



Long-term Care Forum

The Role of the Geriatric Psychiatrist in
the Nursing Home

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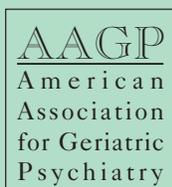
Editorial

Joel E. Streim, MD
Expanding the Role of
the Geriatric Psychiatrist
in the Nursing Home

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Introduction

Even as medical experts and government agencies debate the merits of mental health services in nursing homes, many psychiatrists are meeting this important health care need by expanding their psychiatric practice into this patient care environment. Some are even making it their full-time practice.

The current issue of *Long-term Care Forum* explores this evolving specialty. We start with an interview with Stephen Bartels, MD, president of the American Association for Geriatric Psychiatry, who discusses the results of 2 studies by the Office of the Inspector General (OIG) that were critical of psychiatric services in nursing facilities. According to Dr. Bartels, the emerging literature documents the nursing home needs for mental health services and the effectiveness of psychiatric interventions in nursing homes.

Marc Agronin, MD, director of mental health services at the Miami Jewish Home and Hospital for the Aged, is engaged in a full-time psychiatric practice at that institution. In addition to patient care, Dr. Agronin maintains administrative responsibilities, participates in staff education and training, and conducts clinical research through his affiliation with the University of Miami.

In the final article, Joel Streim, MD, who has provided innovative consultation services for more than a decade, presents a series of case histories that illustrate how a psychiatrist in clinical practice can improve the design and function of patient care facilities.

Among today's 1.5 million nursing home residents, 80% have one or more psychiatric diagnoses. The contributors to this issue of *Long-term Care Forum* have found that psychiatric practice in the nursing home environment is challenging and rewarding. I invite our colleagues to join us.

Jacobo Mintzer, MD

Charleston, South Carolina

Faculty Disclosures

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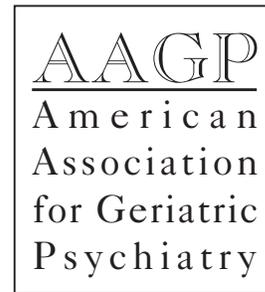
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Purpose and Overview

The dramatic growth in the elderly population will continue in the United States over the next 30 years, and will comprise the fastest growing population segment. The major barriers to increasing the mental health services provided to nursing home residents have been identified as the lack of trained mental health professionals and factors contributing to this shortage, and the disparity in reimbursement for psychiatric services and to patients for psychiatric-related treatment.

Learning Objectives

Upon completion of this program, participants should be able to:

- Discuss current research regarding the need for mental health services in nursing homes
- Identify ways to best meet that need as part of day-to-day clinical practice
- Identify administrative roles for the geriatric psychiatrist in the nursing home setting
- List opportunities for staff education and training, and clinical research in nursing homes
- Identify consultative services deliverable to nursing home staff and administration

An Interview With Stephen J. Bartels, MD, MS, President of the American Association for Geriatric Psychiatry

Stephen J. Bartels, MD, MS

Associate Professor of Psychiatry

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We know that there is a dramatic unmet need for mental health services.

Fortunately, there is growing research on the effectiveness of psychiatric interventions in nursing homes.

Up to 80% of nursing home residents have a mental disorder, including Alzheimer's disease, depression, anxiety disorders, and psychotic disorders. There is a general consensus in long-term care settings that the availability of adequate mental health services for those in need is lacking. In this article, *Long-term Care Forum* interviews Dr. Stephen Bartels on issues centering on the debate about mental health services in nursing homes.

- Current research regarding the unmet need for mental health services in nursing homes
- How to best interpret this unmet need in the context of the results of 2 recent federal studies by the Office of the Inspector General (OIG)
- What research shows about the effectiveness of mental health services in nursing homes

Research on unmet needs for mental health services in nursing homes

LTC Forum: Dr. Bartels, how much do we know about the unmet need for mental health services in nursing homes?

Dr. Bartels: We actually know quite a bit through surveys of nursing homes and studies of the use of services by individual residents of nursing homes who have a psychiatric problem.

A recent survey of nursing homes in 6 states found that 38% of nursing home residents were in need of psychiatric evaluation, but only half had adequate psychiatric consultation treatment.¹ The greatest unmet need was in rural and small nursing homes. Approximately half of nursing homes find it difficult to obtain psychiatric services, and only one fifth of nursing home residents with identified psychiatric disorders see mental health specialists for treatment. Those who are least likely to see mental health specialists are the oldest and most physically impaired.^{2,3} Thus, there is a considerable unmet need for mental health services in nursing homes. Only the minority of individuals who need treatment get it.

LTC Forum: In 1996, the OIG reported that nearly half of all Medicare psychiatric services in nursing facilities were either medically unnecessary (32%) or questionable (16%).⁴ A follow-up report in 2001 found that 27% of psychiatric services provided in nursing homes were medically unnecessary.⁵ How can we explain the difference between the need demonstrated by research and the findings of the OIG with respect to Medicare payments?

Dr. Bartels: The American Association for Geriatric Psychiatry (AAGP) has directly responded to these findings. Although the reports refer to "psychiatric services," it is more accurate to state that psychological services such as psychotherapy and psychological testing were the primary concern.

A serious shortcoming of the OIG reports is their lack of specificity in describing the nature of the services provided, as well as lack of information on the specific types of providers of those services. Greater distinction should have been made between "medically unnecessary" services related to billing for questionable psychotherapy and psychological testing for advanced dementia versus medically necessary and essential psychiatric treatment for cognitive disorders, behavioral problems, depression, and psychoses. From the standpoint of influencing health policy legislation, it is dangerous and irresponsible to release general summary statements of finding that 27% to 32% of all psychiatric services in nursing homes are "medically unnecessary" without clearly identifying which services and

providers are the source of concern. These statements leave the false impression that there is an overabundance of psychiatric services in nursing homes, when in actuality, nothing could be further from the truth.

