Is Education All That’s Needed to Reduce Inappropriate Drugs in Long-Term Care?

David A. Smith MD, CMD, Keith Guest RN, MD, CMD

It is interesting to watch the changing long-term care environment. As we become more inclusive, words like American become replaced by terms like Society. The team approach to long-term care has begun to include more medical disciplines and cultural viewpoints, and articles from other countries are becoming more frequent. In the December 2014 issue of JAMDA, Dr Garcia-Gollarte and colleagues presented a Spanish study showing benefit of an educational intervention directed to long-term care physicians for the reduction of inappropriate drug prescription (including antipsychotics) to nursing home residents. The authors informed us that the physicians were employed by a single entity and were accustomed “to follow direction and to review feedback from quality control systems.” Not surprisingly, reduction in inappropriate prescriptions had some positive impact on health outcomes and costs. It is surprising, however, that they were able to demonstrate this within the relatively short 3-month study period.

Although the study purports to test the value of this 10-hour educational curriculum followed by “on-demand support by phone,” it also can be interpreted as a descriptive study of changing physician prescribing behavior by setting expectations in a closed staff/employed physician model. As the control group, physicians not only received none of the curriculum provided to the intervention group but also were blinded to the fact that the research question was being studied; their prescription behavior was not influenced by the Hawthorne effect. We suspect that the Hawthorne effect may be especially powerful in a study in which the participants could be terminated if they do not meet expectations.

Perhaps the study’s outcome was due to the educational intervention. It is also possible that it was only a minor contributor to the outcome, given that, in this model, simply telling these employed physicians what was expected of them might be enough to change prescriptive behavior. A survey of the participants to ask what proportion of the curriculum was new information to them might be illuminating. And, were any participants/physicians unable to affect change and subsequently counseled, demoted, or terminated? Although the authors are to be commended for their contribution and this study is quite interesting, it would be a mistake to generalize its findings to the practice environment found in most skilled nursing facilities (SNFs) in the United States or those other countries in which an open staff model composed of independent physicians is the norm.

There is a paucity of medical staff governance in long-term care facilities to improve accountability. Nursing homes frequently do not credential physicians, and attending physicians are not required to adhere to bylaws or rules and regulations. There has been a call for more governance in long-term care, which could empower the medical director to improve the accountability of attending physicians.

As managed care becomes more involved with pharmacy and professional services reimbursement in long-term care, it is likely that these payers will demand adherence to certain practice and prescription expectations by attending physicians, with the power of the purse as their tool. It remains to be seen whether total quality management aimed at best outcomes and cost per disease will drive this process or whether cost containment and/or profits will have the day. Certainly, without professional organizations like AMDA, medical decision making is at risk of falling from the hands of physicians to managed care actuaries and executives.

Also in the December issue, Pitkala and colleagues published a Finnish study of an educational intervention for assisted living facility (ALF) nurses designed to reduce potentially harmful medication use. Harmful medication use was defined as use of drugs on the original version of the Beer list, anticholinergic drugs, nonsteroidal anti-inflammatory drugs, proton pump inhibitors, and the use of multiple psychotropic drugs (antipsychotics, antidepressants, anxiolytics, and hypnotics).

Although the study venue is described as ALFs, it should be noted that for cultural and regulatory reasons, Finnish ALFs appear to be more akin to nursing facilities than to ALFs within the United States. Pitkala and colleagues described their educational intervention as “light,” in that it consisted of 2, 4-hour sessions, but explain that its success in changing geriatric prescribing behavior (nurse recognition of potentially inappropriate prescription, communication of that concern to the physician, and new physician orders) may be related to its design including “modern activating learning methods” and “constructive learning theory.”

