

The American Geriatrics Society and American Association for Geriatric Psychiatry Recommendations for Policies in Support of Quality Mental Health Care in U.S. Nursing Homes

American Geriatrics Society and American Association for Geriatric Psychiatry

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Approximately 1.5 million older adults reside in nursing homes,¹ and 65% to 91% of residents have a significant mental disorder.²⁻⁴ Moreover, the majority (89%) of older adults with severe mental illness who receive institution-based care are in nursing homes, and only 11% are in hospitals.³ Depression and behavioral and psychiatric symptoms associated with dementia are the most common psychiatric problems in nursing homes. Approximately 30% to 40% of persons with dementia have significant behavioral and psychiatric symptoms, and approximately 22% of nursing home residents have symptoms of depression.⁵⁻⁷ In addition to the psychological suffering caused by these disorders, psychiatric disorders in nursing homes are associated with high rates of functional impairment and disability. Behavioral symptoms and depression are associated with worse health outcomes, physical injury, increased rates of hospitalization, and greater emergency service use and lower rates of retention of nursing home staff.⁸⁻¹² However, despite the high prevalence and effects of psychiatric and behavioral symptoms in nursing homes, nursing home staff are generally ill equipped to serve residents with chronic mental illness.¹³

The consensus statement of the expert panel assembled by the American Geriatrics Society and the American Association for Geriatric Psychiatry, also published in this issue,¹⁴ focuses on these important mental health concerns for the United States' 1.5 million nursing home residents. Assessment and treatment for nursing home residents take place within the framework of local, state, and federal health systems and their regulations and policies, which can support or hinder quality mental health care. As the expert panel developed the consensus statement, it became clear to many panel members that a commentary on health policies

to support quality mental health care in nursing homes was needed. A subgroup of the panel took on the responsibility of drafting policy statements and comments into a document for review by the full panel. Many statements herein reflect discussions that took place during the development of the panel's consensus statement.

Government, academic institutions, public advocacy groups, and providers must work together to give U.S. nursing home residents the quality mental health care they need and deserve. The unintended consequence of some government regulations is to discourage quality mental health care. Even policies that address improved mental health care often fail to ensure that supportive financing is made available for the effort. Although some nursing homes make every effort to provide quality mental health care, too many still view mental health concerns as tangential to quality. Providers have too often focused on how to reduce regulation rather than improve it. Unless government and providers work together to craft policy that supports quality mental health care, the assessment and treatment practices that the panel advocates are unlikely to be implemented.

Screening, Assessment, and Referral: Access to Needed Services

1. Policies affecting long-term care for older persons should promote and enhance the availability of mental health services to nursing homes, especially rural and publicly financed nursing homes.

Rationale: A six-state survey of almost 900 nursing home administrators found that psychiatric services are needed by more than one-third of nursing home residents, yet three-quarters of nursing homes are unable to access consultation and educational services for behavioral interventions.¹⁵ Long-term-care policy should support mechanisms that expand the availability of mental health professionals in nursing homes. The high prevalence of mental disorders in nursing homes indicates that mental health services should be considered a core component of nursing home care. Two mechanisms are recommended to facilitate enhanced access to mental health services in nursing homes.

- 1.1. Formal agreements with consulting mental health providers for training, consultation, and treatment services should be a required component of care in

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nursing homes. Such agreements ensure access to needed services and continuity of care.

- 1.2. Medicare-covered services should be expanded to ensure adequate payment for the additional costs associated with the training of nursing home staff, administrative consultation, record review, telephone coverage, and supervision of care.

Rationale: Although some of these services are currently covered in the portion of per diem payment related to indirect costs, incentives and payment are inadequate and are commonly displaced by other costs. The Centers for Medicare and Medicaid Services (CMS) should be directed to revise payment codes to include appropriate and adequate coverage specific to these essential services.

2. Compliance with existing regulations on screening, assessment, and referral of nursing home residents for mental health services must be more rigorously enforced and supported.