In addition to these concerns, there were surprisingly uninformed assumptions made by the OIG about the efficacy and appropriateness of psychiatric services for nursing home residents with dementia complicated by severe problem behaviors. For example, the 2001 OIG report states, “more than half of all unnecessary services are provided to individuals who have limited cognitive ability and therefore may not benefit from the psychiatric intervention. Services are given to patients with, for example, advanced dementia, severe agitation, delusions, and paranoia.”⁵ Although this statement may have been a response to inappropriate use of psychotherapy or psychological testing, it strongly implies that the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, should not pay for psychiatric services provided to individuals with cognitive impairment, such as those with advanced dementia and psychiatric symptoms. In fact, the presence of severe agitation, delusions, and paranoia is a clear indication for services by a psychiatrist, including psychotropic medication and behavioral interventions.

There are considerable data supporting the appropriateness and medical necessity of psychiatric treatment for this group of vulnerable patients in nursing homes. As currently written, this statement is grossly misleading and unsupported by clinical, scientific, and health care literature.

LTC Forum: What about the OIG concern over billing for inappropriate services?

Dr. Bartels: There are a small number of entrepreneurial mental health providers that are exploiting older persons with mental disorders in nursing homes by billing for inappropriate services at the expense of all of us. This should not be tolerated. We support identifying these providers and taking appropriate measures to protect the integrity and financing of critically needed services. At the same time, even the OIG reports recognized that nearly 4 of 5 nursing homes complain that there are significant barriers to access of needed mental health services for their residents. Put simply, the challenge is to get the right services to the right residents, particularly in the context of the significant unmet needs that have been demonstrated through research.

Research on the effectiveness of mental health services in nursing homes

LTC Forum: What do we know about the treatment of mental disorders in older persons?

Dr. Bartels: The recent Surgeon General’s report on older adults with mental disorders and the Older Adults and Mental Health report by the Administration on Aging documented numerous effective treatments for a host of problems experienced by older adults.^{6,7} In addition to these general

summaries supporting the effectiveness of mental health interventions in older persons, emerging literature supports the important role of mental health services in improving outcomes in nursing homes.

LTC Forum: In what areas are outcomes data available on the impact of mental health services in nursing homes?

Dr. Bartels: There are outcomes data in 4 areas:

1. Impact of services on residents’ symptoms and functioning
2. Acute service use
3. Nursing home staff functioning
4. Physician prescribing behavior

Research on the impact of mental health services on resident symptoms and functioning show that one half to three quarters of residents have significant improvement in their symptoms and functioning when they receive psychiatric services.

LTC Forum: What is the impact of these services on the overall cost and use of services?

Dr. Bartels: Mental health services in nursing homes can reduce acute hospitalization and acute emergency service use overall, resulting in what are likely to be cost savings. We also know that mental health services that include education and training of staff can have a dramatic impact on staff knowledge and performance, and can even result in decreased staff turnover.

In addition, we know that targeted education and feedback to prescribing physicians in nursing homes can have a dramatic impact on decreasing inappropriate use of antipsychotics and antianxiety medications, while enhancing the use of needed antidepressant medication.^{8,9} Overall, the available data support the effectiveness of quality mental health services in nursing homes.¹⁰

LTC Forum: What components are associated with quality mental health service models in nursing homes? In other words, what are best practices when it comes to the types of services that are provided?

Dr. Bartels: Experts in treatment of older people with mental disorders in nursing homes appear to agree on several recommendations for the best models for treatment.

First, models that are least effective include those in which a consultant makes a one-time visit when an emergency occurs and simply writes recommendations in a chart consultation without talking to the staff or providing staff education. We know from research that chart recommendations alone are only followed one third of the time, and a one-time consultation is problematic with respect to follow-up. The best treatment plan includes follow-up visits to ensure that prescribed medication or behavioral treatment is implemented appropriately and that the resident is responding without side effects or problems. Services that are consistent with the best practices are listed in Table 1.

LTC Forum: The first component of geriatric psychiatric services is a multidisciplinary team approach. How might this work in practice?

Table 1

Five Components of Geriatric Psychiatric Services Consistent With Best Practices

1. A multidisciplinary team approach
2. Specific geriatric expertise and competence
3. Individualized assessment and treatment planning with routine follow-up, ideally using standardized outcome measures
4. Collaborative treatment planning between the consultant and the nursing home staff
5. A strong educational component

Dr. Bartels: The multidisciplinary team model contributes a range of resources and skills that result in optimal treatment. For example, a geriatric psychiatrist conducts a comprehensive evaluation and makes specific recommendations for optimal treatment with medications. Concurrently, a psychologist or psychiatric nurse specialist on the team recommends behavioral programs in the management of problem behaviors. This team approach can also be an efficient way to use different types of skills in identifying and evaluating specific problems.

LTC Forum: Could you specify the geriatric expertise and competence required by members of the team?

Dr. Bartels: For example, the presence of a geriatric psychiatrist with added qualifications in geriatric psychiatry or a psychiatrist with significant experience in geriatrics is extremely desirable. Similarly, social workers, psychologists, and nurses on the team should have experience and training in geriatric assessment and treatment.

LTC Forum: The ability to individualize therapy is important in most areas of patient care. How might the multidisciplinary team accomplish this?

Dr. Bartels: Optimal care includes assessment and treatment that is individualized and includes follow-up evaluations to ensure that treatment has been effective. Routine or “one-size-fits-all” use of psychological testing or of group therapy services regardless of diagnosis should be discouraged. Instead, assessment and treatment should show attention to the resident’s specific problems, with an individualized treatment plan and treatment recommendations.

