

What Primary Care Physicians Want and Need for Mental Healthcare for Seniors in Nursing Homes

A discussion group was held with well respected primary care physicians who actively practice in long-term care. The purpose of this group was to gain a better understanding of the realities of services available, barriers to providing mental healthcare to seniors, and clarification of manners to improve the quality of care and quality of life for seniors in long-term care facilities.

This report summarizes the conversation and comments. Best efforts were made to minimize revision and this information is presented in the verbatim form with minimal revision.

Participants

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1) Initial Impressions:

- Problem – Mental professionals not adequately trained for geriatrics.
 - Professional comes from acute care and cannot become geriatric care specialist overnight. It takes time to understand the Long-Term Care (LTC) environment and the needs of the patients and clinicians that practice there.
 - Psychiatric consultant doesn't spend a lot of time learning what we need: there are regulations that govern even the psychotropic medications to be used, the dose of those medications that can be utilized and even how long they can be given.
 - Implements documentation and orders that LTC facilities cannot implement, and may even violate LTC regulations. This may include services, time frames, actions (such as "transfer to psychiatric facility") and medications.

- Solution.
 - Excellent model to use is to engage residents and fellows from local teaching programs. Have them work with LTC clinicians and in LTC facilities during training to introduce them to LTC appropriately. Then can hire them as they complete training.
 - Have an independent in-house “Consulting pharmacist.”
 - Consulting Pharmacists (CP) usually work for the pharmacy vendor which supplies nursing homes (NH). Thus a potential conflict can develop where there is little incentive to stop medications, and a large incentive to utilize medications stocked by the vendor.
 - Consulting pharmacists have been intimidated by, and may misunderstand federal/state regulations. A good example is gradual dose reductions on anti-depressants. Many patients require treatment for life with a complicated depression. However, confusion often arises about how to appropriately document this and avoid unnecessary and potentially harmful reductions or discontinuations. There was debate about the regulations/guidelines for dose reduction and how they are best interpreted and implemented. There was agreement that there is a need to effectively document why a medication was, or was not, altered including what effect prior reductions/discontinuations had on the patient..
 - Consulting pharmacist can be a great ally. Noting inappropriate medications, improper dosing or frequency of medications and suggesting lab follow up on the monthly medication reviews is important. While the CP is required to comment, the physician is not required to follow the recommendation, but is required to respond. The clinician can state any recommendations are not clinically indicated, were previously performed, etc.
 - All agreed they prefer having an in-house “psychiatrist” or mental health (MH) professional available, both for routine consults and especially for psychiatric emergencies. Attendees understood the fiscal need for a “critical mass” of patients in a facility to make the MH model fiscally viable and to allow the NH to incorporate the treatment protocols into day-to-day operations.
 - Developing Mental Health treatment protocols consistent with OBRA-87 guidelines would be important for treatment regimens, as well as to educate both LTC clinicians and to train outside practitioners entering the LTC arena.
 - There likely would be acceptance of a MH program cooperating with primary care clinicians within LTC to improve MH services.
- Problem – Definitely need psychiatrist who is trained for geriatrics, specifically the unique population within LTC.
 - While it is important to have MH professionals who understand the regulatory side of LTC, it is equally important to have them knowledgeable of the unique needs of the frail elders who require psychiatric services in NH. End-of-life and ethical issues, particularly around cognitive loss are common. There must be an acceptance of the interdisciplinary team concept of care and recognition of the multiple medical co-morbidities and poly-pharmacy in this population. (9:20)
 - There is also a younger population, often with degenerative neurological disease states and severe functional decline.
- Problem - Sending someone with dangerous, disruptive behavior or suicidal depression to a psychiatric hospital is impossible except in a few localized practice areas. This is why there is a growing need for integration between the medical and psychiatric model for MH treatment on site in NH.
 - 1) MH facilities are not doing long term, individual psychiatric care anymore. Now they are doing short term stabilization averaging 4.5 days and doing group, rather than individual therapy. Units operated with groups do not address Alzheimer’s patients, as they don’t fit in well. A 4.5 days stay is nonsensical as it takes 3-4 days before the effects of medications are even apparent. In this

environment the clinician must guess correctly on therapeutic drugs and dose upon admission every time.