Rationale: Congress enacted the Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) to improve care in nursing homes, including specific steps intended to ensure appropriate and adequate mental health care for nursing home residents. Regulations require preadmission screening to prevent inappropriate placement of individuals in nursing homes whose primary disorder is psychiatric and who could therefore more appropriately be served in other settings. For those with psychiatric disorders who are admitted to nursing homes, these regulations require that the review ensure that a resident who displays mental or psychosocial adjustment difficulties receives appropriate services to correct the assessed problem.^{16,17}

Studies indicate low rates of compliance with the systematic implementation of required screening and recommended mental health services.^{18,19} Fewer than half of nursing home residents with a serious mental illness receive appropriate preadmission screening, according to the Department of Health and Human Services Office of the Inspector General.²⁰ The recent Olmstead decision underscores the failure of states to provide alternatives to the many persons with severe mental illness who would more appropriately be served in an alternative setting.²¹ Once people with mental disorders are admitted to nursing homes, most recommendations concerning their mental health treatment are ignored. Only 35% of preadmission screening recommendations for new mental health services are followed.²²

Federal requirements mandating mental health services in nursing homes have not been successful in ensuring that those who need mental health services receive them.^{23,24} Because regulations alone have had a limited effect on improving access to and the quality of mental health services in nursing homes, reforms are needed that provide incentives for improvement. For example, CMS launched a system in 1999 to rank nursing facilities within states according to 24 quality indicators that include behavioral-emotional problems, cognitive patterns, and psychotropic drug use. This system of indicators has only limited ability to measure the quality of mental health outcomes, although it is a first step toward the development of quality indicators that would be made available to consumers

and that would potentially drive quality improvement and reimbursement.²³

- 2.1. CMS should be directed to enforce compliance with recommendations for indicated mental health services under OBRA 1987.
- 2.2. CMS should be encouraged to pursue outcome- and incentive-based policy strategies that support screening efforts linked to the provision of appropriate and effective services, with specific attention to quality indicators for mental health services and outcomes.
3. A trained workforce of mental health professionals with expertise and a commitment to practice in long-term care settings should be developed.

Rationale: Nursing homes will be unable to comply with regulations mandating mental health services without a trained workforce of specialty mental health providers who are willing and available to work in long-term-care settings and committed to doing so. A recent survey of practicing psychiatrists determined that only 1.7% of general psychiatrists provide services in nursing homes.²⁵ Although a substantially greater proportion of geriatric psychiatrists make visits to nursing homes, the workforce of geriatric psychiatrists is grossly inadequate to meet current need. Since 1991, approximately 2,600 psychiatrists have received subspecialty certification in geriatric psychiatry.²⁶ Little is known about the extent of nonphysician mental health providers in nursing homes, but a recent survey indicates that only 3% of American Psychological Association members have geriatric patients as their primary workload.²⁷ Similarly, fewer than 3% of students pursuing a master's degree in social work specialize in aging, and fewer than 2% of the remaining students pursue graduate coursework in geriatrics.^{28,29}

General medical physicians, nurse practitioners, nurse specialists, psychologists, and social workers with geriatric specialization and additional training in mental health interventions are important providers of psychiatric treatment, but current estimates suggest that there will be dramatic shortfalls in the workforce to meet the anticipated need. For example, there are 9,000 physicians with geriatric certification in the United States, which at best meets only 45% of the current need. Unless reforms are enacted, the shortfall of physicians in geriatric medicine may reach 25,000 by 2030.³⁰ Despite recent growth in the number of training programs for physicians with advanced training in geriatrics, current rates of unfilled residency positions suggest that early career physicians do not see the field of geriatrics as attractive. In 2001–2002, 69% of geriatric medicine fellowship positions were filled, and only 61% of geriatric psychiatry fellowship positions were occupied.³¹

Developing a workforce with expertise and a commitment to providing mental health services in long-term care settings will require a multipronged effort on the part of professional organizations, educators, healthcare provider organizations, and payers.

- 3.1. Specialty psychiatry and allied mental healthcare provider organizations should be encouraged to promote careers centered on the provision of services to older persons, including specific attention to the opportunities and needs for practice in long-term care settings.