Recommendations for changes in medications or behavioral treatment plans should include evidence that a follow-up assessment occurred, ideally with standard outcome measures. Follow-up evaluation should include an assessment of the effectiveness of the recommended intervention

and address any side effects that may have occurred, especially when new medications have been recommended.

LTC Forum: The collaborative process of planning and implementing treatment implies that the plan and its implementation should be discussed with the nursing staff. Is this practical in the busy nursing home?

Dr. Bartels: There should be discussions, and ideally documentation should be present in the chart showing that this interaction occurred. Again, we know from research that simply placing a note in the chart with recommendations that have not been discussed results in treatment being implemented only one third of the time.

Meeting with the staff is time well spent. Members of the nursing staff are most likely to provide successful treatment when they understand how the treatment is to be implemented and have an opportunity to collaborate on the individualized plan.

LTC Forum: The fifth component of quality best practices and mental health services is evidence of a significant educational program within the nursing home with respect to identification and management of behavioral health problems. Again, this requires time and a coordinated effort among the staff. What clinical evidence supports this activity?

Dr. Bartels: We know from research that training increases the confidence of the on-site staff. It is accompanied by better treatment and even decreases staff turnover in nursing homes.^{11,12}

There is emerging research on the nursing home needs for mental health services and on the effectiveness of psychiatric interventions in nursing homes. We know that there is a dramatic unmet need for mental health services and, in some instances, the right treatments are not getting to the right residents.

Mental health treatments can be effective in older persons, and the most effective models of mental health services, or best practices in nursing homes, include a multidisciplinary treatment team with geriatric expertise. Ideally, this team includes a geriatric psychiatrist to develop treatments that are individualized and routinely followed up. Residents do best when treatment planning is undertaken as a collaborative effort between the mental health consulting team and the nursing home staff.

In addition, we know that education is an essential component of quality care. Educational programs should be designed to improve the ability of the staff to identify, treat, and manage behavioral health problems in older adults.

Editor's note: Dr. Bartels is Associate Professor of Psychiatry, Dartmouth Medical School, and a practicing geriatric psychiatrist. He is also Director of Aging Services Research at the New Hampshire-Dartmouth Psychiatric Research Center, Co-Director of the New Hampshire-Dartmouth Mental Health Policy Institute, and Medical Director for the Division of Behavioral Health for the State of New Hampshire. Dr. Bartels is President of the American Association for Geriatric Psychiatry.

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A Nursing Home-Based Geriatric Psychiatry Practice: An Interview With Marc E. Agronin, MD

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There is no shortage of patients with psychiatry-related issues who will benefit from the input of the psychiatrist with a nursing home-based geriatric psychiatry practice.

Introduction

As previously discussed by Dr. Bartels and in agreement with statements by the American Association for Geriatric Psychiatry (AAGP) and the American Geriatrics Society (AGS), nursing home residents with psychiatric disorders are entitled to the full benefits of treatment with the broad spectrum of therapeutic options available to clinicians responsible for their care.¹ This need is significant, as cognitive and mental disorders, along with circulatory diseases, are the most common admission diagnoses in nursing home residents.²

Further in his remarks, Dr. Bartels reiterates that geriatric psychiatry services in the nursing home are not only beneficial to the patient but also cost-effective, saving costs in acute hospitalization and in the use of acute emergency services.

Dr. Bartels' interview also elucidates that the traditional one-time consultation model is inadequate in the nursing home environment. Nursing home patients usually present with complex problems requiring an ongoing individualized, multidisciplinary approach.

While researchers continue the quest to identify the best and most effective geriatric psychiatry practice model in the nursing home, practitioners struggle daily to address the mental health needs of nursing home patients.

One approach to address the mental health needs of the elderly population in nursing care facilities is to have a full-time geriatric psychiatrist on staff. The Miami Jewish Home and Hospital for the Aged (MJHHA) in Miami, Florida, is a long-term campus with nearly 700 residents and one of a growing number of health care institutions maintaining full-time geriatric psychiatry practices.

Dr. Marc Agronin, who has a full-time geriatric psychiatry practice in the MJHHA, provides insight into the characteristics of this type of practice.

LTC Forum: Before describing your position at the MJHHA, could you please explain why a geriatric psychiatrist would consider a career as a full-time staff geriatric psychiatrist in a large nursing home?

Dr. Agronin: There is a growing need for geriatric psychiatry services

in long-term care (LTC) and assisted living facilities. In the United States, there are currently more than 34.5 million persons over age 65 years.³ That cohort is expected to increase to nearly 79 million by 2050.⁴ The number of persons 85 years of age and older will increase from 4.2 million presently to more than 18 million in 2050.³ Accordingly, the number of nursing home residents is expected to double by 2030² and comprise increasingly older, more ill, and more functionally dependent individuals.⁵

It is anticipated that 2 of every 5 persons who became 65 years of age in 1990 will reside in a nursing home at some time before they die.⁵ One in 4 persons will spend at least 1 year in a nursing home, and 1 in 11 will be a nursing home resident for 5 years or longer. Most of these patients will have dementia and associated psychiatric conditions that require ongoing care. In other words, physicians should be where their patients are.

LTC Forum: Mental disorders such as dementia and associated psychiatric conditions, depressive disorders, anxiety, and organic brain damage are among the most common conditions patients present with at the time of admission to a nursing home. How extensive is this problem?

