The chief cause of problems is solutions. — Eric Sevareid

This month’s column explores the challenges of using psychiatric consultants to help address behavioral and psychiatric issues in nursing homes. It is well known that behavioral and psychiatric issues are prevalent in nursing homes. Even after 40 years of guidelines, protocols, and regulations about managing these issues, it is still a significant challenge for staff and practitioners to manage them safely and effectively and tailor all the general guidance and advice to specific situations and individuals. The current Omnibus Budget and Reconciliation Act (OBRA) regulations and related surveyor guidance mention “behavior” several hundred times. The regulations and guidance at F483.40 (F741) require facilities to:

- identify underlying causes of an individual’s behavior through assessment, diagnosis, and treatment by qualified professionals, such as psychiatrists;
- provide enough competent staff to manage behavior;
- try to secure professional behavioral health services, when needed;
- use nonpharmacological approaches to care, unless contraindicated, based upon the comprehensive assessment;
- monitor the effectiveness and safety of interventions and attempt alternative approaches, if necessary.

In addition, F757 (Unnecessary Drugs) covers expectations that all psychopharmacological medications — not just antipsychotics — should be used only “with a documented clinical indication consistent with accepted clinical standards of practice.” Of course, that is a loaded statement because of the need to determine whether alleged clinical indications in individual cases actually conform to standards of practice.

Unfortunately, as per my April and June/July 2020 columns, both the Centers for Medicare & Medicaid Services and the survey process have overemphasized interventions (e.g., don’t use antipsychotics) and barely considered important aspects of the care-delivery process (i.e., detailed problem definition and accurate cause identification) that underlie appropriate treatment. Thus, the survey system, the Minimum Data Set (MDS), and the standard Quality Assurance Performance Improvement process are minimally helpful in identifying the “right thing” in specific cases.

Nursing home staff and management want interventions because behavior is often disruptive and sometimes damaging to a resident and to others. Both medications and nonpharmacological interventions are only sometimes helpful, and one-on-one care is a time-consuming use of scarce staff. Often, medications have already been started before admission, they have been changed or added by multiple prescribers, and they lack a clear rationale or other information to justify their continued relevance. What would pass for normal or quirky conduct outside the facility often must be investigated and reported as possible abuse in a nursing home (see the April 2020 column, https://bit.ly/383UpB1).

Understandingly, facilities fear survey deficiencies and possible abuse allegations, so they try hard to prove that they have done the right things and that negative outcomes (e.g., continued behavioral symptoms of distress or alterations with others) occur despite their best efforts. For various reasons, most nursing home staff and practitioners manage behavior and psychiatric issues hesitantly, or they prefer to let someone else handle it.

Thus, a whole industry of psychiatric consultants (PCs) and behavioral health consultants (BHCs) has arisen nationwide. These providers may include psychiatrists, psychiatric nurse practitioners, psychologists, psychiatric social workers, and other consultants who prescribe or recommend psychopharmacological medications and other nonpharmacological interventions.

So how should nursing home staff and practitioners use these consultants, and what should they be able to expect of them? To answer this, we turn to the care-delivery process as discussed in this column throughout 2020. All the aforementioned consultants should be able to competently assist in some or all of these steps: recognition/assessment, cause identification/diagnosis, treatment, and monitoring.

**Problem Recognition, Assessment, and Definition**

Because they are nonspecific and could represent any number of underlying causes, all behavior and psychiatric symptoms need clear problem statements: What exactly is the issue? Who is affected? Why does it need an intervention? A capable PC/BHC asks the right questions and guides the staff and practitioners to formulate a clear picture of the situation, including a description of the behavior and the frequency, intensity, and duration of symptoms. They take time to obtain, review, and validate with the interdisciplinary team (IDT) — not just with a single staff person such as a frontline nurse — the key information.

They examine behavior details over an extended time, past psychiatric notes, psychosocial and functional (activities of daily living) history, and any recent inpatient discharge summaries. They help facilities understand the issues and identify the causes in detail so that the staff and practitioners are not just reacting to symptoms and demanding medications.

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**Diagnosis and Cause Identification**

Section 483.10 (F605) in the CMS State Operations Manual notes that potential underlying causes for behavior may include — but are not limited to — delirium, pain, medication-related adverse consequences, and environmental factors such as hunger and noise. However, most of the related guidance to facilities and training is about nonmedical causes and interventions.

Capable PCs help facility staff and practitioners seek, understand, update, confirm, or challenge existing psychiatric diagnoses. They know that these are often incorrect, incomplete, incompressible, or no longer relevant. They know how to use guidelines for competent differential diagnosis, which requires context, including details of the current symptoms and more remote history (First MB. DSM 5: Handbook of Differential Diagnosis. American Psychiatric Publishing, 2014).

