Nursing Homes Seeking Psychiatric Consultants

By Doug Brunk
San Diego Bureau

Salt Lake City — Geriatric psychiatrists can relieve some of the burden on nursing homes and help provide optimal care, the medical director of a large system of senior living facilities said.

Geriatric psychiatrists are hard to find, but it’s important to convince administrators that timely psychiatric consultations and appropriate recommendations may reduce litigation risks and help nursing homes with risk management, Dr. Jeffrey B. Burl, medical director of Overlook Masonic Health System in Salt Lake City, said at the American Psychiatric Association's Geriatric Psychiatry Forum.

Today, up to 70% of residents in nursing homes have dementia or a dementia-related diagnosis. “We’re all seeing these types of patients admitted to our facilities [as assisted living programs],” Dr. Burl said. “They nurture these people until it finally reaches the point where the behavior is so untenable that they are admitted to a nursing home.”

“It took a little bit of push from us to convince these nursing homes to pay for the stent, but once they saw the number of antipsychotic medications going down and the number of psychiatric medications going down [after psychiatrists' interventions], that got their attention,” said Dr. Burl, whose system offers a continuum of services that includes independent housing, assisted living, a skilled nursing facility, subacute care, a visiting nurse association, and hospice care.

Other facilities have used the services of specially trained geriatric psychiatrists to provide skills and expertise in geriatric mental health. They usually collaborate with consultant psychiatrists in providing timely care in facilities.

Overlook Masonic Health Care recognized this opportunity during a meeting with the consulting team at San Diego-based Medacare, a company that helps other organizations form joint ventures. The meeting was mediated by Dr. Mason Leavitt, who took the initiative to form a joint-venture agreement with Overlook Masonic Health Care.

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Dr. Burl

nizes six indications for a geriatric psychiatric consultation: recurrent depression or being nonresponsive to medications for depression, suicidal ideation or hopelessness, depression with psychotic features, aggressive behaviors that result in harm to staff or to other residents, refusal to eat or drink despite no obvious medical problems, and displays of acute or chronic psychosis including paranoia, hallucinations, and personality changes.

Outlining expectations for a psychiatric consultant is important, Dr. Burl said. For example, agree whether you’ll notify the consultant by phone, fax, or e-mail. What processes do you have for regularly communicating with the consultant? What’s your expected turnaround time for such communications?

It’s also essential to delineate how recommendations from the consulting psychiatrist will be transmitted to the primary care physician to devolve a procedure for addressing the consultant’s recommendations when the attending isn’t available or refuses the recommendations.

Dr. Burl reminded his audience that as stated in the Centers for Medicare and Medicaid Services’ F-tag 150 language, medical directors are ultimately responsible for coordination of care and implementation of policies and procedures. They might need to intervene to make sure that all consultants to a nursing home are meeting expectations.

After all, he said: “Our cases are getting more complex. This is our challenge.”

Dr. Burl said he had no relevant conflicts to disclose.