Dr. Agronin: According to the American Health Care Association, more than 1.5 million individuals in the United States reside in nursing homes.⁶ Within this population, 42% have some level of dementia and 33% have documented symptoms of depression.⁴ Rovner and colleagues demonstrated that, among 454 consecutive new nursing home admissions who were evaluated by psychiatrists and diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*, 80% had a psychiatric disorder.⁷ Dementia syndromes (67.4%) were most common, along with affective disorders (10%). Among nursing home admissions with dementia, 40% suffered from other psychiatric syndromes including delusions

and depression, and these patients constituted a distinct subgroup that predicted frequent use of restraints and neuroleptics, and the greatest consumption of nursing time.

It is not surprising, therefore, to hear Dr. William Reichman, former president of the American Association for Geriatric Psychiatry, describe nursing homes in America as “largely forgotten psychiatric hospitals... They are not in any way prepared to take care of mental health problems.”⁸

LTC Forum: Are these problems so challenging for the nursing home staff that a totally dedicated geriatric psychiatrist is required?

Dr. Agronin: These problems are a challenge because nursing homes were originally intended to treat chronic physical problems, not Alzheimer’s disease and other dementias, behavioral problems, and depression. Nursing homes are today’s chronic psychiatric hospitals for the elderly, and therefore the presence of a geriatric psychiatrist who specializes in providing care for this population is often required.

LTC Forum: Please describe your role as full-time geriatric psychiatrist at an LTC facility?

Dr. Agronin: More than 2 decades ago, Borson and colleagues proposed a 4-fold role for the psychiatrist in a nursing home practice, which encompassed clinical care, consultation, teaching, and research.⁹ In addition, I would include administrative services (Table 1).

Like many of my colleagues, the majority of my time is spent in clinical psychopharmacologic practice. For 3 1/2 to 4 days each week, I see patients in our outpatient clinic. Diagnoses range from agitation and psychosis associated with dementia, to depression and other mood disorders, to anxiety and personality disorders. Adjustment reactions to nursing home placement and severe medical illness and pain are common problems

Table 1

Roles for the Geriatric Psychiatrist in the Nursing Home

Clinical care

- Psychiatric assessment and treatment (primarily pharmacologic)
- Maintain Omnibus Budget Reconciliation Act (OBRA) standards for psychotropics
- Intervene with family issues, especially conflicts between staff and families
- Help caregivers understand and cope with issues related to dementia care
- Crisis management, hospitalization
- Dementia unit clinical team meetings
- End-of-life and palliative care
- Management of the therapeutic milieu

Administrative

- Liaison with medical director and directors of nursing, pharmacy, and social work

- Ethics committee participation
- Medical executive committee (ie, credentialing, risk management)
- Coordinate selected mental health staff services

Staff education and training

- In-service programs (ie, psychiatric issues)
- Crisis counseling (ie, residents and staff)

Research and training

- Psychiatric disorders, medicine-psych issues, etc
- Pharmaceutical trials
- Clinical supervision of fellows, students, and other trainees

encountered by patients in my practice, as well as grief reactions due to the loss of loved ones. These patients are often referred to our staff of psychologists for individual counseling.

Most appointments are for follow-up visits, plus 5 or more new evaluations weekly. These come from either the LTC units, the independent or assisted living facilities on campus, or from referrals through our day-care or affiliated community services. In cases where patients on nursing units are either unwilling or physically unable to keep an appointment, or they are unavailable, I usually serve as a liaison with staff members on the unit and make “house calls” there. Although the prevailing model for most geriatric psychiatrists in the community is to visit nursing home patients at bedside, we try to do things a little differently and structure resident appointments like a regular visit to a physician.

LTC Forum: What are the advantages of working full-time in the nursing home?

Dr. Agronin: One advantage is that the psychiatrist can establish close working relationships with a wide variety of staff members. This makes it easier to remain apprised of issues related to patient care and to intervene with staff members, residents, and even with family members, when necessary. The full-time staff geriatric psychiatrist becomes an integral part of the community. Residents are more likely to recognize me, which makes it easier for them, as well as the staff, to ask questions or make requests. Overall, it makes mental health services more accessible, both for routine as well as emergency situations.

LTC Forum: How do you become involved with the concerns expressed by family members regarding the care of their loved ones?

Dr. Agronin: Family members often have concerns about the care of their loved ones. In all cases their involvement is welcome, and I participate in family meetings in order to provide education and counseling regarding their loved one’s diagnosis. Family members sometimes have unrealistic expectations or demands regarding care issues. In these circumstances, I serve as a contact to discuss and resolve their concerns. In other cases, family members, themselves, have psychiatric issues that can sometimes lead to disruptive behaviors during visits.

For example, the daughter of a resident with bipolar disorder began acting in a very disruptive, inappropriate, and threatening manner toward the staff on her mother’s unit. She appeared to be demonstrating symptoms similar to those we had observed in her mother. We worked to establish rapport with her to defuse the tension and ensure the safety of staff and residents. We then asked other family members to seek help for the affected daughter. Being on staff made it easier for me to advise the nursing staff as well as our security staff on the most appropriate way to approach the disruptive family member without inflaming the situation.

LTC Forum: Do you also provide administrative services to the nursing home?

Dr. Agronin: As the Director of Mental Health Services, I serve as a liaison to the medical director, and the directors of nursing, social work, and pharmacy, to develop administrative policies and guidelines for staff education. For example, we are developing guidelines concerning residents’ sexual expression in the nursing home, as well as for appropriate staff education. I also serve on the ethics committee and help provide a psychiatric perspective on numerous issues. During quarterly medical executive committee meetings, I address credentialing issues and risk management. I also serve on the multidisciplinary team that runs our specialized dementia unit.

LTC Forum: We understand now the benefits that the patients and the nursing home administration gain from your presence. Does the nursing staff benefit from having a full-time geriatric psychiatrist on the team?