For example, many patients have multiple dementia diagnoses, despite other evidence suggesting that their cognition is largely intact or has been impaired by reversible causes or by misdiagnosed schizophrenia or bipolar disorder. Not all delusions are psychotic or need psychopharmacological treatment. Aggression can have causes as diverse as depression or personality disorder. Many patients have akathisia, tremors, or other neurological symptoms that are erroneously described as agitation, anxiety disorder, or another psychiatric condition.

Delirium is a common, high-risk condition of brain failure due to medical causes. It often presents with psychiatric symptoms, and it requires prompt medical intervention to diagnose and address causes (JAMA 2017;318:1161–1174). Capable PCs help practitioners and staff interpret and apply the screen for delirium (the Confusion Assessment Method), which is already integrated into the MDS. They also realize that delirium often results from medication-related adverse consequences.

A capable PC does not just operate in a “psychiatric silo” or assume that someone else will identify and point out medical issues, including medications that so often cause behavior issues and psychiatric symptoms (Med Lett Drug Ther 2008;50:100–103). They help the staff and practitioners do their “workbook” to rule out medical and medication-related causes before seeking psychiatric consultation (DSM-5, 2–8).

**Patient Management and Treatment**

Despite the heavy OBRA survey emphasis on interventions other than psychopharmacological medications, systematic clinical reasoning is needed before or soon after initiating any interventions, to minimize unhelpful if not hazardous guessing.

Capable PCs collaborate with the staff and practitioners to identify the history of prior interventions for behavior, mood, and psychiatric symptoms, as well as the rationale, goals, and positive and negative results of such interventions. They help facilities target the underlying causes and not just the behavior.

However, PCs should not just function as psychiatric medication managers. They are not solely into lingo such as “medication reconciliation” and “gradual dose reductions.” In fact, it would be unsound and dangerous to prescribe and adjust psychopharmacological medications in a silo, without coordinating the care or having meaningful discussions.

Capable PCs can provide a detailed, clinically pertinent rationale (not just a diagnosis) for any recommendations to initiate, add, or change medications. They know how to manage multiple medications using a prioritized approach based on effective clinical reasoning. They always look at the entire medication regimen, as medications in many categories (e.g. anticholinergics) can impair mood, behavior, and cognition.

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They recognize or aggressively look up medication indications, interactions, and major adverse consequences (Provider, June 1, 2020; https://bit.ly/39xoCM5).

Monitoring

Effective monitoring requires more than just IDT meetings and flow sheet completion. It reconsider current diagnoses and treatments based on detailed evidence and on knowing when to stop or change treatment, based on a clearly articulated clinical rationale.

Capable PCs help the staff and practitioners monitor patient responses to interventions and adjust them effectively — especially when the targeted behavior or symptoms are not stable or not gradually resolving (i.e., become less frequent, intense, or enduring) as anticipated. They know how to adjust a complex treatment regimen, including exactly what to raise and lower. For example, they can identify that an agitated resident is not benefiting from clonazepam or valproic acid or that an antidepressant needs a substantial increase in dose or a change to a different antidepressant.

Responsibility of Facility Staff and Practitioners in Relation to Psychiatric Consultants

For various reasons, many managers, staff, and practitioners in nursing homes believe that PCs/BHCs can be expected to handle many of the residents’ behavioral symptoms as well as individual residents with challenging psychiatric needs. However, the laws and regulations still hold the facility and its professionals ultimately responsible for the care of residents.

All nursing homes have a responsibility to understand the value of PCs and use them properly. Everyone has a role in defining and clarifying issues and thinking about causes. Medical practitioners should recognize that behavior and psychiatric symptoms often have medical causes or correlates (e.g., delirium) and should not view psychiatric and behavioral issues as primarily psychosocial problems to be handled solely by nurses, social workers, and PCs/BHCs.

Even the best PCs are impeded by nebulous and disorganized information, unrealistic facility and staff expectations, excessive preoccupation with regulatory compliance that leads to intense pressure to do the wrong thing, and inadequate understanding of the issues. In addition, staff and practitioners should at least understand the different roles of different consultants (e.g., the differences in training and skills between psychiatrists and psychologists). And they should not expect a capable PC to succumb to pressure to do inappropriate things because a facility is preoccupied with regulatory compliance or deference to family requests.

So let us conclude with some tips for more optimal collaboration between nursing home staff and practitioners and their PCs:

- In selecting a PC/BHC, interview candidates and identify exactly what they propose to do and to what extent it covers the things discussed in this column.
- Expect PCs/BHCs to acknowledge their limitations as well as capabilities.
- Expect and review details of nebulous promises such as “will educate staff” and “will help the facility maintain survey compliance.”
- Facilitate HIPAA-compliant ways for practitioners and PCs/BHCs to communicate with each other.
- Clarify how PCs/BHCs are paid for services, what their organization expects in terms of billing quotas, and what the facility’s obligations are for a consultant’s nonbillable time.

In using the input from the PC/BHC for your individual resident/patient care:

- Even while seeking consultative support, don’t simply abdicate all responsibility to the consultant.
- Encourage the PC/BHC to attend rounds or medication-related reviews and ensure their meaningful involvement in the care plan discussions for more complicated residents.

