

The Treatment of The Elderly In Long Term Care

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The services psychologists can provide patients in long-term care results in benefits to patients and the healthcare system. Prior to the Nursing Home Reform Act of 1987, the traditional model of care in nursing homes was referred to as the *custodial* model. When looking at the negative stereotype of the nursing home, the *custodial* model represents much of what was undesirable about these settings, and is much less common today than even a decade ago. The *custodial* care model provided for the basic needs of patients, their food, cleanliness, medication and whatever medical care was necessary. But, there were no expectations for keeping the patient at his or her highest level of functioning, or for individualizing the psychosocial care. Fortunately, with nursing home reform 1987, and the accompanying emphasis on patients' psychosocial needs and restraint reduction, that traditional *custodial* model has evolved into what is now called a *functional capacities* model. Here, in addition to the usual focus on patients' medical condition and requisite nursing care, we are also interested in looking at different areas of functioning of the residents and developing individually tailored, multi-disciplinary care plans that take into account patients' level of cognitive, psychological, and behavioral functioning.

This shift from *custodial* care to a model that emphasizes *functional capacities* has had a profound effect on the professional role of psychologists in these settings, and underscores the position that comprehensive care for older adults in nursing homes goes beyond medical and pharmacological approaches. Rather, it should include psychological assessment and treatment while also incorporating professional consultation, staff training and education, and care planning. In fact, NAPPP believes that treating patients only in the medical context constitutes under-treatment when the care team is not looking at patients' co-morbid psychological issues, or the patients' ability to recover from or better manage their medical conditions, or offering new ways to cope with an irreversible illness or disability. NAPPP advocates for the multi-dimensional role of psychologists in nursing homes, and how this role favorably impacts patients' well being as well as the cost of long term care.

Nursing Home Demographics and the Need for Psychological Treatment

Data from the National Nursing Home Survey (2004) revealed that mental disorders were the second leading primary diagnoses among residents at time of admission (16.4%), second only to diseases of the circulatory system (23.7%). According to the American Geriatric Society ²³⁷, there are 1.5 million older adults in nursing homes, and anywhere from 65% to 91% have symptoms of a psychiatric disorder. An alternate look at the incidence of psychiatric illness in older adults reveals that 89% of this age group who have a diagnosed mental illness resides in nursing homes, while only 11% are in psychiatric hospitals. This is attributed to the sharply reduced number of long-term psychiatric hospitals in the U.S., and the fact that nursing homes are now the setting of choice for the population with chronic psychiatric illness when they cannot be managed in community-based residences. In nursing homes, depression, behavioral symptoms, and dementia are the most common psychiatric problems.²³⁸ Behavioral symptoms include verbal and physical aggression toward staff, other residents and visitors, non-compliance with nursing care, disruptive outbursts, inappropriate sexual behaviors, and agitation and wandering. Further, when psychiatric problems are present, these problems are associated with worse health outcomes, higher rates of hospitalization, higher emergency room use, and higher staff turnover.

In addition to the presence of depression, behavior disturbances and dementia noted in the AGS data, there are many other disorders that are psychological in nature, including adjustment disorders, grief and bereavement conditions, anxiety and other mood disorders, sleep and eating disturbances, chronic psychiatric conditions (e.g., schizophrenia and other psychotic disorders), and personality disturbances (e.g., paranoid, antisocial, borderline and obsessive-compulsive personality disorders). There are also many types of cognitive dysfunction caused by dementia (e.g., Alzheimer's, Parkinson's disease) and by delirium.

Beyond these primary psychiatric diagnoses, many of the medical conditions presented on admission have underlying psychological factors that contribute to or exacerbate the conditions. Examples include hypertension and high blood pressure, respiratory disease (e.g., chronic obstructive pulmonary disorder, emphysema), obesity, congestive heart failure, non-malignant pain, diabetes, and kidney failure. Management of each of these medical conditions, whether presenting in acute or long term care, can benefit from the contributions of a psychologist, particularly if the psychologist has a background in behavioral medicine or health psychology. We now know that approximately 133

million people have chronic conditions in the United States, according to the Disease Management Association of America (DMAA).²⁴³ This is projected to increase to 157 million by the year 2020.

