” and “chemical restraints” in nursing homes. In its review of this initiative, the AAGP recommended certain modifications. As a result, the CMS convened an ad hoc working group and began revising the initiative’s language. A new proposal is expected in 2002.

On another front, the important issue of the aging “baby boomer” population has been addressed by Dr. Reichman. The needs of this population for the services of specialists in geriatric medicine and psychiatry will far exceed the number of specialists in practice now and who will be in the future. The AAGP is also supporting legislation to provide incentives to medical students to specialize in geriatric psychiatry by increasing the number of GME fellowships allowed in the field.

Finally, in her description of the current pharmacologic complexities involved with the treatment of nursing home residents and the role new technology may play in future treatment, Dr. Daiello has touched on public policy issues. In that regard, the AAGP is considering the best avenue for educating policy makers on the problems associated with the routine exclusion of older adults from drug trials. And the costs associated with technologic advances ultimately will be addressed to some degree in the public sector. Advocacy for public policies that enhance the health and welfare of the geriatric population will continue to be an important component of the AAGP’s mission.

Source: Department of Government Affairs, AAGP.