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Reforming Management of Behavior Symptoms and Psychiatric Conditions in Long-Term Care Facilities: A Different Perspective

Steven A. Levenson MD, CMD *, Abhilash K. Desai MD [a,b,c]

[a] Department of Neurology and Psychiatry, Division of Geriatric Psychiatry, Saint Louis University School of Medicine, St. Louis, MO
[b] Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, Seattle, WA
[c] Idaho Memory and Aging Center, P.L.L.C., Boise, ID

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A B S T R A C T

Despite much attention including national initiatives, concerns remain about the approaches to managing behavior symptoms and psychiatric conditions across all settings, including in long-term care settings such as nursing homes and assisted living facilities. One key reason why problems persist is because most efforts to "reform" and "correct" the situation have failed to explore or address root causes and instead have promoted inadequate piecemeal "solutions." Further improvement requires jumping off the bandwagon and rethinking the entire issue, including recognizing and applying key concepts of clinical reasoning and the care delivery process to every situation. The huge negative impact of cognitive biases and rote approaches on related clinical problem solving and decision making and patient outcomes also must be addressed.

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Concerns about the management of individuals with behavior symptoms and psychiatric conditions (BSPCs) are nothing new. Despite pockets of competent practice and some progress over time, BSPCs are often misunderstood and mismanaged in all settings, including nursing homes and assisted living facilities.[1–4]

Various initiatives and activities have been launched to try to improve care of long-term care (LTC) residents with BSPCs. For example, under pressure from consumers and Congress, the Centers for Medicare and Medicaid Services (CMS) launched a national partnership in 2012 to try to improve "dementia care" and reduce the use of antipsychotic medications.[5,6] Recently, this initiative has expanded to include other psychopharmacologic medications as well as a broader focus in updated nursing home regulations on so-called "behavioral health."

Since 2011, antipsychotic medications use among nursing home residents has declined by approximately 30% nationwide. These and other initiatives have brought considerable publicity and a sense of accomplishment, while intensified harsh criticism about remaining issues has led to the imposition of additional regulatory requirements.[7] Despite these various opinions about improvement or lack thereof, there is little to clarify just what the numbers mean for the overall quality of life and quality of care of LTC residents with BSPCs.

If quality improvement initiatives and regulatory requirements are to truly improve care of LTC residents with BSPCs, they must (1) promote and not inhibit correct and pertinent approaches and (2) inhibit and not inadvertently promote inappropriate approaches. It is inadequate just to look at narrow outcomes (eg, reduction in antipsychotic medication use), as the ends do not necessarily justify the means. The question is whether current efforts to improve management of BSPCs are promoting or undermining desired approaches or possibly even having unintended undesirable consequences.

Effective Management of BSPCs is Possible

LTC residents and patients transferred from a hospital to a LTC facility for postacute care have a broad array of serious and complex medical and psychiatric illnesses and impaired function,[8] more so than commonly recognized. Many of them have major psychiatric comorbidities ranging from dementia to substance use disorders.[9,10]

It is possible to manage BSPCs effectively and to use psychopharmacologic medications responsibly with a positive impact on quality of life, despite the many related challenges.[11–13] On the other hand, improper approaches are ineffective and often compromise quality of life of LTC residents.[14]

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* Address correspondence to Steven A. Levenson, MD, CMD, 7801 Ruxwood Rd, Baltimore, MD 21204.
E-mail address: salanlev@cs.com (S.A. Levenson).

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Care Delivery Process as the Vehicle

As with all symptoms, effective management of BSPCs requires faithful adherence to clinical reasoning based on patient-specific evidence.[15] As discussed in more detail herein, key care delivery process steps include (1) collecting and analyzing information, (2) detailed problem definition and cause identification, (3) selection of pertinent interventions, and (4) monitoring the results and adjusting interventions accordingly.

Information Collection

All symptoms related to behavior, mood, and cognition are nonspecific; that is, they could represent any number of underlying causes. Individual symptoms or findings rarely are diagnostic, nor do they help identify appropriate interventions. By themselves, symptoms and test findings (for example, Patient Health Questionnaire-9 scores) do not necessarily warrant an intervention. Instead, they require additional validation.

The "chief complaint" (ie, "agitated" or "combative") is insufficient. Without details, treatment is likely to be based on guessing.[16,17]

For example, sadness and anxiety are normal human emotions. In excess, they can impair function and quality of life. Therefore, a finding such as anorexia or crying is a possible clue that requires further investigation, but not enough by themselves to justify diagnoses and warrant medical treatment.