The DMAA proposes that the principle of disease management includes a system of coordinated healthcare interventions and communications for populations with conditions in which self-care efforts are significant. To the extent that this population with chronic diseases gets older and is placed in nursing homes, the need for the behavioral health psychology specialist will only increase. Compounding the incidence of chronic disease, many research studies have repeatedly shown that higher costs and reduced quality of life for medically ill individuals are associated with depression, stress, and negative future outlook.^{244,246,254}

One additional – and major – factor to consider in addressing the need for psychological services is the shift in the nursing home admission pattern and the change in population. A study published by the National Hospital Discharge Survey²⁴⁰ gives a contemporary picture of nursing home admissions, divided into the “short stayers” and the “long stayers.” Short stay is defined as up to eight weeks; “long stayers” are generally over eight weeks, and on average, up to two years. “Short stayers” are considered sub-acute, with a variety of issues, usually very short-term rehab issues, but also some terminally ill conditions. These short-term admissions will receive intensive treatments and return to the community whenever possible. The “long stayers” are those who don’t succeed in their rehab (if that was the plan), or they are known at the outset that long term placement will be necessary. Often, there may be other more serious conditions with the long-term, chronic care population, such as cognitive impairment or a combination of cognitive and physical impairment.

Many skilled nursing facilities are converting long-term care beds to these short-term, Medicare Part A beds. Medicare will pay for the rehabilitation portion of the nursing home stay, as long as the patient remains eligible to receive these benefits. Once the patient gets off Part A, no longer qualifies for Part A, or loses Part A eligibility, the patient either returns home or is transferred to a long-term care unit in the facility. The “short stayers”, then, by definition, are in the Part A portion of their stay, and Medicare reimburses the facility for these Part A days.

The National Hospital Discharge Survey also reflected a trend that the admissions from hospitals are “quicker and sicker.” The length of stay is shorter in the acute care hospitals. There are more transfers from the acute to the sub-acute, and there is a higher volume of patients passing through the system.

And, of course, there is a higher medical acuity, but these patients end up in nursing homes, nonetheless. This means that we are seeing more admissions, and more discharge activity. Even the term “nursing home” is less in favor, and is being replaced by “rehabilitation center,” and names with similar connotation.

The recommendations from the NHDS report strongly advocate greater interdisciplinary collaboration, including all different types of staff expertise and staff input. Again, the behavioral health professional is central to this collaboration, with an emphasis on interdisciplinary involvement, discussion, and participation in treatment planning with other team members.

Shortage of Trained Professionals

The Institute of Medicine (IOM) recently reported on the future health care workforce for older Americans in a publication, *Retooling for an Aging America: Building the HealthCare Workforce*.²⁴⁸ The publication projects significant shortages of all health professionals with specialized training in geriatrics and aging. This shortage is attributed to a number of factors, including relatively fewer faculty and training institutions with expertise in aging (in contrast with other health care fields), aging of the workforce itself, and reduced financial incentives to provide professional services to older patients. In a landmark study, Jeste et al.²⁴⁹ reported that the demand for trained mental health professionals far exceeded the supply, and that at the time of that publication, the number of psychologists to work with the elderly was only 10% of the total number needed, and that percentage would drop to 5% by 2030. (Psychiatrists were at 55% of the current demand, and licensed clinical social workers were at 18%.)

Clinical Role of Psychologists in Nursing Homes

Many of the traditional professional services provided by psychologists in nursing homes address residents' adjustment disorders. These conditions are often precipitated by sudden placement in the facility, following an acute medical event, such as a stroke or fracture from a fall. Chronic medical conditions can also trigger a need for long-term placement, in which the patient now requires 24-hour nursing care, for diagnoses such as heart disease, severe respiratory disease, or progressive dementias such as Alzheimer's or Parkinson's disease. Other placements may be less sudden, but the adjustment difficulties are still exacerbated by a loss of independent functioning, separation from one's home and family, and becoming dependent on caregivers. Depression and generalized anxiety symptoms are

frequently in the clinical picture, and manifested typically by withdrawal and isolation, eating and sleeping problems, non-compliance with treatment plans, and disruptive behaviors. Also, behavior problems often accompany the mental decline seen that accompanies dementia.

