

Nursing Home Recruitment and Psychotropic Medication Workgroup

Participants:

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Meeting dates: March 23, March 24 March 30, April 2, April 6, April 13, and April 19

Identified Goals:

- To improve the recruitment of physicians into nursing home settings
- To improve the quality of psychotropic medication prescription in nursing homes

Guiding Statement

The goals of the work group were two fold: first to focus on physician recruitment and secondly to look at the issue of medication safety. To accomplish these goals the workgroup broke into separate subgroups after an initial organizing meeting and the recommendations of both workgroups were reviewed at a final plenary session.

Providing safe and quality care to patients in nursing homes requires active participation by physicians with the skill set necessary to address the complicated medical and psychiatric issues that are often present in residents needing this level of care. The subgroup on physician recruitment focused on identifying barriers and possible solutions to physician involvement. The lack of training opportunities in long term care settings for both medical students and residents was also identified as an impediment for recruitment and the provision of quality of care for nursing home residents.

Psychotropic medications are an area of care in nursing home settings that, unless carefully monitored, can present significant risk of harm to individuals receiving them. The subgroup on psychotropic medication focused on issues of safety with a specific focus on safe prescribing and monitoring of side effects and minimizing the potential for misuse of psychotropic medications.

Both groups noted the lack of a recovery model and treatment planning for persons with serious mental illnesses in nursing home settings primarily related to federal regulations focusing on the needs of the elderly population. The lack of quality/outcome measures that are relevant to the recovery of person with severe mental illnesses (e.g. relapse rates, re-hospitalization, suicide attempts, etc.) was also noted as a barrier

NHSTF Physician Participation Recommendations

Issues Reviewed:

1. Lack of training opportunities in long term care settings for both psychiatrist and primary care doctors
2. Lack of clinical continuity between hospitals and nursing home settings
3. Unrealistic expectations in terms of the severity of illness that can be managed in open, non-secure community based settings such as nursing homes.
4. Stigmatization of providers who work in long term care settings
5. Inadequate reimbursement rates
6. Community and Home care based models that minimize the need for nursing home care

Recommendations:

1. Nursing Homes and hospitals partnerships should be encouraged to form a system of care designed to promote recovery in the community, including community based living options.
2. Educational experiences for residents and medical students in nursing homes should be encouraged.
3. The use of electronic medical records should be encouraged.
4. Consider creation of "teaching nursing home" models where universities partner with nursing homes as potential clinical care sites for trainees of different disciplines.
5. Consider using physician extenders to increase availability of treatment providers in nursing homes.
6. Nursing homes should have paid staff doctor positions to care for patients (modeled after the hospitalist model) augmented with psychiatric nurse advanced practitioners.
7. The Medical Director should have a dedicated paid percentage of time for administrative direction/oversight. The medical director should not serve both this role and the role of the facility's primary admitting doctor.
8. Nurse practitioners can be hired to augment clinical treatment at nursing homes (disease management model)
Note: (read recommendations 6-8) (Reimbursement strategies should be explored and implemented that support appropriate clinical and administrative care of patients.
9. A public education campaign about what level of care and services are appropriately provided in nursing homes so families can make an informed decision about whether a nursing home is the appropriate level of care for their loved one.
10. Nursing homes must have adequate resources to support the recovery, treatment and community reintegration of the population of patients they admit.
11. An emphasis must be placed on increasing community treatment options to support appropriate transitions out of nursing homes for patients with a primary psychiatric illness.

NHSTF Psychotropic Medication Recommendations

Issues Reviewed:

1. Informed Consent
2. Standards/guidelines for prescribing psychotropic medications to patients with primary mental illness and special co-morbidities in nursing homes
3. Approaches for improving safety for patients receiving psychotropic medications in nursing homes
4. Knowledge and skills necessary to safely prescribe and monitor psychotropic medications
5. Medication history collection and assessment of response and side effects history

Recommendations:

1. All patients with a history of mental illness should be assessed using a specific Minimal Data Set (MDS) for psychiatric illness. Results of this assessment should be incorporated into treatment planning and specifically address the prescription of psychotropic medication for mental illnesses.

2. All pharmacy providers in nursing homes should use a computerized drug interaction program and that allows for the preauthorization and peer review of certain medication combinations and doses.
3. Monthly medication regimen reviews are currently required, but should be guided by information provided in the data system with a focus on problematic drugs, doses (too high or too little) and drug combinations. Enhanced reimbursement for more time consuming reviews such as those at the time of admission, if there is deterioration of clinical status or after significant changes in medications, should be considered.
4. A centralized independent peer reviewed, preauthorization process should be required for all long-term care facilities where psychotropic medication is prescribed.
5. A pattern of substandard prescription practice or poor outcomes should be reported to the facility Medical Director, HFS and DPH with the option of terminating physician providers from the Medicaid provider list if the problem is persistent and can not be remedied.
6. The centralized Illinois Medicaid prescription base should be available to nursing home facilities to allow for a complete medication history to be available to the facility and prescribing doctor for review
7. The current administrative rules regarding psychotropic medication should be updated and done so on a regularly scheduled ongoing basis. Specific rules should be developed for specialty populations including geriatric age, those with developmental difficulties or co morbid addictive illnesses. These rules can form the basis of the criteria used to trigger the prior approval and peer review process before psychotropic medications are prescribed in a potentially unsafe or unwarranted manner.
8. Informed consent is an ongoing process with patients, families and guardians. The routine use of written information and being provided the time to review indications, discuss potential side effects, and to ask questions prior to starting and during the course of treatment, needs to become a routine and ongoing practice that is more thoroughly documented.
9. Ongoing education of direct care staff, licensed clinical staff and physicians is critical to improve the quality of care received in Illinois's nursing homes. Psychiatric co-morbidities are frequent in patients admitted to skilled facilities but the knowledge base of staff is limited in this area. Staff that work in IMD and skilled settings should be required to participate in a percentage of CME, CEU, and in-services that directly focus on the issue of mental illness, behavioral management, and medication monitoring including: side effect identification and monitoring of clinical response.
10. All patients in nursing home settings with co-morbid psychiatric illness, should receive at a minimum, yearly consultation by a psychiatrist. There should be consideration of tele-psychiatry services being developed in rural and underserved areas where in person consultation services are difficult to obtain.