Similarly, so-called "agitation" is a completely nonspecific finding that can reflect anything from minor anxiety to overt psychosis. It may relate to very diverse causes such as anxiety, pain, mania, delirium, neurologic disorders, substance abuse, fluid and electrolyte imbalance, and major medication side effects. Therefore, interventions based primarily or solely on a chief complaint of "agitation" may be inappropriate and are often harmful.

Effective cause identification (including medical diagnosis) requires matching a collection of findings to relevant criteria. LTC staff must seek, describe, document, and report findings accurately and in detail, using appropriate terminology (Table 1). Along with staff, the practitioner (who is rarely present to observe a resident's behavior, cognition, and mood over time), must analyze this information and ask pertinent questions, draw the right conclusions, help determine the causes (including medical diagnoses), and select appropriate interventions including, but not limited to, medical treatment.

All situations involving BSPCs need a "story" of the symptom and the resident, and a clear problem statement (what exactly is the issue or concern, including why they are considered problematic). Elements of a "story" include onset, what happened (in sequence), the intensity (severity) of behavior, frequency (how often it occurred), duration (how long it continued) and what happened over time, and its consequences (including impact on self and others).[16]

Table 1
Examples of Clues Related to Diagnosing and Managing Behavior Symptoms and Psychiatric Conditions

- Disorganized thinking (eg, rambling, irrelevant or incoherent speech)
- Perceptual disturbances (eg, misinterpretations, illusions, or hallucinations)
- Disturbed cognition/executive function (eg, impaired ability to understand others, difficulty with daily decisions; disorientation to time, place, or person)
- Aggression (eg, verbal or physical aggression, or resistance to activities of daily living assistance)
- "Agitation" (eg, restlessness, pacing and wandering, disruptive vocalization, disinhibition, inappropriate disrobing)
- Change in mood and affect (eg, depressive symptoms with or without excess disability, manic symptoms, persistent irritability)
- Vegetative symptoms (eg, insomnia, hypersomnia, or change in appetite or food refusal)
- Anxiety (eg, apprehension, dread, distress)

Documentation is Just the Beginning

There are many documentation tools and rating scales related to mood, cognition, behavior, and function. Some are required [for example, Brief Interview for Mental Status (BIMS) and Patient Health Questionnaire-9 that are part of the Minimum Data Set (MDS)], whereas others are optional.

Ultimately, no matter what assessment instruments or documents are used, assessment is always a means to an end and not an end in itself. Its purpose is ultimately to help define mood, cognition, function, and behavior in enough detail to enable problem definition (ie, what exactly is the concern, and why), cause identification, and optimal patient management. The staff and practitioner must use the information to draw correct conclusions.

For example, the results of the BIMS, included in the MDS, provide a snapshot of a person's cognition but are not diagnostic of any illness or condition, including dementia. The BIMS score can then be supplemented as needed with more detailed information (eg, tests of executive function) to identify the nature, extent, and permanence of a resident's cognitive impairment.

Despite the growing list of required data elements and documentation in the MDS and elsewhere related to psychiatric and behavior issues and medications, there is no reliable evidence that just adding more documentation requirements to forms and data sets is helping to improve the subsequent decision making process.

Understanding and Managing Behavior Symptoms and Psychiatric Conditions in Context

While it has major psychosocial influences, all behavior nonetheless stems from brain activity. In turn, everything that the brain does both influences and is influenced by the rest of the body. Therefore, understanding and managing BSPCs requires thinking in terms of both the brain and the body acting together.

Thus, overall approaches to residents with BSPCs should not just be either psychosocial or medical. Concepts such as "chemical restraints," "behavioral health," and behavior as representing "unmet needs" require the application of science and clinical reasoning, as otherwise they are largely metaphorical. The neurologic and medical aspects of behavior are always as relevant as the psychosocial ones, despite the fact that nonpharmacologic approaches can influence behavior and medications may not necessarily do so.[18–21]

Diagnosis/Cause Identification

As has been noted for some time, "behavioral symptoms can arise as a result of… dementing illness, a concomitant medical illness, or iatrogenic causes. Typically, there are several precipitating factors. A common error in management of behavioral disturbances is to treat them by identifying one symptom precipitant (eg, urinary tract infection) and not looking for others (eg, pain, counter-therapeutic staff approaches). Before treatment is instituted, disruptive behavior should be categorized and underlying causes sought."[22]

Table 2 identifies a simple sequence of thinking about common causes of BSPCs. All primary care practitioners, consultants, and staff must use this or a comparable systematic approach in all but the simplest situations, especially when the cause is not obvious or current interventions are not fruitful.

Medication-related effects and adverse consequences are a very common and important cause of many BPSCs in susceptible individuals.[23,24] Many residents are admitted from the hospital and

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