- 2) Psychiatrists don't want to deal with elderly patients with dementia with acute mental status change. There is the need to clinically rule out delirium each time such changes occur, and this is not regularly done.
- 3) In most states, to go to a psychiatric unit right now, a patient can sign him/herself in voluntarily, or has to be committed if determined to be harmful to self or others. However, this is more often statute than practice. Being "Harmful to self or others" today only "buys you" a visit from a psychiatrist for evaluation rather than commitment. The state has the option to decide the NH is as safe a place as a psychiatric facility, throwing the care of such patients back into the LTC facility.
- Motivation of a LTC facility is that they must ensure the safety of both the affected person and other patients. If they cannot provide a medical workup or psychiatric care, they must try to offload the dangerous patient any way they can. Typically, there is nowhere to send them.
- Definitely need geriatric psychiatrists and MH programs in LTC and a market is waiting.

2) Nursing Home Staff:

- **Problem –An uncomfortable, disconnected relationship may exist between the PCP, the psychiatrist, and the facility. What bad looks like:**
 - An example provided by the panel: As a PCP, I remember the day I saw a patient who was getting a consult/evaluation from a psychiatrist and I wasn't aware the consult was ordered or why it was even needed.
 - The facility can order a consult without notifying the PCP. The PCP feels he/she should be in control of the treatment plan. The perception then becomes that the Psychiatrist will visit patient for minimal length of time, write illegible notes, and prescribe three medications. The psychiatrist may not realize significant underlying medical issues and history. Then the PCP must deal with any problems that arise and deal with the family. It is a setup for poor outcomes.
 - Psychiatrist in this scenario is not seen as a positive resource but someone who is intruding into the care of the patient.
- **Nursing Home Care Models:**
 - Psychiatrist/psychologist model – successful is where psychiatrist comes regularly, perhaps at least once a month, sometimes more frequently if needed.
 - Another model is that of nurse practitioners who are doing behavioral medicine. They have received geriatric education. Then the NP's received further experience and additional instruction through teleconferences, then instructed in the use of MH protocols. A standardized form of communication and lines of authority were established to insure accountability. This turned out to be a good model. It worked as a team working together to provide care: collaborative relationships, working with the PCP, insuring systems are in place to communicate and respond. The NH staff knows who to call for a particular problem. This system has worked very well. They have done a good job and facility has kept them. This is not a floating group of professionals, but clinicians consistently tied to a specific NH.
- **Problem – “Fly-by psychiatry” is not good for the facility, the patient or the clinicians. This model is due in large part to horrible reimbursement for MH services. The end result is that you get what you pay for.**
 - The ideal is to have on-site psychologists and behavioral staff. That allows for a culture of communication and earlier intervention.
 - De-escalation of MH crises occurs more rapidly with behavioral professionals regularly working with staff, and this also reduces staff stress. Additionally, it allows regular integration of MH principles into day-to-day patient care in the facility.
 - Negative experiences noted by the panelists:
 - I don't need a psychiatric consult to document that my patient doesn't need a gradual dose reduction for an anti-depressant. As the PCP I feel comfortable doing this.