As stated earlier, many nursing home admissions may be medically triggered, but the patients can have co-existing psychiatric disorders that complicate the stay and require the interventions of a mental health specialist. Of course, the theme of death and dying must be included in the purview of the consulting nursing home psychologist, as well as counseling and support for the patient's family, and psychoeducation on a variety of clinical issues. Cognitive and psychological assessment is also essential with this older adult population. Brief measures of cognitive functioning, the presence and severity of psychological disturbances, decision-making capacity, and attitudes toward recovery, among many other factors that can be looked at, play an important role in treatment planning.

Limitations of the Biomedical Model

Despite the prevalence of psychological disorders in nursing homes, psychological services have been impacted by the medicalization of behavioral health. Essentially, this biomedical model looks at disease in isolation from the patient. The disease is on the center stage. It is independent from the person suffering from it. Each disease has a specific cause and the cause can be correctly determined through enough diagnosis. Essentially, this biomedical model says the patient is a passive recipient in the process.²⁵⁰

Unfortunately, there are many, unfavorable consequences of this limited viewpoint. First, this does not allow us to address the psychological risk factors for morbidity, or the pathways that lead to over-utilization of medical services. We are just looking at the disease; we are not looking at the precipitating, or predisposing psychological risk factors. Secondly, the biomedical model does not allow us to look at the actual psychological impact of having a medical illness. A third consequence of this view is that typically a primary care physician is treating these psychological conditions because he is the one consulted by the patients, and behavioral health professionals are not consulted.

An Alternate Model: The Biopsychosocial Model

The body does not function in a vacuum. The mind and body are closely related, such that an imbalance in one leads to symptoms or disease in the other. One interpretation of this model speculates that treating patients only in the biomedical context could constitute under or mal-treatment, if the psychological conditions are not being considered, including patient's attitudes about recovery, or their motivations that impact the onset or management of the medical condition. Without the behavioral health perspective, the patient is often being treated without taking into account the whole clinical picture. This contributes to uneven recovery, potential harm and increased healthcare costs.

Costs Associated With The Biomedical Model

We know there are significant financial health care costs that are unnecessary effects of medicalization because we are not addressing significant psychological factors influencing management of or recovery from medical conditions. The Department of Health and Human Services published a report ²⁴² saying that seven out of the ten leading health and illness indicators are psychological, such as inactivity, obesity, smoking, substance abuse, behavioral illness, irresponsible sexual behavior, and violence. Further, early research on causes of death in the United States indicated that seven of the nine leading causes of death are psychological in nature.²⁵¹ This is not new information, but it is related to the need to address the underlying psychological issues in the short-term stay nursing home patient.

Moreover, there are numerous studies reporting the medical cost offset of behavioral health services with medical patients. Chiles, Lambert and Hatch conducted a meta-analysis of 91 studies, looking at the effect of psychological interventions on medical utilization, and found that of these 91 studies, 90% showed reduced medical utilization following some psychological intervention and a corresponding reduction in cost. This is further evidence that behavioral health approaches can reduce unnecessary utilization of health care services, and can improve the overall care of the individual. ²⁴¹

Psychologists working with these patients can accomplish several objectives: Providing necessary psycho-educational information about the medical condition, its etiology and contributing factors, and steps toward self-management. Psychologists are also able to reduce the high levels of psychological stress, and change unhealthy behaviors, or so-called health risk behaviors. Psychologists can provide social support and help to identify or mobilize new sources of social support. We can detect and treat under-diagnosed behavioral illness and we can also address the somatization issues where patients keep

presenting with multiple, and often vague medical complaints, request frequent doctor visits and trips to the emergency room, and overall seek more attention from their medical providers.