- 3.2. Physician, nursing, and other health educators should include geriatrics as a core component of the curriculum, including clinical opportunities for training in mental health interventions in long-term care.
- 3.3. Professional societies with specific expertise in geriatrics and mental health should play an active role in training professionals in the delivery of effective nursing home interventions and services.
- 3.4. Hospital- and community-based mental healthcare provider organizations should include outreach to long-term care settings as an integrated service component.
- 3.5. The development of an adequate workforce in medical geriatrics and geriatric mental health care will require a realignment of incentives and payments to encourage and support the treatment of mental disorders in older persons.

Insurance for Nursing Home Residents

4. Public and private insurance for nursing home residents should include coverage for appropriate mental health services and medications on parity with coverage for other medical disorders and should pay for treatments and other interventions that are intended to reduce behavioral symptoms.

Rationale: Healthcare financing trends continue to move payment in nursing homes away from separately paying for individual services, but many services are still not part of the typical per diem payment. Current insurance coverage often inhibits quality mental health care. Medicare and many private insurers, for example, do not provide for parity in mental healthcare coverage. In contrast to medical and surgical treatments that require a 20% copayment, psychologically based services require that the consumer provide a 50% copayment through out-of-pocket funds or second-party coverage. Although it has been argued that enacting equitable mental health copayments will be financially prohibitive, state parity laws applied to managed care and non-Medicare services have raised costs by less than 5% and require minimal cost when implemented within an existing integrated service network.³² Lack of a prescription drug benefit also limits Medicare coverage for older persons.

Recent changes in Medicare rate setting have resulted in declining payments for Medicare services, which has been associated with a growing number of physicians and carriers who are declining to enroll as providers in the Medicare program. Medicaid provides copayment and drug prescription benefit coverage for the subset of dually eligible (Medicaid and Medicare) recipients, but billing codes and reimbursement are biased toward conventional face-to-face visits and procedures or bundled services that do not accommodate an array of effective behavioral, educational, or consultative practices intended to address behavioral symptoms.

The following actions are recommended to address the need for adequate and appropriate coverage of psychological and pharmacological treatments for mental disorders in nursing homes.

- 4.1. Congress should enact legislation removing differences in coverage of mental health and medical

disorders under Medicare and other federal health insurance programs. Medicare's statutory, discriminatory 50% copayment for psychological services should be repealed and replaced with the same 20% copayment now charged for all other Medicare Part B services.

- 4.2. Congress should be urged to pass comprehensive Medicare prescription drug coverage legislation to ensure that older adults receive appropriate and effective medications.
- 4.3. Congress should direct CMS to provide adequate and appropriate coverage for activities that support assessment and delivery of behavioral interventions in nursing homes. Coverage and billing codes should be provided that accommodate effective and necessary components of mental health service delivery in nursing homes, including consultation, supervision of behavioral interventions, and review of delivery of mental health care for individual residents.

Rationale: Current regulations mandating billing for time in face-to-face visits with residents do not accommodate these essential components of quality mental health services in nursing homes.

Incentives for Providers

5. Nursing home payment systems should reward facilities for providing appropriate pharmacological and non-pharmacological treatment for residents with a mental illness.

Rationale: Current nursing home per diem rates under prospective payment reflect case-mix adjustment that is based on resident needs that are categorized under 44 Resource Utilization Groups (RUGs). Despite the heavy weighting of RUGs toward the specialized needs of the Medicare resident, these adjustments are generally inadequate to compensate for the added intensity of nursing and social services often needed by persons with psychiatric disorders. As it is currently structured, the RUGs reimbursement system provides a negative incentive for nursing homes to accept behaviorally disturbed patients because it does not adequately value the added nursing home staff time and effort required to care for any but the most behaviorally disturbed residents (e.g., those who have frequent hallucinations or aggressive behavior).

- 5.1. Congress should direct CMS to conduct a study aimed at developing RUGs that more accurately capture the resource inputs related to the care of psychiatric and behavioral symptoms with dementia. Subsequent adjustments should be made to reflect these additional resource needs.

Rationale: Medicare reimbursement fails to provide adequate coverage for Part B professional services by psychiatrists, nurse practitioners, physician assistants, psychologists, and social workers under psychiatric billing codes. Recent reductions in Medicare payments for professional charges have further eroded insufficient reimbursement for psychiatric codes under Medicare Part B.

