# Psychiatric Consultation to Nursing Homes

Sanjay Gupta, M.D.
Marion Zucker Goldstein, M.D.

Patients seen in psychiatric practice in nursing homes, or skilled nursing facilities, differ from those seen in mainstream psychiatry in several ways. First, the practitioner sees patients who have medical as well as psychiatric problems. Second, after the initial diagnostic evaluation, patients generally have infrequent visits with the practitioner. Third, patients are more likely to have impaired judgment and impaired communication skills. Finally, patients have experienced relocation from their personal residence.

Five percent of the population over age 65 currently live in skilled nursing facilities, and 20 to 50 percent of people over age 85 will live in one at some point in their lives; women constitute the majority of nursing home residents in both age groups (1,2). The prevalence of psychiatric disorders in skilled nursing facilities may range from 91 to 94 percent (3–5).

Skilled nursing facilities have replaced state psychiatric hospitals as the primary source of residential psychiatric care for elderly persons (1,6). However, a national survey in the early 1990s revealed that only 2.3 percent of nursing home residents had received a mental health consultation in the previous month (7,8). A recent study of psychiatric consultations in the skilled nursing facilities of six states found that the perceived need for psychiatric services is far greater than the level of services provided (2). The researchers suggested that incentives be provided for psychiatrists to work in nursing homes and recommended assessment of the effectiveness of mental health services in those settings.

Abuses in Medicare billing by some nursing homes have been detected. Instances of fraudulent billing, such as billing for psychotherapy for patients with advanced dementia and billing for patients not actually seen, have been reported, and in recent years nursing homes have come under greater regulatory scrutiny. For example, in 1995 the federal government launched Operation Restore Trust, a major initiative to eliminate Medicare fraud (9,10). Because of this program, some nursing homes may be required to submit records, patient care notes, and consultation notes to get Medicare reimbursement.

Setting up a psychiatric consultation practice for skilled nursing facilities has become increasingly challenging due to the many regulations affecting nursing homes. Other variables affecting the degree of difficulty of establishing a psychiatric consultation in a nursing home setting include the characteristics of the regional Medicare intermediary and the expertise of the psychiatrist who is trying to set up the consultation. This column reviews issues in initiating psychiatric consultations in nursing homes and working with nursing home administrators and clinical staff of various backgrounds. It also provides an overview of regulations governing nursing home practice, offers suggestions for use of brief hospitalization and medication, and summarizes some requirements for documentation and billing.

## Initiating a nursing home consultation

The three As of effective psychiatric consultation in skilled nursing facilities are availability, affability, and ability. Most facilities have a medical director who is an internist, and who is often a geriatrician, who could be of considerable help in facilitating the appointment of a geriatric psychiatrist. The prospective psychiatric consultant may write to the nursing home's administrators and medical director outlining the consultant's availability and the objectives of a geriatric psychiatry consultation. The letter should be followed up by a phone call and a meeting with the nursing home's administrative and clinical managers.

The stigma of being a psychiatric patient may remain prevalent in skilled nursing settings among staff, nursing home residents who are cognitively intact, and residents' family members. Psychiatrists should address this issue whenever it is manifested as resistance to assessment and treatment.

A psychiatrist appointed as a consultant to a nursing home is often asked to assess disruptive patients. Effective care of an elderly patient with a behavioral disturbance either in the skilled nursing facility or during

***Dr. Gupta*** *is clinical associate professor in the departments of psychiatry at the State University of New York Health Sciences Center at Syracuse and at the State University of Buffalo School of Medicine and Biomedical Sciences.* ***Dr. Goldstein,*** *the editor of this column, is associate professor of psychiatry at the State University of Buffalo School of Medicine and Biomedical Sciences. Address correspondence to* ***Dr. Gupta*** *at the Research and Education Division, Psychiatric Network, Olean General Hospital West, 2221 West State Street, Olean, New York 14760 (e-mail, network1 @ecnet.net).*

a brief hospitalization helps inspire confidence in the psychiatric consultant among staff and relatives.

An approach in which the patient's family physician and internist have access to the psychiatrist for telephone consultation is often useful. Other primary care physicians prefer to write a request for a consultation and have a social worker or nurse on the nursing home staff call it into the consultant's office or fax essential patient information to the consultant. The primary care physician should document the reason for requesting the consultation and order follow-up by the psychiatrist, if necessary.

Most skilled nursing facilities need explicit instructions about the information required by the consultant for expedient consultation and billing services. The consultation request should include the physician's order, including the reason for the consultation that is noted in the patient's chart; a copy of the patient's identification sheet; the primary care physician's UPIN (Universal Personal Identification Number); two copies of the consultation sheet—which contains demographic and diagnostic information about the patient—one copy for the billing office and one for the psychiatrist; and pertinent patient records, including progress notes provided on request to Medicare. The psychiatrist should visit the facility on a predictable schedule.

Nursing homes often appreciate the psychiatric consultant's ability to arrange brief psychiatric hospitalizations for aggressive or suicidal patients. However, such arrangements should be made only if the nursing home agrees that the patient can return to the nursing home after discharge regardless of the outcome of treatment. Medicaid will allow the patient's bed in the nursing home to be held for 21 days.

