Can Ignorance Be Bliss?

By Karl Steinberg, MD, CMD, HMDC

Back in the 1980s, when Studio 54 was in its heyday, I taught high school science in New York City for a few years. Having graduated from a large public high school myself in a suburb of Cleveland, living in Manhattan in the early ’80s was a culture shock for me: exhilarating and wild but also a little scary. I was amazed at how many people were crowded into the city. The sidewalks were filled with drug users, sex workers, and mentally ill individuals — many of whom seemed very angry and sometimes threw projectiles at others for no apparent reason. As a pedestrian and subway rider, I was uncomfortable with people crammed so close every day and felt vaguely, or sometimes not so vaguely, threatened.

These experiences led me to say ill-advised things to my students on a frequent basis, like “I cannot imagine what kind of parents would choose to bring up their kids in this city.” To which the typical response was, “Oh, I suppose you will raise your kids on a farm, where they will grow up naïve and clueless and have no idea what the real world is like, so they will be completely unprepared for real life.” To which I would generally reply, “What makes you think this cesspool of a city constitutes the real world?”

You get the picture.

Yes, I had this conversation with tenth-graders, and yes, I actually enjoyed my years in the city although I was happy to get back to Ohio, specifically cow-town Columbus, for medical school after a few years of teaching. And no, it turns out that I never did raise kids on a farm (or elsewhere), but I did move to San Diego, where I have lived since residency.

But let’s get down to the central question of this column: Is it better to be blissfully ignorant or painfully aware?

The answer is different for different people and for different subjects. My attitude as a high school teacher was that it would be better to raise children in a place where they would not be subjected to dangerous and inappropriate adult behavior, at least at a young age. But I also clearly had a drive to experience “real life” in different places as I came into adulthood. That desire stemmed from a deep belief that knowledge is important, facts are important, science is important, and my ability to make informed decisions in life is only as good as the information I have to base them on.

This deep belief has stayed with me. Throughout most of my later adult life, I made it a priority to stay abreast of current events, follow new developments in medicine and science, and to be a knowledgeable person. I’ve learned a great deal about clinical geriatric medicine and our post-acute and long-term care settings and all they entail, including the regulatory and liability arenas. I am sought out as an expert on these topics because I know them well.

I have also historically made an effort to stay focused on organized medicine for the betterment of the patients we serve, as a member and delegate of AMDA – The Society for Post-Acute and Long-Term Care Medicine as well as the American Medical Association (AMA) and California Medical Association (CMA). Along with many like-minded colleagues, we have tried to make meaningful changes to policy and regulations over the years, in part by communicating with legislators and regulators.

We recently lobbied for the passing of legislation in California that will require all nursing home medical directors to be certified. And at June’s AMA House of Delegates, the resolution sponsored by the Society requesting that the Centers for Medicare & Medicaid Services create and maintain a listing of all medical directors became AMA policy.

Over the years I’ve also grown accustomed to watching the news a lot, although these days what passes as “news” on most networks is pretty biased. Well into the early part of the pandemic, I would leave cable news stations on for hours every day. I realized, after considerable self-reflection and talking to trusted family and friends, that the information I was absorbing — even when recounted objectively — was just making me feel miserable, hopeless, and powerless. There were so many things going on all over that I had no direct ability to change.

I’ve always been a champ at sleeping, but I started to have occasional trouble falling and staying asleep because the sad state of our country and the world were bothering me. And worse, I was finding it increasingly difficult, given some of the responses to the pandemic, the anti-science movement, and domestic and international politics in general, to believe that most people are generally good. I still hope that’s true, but it’s hard to believe in my gut these days.

So my household made a bold move last year: we just decided to stop turning on the news. Now when we are indoors we put on a variety of awful reality shows featuring ill-behaved millennials, cooking shows, tennis tournaments, home renovation programs — anything except the news. And, perhaps not surprisingly,
only touches a small minority of patients in need — often this option is available only in large urban areas. Although psychotherapists have found success in delivering on-site talk therapy, models of psychiatry prescribers coming into communities are harder to come by.