Dr. Agronin: The staff usually recognizes dangerous or disruptive behaviors. However, education helps staff members to recognize less dramatic presentations of psychiatric disorders, such as withdrawal, decreased initiative, diminished activity, or decline in functional capacity. To meet this need, I provide frequent staff in-services, including a monthly mental health talk on key issues in psychiatric management. This includes a series of lectures on dementia assessment and treatment, which focus on dealing with agitation.

I occasionally provide brief counseling for staff members who are stressed by overwhelming caregiving issues on a unit (for instance, when there is a particularly disruptive and abusive resident) or by grief over the loss of a beloved resident or even another staff member. Practicing in an environment where psychiatric disorders are highly prevalent can lead to significant distress for nursing home staff, most of whom do not have specific training in mental health. Consultation with these individuals is intended to improve staff effectiveness and job satisfaction, and reduce absenteeism and staff turnover.

Last year our facility experienced the tragic and sudden death of an administrative secretary. The psychologists and I quickly put together a meeting for staff to talk about their feelings, and I wrote a brief letter to the staff explaining how grief reactions become manifest, and how to cope with them. My full-time position allowed me to circulate around the campus and discuss with staff how they were coping with the tragedy.

LTC Forum: You also provide supervision and teaching for trainees?

Dr. Agronin: The MJHHA has a long-standing collaborative relationship with the University of Miami School of Medicine whereby several of our staff members serve on the clinical faculty, and we participate in teaching, training, and research. In this capacity, I have the opportunity to serve as a supervisor for a geriatric psychiatry fellow and for medical students during clinical rotations. These trainees spend, on average, approximately 20 hours with me each week. The MJHHA also serves as a site for a longitudinal clinic for a geriatric psychiatry fellow, which provides me with the opportu-

nity to observe several residents over the course of the year and provide both pharmacologic and psychotherapeutic supervision, when necessary.

In addition, the Florida legislature has honored the MJHHA by designating it as Florida's teaching nursing home. In this capacity, our facility hosts a variety of trainees across the spectrum of long-term care. As a result, there is an academic spirit of learning and teaching that energizes our facility and provides numerous opportunities for me to interact across a variety of clinical disciplines.

LTC Forum: Do you participate in research?

Dr. Agronin: Yes, we are currently conducting 2 pharmaceutical trials for new and established psychotropic medications. These trials focus on treating psychosis and agitation associated with dementia—probably the most common psychiatric problems in my practice. I am also involved in primary research on personality disorders in late life, including an assessment of the relationship between dementia and personality change. We plan to start a third pharmaceutical trial to examine a popular antidepressant.

LTC Forum: We understand you have a research background studying personality disorders in the elderly. What types of personality disorders are most challenging to the geriatric psychiatrist in this setting?

Dr. Agronin: We know that personality structure forms the foundation of a person's response to both normal and pathologic aging. An older person's response to age-related stress depends on the balance of personality strengths and weaknesses.¹⁰

Normal aging of the brain may not greatly influence personality,

but brain injury and disease often lead to personality changes. Severe or multiple stresses in later life may overwhelm a person's coping skills and also lead to personality change. Personality disorders represent a more extreme form of dysfunctional personality traits and present in many different forms in LTC settings.⁶ The most challenging cases usually involve narcissistic, paranoid, and borderline disorders, given the frequency of comorbid agitation, depression, and psychosis. The key to treatment always comes down to building a relationship between the institution and the individual in question.

LTC Forum: How does a geriatric psychiatrist prepare for a full-time practice in a nursing home?

Dr. Agronin: Necessary training to enter into a full-time geriatric psychiatry practice in a nursing home includes board certification in psychiatry and successful completion of a geriatric psychiatry fellowship. Medical students and residents interested in geriatric psychiatry should gain experience working with psychiatrically impaired residents in LTC facilities. Although clinical experience is essential, trainees also need to acquire an understanding of the rules and regulations that affect psychiatric care in LTC settings, such as Omnibus Budget Reconciliation Act (OBRA) guidelines and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) priorities. Long-term care can encompass a variety of environments—dementia units, rehabilitation, assisted living, independent living, hospice—all of which have their own needs. Given the demographic trends mentioned earlier, opportunities for geriatric psychiatrists in all of these LTC settings are available and increasing.

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Expanding the Role of the Geriatric Psychiatrist in the Nursing Home

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Geriatric psychiatrists must be prepared to provide consultative services to nursing home staff and administrators, as well as direct care for the patients who reside in nursing facilities.

Although a full-time nursing home practice seems appropriate, given the magnitude of the psychiatric problems patients present with and the level of involvement the geriatric psychiatrist needs to have in the nursing home environment, this model is not feasible or ideal for every type of nursing-home setting. Some nursing homes may not be large enough to support a full-time geriatric psychiatry practice, or there may not be an available geriatric psychiatrist willing and able to have a full-time nursing home practice. The amount of time and dedication required in each particular case may change, but according to experts like Dr. Bartels, the type of services needed remain the same. The question is whether nontraditional services, such as help with interior design, aiding to resolve problems of interactions between patients and staff, facility planning, program design, and regulatory compliance, can be achieved using a consultation rather than a full-time practice model.

Accordingly, LTC Forum asked Dr. Joel E. Streim, who provides nursing home geriatric psychiatry consultation services, to offer some concrete examples of nursing home consultations and the impact they have had.

Improving architectural and interior design for cognitively impaired patients

Psychiatric disorders among nursing home patients (eg, dementia and its behavioral complications) present major challenges for long-term care facilities. Unfortunately, most nursing homes chartered during the second half of the 20th century were designed to provide residential care for cognitively intact and behaviorally stable patients. Most proprietors, facility administrators, and nursing home staff did not anticipate that it would be necessary to care for patients with cognitive impairment or other psychiatric symptoms.