## Working with administrative and clinical staff

In the past, nursing home residents who needed psychiatric evaluation and treatment were often sent to an outpatient psychiatric clinic, accompanied by an aide who often was unable to give a comprehensive history. Now nursing homes commonly use the psychiatric consultation-liaison model to obtain psychiatric care for residents (11,12). The psychiatrist consultant helps with diagnosis, optimization of medication use, and simplification of medication regimens. In addition, the psychiatrist is skilled in assessing interactions between nursing home residents and staff that may contribute to residents' disturbed behaviors. The psychiatrist may also advise residents' primary care physicians about residents' ability to make decisions related to advance directives and other medical issues (13).

The psychiatrist may train members of the nursing or social service staff to administer the Mini Mental State Examination (14) and the Geriatric Depression Scale (15). These measures help gauge the progression of mental illness or treatment effectiveness, and the results can become part of the consultation notes. Use of the Abnormal Involuntary Movement Scale (16) may be considered for monitoring patients who are taking antipsychotic medications, particularly those being transitioned from conventional to atypical agents.

The psychiatric consultant may find that the charge nurse is a helpful contact person during nursing home visits. The charge nurse can be expected to gather information from floor nurses, family members, and aides about the patients to be seen by the consultant and to present the reason for the consultation if the primary care physician has not communicated with the consultant directly. The charge nurse can also provide information on the patient's current medications and past and present medical problems; recent laboratory data; recent changes such as relocation, illnesses, and losses; sensory deficits; mobility deficits; eating and sleeping patterns; family relationships; interests and visitors; and response to initial recommendations.

Family members who are unduly stressed or disturbing to the nursing home staff may be offered an office visit with the psychiatrist that would be covered by their own insurance. Medicare reimbursement of family interventions, although clinically optimal, is subject to regional variations and often denied. The psychiatrist should give staff the opportunity to discuss their contacts with patients' family members and friends. If family members have any concerns related to the psychiatrist's recommendations, they should be documented and communicated to the primary care physician and nursing staff (17).

During the consultant's visit to the nursing home, the consultant should explain to staff the rationale for particular therapeutic strategies, including medication titration schedules, and should discuss potential medication side effects and interactions. This information should be documented by staff and conveyed to the primary care physician who coordinates care.

The consultant should review with nursing home staff the use of medications available for psychiatric emergencies, such as severe aggressive behavior by a patient with dementia. Staff should be reminded that delirium could be the result of drug toxicity, drug-drug interactions, or medical illnesses. Staff may find it useful to stock the parenteral form of haloperidol, lorazepam, benztropine, and hydroxyzine in an emergency kit.

The psychiatrist consultant should be aware of effects on patient care of decisions made by other professionals affiliated with the nursing home. For example, the nursing home's consultant pharmacist may recommend substitution of cheaper medications for those prescribed by the consultant. The psychiatrist should decide if substitution is reasonable on a case-by-case basis. The consultant pharmacist may be available to advise staff about the possibility of drug-drug interactions. Other professionals may also contribute to the overall treatment plan. For example, a psychologist may help facilitate behavior modification efforts for both staff and patients.

## Educating nursing home staff

Front-line staff in skilled nursing facilities have been characterized as having poor training, low pay, and high rates of turnover (18). The psychiatric consultant should create opportunities to educate staff in techniques to improve patient care. Areas in which staff may benefit from additional training include nonpharmacological management of behavioral dis-

turbances, family notification and education, recognition of personal feelings toward elderly persons, characteristics of commonly used psychotropic medications and their side effects, prevention of injury, and ways to minimize use of restraints.

Providing education about psychiatric disorders assists staff in managing behavioral disturbances more effectively (8). A review of the symptoms and signs of common psychiatric disorders among elderly persons, including the stages of dementia, the different etiologies of depression, and the etiologies and presentation of delirium, would be beneficial. A fee for the consultant's educational activities may be negotiated in terms of a dollar amount per bed per year or an hourly fee. Reimbursement for travel may also be negotiated.

## Regulations affecting clinical care

Attention to the quality of care in skilled nursing facilities was stirred in 1986 by an Institute of Medicine report highlighting the underuse of antidepressant medications for the treatment of mood disorders in nursing homes (19). The Nursing Home Reform and Amendments of the Omnibus Budget Reconciliation Act of 1987 (OBRA) (20) require prescreening of patients admitted to nursing homes for major psychiatric disorders other than dementia (21). The regulations require a psychiatric evaluation to establish a diagnosis and determine the need for acute inpatient psychiatric care if the initial screening suggests psychiatric illness (22).

OBRA requires that the nursing staff and other members of the interdisciplinary health care team complete the Minimum Data Set (MDS) (23) or an equivalent instrument for each nursing home resident on a regular basis. The MDS has a section on mental illness that requests information on the patient's mood, cognition, communication, behavior patterns, activities, functional status, psychosocial well-being, nutrition, comorbid diseases, and medications and other treatments. The MDS is updated every three months of the resident's nursing home stay.