What does the psychologist do with these primary medical conditions? With both the short- and the long-term nursing home admissions, the psychologist first helps the patient understand the emotional impact of the condition that led to his or her admission. The patient may have had a fall, but what are the accompanying emotional considerations that this person needs help with? Secondly, we assess the values and perceptions of the patient regarding his future. What is this person's outlook like?

Third, we identify what kinds of barriers there are in participating and benefiting from rehabilitation and help to overcome these barriers, collaborating closely with the rehabilitation team. Fourth, we offer therapeutic interventions that facilitate the safe and effective progress of rehabilitation, effectively, helping the patient to stay engaged once he does become involved in his physical therapy. And, fifth, psychologists trained in medical psychology, including psychopharmacology, can significantly reduce polypharmacy, adverse drug events and the significant costs associated with additional hospitalization as a result of inappropriate prescribing. This means continually integrating the different approaches among the healthcare providers, to ensure these patients are involved in and maximize their benefit from their treatment.

The psychological approaches employed with the long-term, or chronic care patient, are different. With these cases, it is necessary to monitor depression and withdrawal, assist with adjusting to and accepting irreversible physical illness and debility, and identify positive sources of reward, support, and social involvement. This often takes place in the process of understanding an individual's resistance to treatment, and supporting his or her decision-making process, while informing the patient of other possible courses of action. Finally, it is necessary to address the person's thoughts and fears about death, whether imminent or not.

This brings the focus back to interdisciplinary collaboration, reiterating the major premise that the mind cannot be separated from the body. The more we can advocate this interdisciplinary collaboration, the better patients will be served and costs contained. This is done by being allowed to provide the services we are fully trained and experienced to do, while supporting and facilitating a culture of integrated care. It is necessary to keep reiterating the premise that patients are not isolated from their disease, while emphasizing the importance of the behavior health approaches in understanding, assessing and

treating the patient, especially where the coping resources are limited or taxed. The treatment provided by psychologists in nursing home settings is characterized by brief, problem-focused interventions in which the emphasis is on shared understanding of treatment goals and barriers. Moreover, psychologists are trained to provide concise information and to provide the needed updates on a patient's condition. As part of an interdisciplinary team, this communication with medical professionals is mandatory and necessary. ²⁴⁷

Barriers to Effective Care

There are several barriers to more effective care in nursing homes from the perspective of a practicing geropsychologist. Some have been alluded to already, namely, the tendency to separate the medical condition from the psychological condition, rendering attempts to treat the patient's physical problems, in the absence of understanding the emotional and attitudinal problems, frequently unsuccessful. This treatment pattern also leads to another complication, the tendency to over-rely on psychoactive medications to address psychological and behavioral problems before non-medication approaches are used. Psychotropic medications are drugs that affect an individual's mental processes and behavior, and are considered legally inappropriate if they are not used to ensure the physical safety of patients or of others. Federal law stipulates that each resident's drug regimen must be free from unnecessary drugs, defined as any drug used in excessive dose, for excessive duration, without adequate monitoring, without adequate indication for its use, or in the presence of adverse consequences, which indicate the dosage should be reduced, or discontinued. This rule was implemented to reduce and eliminate drugs to chemically restrain patients.

There are generally four categories of psychotropic medications: anti-psychotic, antidepressant, anti-anxiety, and hypnotic sedatives. These medications are frequently prescribed to nursing home patients. Psychotropic medications have their place in nursing homes, and can be an effective adjunct in the overall treatment plan for many patients. However, psychologists should always be part of the intervention strategy with any patients on these medications, for two reasons.

First, the medications do not help the patient learn new ways to manage or cope with a stressor, but rather only serve to reduce the symptoms of the condition, such as tearfulness, agitation, or disordered thought processes. Psychological services include helping with the development of more effective coping skills, problem-solving, and affective expression. The second reason for including

psychologists as a complement to the use of medications is to help with the patient engaging in non-purposeful, non-intentional but difficult, obstreperous behaviors. These patients are too confused to participate in or benefit from counseling and psychotherapy, or any one-on-one direction, but yet display problem behaviors. In these cases, the requisite approaches include milieu or environmental strategies to modify the problem behaviors. This is accomplished by developing behavior management programs and consulting with staff on optimum caregiving approaches for these residents. These behavior management strategies can shape or modify behavior by changing the environment that the patient is responding to, instead of resorting to higher or excessive dosages of the psycho-active medications.