In an abundance of caution, the possible signal of higher mortality in the intervention group than the control group in this study should be scrutinized. Although not statistically significant by Cox proportional hazard model, a 24% higher mortality in the intervention group in which medications were discontinued should be a subject of interest if and when this trial is replicated. Is there danger if harmful medications requiring prescription of a therapeutic alternative or

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titration to avoid withdrawal syndromes are summarily discontinued? Were the therapeutic risk/benefit ratios of drugs appearing on the list of harmful medications properly assessed on an individualized case basis or dogmatically discontinued? Were ALF residents’ strongly held beliefs and wishes considered or were medications (such as a Beer-list drug with low potential for harm) discontinued against their wishes, leading to emotional distress and loss of rapport with the nursing staff and/or physician? Perhaps the art of medicine sometimes trumps dogma, although we should not allow this argument to be used routinely.

It is widely held, and we agree, that psychotropic medications are overused in long-term care; yet, nursing home caregivers may receive mixed messages from regulators. Quality Measure (QM) 2.2 assesses facility performance by measuring “Residents who have become more depressed or anxious,” whereas QM 2.2 records the “Prevalence of behavior symptoms affecting others” and 2.3 assesses facility performance measuring the “Prevalence of symptoms of depression without antidepressant therapy.” These set an expectation for the facility to relieve psychotropic or psychological distress without clearly specifying type of treatment, although QM 2.3 implies pharmacotherapy. At the same time, quality measures 10.1 to 10.3 imply higher quality of care by the facility for decreased prevalence of antipsychotic, anxiolytic, and hypnotic use. Regarding these mixed messages, we perceive that most SNF administrators and directors of nursing feel great regulatory risk in the event that one resident physically or sexually assaults another or successfully elopes. In the absence of very generous staffing with well-trained people (not reality), such risk incentivizes chemical restraint or inappropriate transfers.

Medicaid reimbursement for residents with behavioral and psychological symptoms of dementia (BPSD) may be unrealistic when considering the real facility costs of thorough interdisciplinary evaluation of the individual BPSD sufferer. Common unreimbursed expenses include providing objective symptom monitoring and reevaluation, the additional staff time to collaborate with attending physician and family, the provision of adequate staffing to prevent elopement and physical/sexual assaults (often “line of sight,” sometimes “one on one”), and the cost of individualized activities (eg, staffing, snoozelens room), all in an attempt to provide effective nonpharmacologic alternative therapy.

Unfortunately, although nonefficacious and potentially harmful psychotropic medication is certainly to be denounced, these proposed alternative nonpharmacologic therapies have failed to demonstrate much evidenced-based efficacy in the few randomized controlled trials that have been done.3 It is likely that nonpharmacologic therapy must be crafted in a highly individualized fashion if there is an expectation for it to be efficacious beyond satisfying platitudes about loving care of the elderly. This individualization requires physician, nursing facility staff, and family collaborations that are not typical of current practice, and the pathways for reimbursement of this professional time are unclear. The reader will recall the Rumpelstiltskin fantasy tale in which the princess is required to somehow magically spin straw into gold.

The authors were unable to obtain a ranking of states by Medicaid reimbursement for TIEF (Texas Index for Level of Effort) or RUGs (Resource Utilization Group) levels “Impaired Cognition” and “Behavior Problems” from 2013 in time for publication to make a strongest possible examination for correlation between reimbursement (putatively allowing better staffing and resources to evaluate for and implement nonpharmacologic therapy and person-centered care) and prevalence of antipsychotic use for BPSD. But, we were able to compare the published fourth quarter of 2013 ranking of states on prevalence of antipsychotic use for long-stay residents2 with a Kaiser Foundation ranking of states on Medicaid funding per elderly enrollee (regardless of dementia diagnosis or institutional placement) from 2010.6

<table>
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<th>Table 1</th>
<th>Five Lowest and Highest States by Prevalence of Antipsychotic Use in Long-Stay Residents of Nursing Facilities* Compared With State Ranking of Greater to Lesser Medicaid Payments per Elderly Enrollee†</th>
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<td><strong>Ranking by Low AP Use</strong></td>
<td><strong>State</strong></td>
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<td>1.</td>
<td>Hawaii</td>
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<td>2.</td>
<td>Alaska</td>
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<td>3.</td>
<td>Michigan</td>
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<td>4.</td>
<td>District of Columbia</td>
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<td>5.</td>
<td>New Jersey</td>
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<td>Louisiana</td>
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†http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/.

