Letters to the Editor

MDS 3.0 Perspective: A Better Tool for Patient Care

To the Editor:

The new Minimum Data Set 3.0 (MDS 3.0) should be of interest to physicians practicing in nursing homes because significant changes improve the usefulness of this data for the purpose of individual patient care. MDS 3.0 has been in effect in certified nursing homes in the United States since October of 2010 and in Veteran Affairs facilities since 2012. It does a better job than MDS 2.0 in assessing nursing home residents, especially in the domains of mood, cognition, delirium, and pain. The improvement largely results from patient interviews that include validated, objective instruments that have the potential to provide clinicians with useful information to assess and manage the patient. Three key instruments in MDS 3.0 are Patient Health Questionnaire (PHQ-9), Brief Interview for Mental Status (BIMS), and Confusion Assessment Method (CAM).1 PHQ-9 is a well-known and useful tool for identifying and following patients with depression over time.2 In contrast, the BIMS is not well-known, as it was designed for the MDS 3.0. It uses repetition of 3 items, temporal orientation (day, month, and year), and recall of 3 items, with partial credit given for getting close to the date and for items that are recalled with prompts. It is quick to administer (3.2 minutes in the study) and gives information comparable to other well-known cognition instruments.3 Additionally, administering the BIMS gives the nurse important information that can be used to answer the CAM questions to screen for delirium. The CAM is widely used in hospitals for the detection of delirium. Finally, pain is assessed using 1 of 2 accepted pain scales (numeric or verbal descriptors), and 2 questions explore the effects of pain on sleep and daily activities.

The reliability of the MDS 3.0 data when measured between research nurses and facility staff was generally good. Also, the response rates for cognition, mood, and pain were all more than 85% when residents who are able to make themselves understood at least some of the time were included.4

Conventionally, physicians and medical directors have not had timely or easy access to individual resident assessment data for the purpose of incorporating it into their assessments and management of individual patients. Even with improvements in the quality of MDS 3.0 data, still the timing of MDS data collection and the visits of healthcare providers may not facilitate collaborative planning. This issue was well illustrated by the Delirium Abatement Program for skilled nursing facilities,5 which was a randomized controlled trial that systematically assessed delirium, common reversible causes of delirium, and complications of delirium. In carrying out the trial, substantially more delirium was detected by the nurses trained to implement the CAM; however, they did not communicate this to the physicians or nurse practitioners, and this may have contributed to a lack of improvement in patient outcomes. Clearly, mechanisms should be in place so that clinicians are informed of the results of MDS assessments, especially if they reveal problems that have not already been addressed in the medical record. Attending physicians and medical directors should work with nursing home leaders to develop mechanisms to ensure that they are informed of the results of mood, cognitive, delirium, and pain assessments on their patients.

Although the physician can clearly benefit from the helpful information contained in the MDS 3.0, there are several ways in which the physician (or nurse practitioner, physician assistant, or clinical nurse specialist) must participate to ensure that the MDS is completed comprehensively and accurately. In particular, there are 3 items that must be accurately documented in the physician note: (1) the ‘active’ diagnoses, (2) the prognosis, and (3) prescription of weight loss or weight gain regimens.

The MDS 3.0 contains helpful, quantitative information in the patient’s voice. Making full use of this information should entail enlisting the clinician in the response to cognitive dysfunction, delirium, depression, and pain. Careful review of current medications for adverse effects, assessment/diagnosis of acute illness, medical treatment of pain, and depression must be fully pursued to optimize function and quality of life. Medical directors should help their facility leaders to develop formal protocols for communicating the MDS data to providers. However, this communication should entail more than a score; real communication entails nurses, pharmacists, social workers, therapists, and physicians sharing their interpretation of this data. Truly effective care requires that professionals share their expertise, assess the effectiveness of current interventions, and work together to develop future interventions. As we collect relevant data, interpret that data in the context of the individual patient, share our expertise, and monitor the patient over time, we will gradually improve both quality of care and quality of life in US nursing homes.