- 5.2. Congress should direct CMS to conduct a study of Medicare Part B payments for psychiatric services in nursing homes to establish adequate and appropriate rates that ensure access to psychiatric services and interventions with proven effectiveness.

Training for Nursing Home Staff

6. Innovative approaches to ongoing training and support for nursing home staff are needed in assessment and interventions for mental health and behavioral needs of residents. Adequate funding for training should be included in payment systems or separately provided by payers to support these efforts.

Rationale: Nurse training requirements inadequately address many mental health problems or require coverage of so many other topics that mental health problems cannot be adequately emphasized.³³ Conventional nurse training focuses on medical care, with minimal attention to behavioral health care. Nursing assistant training is inadequate to address the complex behavioral symptoms that are highly prevalent in nursing homes. Current federal regulations require just 75 hours of pre-employment training and 12 continuing hours annually of in-service training for nurses' aides. Adequate training requirements in mental health for other nursing home staff are similarly lacking. Mental health assessment and intervention are integral elements of nursing home care. Nursing home administrators have been variably receptive to allocating sparse resources to training, but an investment in training can result in added value beyond better health care for residents. For example, training frontline staff in behavioral assessment and interventions is associated with enhanced staff satisfaction and retention.³⁴

Unfortunately, conventional in-service training, continuing education, and treatment guidelines provided to healthcare providers have limited effectiveness in altering provider practices.^{35,36} High turnover rates among staff in nursing homes and the minimal training of front-line providers, such as certified nurse assistants compounds this limitation.³⁷

- 6.1. CMS should develop standards that promote and support the implementation of training models with demonstrated effectiveness.

Rationale: For example, successful service models include "train-the-trainer" programs that augment external mental health consultation services with a staff nurse employed by the nursing home who is specially trained to provide follow-up mental health monitoring and who can provide resident-specific supervision to general nursing staff in behavioral assessment and treatment.^{38,39}

- 6.2. Further research should be supported on the development of innovative and effective models of training staff in behavioral health care in nursing homes.

Rationale: The emergence of new technologies allows the development of approaches using, for example, interactive computer-based modules and electronic decision-support systems.

Quality Measures: Incentives and Public Accountability

7. Consumers should have access to information about nursing home quality that includes well-designed mental health measures.

Rationale: Current efforts to provide public information to consumers on nursing home quality (e.g., Nursing Home Compare, the Nursing Home Quality Initiative) do not provide any information on the quality of mental health care in nursing homes. Largely, this is because current data collection efforts do not offer well-designed measures of quality mental health care. The training given to state surveyors and the survey process itself often discourage creative, individualized solutions for residents with mental illness, especially in the areas of behavioral symptoms and nonpharmacological interventions.³⁷

- 7.1. Mental health indicators should be collected and reported from the Minimum Data Set as a part of the quality improvement profile reported in Nursing Home Compare, Online Survey Certification and Reporting (OSCAR) data, or the Nursing Home Quality Initiative. For example, potential mental health indicators reported by CMS could include the proportion of residents with a significant number of depressive symptoms occurring daily, with behavioral symptoms that occur frequently, and with these symptoms who are receiving mental health treatment. These data are currently available through the Minimum Data Set and could be used as quality indicators for nursing homes.
- 7.2. Subsequent efforts by state and federal agencies should work to improve mental health quality measures and processes in the Resident Assessment Instrument and the nursing home survey system.
- 7.3. Research should be conducted to identify new processes for collecting data and measuring quality of mental health care in nursing homes.

Regulations and Policy Consistent with the Evidence

8. Regulatory and reimbursement policy should reflect support for interventions and services with proven effectiveness while also defining inappropriate treatments based on empirical findings.

Rationale: An evidence base exists that supports the effectiveness of an array of mental health interventions for late-life mental disorders,⁴⁰ including research literature specific to nursing homes on the effectiveness of specific interventions⁴¹ and service models.⁴²

9. Clear distinction should be made in regulatory language and in nursing home practice between the appropriate use of antipsychotic and other psychiatric agents for the treatment of identified psychiatric symptoms and the use of these agents for purposes of restraining residents' behavior or activity.

