Dear Dr. Jeff:

A consulting psychiatrist who is board-certified follows all of our residents on psychoactive drugs. She is very faithful in making rounds and routinely reviews resident behaviors with the nursing staff and social worker. Unfortunately, these discussions frequently lead to recommendations for atypical antipsychotic medications. Our utilization rates are high and I am worried about how this will look during a survey, even though the psychiatrist notes diagnoses justifying these medications. Once a recommendation is written, our physicians feel obligated to follow it. What do you suggest?

Dr. Jeff responds: In many parts of the country, it is very difficult to get any qualified mental health professional to evaluate nursing home residents. Even when a consultant is willing to deal with Medicare reimbursement levels and 30% copayment complications, it is still rare to get that person to make regular rounds in a skilled nursing facility. So when you describe a professional who is well-trained, comes regularly, follows patients appropriately, and actually collaborates with other members of the interdisciplinary team, you are describing a jewel.

Unfortunately, your worries about survey deficiencies are entirely appropriate. The Centers for Medicare & Medicaid Services (CMS) has made its intentions in this area very clear. CMS was spurred by a report from the Office of Inspector General identifying the extraordinary, off-label use (and cost to the Medicare system) of these medications in dementia patients, despite the Food and Drug Administration’s black-box warning of potential side effects. Our utilization rates are high and it is still rare to get that person to make regular rounds in a skilled nursing facility. So when you describe a professional who is well-trained, comes regularly, follows patients appropriately, and actually collaborates with other members of the interdisciplinary team, you are describing a jewel.

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Over the past 25 years, most facilities have reasonably complied with the OBRA ‘87 standards—with the exception of the utilization of psychotropic medications, although even here, typical care in skilled nursing facilities exceeds what in most hospitals and community settings. Thus, the Affordable Care Act (“Obamacare” or “health reform”) added the Quality Assurance and Performance Improvement (QAPI) process to engage stakeholders and national experts in the development of tools and systems for improved care.

It’s true that certain aspects of very high-quality care can conflict with, or at least appear to conflict with, federal regulations and initiatives. But that is not the case with antipsychotic drugs. The CMS and FDA initiatives are, if anything, slow and hesitant responses to an obvious disparity between what experts in dementia care have known for years and what the prevailing care patterns in nursing homes have been.

All available scientific data tells us that these medications, which were developed to treat schizophrenia and major mental health disorders, were never intended for the behavioral complications of neurologic diseases. These chemicals have effects on neurotransmitters that suggest they would have little efficacy in behavioral disorders. They have been through multiple clinical trials that have documented low efficacy and shown the drugs to be significantly more dangerous than placebo.

Some psychiatrists, trying to avoid CMS strictures, have moved toward the use of sedating antidepressants or even drugs developed for the recently popular diagnosis of pseudobulbar affect. This is probably a real problem for some traumatic brain injury and multiple sclerosis patients, but it is not an aspect of the dementing diseases.

Unfortunately, you are faced with a situation where a very good doctor is giving you very bad advice. She is attempting to help the staff provide care for residents whose behaviors are difficult and detrimental to other residents. As undesirable as the atypical antipsychotics may be, they do benefit a very small group of agitated dementia patients with psychotic symptoms, for which no drug is approved by FDA or supported by the literature. Just as in the old days when nurses would call to request an order for a physical restraint, nurses are looking for a chemical restraint to deal with unacceptable behaviors. And, just as programs to reduce physical restraints are recognized that alternative approaches needed to be implemented, eliminating the use of antipsychotic medications requires a staff trained in a variety of individualized approaches and with good resources available to them every day, for every shift.

What the surveyors want to see is exactly the same as what dementia experts would unanimously call quality care: giving individualized nonpharmacologic behavioral management a good try before any pharmacologic approach is entertained. Without this, you may be cited for “unnecessary medications,” even if the patient’s chart includes a diagnosis for which antipsychotic treatment is approved.

Because every dementia patient is different, and because behaviors represent an extension of the patient’s premorbid personality, physical health, and progressive neurologic disease, there can be no one-size-fits-all nonpharmacologic treatment. Conditions such as “agitation” and “calling out” are grab bag symptoms representing a daunting number of possible etiologies.

How many nursing notes or physician telephone calls describe a resident as “yelling” without noting what the resident said, much less a stab at the underlying message? Certainly, a 90-year-old calling out for her mother is “agitated, disoriented, and confused.” But why do human beings usually call out for their mother? Because they are hungry or soiled or in pain or lonely. These are all problems that have different solutions but don’t require a psychiatric medication.

Residents yelling “help” generally need just that, although it may not be obvious exactly what kind of help is needed. Depending on the problem, the solution might be repositioning, toileting, pain medication, treatment of a worsening medical problem, or release of a wheelchair’s brakes. Occasionally, the problem really is a urinary tract infection with dysuria, the go-to explanation for many clinicians.

The important message is not that you need to find one particular nonpharmacologic approach to behaviors but that the interdisciplinary team needs to develop a whole new dementia-care system—to be implemented before the psychiatrist becomes involved. Since the selection of psychotropic medications and their dosages is, indeed, the realm of the psychiatrist, she should be consulted for the large number of nursing home residents with significant depression or other major mental health disorders.

To correctly understand the etiology of dementia behaviors often requires the collaborative efforts of the whole interdisciplinary team. The burden should not simply fall on an already stressed floor nurse. Since boredom is a frequent cause of undesired behaviors, and “redirection” is often the first nonpharmacologic approach recommended, therapeutic-recreation specialists can play a significant role in improving behaviors.

For too many facilities, the recreation schedule revolves around the three Bs—birthdays, Bible, and bingo—with very little to offer dementia patients. Besides group programming for these residents, there need to be activities for individuals available on the dementia unit. These might include individualized music therapy (occasionally as simple as listening to the radio), magazines to look through, simple tasks to perform, or warm and comforting objects to hold.

Some facilities have implemented a rule that the physician or nurse practitioner is called about a non-life-threatening behavior only after at least two nonpharmacologic approaches have been attempted and failed or an etiology, such as pain, requires an order for treatment. The primary care practitioner then requests a psychiatric consultation after he or she has excluded possible medical etiologies, including delirium. Approaches like this will help you to improve the quality of life for your residents and decrease the use of psychotropic medications.

Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island. He invites your questions for possible discussion in this column, to caring@elsevier.com. You can also comment on this and other columns at www.caringfortheages.com, under “Views.”