The OBRA sections on residents' rights, quality of care, and facility practices address pharmacological interventions, behavioral management, and psychiatric care (21). Antipsychotics, antianxiety agents, sedative-hypnotics, and related drugs are specifically targeted (24). Nursing home residents' records should include clear documentation of the need for antipsychotics, including specific target symptoms. Documentation should reflect the failure of nonpharmacological behavioral interventions. Practice guidelines developed by the American Psychiatric Association for the management of dementia are a valuable guide (25).

The impact of OBRA on long-term care is being assessed by a committee formed by the Institute of Medicine. The American Psychiatric Association and American Association of Geriatric Psychiatry have made strong recommendations for the development of outcome measures to assess the quality of mental health services in nursing homes (26).

Skilled nursing facilities are usually inspected by the state health department. The inspections usually focus on the state of the facility environment, rooms, cleanliness, food, medications, temperature control, and resident care. Some nursing homes are obtaining certification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Complying with JCAHO requirements may increase the facility's operating expenses.

## Brief hospitalization

The psychiatrist who practices in several nursing homes should try to network the facilities with a local inpatient psychiatric unit where staff are trained to deal with patients with dementia who become aggressive. Procedures for referral and screening should be set up to ensure that the patient's behavioral agitation is not the result of an acute medical problem. Procedures should be established to process any legal papers needed for hospitalization. Discharge procedures include preparing a discharge summary to be sent to the receiving facility at the time of discharge, arranging transportation, and communicating vital information to the receiving facility.

## Medications

OBRA requires that antipsychotic medication administered to nursing home residents be reduced at regular intervals and that the psychiatric consultant determine and document that the patient is on the minimum effective dosage. However, antipsychotics should not be viewed as the mainstay of treatment. Alternatives to antipsychotics minimize the risk of tardive dyskinesia. No medication is specific for treatment for aggression, and hence medication trials are empirical. Antidepressants such as trazadone and selective serotonin reuptake inhibitors and other medications such as hydroxyzine can be helpful as first-line agents to treat agitation, and their use may preclude the need for antipsychotics.

Other alternatives for the treatment of aggressive patients include anticonvulsants such as divalproex at a starting dose of 125 mg twice a day and, for severe aggression, gabapentin at a starting dose of 100 mg three times a day. Patients' blood levels of divalproex and hepatic functions should be monitored at baseline and every three months, and the dosage should be gradually increased to therapeutic efficacy. Use of gabapentin, which is renally cleared, does not require monitoring of hepatic functions or blood levels. Gabapentin also needs to be titrated to therapeutic efficacy.

## Documentation, coding, and billing

Documentation must substantiate the reasons for consultation and give the patient's pertinent history, including medical conditions, sensory and functional impairments, any interactions with family and friends, and adaptation to the skilled nursing facility. The actual content of the interview and scale scores on which the diagnosis and recommended treatment are based should also be documented. A commonly used approach includes a brief synopsis of the case and an observation-based diagnosis. Nursing home staff can facilitate the consultation by preparing a list of the patient's medical diagnoses and prescribed medications for the consultant.

Procedures for coding and billing

are usually not covered in residency or fellowship training programs. However, the consultant should pay careful attention to these procedures and stay up to date about changes that may affect reimbursement.

Medicare reimbursements vary by region. The consultant should meet with the local Medicare intermediary to determine the procedural codes and levels of reimbursement that apply in nursing home practice. The consultant should request that the intermediary provide recommendations in writing, and the minutes of the meeting should be retained by the consultant.

Billing may be based on time and the complexity of the service or on the tasks performed, such as a psychiatric diagnostic interview. A copy of the consultation sheet is often requested for reimbursement.

Two models for nursing home consultation reimbursement are in use. In the first model the consultant and the nursing home agree to an hourly rate for psychiatric services, and the nursing home bills the patient or third-party payer for the services. However, many nursing homes have several patients that need to be seen in a short span of time. Nursing home budgets are tight, and many homes may not realize the long-term benefits of paying a suitable hourly rate.

The other model is fee-for-service; the consultant seeks reimbursement from Medicare, Medigap, and Medicaid in appropriate sequence. Careful documentation of the complexity of the case is required to justify the billing code. The time spent with the patient, staff, and the patient's family must be documented. The codes vary between skilled nursing facilities and domiciliaries and are frequently revised, and up-to-date information about billing codes is essential (10,27). Coding errors result in denial and delay in reimbursement or in audits and allegations of fraudulent billing. Although telephone consultations are useful for patient care, they are nonbillable. In most cases the nursing home's coordinating nurse will be able to help the consultant obtain authorization from third-party payers for evaluation and follow-up.

## Conclusions

Many patients in skilled nursing facilities are in dire need of specialized psychiatric services. Well-organized and well-trained staff who are familiar with the social, familial, and clinical issues of the patient population can be a great asset to the nursing home. The psychiatrist consultant can have a major role in the development of staff, a task that may be ongoing over several years. Outcome studies are needed to examine satisfaction with psychiatric care among nursing home administrators, medical directors, consultants, staff, patients, and their family members. ♦


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