Racial Disparities, Reimbursement for Care, and Quality of Life: Factors That May Influence the Prescribing of Antipsychotics for Minority Nursing Home Residents

Recently there has been an upsurge in published studies that have focused on the inequalities existing in the provision of care to minority residents of nursing homes. Analysis of data during COVID-19 has emphasized these disparities, reporting the increased number of deaths among Black and other minority residents during the crisis.

As we have collectively focused on the pandemic, facilities may have shifted their attention away from the safe and appropriate prescribing of antipsychotics in the nation’s nursing homes. As a consultant pharmacist, identifying patterns and trends is paramount to what we offer facility medical directors and executive leadership. Are there any patterns or trends indicating disparities in prescribing antipsychotics to minority residents in nursing homes?

Race and Antipsychotics in Nursing Homes

Scant recent literature has been published about prescribing patterns of antipsychotics linked with the racial composition of the nation’s nursing homes. Several studies have analyzed data from before the introduction of federal initiatives to reduce antipsychotics in nursing homes beginning in 2012. One recent analysis of that data found a reduction in the use of antipsychotics in Black residents, possibly attributed to recognition that common comorbid conditions such as diabetes and hypertension can be worsened with the use of antipsychotics (J Am Geriatr Soc 2020;68:630–636). Data also exist through the federally mandated collection portals on the prevalence of the use of antipsychotics in long-stay residents (30 days or longer). The 2012 National Partnership to Improve Dementia Care in Nursing Homes initiative provided a benchmark with the goal of reducing the percentage of residents receiving these drugs.

By 2016, Centers for Medicare & Medicaid Services reported that facilities achieved the overall goal of a 30% reduction in the use of unnecessary antipsychotics in long-stay residents; it also announced a new goal of a further 15% reduction “by the end of 2019 for long-stay residents in those homes with currently limited reduction rates” (“National Partnership to Improve Dementia Care in Nursing Homes,” updated July 29, 2022, https://go.cms.gov/3QMuIF5k). The national average declined from 23.9% in the fourth quarter of 2011 to 14.5% by the fourth quarter of 2021, according to data provided by CMS via Medicare and Medicaid pharmacy claims, facility Minimum Data Set reporting, and CMS recertification surveys.

Reimbursement and Structural Inequalities

One recent study examining deaths of Black residents during the pandemic provides insight about racial disparities, structural biases, and financial challenges in providing care. The authors found that disparities were greatest in rural settings and that “on average, nursing homes with the highest proportions of Black residents were more likely to be for-profit organizations, report staffing shortages, have the highest percentage of Medicaid residents (~75%), and have the least amount of [registered nurse] and aide hours per resident day” (J Am Med Dir Assoc 2021;22:P893–898.e2).

Another study arrived at a similar conclusion: Medicaid-reliant nursing homes have a higher use of antipsychotics (J Am Geriatr Soc 2020;68:630–636). Medicaid-reliant facilities also generally do not have the resources to provide adequate staffing for enhanced support services, which could be a factor in why antipsychotics are prescribed in greater numbers as an intervention.

Challenges for Providers

Although we don’t have statistics reporting whether minority residents receive antipsychotics at a greater percentage than White residents after admission to a nursing home, we do know that inappropriate diagnosing, such as for schizophrenia, occurs for Black residents in greater numbers than for White residents (J Am Geriatr Soc 2021;69:3623–3630).

Regarding the prescribing of antipsychotics and specifically antipsychotics providers are at a disadvantage when a resident is admitted because they do not know the subjective physical, emotional, and socioeconomic background of each individual. Providers caring for a new resident for the first time are unwrapping a complex package: objective reports (discharge summaries, laboratory results, ICD-10 diagnoses, medication lists), which are superseded by the unknown. Save for an obvious medication interaction or increased risk for side effects, antipsychotics are generally continued after admission.

Although barriers occur around facility formularies and reimbursement (Medicare A stays; commercial insurance), antipsychotics generally have adequate insurance coverage in the initial short-stay admissions period and then when converting to Medicare Part D coverage for long-term stays. One challenge when assessing medications is to recognize whether the medical history provides an accurate picture of the resident, while being cognizant of the CMS mandate to eliminate unnecessary psychotropic drugs in nursing homes. For residents who convert to long-term stays or who are straight long-term admissions, additional scrutiny begins as antipsychotics are tallied in the quality measure statistics.

Quality of Life Indicators for Minority Residents

Do prospective residents have a choice in their selection of a facility placement, and will they be admitted to a facility that aligns with their personal life story? Most may not. When a resident converts to a long-term stay or if they are already established in the facility, there needs to be a better assessment and integration of their clinical, social, and cultural background, with an emphasis on the accuracy of medical diagnoses and any indications for use of antipsychotics. Quality of life (QOL) indicators provide insight into factors that may be underaddressed in facilities and may lead to increased use of psychotropics and antipsychotic use for all races if left unaddressed.