In particular, the architecture and interior design of most nursing facilities do not address the needs of patients with cognitive disorders, including the impairment in visual memory, visual-spatial deficits, and disorientation often associated with dementia. Environmental modifications can be an important element of treatment for these patients.¹ When these considerations are ignored during the design of a facility, the result can be an environment that is irritating to cognitively impaired patients and that leads to behavioral disturbances. Poorly designed environments also can be confusing, reducing residents' functional status and causing excess disability beyond that attributable to a dementing illness.

Based on the recognition that dementia leads to impairment in several cognitive domains and can include amnesia, agnosia, apraxia, aphasia, and impaired visual-spatial function, the objective is to identify ways in which the environment can be modified to support patients in areas where they have preserved cognitive function. At a minimum, it is important to avoid amplifying problems in areas where patients have cognitive deficits.

Case history 1

Reducing the negative effects of the configuration of living and working spaces

In this particular facility, the nurses' station was located in an area set back from a long, poorly lit corridor. To facilitate nursing surveillance, cognitively impaired residents were usually lined up in wheelchairs along this narrow hallway adjacent to the nurses' station. This posed problems for the residents and the nursing staff.

Being in close proximity to one another, the residents tended to become involved in altercations. It was common to see a noisy or intrusive resident provoking verbal or physical retaliation from another resident. The nursing staff had difficulty managing this situation because they were located behind a desk at the nurses' station a distance from the residents. This limited their ability to prevent residents from injuring one another.

My consulting service in this case was to recommend several environmental modifications including a redesign of the nurses' station and the hallway. Two storage rooms across from the nurses' station were structurally modified to create an open commons or living room area. The redesign included improved lighting and placement of objects on the walls that the patients could safely handle and manipulate in order to promote tactile stimulation. The rationale for this change was that patients who are busy manipulating a false doorknob or faucet handle mounted on the wall are less likely to hit or grab their neighbor's arm. The area was also carpeted to reduce noise, which was thought to be contributing to the verbal and physical agitation. Equally important, the nurses' station was redesigned with a semicircular desk that extended into the common area.

Outcome

Reconfiguration of the area around the nurses' station facilitated surveillance of patients' activities and prompt intervention when residents became agitated or combative. The enlarged common area was less noisy, reducing the sense of overcrowding and frequent violation of personal space that previously had contributed to agitated and combative behavior among the residents. There was access to safe objects that were appealing in terms of color, shape, and form—even for those residents with agnosia (who could no longer recognize the objects or their purpose). These objects were placed within residents' line of sight and made readily available. Overall, the changes facilitated improved staff supervision of the residents and reduced the negative interactions among them.

Case history 2

Reducing visual-spatial confusion

A bedroom in the facility was decorated with brightly colored wallpaper in a contrasting vine and floral pattern. A new occupant became very fearful whenever she was wheeled back into her room, repeating "You're strangling me, you're strangling me!" Removing the wallpaper and painting the wall a soft

pastel color stopped the repetitious vocal behavior.

Another resident frequently wandered into the rooms of other residents and urinated in their wastebaskets. This was frustrating and upsetting for staff and other residents. However, he was continent most of the time and did not have agnosia (eg, he still recognized the purpose of a toilet) or apraxia (eg, he was able to unzip his pants and press the lever to flush the toilet). Staff noted that he could not find his own room and often got lost within the facility. At my recommendation, they painted the doors of his room and his bathroom bright yellow to help him locate his own bathroom and find the toilet.

Outcome

Visual-spatial deficits may alter a person's perceptions in ways that lead to agitation and inappropriate behaviors. In the case of the first resident, it is possible that she misperceived the wallpaper as threatening; perhaps the vines appeared as something that might strangle her. For the second resident, his visual-spatial deficits—and the lack of environmental cues—prevented him from toileting himself appropriately, making maximal use of his preserved recognition, praxis, and continence. It is fairly easy to overcome these problems in the environment, but first one must recognize the underlying problem.

When the nursing home staff understands resident behavior in the context of unmet needs, environmental irritants, medical illnesses, and psychiatric disorders, they learn to consider the person as someone who is sick or disabled rather than as an annoyance.

Improving interactions between residents and staff

Daily contact between residents and staff represent opportunities for therapeutic interactions that support and enhance residents' functioning and sense of well being.²⁻⁶ However, these interactions also can be counterproductive and lead to behavioral disturbances. In some cases, residents are verbally or physically abusive toward staff; however, the staff also can become abusive toward residents. The geriatric psychiatrist can play a vital role in raising awareness of the causes of behavioral disturbances as well as the occurrence of abuse between staff and residents. The psychiatrist can help the staff understand resident behaviors and guide them to respond in ways that are more supportive and therapeutic, rather than adversarial or abusive.⁷ When the nursing home staff understands resident behavior in the context of unmet needs, environmental irritants, medical illnesses, and psychiatric disorders, they learn to consider the person as someone who is sick or disabled rather than as an annoyance.⁸

When the nursing home staff understands resident behavior in the context of unmet needs, environmental irritants, medical illnesses, and psychiatric disorders, they learn to consider the person as someone who is sick or disabled rather than an annoyance.

Case history 3

Verbal abuse

A social worker witnessed several incidents in which nursing assistants were raising their voices in a tone of annoyance and castigating residents for not cooperating. For example, one resident who was to be transferred from her bed to a wheelchair was yelling at the staff, "Leave me alone!" The staff, in turn, yelled back at her, "No, it's time for lunch. You have to do this. I'm going to put you in the wheelchair. Now, put your arms down so we can move you into the wheelchair!"

