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Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Heath Care

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More than 130 mental health and aging experts gathered at a December 1993 invitational conference, exchanged knowledge and opinions of how to facilitate and enhance the mental health of nursing home residents, including the treatment of residents with mental illness, and set the stage for further development of effective strategies for quality improvement. Key mental health issues and points of consensus were identified, research findings shared and public policy and research agendas and recommendations developed. This policy brief describes the consensus reached on principles for achieving good mental health of nursing home residents, the overall conference conclusions and more specific ideas developed by workshops at the conference and supported by conferees when presented at the final plenary sessions. Conference recommendations are organized according to the themes of the conference workshops: financing and reimbursement, treatment and practice, service delivery and quality management. The policy brief also addresses the prevalence of mental health problems (including behavioral symptoms) in the nursing home, treatment rates, and treatment gaps. Also included in this section are descriptions of some model programs, and past federal and state policies relevant to mental health care in the nursing home. These include the Nursing Home Reform Act, pre-admission screening and resident review (PASARR), Institutions for Mental Diseases (IMD) designation, case-mix reimbursement initiatives, and the

increasing emphasis on special care units. Conferees recommended additional funding for research, staff training, and consumer education initiatives to increase access to mental health services to nursing home residents. They also called for improved Medicare and Medicaid reimbursement to pay for mental health liaison services; the unbundling of mental health services from nursing home per diem rates; full implementation of all OBRA '87 and '90 mandates; and increasing Medicare and other federal and private payments for all mental health services to be comparable to payment ratios for other health services. Additional recommendations call for changes in practice and policy that would allow the good results of model programs, such as those described, to be adopted throughout the nation. The brief emphasizes low-cost ways of improving mental health of residents such as tilting facilities' in-service training budget toward topics related to mental health and behavioral symptoms, utilizing mental health specialists in educational and liaison capacities or redesigning jobs. Research is needed to better target effective programs and treatments and delineate costs and benefits.

Congress passed sweeping nursing home reforms in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) in an attempt to ensure quality of care. The law's reform provisions mandated that facilities work to attain the "highest practicable physical, mental and psychosocial well-being of each resident." (Omnibus Budget Reconciliation Act, 1987). It further required a preadmission and resident review process to prevent inappropriate placement of the seriously mentally ill in nursing homes and ordered certified nursing facilities to provide for the mental health needs of every resident.

While OBRA '87 implied a major initiative to address the mental health needs of nursing home residents, there were no commensurate changes in staff education, administrative policies, or reimbursement to realize the Act's intent. However, diagnostic accuracy and care planning appear to be slowly improving according to a major study commissioned by HCFA (Phillips, Hawes, Morris, Mor, & Fries, 1994), and as perceived by some nursing home administrators — apparently as a result of facilities using the Minimum Data Set (MDS) or implementation of preadmission screening and resident review (PASARR), both required by the law (Emerson Lombardo et al., 1992; Emerson Lombardo et al., 1994; Phillips et al., 1994). And, billions of dollars in hospitalizations and acute care costs have reportedly been saved as a result of improved diagnostic accuracy and other improvements in the process of care stimulated by OBRA mandates.

Though comprehensive health care reform is now off the national agenda, reforms of federal programs for the financing and delivery of health care services, especially Medicare and Medicaid, are under active consideration at both the state and national levels. Medicare and Medicaid revisions call attention to the need to address openly and clearly the fundamental question of who should pay for long-term care for persons with a chronic mental illness — including dementia — and/or those with a combination chronic physical and mental illnesses — the federal government, states or private sources including individual, residents' families (Goldman & Frank, 1990; D. Shea, personal communication, April 18, 1995).

With major changes looming for Medicaid and Medicare policies, it is timely to reassess the continuing barriers to optimal mental health care for nursing home residents. The May 1995 White House Conference on Aging (WHCoA) report included a comprehensive resolution on ways to improve mental health of the elderly which highlighted nursing home residents and another resolution to increase funding for Alzheimer's research; both resolutions were initiated by petitioning of delegates and reflect the growing awareness of mental health issues (White House Conference on Aging, 1995). The adopted WHCoA resolution reflected philosophies expressed in a WHCoA Mini-Conference sponsored by the Washington, D.C.-based Coalition on Mental Health and Aging (Coalition on Mental Health and Aging, February, 1995).

TOWARD A NATIONAL CONSENSUS

In December 1993, the Research and Training Institute of the Hebrew Rehabilitation Center for the Aged in Boston, and the Washington, D.C.-based Mental Health Policy Resource Center organized an invitational conference[1] which brought together over 130 mental health and aging experts. Initial organization support and impetus for the conference was given by the Public Policy Institute of the American Association of Retired Persons. This conference facilitated an exchange of knowledge and opinions of how to facilitate and enhance the mental health of nursing home residents, including the treatment of residents with mental illness, and set the stage for further development of effective strategies for quality improvement.