Rationale: Regulatory reforms under OBRA 1987 included specific language aimed at reducing the use of antipsychotic agents as "chemical restraints" in nursing homes. These reforms reduced overall antipsychotic use from as high as

34% before OBRA 1987 to more recently reported rates of 16%.⁴³ A recent Office of Inspector General report determined that the use of antipsychotics or other psychiatric agents as chemical restraints is rare. The majority (85%) of psychotropic drug prescriptions in nursing homes were deemed “medically appropriate.”⁴⁴ Nursing home reform and consumer advocacy groups argue that there are methodological flaws in this study and maintain that there is significant inappropriate use of antipsychotic agents in nursing homes. Although controversy persists, there is a consensus that use of psychiatric medications solely for the purpose of restraining difficult behaviors should be avoided.

- 9.1. Language used in regulatory and advocacy documents should avoid the use of the term chemical restraint in reference to specific classes or types of medications.

Rationale: Psychiatric medications (including antipsychotics) used appropriately in the treatment of symptoms and disorders are therapeutic modalities. A class or type of medication should be clearly differentiated from the manner in which the agent is used (e.g., as a chemical restraint).

10. Nursing home staffing regulations and policies should be consistent with current evidence on the relationship between quality of care and staffing.

Rationale: High-quality mental health care in nursing homes is possible only when the level of nurse staffing is adequate to provide the necessary amount of direct care. Adequate staffing permits permanent assignment of staff, allowing relationships between staff and residents to grow and become a source of strength and allowing the nursing home culture to develop a homelike environment. Quality mental health care requires that nurses and other mental health professionals be available in numbers consistent with current knowledge about quality of care and quality of life in nursing homes. Policies are necessary that enable recruitment and training of staff; improve wages, benefits, and working conditions; and identify and require adequate staffing.

Recent research in acute and long-term care has demonstrated a connection between staffing levels and quality of care.^{45,46} Despite data suggesting that higher staffing levels are associated with better quality of care, there is no consensus on optimal staffing levels relative to costs.⁴⁷

- 10.1. CMS or other federal agencies, such as the Agency for Healthcare Research and Quality, that affect state regulations on nursing home staffing should commission studies.⁴⁸ In particular, studies are needed to determine the appropriate levels of nurse staffing for residents with agitation, psychosis, depression, and other psychiatric and behavioral complications of dementia. Appropriate staffing for special care units and Alzheimer’s care units should also be defined through empirical study.
- 10.2. Studies to determine appropriate and adequate staffing related to direct and consultative mental health services should be supported.
- 10.3. Studies that address the effect of payment policy on efforts to enhance access to and quality of mental health care in nursing homes are also needed.²³

Changing the Culture in Nursing Homes

11. Reforms are needed in the culture of nursing homes that include changes in the organizational structure and processes, as well as the incorporation of resident-directed values.

Rationale: Innovative administrative reforms that are likely to modify nursing home culture include changes in the organizational structure and processes in long-term care and incorporation of resident-directed values. Such values are reflected in psychosocial, spiritual, and individualized care that is based on the resident’s preferences and a model of shared decision-making that honors self-determination and choice.⁴⁹ Greater involvement in decision-making by nursing home residents is associated with reduced feelings of helplessness and related depressive symptoms.⁵⁰ For example, organizational change could include procedures that allow residents and their family members to participate in making clinical decisions.

- 11.1. Nursing home staff should be trained in implementing models of shared decision-making and in promoting consumer and family member participation in making healthcare choices, consistent with similar quality improvements in general medical care.

Advancing the Evidence Base

12. Support is needed for research that identifies effective and efficient approaches to addressing the mental health needs of nursing home residents. Funding initiatives and administrative support are needed for mental health research on pharmacological and psychosocial interventions in nursing homes, as well as studies to determine cost-effective service delivery models.

Rationale: Despite recent advances in research on the treatment of mental disorders in older persons, the knowledge base is underdeveloped and requires a major initiative in key areas, including research on mental health care in nursing homes.⁵¹ Reforms in financing and in regulatory policy likewise need to be based on an expanded base of evidence.

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