During another incident, a resident cursed at the staff, which resulted in a verbal response that was again characterized by a tone of annoyance and castigation. The social worker was concerned that this abusive tone was contributing to a vicious cycle of resident demoralization, mistrust of staff, treatment refusal, and further intense verbal abuse by the staff. This led to a request for an in-service program designed to reduce the risk of staff abuse of residents.

In response, I provided a series of 3 in-service programs, repeated for each of the 3 shifts. The first session focused on definitions and perceptions of abuse. Doing so validated staff perceptions that they are frequently abused by some residents, legitimizing this as a cause of frustration (as well as anger and fear), and identifying it as an important risk factor for abuse of patients. The second session discussed other risk factors for abuse, emphasizing those factors that staff and administration can control or modify. The third session generated approaches for preventing and managing abuse, including administrative support and more direct access to geriatric psychiatry consultation.

Outcome

Once the program started, it became apparent that the staff felt abused by the residents and dismissed by the administration. To address this issue, we discussed the events leading to the cycle of abuse and retaliation between staff and residents. This was accomplished partly through the in-service program, partly by bringing staff and administration together for a consultation about ways to reduce absenteeism (which left floors frequently understaffed, contributing to staff feeling overwhelmed and abused), and by ensuring access to consultative support in high-risk situations. The latter involved availability of individual staff consultation by a geriatric psychiatrist or other mental health professional as needed.

The problem of abuse is usually addressed on an individual case basis by administrators (and sometimes psychiatric consultants). In this facility, however, the process of abuse reduction/management was enhanced through in-service programs, subsequent administrative consultation, and a systems approach to giving front-line staff more direct access to consultative support from the geriatric psychiatrist.

Facility planning, program design, and regulatory compliance

Mistakes made in designing facilities during the 20th century should not be repeated in this century. Patient needs are likely to change in the next decade, and geriatric psychiatrists must contribute by guiding administrators in future facility development and design.

Geriatric psychiatrists understand the epidemiology of late-life mental disorders in the community and the nursing home. They also understand the care needs of frail elderly patients with cognitive, affective, and other mental disorders and the regulatory issues that affect mental health services in nursing homes. This subspecialty expertise can be of great value to nursing home administrators in planning for future patient care needs, designing and implementing state-of-the-art care programs, and assisting with the growing challenges of regulatory compliance.

Case history 4

Administrative consultation for program and facility planning

The board of directors of a nursing home was considering a 50-bed addition to the facility designed for the care of patients with Alzheimer's disease. The plan called for 2 levels of care to meet the needs of middle-stage and later-stage patients. However, the project was placed on hold when a member of the board heard that treatments for Alzheimer's disease were advancing. This led to concern that in a few years a patient care area designed to meet the needs of those with Alzheimer's disease would be obsolete.

The administrator requested a consultation to review the prevalence and incidence of Alzheimer's disease in order to reassess the projected needs of cognitively impaired patients with dementia and the impact this might have on future residential care facilities.

In response, I presented the board with a review of the trends in Alzheimer's research, as well as the prevalence of other types of dementia such as vascular dementia, Lewy bodies dementia, and frontal lobe dementias. I also discussed the services people will still likely need when there is a reduction in morbidity from Alzheimer's disease and highlighted other physical and mental health problems associated with disability and frailty that might still require residential care. In particular, I emphasized the importance of demographic trends: with people living longer, we will need to meet both the residential care needs of the very, very old and whatever infirmities emerge in this growing segment of the population.

Outcome

The administrator reported the results of this consultation to the board. The plan for expansion was revised to accommodate

construction of a more flexible facility to meet the needs of frail patients with different kinds of disabilities.

A Final Note

Meeting future needs

Even if geriatric psychiatrists do a better job in treating Alzheimer's disease 10 years from now, new problems are likely to emerge in frail nonagenarians and centenarians. These will become manifest as the proportion of very old adults continues to grow (Figure 1).⁹

Lewy bodies disease, for example, is a cause of dementia that was not well recognized 10 years ago, yet now is thought to represent a significant proportion of people with dementia in nursing homes.

Over time, the needs of nursing home patients will change and continue to challenge the clinical expertise of geriatric psychiatrists.

Editor's note: The testimony of Drs. Bartels, Agronin, and Streim not only illustrates the importance and feasibility of providing geriatric psychiatry services in the nursing home setting, it underscores the impact of these services, as well. Their testimony also illustrates the ability of geriatric psychiatrists to contribute to the quality of life of these patients by providing services to nursing home staff and administrators, as well as directly to the patients who are served.

The Upcoming 3 issues will review the therapeutic tools and the reimbursement options available to the geriatric psychiatrist to successfully provide these needed services.

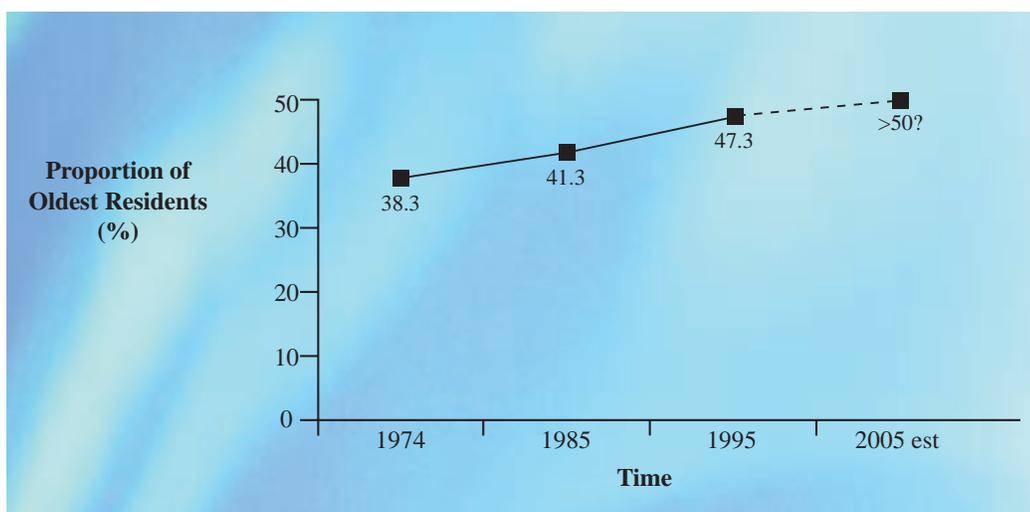


Figure 1. Increasing proportion of the oldest-old (85+ years) in the US nursing home population. Modified from Caywood.⁹