The two-day conference, "Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care for Nursing Home Residents," began with discussions by panels of prominent researchers, health-care and aging professionals, consumers, and federal and state policy makers. Key mental health issues and points of consensus were identified and public policy and research agendas developed. The research findings and policy recommendations are summarized at the conclusion of this article.[2]

This article is organized into several sections. The first describes a consensus reached on principles upon which good mental health of nursing home residents should be based. The second section addresses the prevalence of mental health problems (including behavioral symptoms) in the nursing home, treatment rates, and treatment gaps. Also included in this section are descriptions of some model programs, and past federal and state policies relevant to mental health care in the nursing home. These include the Nursing Home Reform Act, preadmission screening and resident review (PASARR), Institutions for Mental Diseases (IMD) designation, case-mix reimbursement initiatives, and the increasing emphasis on special care units. The third section of this document summarizes overall conference conclusions and more specific ideas developed in workshops at the conference and supported informally by conferees when presented at the final plenary session. Conference recommendations are organized according to the themes of the conference workshops: financing and reimbursement, treatment and practice, service delivery and quality management.

This policy brief will be disseminated to care providers, practitioners, consumers, and policy leaders charged with responsibility for mental health services to nursing

home residents. Care recipients include those individuals with emotional distress but no major mental illness — those with mental and behavioral changes due to systemic illness or medications — and those with major mental disorders due to brain diseases or abnormalities (such as schizophrenia, major depression, bi-polar disorder and most dementias). The issue brief is offered to researchers as a stimulus to future research initiatives on policy-relevant topics.

CONSENSUS REACHED ON SIX PRINCIPLES

The conferees agreed that the needs for improved mental health for residents were great and the issues complex. There was mutual recognition of the urgent need to address the issue comprehensively with a variety of different approaches. Key points of the consensus arrived at by conferees include:

- Mental health services are an essential component of nursing home residents' primary care.
- Mental and physical health are integrally related, particularly for frail elders. Care for physical disorders and disabilities must be integrated with care for mental and behavioral problems.
- Nursing homes must attend to the mental health needs of a variety of special populations, including persons with diagnosed acute depression, chronic schizophrenia, individuals without a psychiatric diagnosis but exhibiting symptoms of depressed or anxious mood, those with behaviors seen as problematic by the nursing home staff, those whose mental problems are caused by physical illness and medications, those with Alzheimer's disease or another dementia, and those with a history of chronic mental illness.
- Each facility staff member should be trained, as appropriate, either to participate in providing mental health care or to help create an environment conducive to residents' mental health.
- Families play an important role in treating residents' mental and behavioral symptoms, and should be invited to participate in care planning.
- The active involvement of mental health specialists in assessment and care planning as well as in direct treatment should be facilitated and encouraged.

BACKGROUND

Prevalence Is High: Treatment Rates Have Not Kept Pace

Regardless of the physical illnesses cited in a resident's medical chart, a contributing factor in most nursing home admissions is a problem with mood, behavior, or cognition that limits self-care or makes home care virtually impossible.

Research indicates that mental health problems are the rule rather than the exception in nursing homes (Shadish & Bootzin, 1981). This should not be surprising, since people entering the nursing home today are older and more severely disabled than in the past. Most of their mental and behavioral problems are related to chronic medical diseases,

or a dementia, both of which are more prevalent at older ages. Studies show that Alzheimer's disease, which is often accompanied by symptoms of depression or psychosis, is more prevalent than previously appreciated (Evans, 1990). In several studies, one third to one half the residents with dementia were found to have other mental morbidities, such as depression or anxiety, that were treatable (Fogel, Gottlieb, & Furino, 1990; Kamholz & Gottlieb, 1990; Lechner, Bertha, & Ott, 1988; Reifler, 1986; Ruben et al., October 1988; Wragge, Jeste, & May, 1989). Unfortunately, once these individuals were labeled demented, little effort was made to identify treatable conditions that the examining psychiatrists believed were related to problematic behaviors and patient suffering (German, Rovner, Burton, Brant, & Clark, 1992; Rovner et al., 1990; Rovner et al., 1991). Demographic trends also indicate that an increasing proportion of elders with dementia and mental illness is from minority groups (Mayeux et al., 1994; Valle, 1989; 1988). Undertreatment may be an even greater problem for minority elders (Baldridge, 1993; 1995).

