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Falling Off a Cliff: Psychiatric Care of Nursing Home Residents

Running head: Psychiatric Care in Nursing Homes

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Currently, nearly 1.1 million Americans are nursing home residents and over 30% have a psychiatric diagnosis such as depression or anxiety.[1] Nursing homes play an important and growing role for patients with psychiatric diagnoses, including those with serious mental illness (i.e., bipolar disorder, schizophrenia, and other psychotic disorders).[2] In fact, the proportion of nursing home residents with serious mental illness is increasing and nearly doubled over a decade to 19% by 2017.[2] The 150,000 individuals with serious mental illness who now reside in nursing homes is a population that equals the entire supply of inpatient psychiatric beds for all conditions and ages across the U.S.[3]

Apart from prisons and jails,[4] nursing homes are the most important setting of institutional care for adults with serious mental illness—though they were not intended to serve in this role. The goal of closing public psychiatric hospital beds (i.e., the deinstitutionalization movement) during the 1950s was that previously hospitalized individuals would be able to live independently in community settings.[5] This initiative was accelerated by the 1954 U.S. Food and Drug Administration approval of the antipsychotic drug chlorpromazine (marketed under the trade name, Thorazine), one of the first blockbuster medications in psychiatry, holding promise to allow patients to receive care in the community rather than institutional settings.[6] Nearly a decade later in 1963, led by President Kennedy, Congress passed the Community Mental Health Act which aimed to decrease the number of institutionalized individuals by shifting care to community mental health care centers.[7] In 1971, the *Wyatt v. Stickney* legislation, sparked by inadequate treatment conditions among state psychiatric hospitals, set forth standards for state mental health codes and regulations including the concept of treatment in the least restrictive setting.[8] However, when deinstitutionalization was not accompanied by adequate funding of community-based services, those with mental illness simply transitioned to alternative institutional settings like nursing homes or jails—a process referred to as *trans*-institutionalization because individuals were never truly deinstitutionalized.[9]

Individuals with serious mental illness are more likely than adults without mental illness to spend time in a nursing facility. For example, among Medicaid beneficiaries, those with schizophrenia are nearly four times more likely than those without to have a nursing home admission.[10] These individuals have complex medical, cognitive, and psychosocial care needs and many long-term care facilities lacking staff trained in mental health to appropriately care for these patients.[11] Indeed, surveys of staff in long-term care facilities suggest respondents feel ill-equipped to meet the needs of this growing population.[11] Unfortunately, in addition to being more likely to spend time in a nursing facility, persons with serious mental illness are also more likely to be admitted to facilities with poorer quality of care indicators, including higher rates of hospitalization, untreated pain, and lower star ratings.[12,13]

Given the disinvestment in other treatment settings for individuals with serious mental illness, policy makers have effectively forced nursing homes to become a critical setting of care for these individuals. Therefore, the findings from Ulyte and colleagues in this issue are particularly concerning. The authors examined patterns of specialty care utilization in a national sample of long-term care residents in the 12 months before and after nursing home entry.[14] Looking across a variety of medical specialties, they found that the proportion of visits to specialty care providers after transition to a nursing home varied widely: Specialty visits to orthopedics and cardiology declined the least (e.g., 14.4% and 27.2%, respectively) following admission, while visits to psychiatrists dropped the most, plummeting 67.9%.[14]

The authors also evaluated care patterns among residents with diagnoses that would benefit from specialty care that would likely continue following nursing home admission, such as serious mental illness, multiple sclerosis, or heart failure. Among residents with such conditions, the group that experienced the largest relative decline in specialty care was those with serious mental illness, which dropped by 67.1% following admission. By comparison, visits by neurologists to those with multiple sclerosis dropped just 0.9%.

As Ulyte et al. highlight,[14] several barriers may exist in nursing home settings that make coordinating and continuing specialty care after admission challenging, including staffing shortages, lack of transportation, or absence of family or other proxy involvement to help coordinate visits. The COVID pandemic has only amplified these barriers, worsening workforce shortages and potentially interfering with family supports given visitation restrictions.[15] But at the same time, unfortunately, the pandemic has contributed to worsening mental health symptoms among residents, which makes the authors' pre-pandemic demonstration of a fall-off in psychiatric care even more concerning in the COVID era.[16]

The authors note that determining the "appropriate" level of visits is challenging with the types of data used in the study. Reductions in specialty care visits following nursing home admission may be concordant with patient and care partner wishes to consolidate care or reduce burdensome visits. Some patients and families may prefer fewer "cooks in the kitchen" and choose to consolidate care with generalist providers within nursing homes. Additionally, residents' need for visits may naturally decrease as their condition improves or stabilizes following admission. However, it is unlikely that new nursing home residents with schizophrenia or bipolar disorder—typically life-long, chronic illnesses—become symptom-free upon admission. In addition, given that nursing home staff report feeling ill-equipped to care for individuals with mental illness,[11] it seems that staff would advocate for active involvement by psychiatrists, were it available.

Supply constraints may also be relevant for these findings, as psychiatrists are the least likely medical specialty to accept Medicare[17]—nursing homes cannot create psychiatrists to see their residents. The relatively small proportion of psychiatrists that see Medicare beneficiaries may simply not have the capacity to care for patients in nursing home settings. Some mental health care delivered to nursing home residents is likely being provided by nurse practitioners. A recent analysis demonstrated that, from 2011 to 2019, the number of psychiatric mental health nurse practitioners treating Medicare patients increased by 160%.[18] As the authors

acknowledge, visits by nurse practitioners were classified in the analysis as generalist visits, which may obscure some portion of mental health care received. But it is unlikely that much of the observed drop in psychiatric care is accounted for by misclassified visits to mental health nurse practitioners.

The authors note that telehealth services could be leveraged to improve access for residents, particularly for a specialty such as psychiatry.[14] Dramatic adoption of tele-mental health has occurred during the pandemic, with many patients and providers finding such services comparable to in-person care.[19] The continued volume and availability of such services will be largely determined by coverage decisions made by the Centers for Medicare and Medicaid Services as the pandemic continues to evolve.[20] Regardless, however, effective use of telehealth, particularly for individuals with cognitive impairment, requires nursing home staff to help set up video visits and ideally also provide collateral information.

This study by Ulyte et al. highlights the enormous mismatch between the specialty care that nursing home residents need and what they may be receiving. Meeting the clinical needs of residents with mental illness is a challenge for nursing homes across the U.S., though this is largely because they have become treatment settings of last resort through a vision of deinstitutionalization enacted decades ago without the corresponding policies and resources to realize it. While nursing facilities should absolutely have the resources to support appropriate staffing, training, and access to specialty mental health care for their residents, there should also be more emphasis on upstream policies and resources to support individuals with mental illness in community settings, should they wish to remain there.

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