Editor's note: Dr. Joel Streim has provided innovative consultation services for approximately 16 years. His interest in developing consultation models for nursing homes began during his geriatric psychiatry fellowship. Today, his consultations involve primarily skilled nursing facilities and focus on the needs of staff and administrators, as well as on direct patient care.

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CME Self-Assessment Test

The Role of the Geriatric Psychiatrist in the Nursing Home

On the answer form located on the back cover, please circle the letter that corresponds to the single most appropriate answer for each of the following questions. Deadline to receive credit is one calendar year from date of publication.

1. What is the approximate prevalence of mental disorders, including Alzheimer's disease, depression, anxiety disorders, and psychotic disorders among residents of nursing homes?
 - a. 10%
 - b. 38%
 - c. 80%
 - d. 99.9%
2. Approximately what percentage of nursing home residents are in need of psychiatric evaluation?
 - a. 10%
 - b. 38%
 - c. 80%
 - d. 99.9%
3. According to the OIG, half of Medicare psychiatric services in nursing facilities are medically unnecessary or questionable, and 27% of psychiatric services are medically unnecessary. What explains the variance between these conclusions and medical research results?
 - a. Lack of specificity in describing the nature of services provided
 - b. Lack of information on the specific types of providers of services
 - c. Extrapolation from a specific patient group to the population at large
 - d. Both a and b
4. In what areas are outcomes data available on the impact of mental health services in nursing homes?
 - a. Impact of services on residents' symptoms and functioning
 - b. Acute service use
 - c. Nursing home staff functioning
 - d. Physician prescribing behavior
 - e. All of the above
5. What percentage of residents show improvement in their symptoms and functioning when they receive psychiatric services?
 - a. Less than 5%
 - b. Up to 10%
 - c. Up to 75%
 - d. Up to 99.9%
6. Identify the components of geriatric psychiatric services consistent with best practices?
 - a. A multidisciplinary team approach
 - b. Specific geriatric expertise and competence
 - c. Individualized assessment and treatment planning with routine follow-up
 - d. A strong educational component
 - e. All of the above
 - f. All of the above, excluding c
7. What is the best training for a full- or part-time geriatric psychiatry practice in the nursing home setting?
 - a. Board certification in psychiatry
 - b. Successful completion of a geriatric psychiatry fellowship
 - c. Geriatric rotations during medical school
 - d. All of the above
 - e. Both a and b
8. Which of the following represents reasonable administrative duties for a full-time geriatric psychiatrist working in a nursing home?
 - a. Ethics committee participation
 - b. Medical executive committee (ie, credentialing, risk management)
 - c. Coordinate selected mental health staff services
 - d. All of the above
 - e. Both a and c
9. One objective for a geriatric psychiatrist is to identify ways in which the environment can be modified to support patients in areas where they have preserved cognitive function and avoid amplifying problems in areas where they have cognitive deficits.
 - a. True
 - b. False
10. An appropriate role for a geriatric psychiatrist is to raise awareness of the causes of behavioral disturbances in order to help the staff understand resident behaviors and guide them to respond in supportive and therapeutic ways.
 - a. True
 - b. False

Personal Information

PERSONAL INFORMATION

The American Association for Geriatric Psychiatry designates this continuing medical education activity for up to 1.0 credit hour in category 1 of the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activities.

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PROGRAM EVALUATION

You must complete this evaluation to ensure processing of your self-assessment test.

Please circle the answer that best applies.

Have the activity's educational objectives been met? _____ Yes _____ No

Discuss current research regarding the need for mental health services in nursing homes _____ Yes _____ No

Identify ways to best meet that need as part of day-to-day clinical practice _____ Yes _____ No

Identify administrative roles for the geriatric psychiatrist in the nursing home setting _____ Yes _____ No

List opportunities for staff education and training, and clinical research in nursing homes _____ Yes _____ No

Identify consultative services deliverable to nursing home staff and administration _____ Yes _____ No

Did you find this program to be objective or biased?

Objective					Highly biased
5	4	3	2	1	

Relevance to your practice:					Irrelevant
Very relevant					
5	4	3	2	1	

Amount of knowledge gained:					None
Great					
5	4	3	2	1	

Level of material presented:					Too simple
Too advanced					
5	4	3	2	1	

Overall evaluation of program:					Poor
Excellent					
5	4	3	2	1	

Hour(s) spent reading this issue (circle one): 1.0 1.25 1.5

Would you recommend this publication to a colleague?

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Ideas for future publications and/or your comments:



Long-term Care Forum – The Role of the Geriatric Psychiatrist in the Nursing Home

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ANSWER FORM

Please circle the letter that corresponds to the single most appropriate answer and fax **both** the Personal Information and CME Self-Assessment Test to the American Association for Geriatric Psychiatry at 303-654-4437 or mail your response to:

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5. a b c d

6. a b c d e f

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10. a b