My observations over many years as a geriatric psychiatrist and consultant in this space are that we can only meet the need by systematically extending the reach of expertise, by training and empowering the primary care providers to address common psychiatric issues.

Above all, we must provide care where people want it — and deserve to have it — in service of the whole person by eliminating the false dichotomy of “medical” and “psychiatric” care. Enter Behavioral Health Integration (BHI).

BHI is not a new concept. Fortunately, a model of BHI already exists in our outpatient primary care and has a strong evidence base for improving health outcomes and patient satisfaction because patients prefer being treated seamlessly and blue.

The Key Components of BHI

The key components of BHI are systematic assessment and monitoring using validated measures, care navigation to support the treating (billing) practitioner, and oversight by a psychiatric consultant. By using a registry for all residents with psychiatric diagnoses, organized by designated case navigators (who can be clinical or nonclinical staff) and populated with objective measures such as the Patient Health Questionnaire (PHQ-9) and Brief Interview for Mental Status (BIMS), we can oversee a large population of patients systematically.

This population health approach includes regular review of data, with prompts to address changes in status and ongoing support (through the electronic health record and secure texting) to the primary care providers for prescribing guidance. Importantly, there are monthly and as-needed meetings with the entire team to discuss difficult cases and care plans. Patients can still be referred for specialty psychiatry care and other services.

Feasibility and Outcomes

The BHI program is like Chronic Care Management and can be billed as such for eligible patients, thus increasing revenue stream that adds to the sustainability of the model. Billing occurs monthly by the main practitioner.

In collaboration with several large provider groups across several states, we currently have over 2,000 residents enrolled in the BHI program. Practice directors report that the program has been feasible and well-received, reducing the number of referrals outside the building and transfers to inpatient psychiatry. Monthly psychopharmacology reviews have shown a dramatic reduction in polypharmacy and an increase in the willingness to stop medications that are no longer helpful.

Training

It was clear from the beginning of translating BHI to the PALTC space that training would need to be a key addition to the model. Unlike general adult outpatient clinics (where BHI has its roots), nursing homes have a significantly higher prevalence and acuity of psychiatric disorders. We focused on the providers closest to the patients — most often advanced practice providers and some physicians — because they hold the most responsibility for the day-to-day care in PALTC settings. Most have had little to no training in psychiatry, yet often they are the main prescribers for these diagnoses.

Tailoring the program to the individual practice, we created a rolling curriculum of nine sessions on the fundamentals of nursing home psychiatry. This includes topics such as serious mental illness, regulatory requirements for psychotropics to personality disorders, multiple sessions devoted to dementia and behaviors. The sessions are in-person or live video format with cameras on and interactive. We routinely address current cases from the participants. A favorite based on evaluations is “med list day,” where participants look at scores of actual medication administration records to learn about potentially dangerous prescribing patterns with psychotropics, pitfalls, and opportunities to deprescribe.

Continued from previous page

I find myself feeling a lot less hopeless and blue.

I do see headlines on my smartphone, and occasionally I read more about things I care about and might be able to act on. Obviously I can’t avoid some level of awareness when I use the internet. But I don’t need to see photos of children shot dead in a school or in the Ukraine for hours on end. I don’t want more detail about how the Supreme Court is chipping away at the rights of Americans or other hypocritical politicians are spouting hateful lies. I am already sufficiently aware of the predictions that Miami will be underwater in 15 years (and really — can San Diego be far behind?).

It’s been positively liberating to step away from the negativity.

How does this relate to our care setting, you might ask? Well, some of our patients who are facing serious or even terminal illness really want to know what’s going on with them — the laboratory values, the imaging results, the physical findings, and the prognosis; others most decidedly do not want to know such details. I read a study many years ago (that I’ve been unable to find, sadly) suggesting that patients who trust the process and do not request a lot of information about their condition actually do better clinically than those who want to micromanage.

Dr. Steinberg was the 2021-2022 president of AMDA – The Society for Post-Acute and Long-Term Care Medicine and is editor emeritus of Caring for the Ages.