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This year has been fraught with challenges, chaos, and stunning surprises. We’ve all desperately needed some source of optimism, energy, and empowerment, and the Foundation for Post-Acute and Long-Term Care Medicine is working with AMDA — The Society for Post-Acute and Long-Term Care Medicine to serve as a beacon of good during these difficult times.

In addition to continuing and strengthening the Futures Program and the Awards Program, the Foundation has been planning some innovations for 2021 to support the Society’s members and other stakeholders. These efforts won’t erase 2020, but they are investments in the future that will enable PALTC practitioners to move into the new year and beyond more confidently.

Foundation Leaps Over Barriers to Boost Practitioners Moving Forward

Last fall, the Society approached the Foundation to seek funding for a new mobile application (app) to enable members to access the information and tools they need more easily and efficiently. In a mobile world where practitioners and others often are working from several locations — including their homes and cars — these types of apps are essential. They enable the seamless flow of information necessary to provide quality, accurate, and real-time patient care without skipping a beat or creating even a moment of delay.

“The role of the Foundation is to support and augment the efforts of the clinician in the PALTC continuum; and we’ve looked to areas where we could most significantly impact how that care is provided in a changing world that has become smaller and more mobile and requires us to deliver care from multiple sites at a moment’s notice,” Foundation Chair James Lett, MD, CMDR, noted. “We felt that this technology is an important investment that will have a significant impact.”

The app, scheduled to be available in early 2021, will provide quick and easy access to:
- COVID-19 resources
- Advance Care Planning (ACP) Toolkit
- My Directives website
- Telehealth application information/resources
- Drug application information/resources
- Frailty assessment and risk scoring tools
- AMDA podcasts
- Clinical alerts and advocacy information
- AMDA Forum and social media
- Upcoming events calendar

Further enhancements will enable users to access the Society’s popular products and tools, including the pocket guides and the Know-It-All series.

Combining Experience With Fresh Ideas

The Foundation welcomes new board member Denise Wassenaar, RN, MS, NHA, a long-time Society member who has participated in developing and revising clinical practice guidelines and has served on several committees. She retired last year from her position as vice president of clinical and regulatory affairs and chief clinical officer at MatrixCare. She still works as owner of Wassenaar Consulting, LLC, in Arizona. She said, “I am at a point in my career where I have the chance to give back to an organization that has been the foundation of my clinical practice and is vital to the care of the older population. By serving on this board, I can support — through active participation — the mission and strategic plan of the Foundation.”

Ms. Wassenaar will chair the Foundation’s Development Committee. “I’ve been involved on a lot of campaigns and initiatives, and I think I can bring some innovative ideas and experiences and help provide a new direction,” she said.

As Development Committee chair, Ms. Wassenaar will be directing different campaigns involving state chapters, industry partners, and other stakeholders. “The Foundation’s dedication to research and education are very important to me,” she said. “I look forward to helping with fundraising efforts that will enable more of those who are interested in geriatric medicine to have more opportunities and resources.”

Happy Anniversary, Futures! Moving into 2021, the Foundation is recognizing an important and happy milestone: the 20th anniversary of the Futures Program. The first Futures class attracted 49 residents and fellows to the 2001 AMDA Annual Conference for an intensive learning experience focused on the numerous career opportunities available in this field. Since that time, futures have flourished and opportunities have increased. Ms. Wassenaar will chair the Foundation’s Development Committee. As Development Committee chair, Ms. Wassenaar will be directing different campaigns involving state chapters, industry partners, and other stakeholders. “The Foundation’s dedication to research and education are very important to me,” she said. “I look forward to helping with fundraising efforts that will enable more of those who are interested in geriatric medicine to have more opportunities and resources.”

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- Seek and review the rationale for treatment (not just a diagnosis) and the context of treatment in the overall care of individual residents.
- Do not authorize PCs/BHCs to initiate or change treatment regimens in a silo, and insist on meaningful review and discussion with staff and practitioners before implementing recommendations.
- Review the consultation notes from the PC/BHC to ensure that they contain adequate, meaningful details.
- Institute a process that encourages the staff and practitioners to question or challenge the recommendations from the PC/BHC, especially when the recommended treatment is problematic or the patient is not improving as anticipated despite previous consultant input.
- Never state or imply that primary care practitioners (PCPs) and staff must do whatever the PC/BHC advises or that a consultant can automatically override a PCP.

There are many capable and supportive PCPs for nursing homes, but there is much room for improvement overall as well (J Am Med Dir Assoc 2002;3:314–317). Every nursing home needs their PC/BHC to be more than just “available and affable” — they need them to demonstrate substantial “ability,” i.e., knowledge and skill.

Dr. Levenson has spent 42 years working as a PALTC physician and medical director in 22 Maryland nursing homes and in helping guide patient care in facilities throughout the country. He has helped lead the drive for improved medical direction and nursing home care nationwide as author of major references in the field and through his work in the educational, quality and regulatory realms.