This admittedly imprecise comparison yields that Hawaii performed best in minimizing use of antipsychotics in long-stay residents and was 18th among all states in generosity for Medicaid funding to elderly enrollees. Texas was the highest antipsychotic-prescribing state and ranks 42nd for Medicaid funding to all elderly enrollees. Table 1 displays this relationship for the 5 lowest- and highest-prescribing states. This exploratory investigation deserves a refined analysis.

There is little doubt that education plays an important role in changing prescribing behaviors as is well demonstrated in these 2 original JAMDA research articles and in the multiple studies these authors have referenced. But, education is a seed of best practices and seeds must fall on fertile ground with circumstances that enable germination, taking root, and growing. Far too often education is considered the sole answer to improving performance when poor motivation or barriers to implementations are the real problem. After multiple educational initiatives to reduce inappropriate psychotics have occurred, a myriad of journal articles have been read, and countless consultant pharmacist inquiries have been received by attending physicians, one may decide that more education is needed about as much as we need the airline stewardess to demonstrate once again how to open and close our seatbelt.

Changing physician prescribing behavior to bring it more into alignment with clinical practice guidelines and the standard of care is an important endeavor. One way to control this is to be in control of the physician. An educational intervention in a closed staff model gives us a glimpse of a relatively benign version of this tactic. An increased involvement of managed care in long-term care with the prerogative to contract with or exclude physicians, driven primarily by economics without concerns for total quality management may be less benign.

Alternatively, autonomously functioning physicians may change prescribing behaviors as a result of an educational intervention. But prerequisite to this, the physician must be incentivized to do so by appeals to professionalism that do not require him or her to act against self-interest. They also may be encouraged to do the right thing when they are made uncomfortable by awareness of practicing as an outlier, to avoid legal (or rarely regulatory) liability, to achieve contract compliance with payers, or to do well in a pay-for-performance environment. Finally, habits must be broken, and this can be difficult, especially when the physician feels pressed for time, is unsure of self, or has a cavalier trust in his or her own judgment over collective evidence.

Education on geriatric prescribing provided to the nursing staff who serve as the “eyes and ears” of the physician in long-term care
and who function in many ways as case managers can be an effective tool to incentivize physicians to better prescription practice. When this is done with the best features of adult learning, crafted to the subject matter and the specific audience, then a better outcome can be expected. This, however, is predicated by a number of circumstances. The employers of these nurses (and let us include certified nursing assistants [CNAs]) must have reason to deliver this education. This may be a desire for high quality for its own sake or its marketing value, to avoid legal or regulatory liability, to achieve contract compliance with payers, or to do well in a pay-for-performance environment. The employers must send an unequivocal message to the nurse or CNA that the learning is important and their subsequent employee performance will be evaluated in its wake. The employers must feel that the education is sufficiently important to dedicate resources to its delivery and that delivery must be a cultural and logistic “fit” with the organization.

Recently in the United States, the Centers for Medicare and Medicaid Services made another initiative to reduce inappropriate antipsychotic use in nursing homes.7 One facet of that initiative is the “Hand-in-Hand Toolkit,” a nursing/CNA educational course concerning nonpharmacologic approaches to care of the patient with dementia.8 In the authors’ opinion, the content of this education is quite good and it is developed with adherence to adult learning principles (DVDs followed by small group discussions with a facilitator). However, it remains to be seen whether many nursing facilities will implement this education, given the requirement to pull staff off the floor for 6 sessions of 1-hour duration with a trainer assigned to each of these sessions, repetitively handling small groups of 4 or 5 learners. The cost of implementation of this “free” education will be significant and long-term care administrators may not be able to clearly see a payback for this investment. It was apparently necessary for a Web site to be created to discourage return of the free toolkit sent unsolicited to nursing facilities out of fear they would be billed if they kept it.9

Tunnel vision on the content of education and state-of-the-art educational methods without an appreciation of the practicalities (staffing implications, cost of implementation, financial reward to the facility from the expected clinical benefits of the educational intervention) will ensure that good material will sit unused in the library.

References