**DEAR DR. JEFF**

Jeffrey Nichols, MD, CMD

**Caring for the Cognitively Intact**

**Dear Dr. Jeff:**

Long-term care residents who are cognitively intact are few and far between. Many have neuromuscular diseases or complex orthopedic problems that require extensive assistance with their activities of daily living. How can long-term care facilities that are largely devoted to the care of dementia accommodate these residents? Should they be cohorted? Should they have specialized facilities?

**Dr. Jeff responds:**

Many readers might be surprised by this question. Long-term care facilities have frequently been criticized for the inadequate care provided for residents with dementia. The major campaigns to remove physical restraints in the 1990s and the more recent national programs to reduce the use of antipsychotics and other psychoactive medications to control the behavior of cognitively impaired residents have highlighted these inadequacies. Nonetheless, many facilities remain poorly designed and many staff poorly trained to care for these residents. Although some cognitively impaired residents will benefit from specially designed dementia units, there is no benefit to completely organizing a facility based on cognition alone. Different populations require different services, and factors such as prognosis, medical needs, age, gender, language, and patient preference all need to be considered.

In 2016, AMDA – the Society for Post-Acute and Long-Term Care Medicine’s House of Delegates approved a white paper entitled “Whom Do We Serve?” The paper described current and evolving data regarding the demographics of the long-term care population, particularly those in nursing homes, later published as a special article in JAMDA (2016;17:574–580). Well worth reading on its own, this multiauthored review of available statistics demonstrates the increasing diversity of the long-term care population. However, even given the variable quality of cognitive assessments and the limitations of the Brief Interview for Mental Status (BIMS), which is embedded in the mandatory Minimum Data Set process (MDS 3.0), there is a large population of cognitively intact adults residing in nursing homes. They are neither few nor far between and may represent up to half of nursing home residents. They are not necessarily the stereotypical little old ladies with gray hair, glasses, and a cane who were once the mainstay of nursing home residents; in fact, nearly 15% of nursing home residents are younger than 65. The Society recently published a manual designed for the entire interdisciplinary team addressing the medical needs as well as the basic human needs of this cognitively intact population.

Many of these cognitively intact residents, along with some with impaired cognition, have been admitted for short-term care. In most facilities, this population is already admitted to designated beds or units. Some states require specific designation of beds into “skilled nursing facility” or custodial “nursing facility” units. Indeed, there are nursing homes exclusively devoted to short-term admissions, some with average lengths of stay fewer than 20 days. These patients, although officially “residents,” do not really reside in the nursing home, and concerns regarding their management center primarily on the medical, nursing, and rehabilitative activities required to return them to the community.

No doubt, positive social interactions and a pleasant physical environment enhance the patient experience, but these are overshadowed by the primary focus on recovery. If other residents with dementia do not create excessive disruption or disturb sleep, there is no real need to try to segregate patients based on cognitive functioning. Indeed, many residents recovering from delirium or a stroke may have dramatic improvements in cognition, while a decline in function demands a workup, not a room change.

Other cognitively intact residents may be located on specialized units designed for particular medical needs, such as ventilator-dependent residents or those recently weaned from the ventilator, who still have tracheostomy tubes in place. They require units with staff trained to meet their medical needs. Others are terminally ill and may receive hospice services. Again, their special needs outweigh specific concerns regarding cognitive status. Although massive brain trauma can produce cognitive loss, many patients with traumatic brain injury have intact orientation and short-term memory despite experiencing symptoms such as retrograde amnesia, mood swings, and difficulty concentrating, which are quite different from dementia. They often are better served by specialized units for their needs rather than commingling with other cognitively intact residents.

**Determining Need for Care**

Practitioners in long-term care rarely question why our residents require institutional care. Medical needs by themselves do not determine a need for skilled nursing care. Even ventilator patients can be managed in the community and frequently are. I have cared for quadriplegic patients living at home, including one who lived alone and dialed a telephone with a special device controlled by her chin. Programs of All-Inclusive Care for the Elderly routinely manage complex, frail, nursing home eligible patients in the community, using as-needed visits to day centers offering a full array of multidisciplinary services. The key determinant of a need for institutional care is not simple functional deficits or required treatments, but the ability of the patient to safely direct their care or the availability of a willing and responsible person — typically someone living with the patient — to direct that care.

Why then might cognitively intact patients require placement? Why couldn’t they direct their own care at home? Sometimes a living situation is so unsuitable that agencies would not consider home services feasible or safe. Structurally unsound or vermin-infested buildings do not offer a home where services can be provided. Some rural seniors live in physically isolated areas without access for home care workers, particularly those who might require public transportation to reach the home. But most frequently, the personality and psychological profiles of cognitively intact frail elders determine the need for institutional care. Nursing home units organized around mental health needs rather than cognitive performance might benefit these residents.