The challenge with working with patients who are too cognitively impaired to benefit from psychological services is the lack of reimbursement. Most insurance plans, including Medicare, cover counseling and psychotherapy, and assessment, but these plans do not cover staff consultation, case conferences, supervision of behavioral interventions, or staff training. Consequently, these services are provided on a *pro bono* basis, and are not made available to the majority of dementia cases that would benefit from these psychological consultations. By not reimbursing for these services, Medicare and other insurers save money on one end but wind up paying much more on the other end. Patients, however, pay the highest price.

Another barrier that has been observed with this population is ageism, or stereotyped views of the older adult based on the person's age, and not on his or her functional abilities. These views are held by health care professionals, insurers, family members, and even by elderly individuals themselves. The belief, for example, that depression or dementia is inevitable in advanced age is an ageist viewpoint, and creates additional barriers to contributions that psychologists can make. Depression in advanced age may be common, but it is never normal. To the extent that psychologists can promote a greater understanding of the role that behavioral health assessment and treatment approaches play in nursing homes, and can integrate these approaches with the rest of the health care team, true comprehensive care can take place.

The Inappropriate Use Of Medications In The Elderly

Inappropriate medications, in and of themselves, may not be the major cause of adverse drug reactions in the elderly. It is the inappropriate use of drugs that is the major problem when treating the elderly. Adverse drug events with this population can be prevented by reducing the number of drugs prescribed to this population.²⁵⁶ It is not uncommon for patients in nursing homes being prescribed between 5 and 13 medications,²⁵⁷ according to a recent study of the elderly in nursing home. The researchers reported that the median number of prescribed medications was 5 and ranged up to 13 medications. Thirty-two percent of the patients studied received inappropriate medications. Patients prescribed more than 5 medications were 3.3 times more likely to receive an inappropriate medication than those taking 5 or less medications. Half of the patients studied with inappropriate prescriptions experienced significant adverse effects of the inappropriate medications. Sixteen per cent of all admissions to hospitals were associated with such adverse effects. The researchers defined an inappropriate medication based on the Beers list²⁵⁸, a list of medications agreed on by the majority of researchers.

Polypharmacy among the elderly is a serious problem, many times resulting in death and is a major factor in increased healthcare costs.²⁵⁹ More than 770,000 people are harmed or die each year in hospitals from adverse drug events associated with polypharmacy.²⁶⁰⁻²⁶² The costs for these preventable hospitalizations adds up to \$5.6 million each year per hospital. These projective costs do not include the ancillary costs associated with malpractice and litigation costs, or the actual costs of the harm to patients. Total U.S. hospital expenses to treat patients who suffer adverse events associated with inappropriate prescribing and polypharmacy during hospitalization are estimated at between \$1.56 and \$5.6 billion annually.²⁶³⁻²⁶⁶ These costs and the harm to patients can be significantly reduced when these patients are being followed and treated by a psychologist. The majority of these medications are prescribed by physicians who rarely see the patient and generally are prescribed at the request of a staff member of the nursing facility.

Concluding Statements

The care of the elderly in nursing facilities is a major concern and public interest issue. The costs for providing care to this population will only increase as the population ages. Medicare costs, a major concern for both legislators and policymakers, needs to be looked at from the perspective of "best service delivery" as opposed to the cost-cutting strategy that most advocate. It is clear from our analysis that better services can be provided as costs are decreased if medical care and decisions also include

psychologists, nurses and other healthcare professionals.

The increasing costs for medications that clearly can be reduced if physicians, more often than not, would include behavioral interventions into the treatment plan. Policymakers, as they frequently tend to do, need to look at the whole picture instead of looking at the many, small details of eldercare. The message is clear, however, leaving physicians in charge of care can and will only lead to increasing costs for care and increased harm to patients. The best available data supports this conclusion.