Next Steps

Reducing the inappropriate use of antipsychotics in nursing homes requires perseverance and is difficult work. Quality metrics will continue to measure trends, and facilities will continue to work toward reducing overall numbers. Hopefully, this article prompts medical

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KEY POINTS

A number of factors directly or indirectly contribute toward patterns or trends of decreased antipsychotic prescribing among minority residents:

- Aiming for diverse racial demographics of all medical provider staff, including medical directors, attending physicians, nurse practitioners (NPs), and physician assistants (PAs).
- Having diverse upper management staff who are the decision makers, including those in clinical and nonclinical roles.
- Ensuring providers are culturally educated about the residents in their care.
- Promoting provider flexibility and medical experience, including open-mindedness regarding inappropriate prescribing of antipsychotics along racial lines.
- Examining the medical model and ensuring providers are financially incentivized to be physically present with and to see an appropriate number of residents, with an increased proportion of time spent providing direct interactions with residents.
- Using the services of consultant psychiatrists or specialized providers who provide both in-person and telehealth services, and are educated on the needs of minority residents.
- Educating and mentoring all staff on diversity, equity, and inclusion; and recognizing how the ethnicity, gender, or other identities of the nursing leadership may impact education and mentoring.
- Acknowledging the power dynamics between the “hands-on” staff who are with residents the most — certified nurse assistants, licensed practical nurses, registered nurses, social workers, housekeepers, dietary staff — and medical leadership; encouraging hands-on staff to interact with medical staff about the status of residents.
- Educating the staff about the literacy levels and communication preferences of minority residents.
Learning From Experience: Examining Implicit Bias in Immigration and Health Care
By Ann Datunashvili, MD, CMD, and Margo B. Kunze, RN, CDP

One of us — Ann Datunashvili — is an international medical graduate, or IMG, and thus entered her career in health care as an immigrant worker. Yet despite this status, I had somehow become blind to the larger issues even as I was acutely aware of the struggles an average IMG goes through to start a career in the United States.

During this process you must find a position that will support your work visa and make sure you are qualified to get it; next comes the interminable wait to be called for an interview, followed by more waiting to hear from the immigration authorities about whether you will be allowed to come to the United States. The process is long — 12 to 18 months for nurses, for example — and costly (multiple thousands of dollars).

At the end of the process, you will be bound to your sponsor organization for a significant period before you can legally change employers.

As I talked about these issues with my co-author, Margo Kunze, we both reflected on our personal experiences of being the “other.” She had grown up living with her family in multiple countries as an American expat. We spoke of the challenges we both faced: prejudice, misunderstanding, and suspicion. I also shared my overwhelming sense of gratitude for being given a chance to prove themselves, to have a chance to succeed. In our discussions, Margo Kunze and I have wondered if this gratitude blunts other issues. For instance, are immigrant health care workers being treated fairly, equitably, with the respect they deserve? Are they aware of the microaggressions they experience, or do they choose to ignore them because it’s “not worth rocking the boat”? Are they concerned that speaking up could cost them their job or make them seem ungrateful?

We have also seen and heard of reverse bias: professionals with international backgrounds who are not able to leave their own baggage behind — including their biases (186,000), a paternalistic approach to patients and families, and mistreatment of team members who are “below” them in the hierarchy.

Of course, bigotry of any kind is unacceptable, especially when rebuilding the health care force necessary to care for our residents. Medical professionals who can’t step out of their stereotypical perceptions of what professional, racial, and gender roles “should be” make it very hard for those who are flexible and able to adapt to the realities of living and working in a new society.

It’s vital that medical professionals work well with others, and that everyone learns to see the field-level care force as partners in care rather than as lesser persons to be marginalized. Without the direct care staff, health care does not get provided to our residents. If we want the care done, we must care about those providing it, regardless of their race, religion, gender identity, sexual orientation, or country of origin.

For these reasons, it’s vital that care force leaders and their organizations work to identify, confront, and mitigate/eradicate both explicit and implicit bias — unconscious favoritism toward or prejudice against people of a particular ethnicity, gender, or social group. We will never completely eradicate such biases, but we need to try.

If we want the care done, we must care about those providing it, regardless of their race, religion, gender identity, sexual orientation, or country of origin.

Pandemic Problems

The COVID-19 pandemic exposed fundamental problems within our health care delivery system. Upward of 400,000 direct care workers and medical professionals left health care during the pandemic, and we continue to hemorrhage caregivers (“BLS January Jobs Report,” American Health Care Association/National Center for Assisted Living, Feb. 9, 2022, https://bit.ly/3KjwenT). To replenish our care force, multiple organizations are exploring the recruitment of immigrants to fill the gaps.

According to the Migration Policy Institute (MPI), in 2018 there are 2.6 million immigrant health care workers, making up 17.9% of the health care workforce. Immigrants constitute 28% of all physicians and surgeons (296,000), 15.5% of registered nurses (512,000), 37.9% home health aides (186,000), and 22.4% of nursing assistants (322,000). (For more of these numbers, see J. Batalova, “Immigrant Health-Care Workers in the United States,” MPI, May 14, 2020, https://bit.ly/3SYQXH0.)

However, we feel that it is important to ensure that the system does not use the immigrant care force to delay wage gap adjustments and improvements in the work environment. During the pandemic, we saw even more clearly that nurses, CNAs, and other allied professionals are the true backbone of post-acute and long-term care. These workers are the ones who carry the burden of direct care for residents and educate incoming care force workers. The CNA/direct care staff must be seen as assets to our communities and facilities.

Regardless of where they come from or what their level is in the hierarchy, all workers need to be seen as vital members of the care team.

Owners and managers should become aware of the ways that they consciously or unconsciously take advantage of the gratitude immigrant workers feel for just getting a chance to live in this country.

They must be welcomed, accepted, and provided with the same respect we extend to our own countryfolk. These immigrants may well provide the solution to our health care force and staffing crisis.

Resources

There are entire organizations dedicated to integrating immigrants into the health care force in the United States. AMDA – The Society for Post-Acute and Long-Term Care Medicine is actively supporting immigration reform and passed two resolutions on immigration in April. One is H22L, “Undocumented Noncitizens for PALTC” (April 27, 2022, https://bit.ly/3b6IVXx), and the other is G22L, “HPSA and MUA Designation for PALTC” (April 27, 2022, https://bit.ly/3KmjpgF). Further resources include:

• PHI — Quality Care Through Quality Jobs: https://www.phina.org/


Readers interested in AHCA/NCAL efforts to contact AHCA’s Dr. Ritchie (dritchie@aha.org) for more information.

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