References


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Antipsychotic Use in Nursing Homes: Response to the Editorials by Dr. Morley and Dr. Volicer

To the Editor:

I read with interest the editorial debate published by Drs. Morley and Volicer and quite honestly it made me think back to my graduate coursework in pharmacology at University of Pennsylvania. It was there I learned, and repeat frequently to patients and students, “every drug is potentially good and potentially harmful.” Moreover, epidemiologic outcomes do not hold true for every individual. What works for one individual may or may not work or may be harmful to another. The 2 editorials combined suggest that management of behavioral symptoms should be focused on prevention of symptoms to the degree possible, appropriate drug use and elimination or dose reduction of any currently prescribed drug. Both Drs. Morley and Volicer acknowledge that the physiological changes that occur with dementia put individuals at risk for behavioral symptoms and, because of chemical changes that occur as part of the disease process, may be best treated with pharmacologic management.

What Makes Drug Use Appropriate?

In his editorial, Dr. Volicer stressed the importance of recognition and treatment of depression and aggressive behavior in older adults with dementia. He strongly recommended drug treatment with selective serotonin reuptake inhibitors to counteract physiological changes that occur in the brain and ameliorate behavioral symptoms. Dr. Morley suggested a reasonable approach to drug use such that drug use be considered when individuals had psychotic symptoms (described as hallucinations, illusions, delusions, and paranoia) that were bothersome to the individual or when they exhibited symptoms that interfered with care. I would support the recommendations to treat depression when indicated and to use antipsychotics to treat psychotic symptoms that left an individual frightened and unable to engage in daily life. I would not, however, endorse or prescribe the use of antipsychotics for care related resistance. There are often unpleasant things that we each have to endure during daily life and health related care interventions. When you understand the unpleasant situation it is easier to tolerate. Just imagine, however, what it is like when you do not understand. There is no evidence that antipsychotics will decrease resistance to care or make for happy bathing, oral care, or venipuncture.

Appropriate drug use should also focus on dose reductions and attempts to wean individuals off medications, particularly as clinical status changes. This requires rigorous monitoring of behavioral symptoms, as recommended by Dr. Morley, for at least 2 weeks prior to decreasing dosages. A useful tool for monitoring by nursing staff could be completion of the Cohen-Mansfield Agitation Inventory. Working with the nursing staff to understand the importance of this information and addressing practical ways to assure that all shifts complete this tool should likewise be done. Demonstrating an increase in behaviors that are unpleasant for the individual would provide the necessary information to help prescribers and caregivers feel comfortable that reinstating the higher dosage and maintaining drug usage is appropriate in the given situation. At the end of life, or as individuals have a change in clinical status they may no longer need medication management for dementia related symptoms. Decreasing the dosage or discontinuing antipsychotic use in these individuals should certainly be considered.

Preventive Interventions

We know that the incidence of dementia is high among residents in long term care settings, and that they risk experiencing behavioral symptoms at some point in the disease progression. We should, therefore, think about prevention and not wait until symptoms and crises occur before we try and implement behavioral interventions. Table 1 provides a list of the many physical and environmental factors that can cause or contribute to behavioral symptoms. Aggressive management and oversight of these problems may help to decrease incidences of behavioral symptoms by virtue of increasing the personal comfort of the individual who cannot otherwise interpret, understand, or express his or her discomfort, fear, or concerns. This may require changing and monitoring physical environments, routinely and rigorously monitoring bowel patterns, avoiding new situations without having someone or something familiar and calming nearby, and optimal management of clinical problems such as congestive heart failure.

Physically “homelike” environments are not the magic solution to prevention of behavioral symptoms for all residents and all situations. Instilling within these homes a sense of community is possibly more important than the physical appearance of the home. Giving residents a sense of purpose and belonging may help to provide the structure and comfort needed to prevent some of the behavior problems that might otherwise occur. Consider the individual resident and the needs of the community and match the resident at risk for behavioral problems with a real “job”; setting the table for meals, cleaning up the table, helping with laundry, dusting, vacuuming, delivering newspapers or mail, or wiping down counters or sinks are all activities to consider. These “jobs” need significant organizing and oversight of a staff cheerleader to...