- We have psychiatric services that come in to provide “motivational counseling” after an already energized patient had a knee replacement. I felt this was Medicare fraud. I don’t like to participate in something that feels yucky like that.
 - Filling out a check-off form after an evaluation that states: “Write an order for CBT (cognitive behavioral therapy)” This appears assembly-line in nature, and does not always result in obtaining what was ordered – and wanted.
- **Problem – MH training needed for NH staff.**
 - Issues in delivering MH care services are a lot of the time with the NH staff. And others come in the interdisciplinary care meetings. Staff may not recognize when MH referrals are appropriate, and not understand why counseling and medication treatments are initiated, thus not properly support or apply them. Mentoring and training of the staff in MH issues is important.
 - Use of standardized documentation for MH subjects is important. Staff learns where information is located and how it is used for care plans and survey.
 - 50% of the NH’s in one program will pick 3-4 patients that will be discuss in depth at a care planning meeting; then go down the whole roster of patients. Are there other patients who have troublesome MH symptoms, even if they are not on the program’s “service.” If so, can recommend that the NH talk to the PCP about the symptoms and the PCP can decide if referral to the program for treatment is appropriate.
- **What does good look like?**
 - “I don’t think it’s about being a psychiatrist, a geriatrician, or geri-pharmacologist, or a geri-psychologist. I’ve got an LCSW who’s been doing this for 20 years – we are all doing practical stuff.” This statement was to indicate that good MH care is less about the license of the person delivering it, than about the knowledge base, experience and commitment to patients of those delivering it.
 - “We need people who know what they are doing.” There is a lack of education even among doctors. Staff and clinicians need to understand that 9 times out of 10 times distressed behavior occurs, it is a precipitating situation that causes the patient to act out. Staff and/or facility activity and policy has a huge role in a patient’s behavior. We need properly educated clinicians and staff to diagnose the cause of distressed behavior and intervene to change it..
 - Mental health parity is an issue in delivering good MH care. Lack of respect, and limited reimbursement affects the MH care delivered.
 - One panelist states” “Good” is largely out of our hands. Frequency of dementia, behavioral problems, and other psychiatric problems is the cause of untoward behaviors in upwards of 90% of cases in a situation where 40% of NH patients are having behavioral problems. Nursing homes are not really nursing homes. They are long term care psychiatry facilities, hospice units and hospitals, but not resourced for that role. As a result, staff is not trained to handle the acuity of these patients. By regulations, may not have exclusions and if we are to avoid transfers to hospitals and to protect other residents, we need to be appropriately reimbursed and clarify the mission of LTC. But can’t do that until you have a trained staff. We sometimes work basically with lay people or people on sabbaticals with no clear awareness of the job that they really have to do.
 - Transition of care is a major concern. The clinicians and LTC facility must have contract with the hospital and doctors, if we are to refer a patient in order to have them treated a certain way. The hospital/ER must have a contract with the NH as well. The LTC facility has to agree that once a patient is treated, they are going to accept the patient back to avoid transfer problems. Then the hospital can pick up the phone, state there is a patient and this is their issue, and the NH can have a team meeting to discuss continuing the plan of treatment.
 - Even if there are good mental health services, there is often a communication disconnect and we don’t want that.

3) **Working with the primary care physician (PCP).**

- SPC goes to the facility clinical leadership, the DON and Medical Director as well as the floor charge nurse of when the MH professional will be seeing a specific patient, and the regularly

recurring schedule that the MH staff will be visiting the NH. The NH staff and clinicians in the patient's care are welcome to meet with SPC. If that time is not convenient, alternatives are offered. Regular interactions with the NH staff can be scheduled, usually once a month. We also encourage SPC staff to see the PCP.

- The PCP would have a few problems with above recommendation. The PCP is unlikely to spend time meeting with someone it was felt by panelists. A better alternative is to keep the PCP informed what is going on. In the MH notes, document the key information that the PCP should review. Consider asking in writing in the note or in the orders for the PCP to review the note and respond to questions or concerns.
- The initial consultation and any questions should be sent to the PCP. If available, using the Electronic Medical Record gets beyond illegibility issues, and can provide standardized progress notes. The information can be shared with other clinicians as appropriate.
- One open issue is to discern what the medical team does verses what the mental health team does. How do we make this communication happen – especially regarding behaviors/crisis that do not occur on a routine basis or that tend to occur at the worst possible times, as on a Friday at 2a.m.?
- Monthly meeting with NH staff and PCP's will provide invaluable information and cement relationships.
- As PCP want to read in chart information about my patient. I like to see the notes to insure communication. I especially need something in the MH notes that helps me collaborate in the MH plan.