Depression, including particularly depression associated with somatic complaints, is a powerful predictor of nursing home placement. Many clinicians are aware the MDS 3.0 includes a screening tool for depression, the Patient Health Questionnaire 9 (PHQ-9). This screen has been validated in primary care clinics and various specialty clinics among younger adults, but has never been validated among elderly patients, much less among those in a long-term care setting. In younger populations, its sensitivity may be as low as 60%. A major benefit is its ease of administration. The PHQ-9 can identify approximately 10% of nursing home residents as depressed, which is actually a smaller percentage than that identified by community prevalence studies. Another screening tool, the PHQ-2, has been tested in an elderly community sample and is actually much more sensitive, although somewhat less specific (J Am Geriatr Soc 2007;55:596–602).

Minor depression, absent suicidal ideation or significant weight loss, is frequently overlooked or justified by observers as a rational reaction to chronic disease and loss of independence.

Dysthymic disorder, renamed persistent depressive disorder in the Diagnostic and Statistical Manual (of Mental Disorders), Fifth Edition, is another mood disorder frequently overlooked in the nursing home. Characterized by symptoms such as helplessness, low energy, disordered sleep, and difficulty concentrating, this chronic condition has a prevalence in the community of between 1% and 2%. Patients with these symptoms generally feel unable to care for themselves at home. Because depression in the elderly is more common in those who also have significant physical pathology, the psychological component of their condition is often overlooked. Families frequently deny that these patients are depressed because “She has always been like that.”

Many other nursing home residents suffer from mental health disorders such as schizophrenia, bipolar disorder, and a variety of personality disorders. Dependent personality disorder is characterized by a sense of helplessness, fragility or weakness, incompetence, and an excessive need to be cared for by others. These residents are not necessarily sad, but they are typically poorly motivated for restorative therapies, and they receive some comfort from an environment that provides total care. Others have schizoid personality disorders with lifelong patterns of reclusive- ness and little need or desire for human relationships. Often residents with these conditions or other mental health disorders have had coexisting substance abuse, which in the elderly is usually alcohol. Many of these individuals, by the time they reach advanced age, have been cut off from family and friends and lack the supports needed to remain in the community. Having spent lives surrounded by cognitively intact individuals did little to address their underlying problems. Many prefer to stay in their rooms or isolate themselves.
Caring for the Ages

Focus on the Few

There is, indeed, a small group of nursing home residents who are both emotion-ally and cognitively intact. Sometimes they find each other on the nursing units, arrange to eat at the same table, enjoy conversation, or even develop romantic attachments. They tend to be the leaders in resident councils and are regular attenders of scheduled activities. We do need to give more attention to these residents, which means much more than segregating them by themselves. Nursing homes tend to infantilize residents, robbing them of their sense of independence and self-worth. The traditional “Three Bs” of therapeutic recreation programs (birthdays, Bible, and bingo) are an inadequate foundation for creating a meaningful daily schedule, while the background noise of daytime television is a poor substitute for an active life.

The concept that the “activities of daily living” consist of eating, urinating, defecating, and getting out of a bed or chair to move around offers a bleak view of human existence. We need to be more creative in designing individual care plans that encourage what Abraham Maslow called “self-actualization,” the desire for self-fulfillment by achieving our potential, even when that potential is limited by physical disabilities. This could include learning, exercise, work, service to others, new experiences, perhaps even a realizable bucket list. What we owe these residents is not a place by themselves, but a fuller life in the world where they live.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.

Benzos Increase Risk of Pneumonia

Community-dwelling individuals with Alzheimer’s disease who received benzodiazepines were more likely to develop pneumonia, according to results from a Finnish study published in the Canadian Medical Association Journal.

Researchers looked at national registries of 49,484 adults diagnosed with Alzheimer’s disease between 2005 and 2011 in Finland. The participants had a mean age of 80 years, and almost two-thirds (62.7%) were women. Researchers studied 5,232 patients taking benzodiazepines and 3,269 patients taking non-benzodiazepines; the remainder were not taking either drug [CMAJ. April 10, 2017 vol. 189 no. 14 doi: 10.1503/cmaj.160126].

They found that benzodiazepines were linked to a 30% increased risk of pneumonia in patients with Alzheimer’s disease, and the risk was highest during the first 30 days of treatment. The association between non-benzodiazepines and pneumonia was not statistically significant, but the authors did not conclude these drugs were safer.

The authors suggested that the sedative nature of benzodiazepines may increase the risk of pneumonia by increasing the aspiration of saliva or food into the lungs. The results are consistent with studies that have found an increased risk of pneumonia in patients of all ages taking benzodiazepines.

“An increased risk of pneumonia is an important finding to consider in treatment of patients with Alzheimer’s disease,” lead author Heidi Taipale, PhD, Kuopio Research Centre of Geriatric Care, University of Eastern Finland, Kuopio, said in a press release. “Benzodiazepines and [non-benzodiazepines] are frequently prescribed for this population, and long-term use is typical. Pneumonia often leads to admission to hospital, and patients with dementia are at increased risk of death related to pneumonia.”

The benefits and risks of the use of benzodiazepines “should be carefully considered for patients with Alzheimer’s disease and include risk of pneumonia,” the authors concluded.