4) PCP Trends

- Significant trends are predicted in two areas:
 - A continuing change to physicians, in partnership with nurse practitioners (NP), who practice only in LTC facilities. The example by one panelist: If you are talking about a 150 bed nursing home, which are going to be phased out nationwide (some states more rapidly than others), 150 LTC patients would be seen about one a month (who each have their office practice) or every two months. Might be 75 to 150 visits from a physician a month might be broken up between 4 doctors – those are the PCP's who the NH's counted on as their referral base. I see that model phasing out. What I see now is 30% -40% of patients in the facility as sub-acute level of care. These are those that were in a facility for 4 days and now need to be seen by their PCP 3 times a week. That PCP is no longer an office doctor; that is not viable any more as it requires the physician to be out of the office too much. If you have 40 sub-acute patients in a 150 bed building and of those there are 40 sub-acute patients which need to be seen 3 times a week, that's 480 visits a month by a PCP, with 400 visits a month being a heavy load for a full-time PCP. The other 110 patients on the LTC side would be seen by a nurse practitioners. So the outside PCP really cannot handle the sub-acute patient load clinically or financially.
 - Culture Change – regarding mental health issues – is coming. This means not just using pharmacologic responses to distressed behaviors, but changing the NH environment to calm the patient. It also involves complementary techniques that go beyond changing the physical environment into altering the culture of NH.
- Is a change in the environment and regulations seen as part of the problem with MH services and MH care? Several members of the panel did not think there is enough experience to make a comment yet as to mental health. Several would like to think that cultural change is a great thing (i.e., introducing such treatments as music and aroma therapy). Discussion ensued about the importance of integrating with other mental health professionals, staff and PCP to provide more alternative care options.
- One panelist stated being in one NH building all the time five days a week. Those LTC patients are not once a month visits anymore cause something is happening to them all the time. If you have a NP, doctor, or even a social worker who is trained in managing complicated dementia behavioral problems, that just opens up additional volumes of business for you. Question is – do you need to outsource the care of complicated MH issues? If you don't have the skills, yeah, outsource that care to someone who does. If you do have the skills, allows you to build volume. Everyone in LTC strives to do 5-7 days a week of being in the building, because you don't get paid for taking care of the people on the telephone. There are opportunities to build a MH crisis team and use non-physicians.

- Another panelist relates: Talking about using LCSW's, 2 of the facilities we see patients in, there are fantastic geri-psychologists who come in do good including having programs that deal with behaviors. Regarding better transitions of care and cultural change, I wish I could agree that it was going to be fast, but think it will take a while. Before that occurs, what if in these larger homes they carve out a "quiet room," a place where the residents are not over stimulated. We are trying to do this with the younger psych patients. What works is having a multi-disciplinary team with good communication and systems that are set up that allow communication including writing good clinical notes, and getting everybody into that habit. You go in, you read the note, and you can seamlessly continue the treatment plan already put into place.

5) **Category – Other Issues to consider**

- How about the concept that reimbursement should value the time spent managing care? You spend 50% of your time with coordination of care talking to staff, speaking with family, accessing lab, x-ray and other information. The actual bedside time is far less. Yet that coordination of the care provided is enormously valuable. (rest of discussion inaudible).
- Another valuable investment of time that is not reimbursable is family sessions. The clinician may need to do them at night or on the weekend.
- Spiritual counseling is another important MH issue. Some studies suggest that 50% or more of patients in NH are spiritual. This is distinct from defined religion.
- Smoking cessation is important, especially with no smoking facilities becoming more prevalent.
- Medication reduction programs are a very important program to pursue
- Telemedicine, particularly in rural areas has real potential and applies well to MH care

6) **Discussion closes**

- It was felt that this discussion is the beginning of an important conversation on MH in LTC, and potentially the start of an advisory board.
- It was felt we should share the passion expressed tonight for improvement in LTC should be continued when all return to their practices make things better.