Many research studies report a high prevalence of mental illness in nursing homes. Up to 88% of all nursing home residents exhibit mental health problems, if dementia is appropriately regarded as a mental health problem (Smyer, Shea, & Streit, 1994). Estimates for admission prevalence rates based on the 1985 Nursing Home Survey were 65% (50% with dementia and 15%, or over quarter of a million, with major disorders such as depression, anxiety and schizophrenia) (Strahan, 1990; Strahan & Burns, 1991). Estimates based on the 1987 National Medical Expenditures Survey (NMES) found 31% of nursing home residents (about 475,000 in 1995) with a primary or secondary diagnosis of mental illness — excluding those with a primary diagnosis of dementia[3] (Shea, 1995). In addition, a large percentage of persons with dementia have comorbid diagnoses or symptoms of depression, anxiety, or other mood or psychotic symptoms and/or behavioral symptoms. Since most of these are largely treatable conditions, they are considered "excess disabilities" to the dementia (Lombardo, 1991). From another perspective, 94% of mentally ill institutionalized elderly reside in nursing homes (Burns & Taube, 1990). Many of these individuals experience delusions, hallucinations, and behavioral problems. Others suffer from mental or behavioral side effects of drugs prescribed for physical illnesses, or emotional reactions to personal losses, including the loss of physical function and the loss of privacy and autonomy associated with nursing home placement. Some suffer from treatable chronic mental illnesses such as schizophrenia and bipolar disorder. Increasing scientific evidence shows that conditions such as schizophrenia, manic-depressive illness and severe depression, have biological determinants such as neurochemical or morphological abnormalities of the brain (Rabins, 1992; B. Rovner, personal communication, 1995). While there is no way to reverse the most common causes of dementia, most of the mood and behavioral problems of nursing home residents can be treated effectively, and at a reasonable cost (Fogel, 1993; Furino & Fogel, 1990; Shea, 1995; Shea & Smyer, 1993).

Estimates of the prevalence of depression among nursing home residents range from about 12% to 22.4% for major depression (meeting all DSM-III-R criteria). An additional 16.5 to 18% or, in one study, over 30% of resident have "minor depression," "subsyndromal depression (defined as one to three DSM-III-R criteria for depression; 5 are required to diagnose major depression [American Psychiatric Association, 1994]) or dysphoria," or "depressive symptoms of insufficient severity to meet these criteria for diagnosis of major depression" (Burrows, Satlin, Salzman, Nobel, & Lipsitz, 1995;

Katz, Parmelee, & Streim, 1995; Parmelee, Katz, & Lawton, 1989, 1992; Rovner et al., 1991). Several studies have indicated that these "minor depressions" should be taken as seriously clinically as major depressions. One study reported that nearly half of minor depressives remained depressed one year later, with 16.2% developing major depression (Parmelee, Katz, & Lawton, 1992). More poignantly, another study, based on 1,113 elderly in nursing homes and congregate housing, found that those with dysphoria/subsyndromal depression were intermediate between those with major depression and no mood problems in measures of disability and pain and equivalent to those with major depression on measures of comorbidity and cognition (Katz, Parmelee, & Streim, 1995). Studies on younger persons report that both major and less-than-major forms of depression are associated with significant morbidity and with decreased physical, social, and role functioning (Wells, Stewart, Hays et al., 1989; Williams, Kerber, Mulrow, Medine, & Aguiler, 1995). Further, these studies report that subsyndromal depression is associated with more disability days and suicide attempts than is major depression (Broadhead, Blazer, George, & Tse, 1990). Regarding anxiety, one study reported prevalence of 3.5% of residents in a 994 bed multilevel long-term-care facility meeting DSM-III-R criteria for the diagnosis of an anxiety disorder (Parmelee, Katz, & Lawton, 1993). Moreover, several studies documented that only one fourth to one half of residents diagnosed as depressed actually received antidepressant therapy and a few also found that physicians were less likely than nursing staff to recognize the depressions diagnosed by psychiatrists for the study. (Rovner et al., 1991; Burrows, Satlin, Salzman, Nobel, & Lipsitz, 1995)

Effectiveness of Treatment Well Established

Research has already shown that depression and anxiety in older persons with chronic diseases, including those with dementia, can be treated successfully with medication and with various forms of psychotherapy and cognitive behavioral therapy (Burns, 1992; Fogel, 1993; Gallagher-Thompson, 1994; Kamholz & Gottlieb, 1990; Katz, Simpson, Jethanandani, Cooper, & Muhli, 1989; 1990; Lewinsohn et al., 1986). Other studies have firmly established the effectiveness of psychotherapy, cognitive behavioral therapy and/or psychoactive medications for persons of various ages with depression or anxiety (Beck, 1976; 1979; Consumer Reports, October, 1995; Ellis, 1984; Georgotas & McCue, 1988).

Behavioral Symptoms Commonly Occur

Studies estimate that more than half of all nursing home residents, including those without dementia, exhibit distressing behavioral symptoms at some point in the course of their illness. For instance, Jackson et al. report a 53.5% prevalence rate of behavioral symptoms in nursing homes. These behaviors include screaming, yelling, getting upset, wandering, physical or sexual aggression, resistance to personal care, and unsafe movement (Aronson, 1994a; Hollman, 1993; Jackson, Spector, & Rabins, 1993; Lair & Lefkowitz, 1990; Spector & Jackson, 1994). One resident's behavioral symptom can be another's environmental or quality of life problem, as when a wandering resident with dementia rummages through the personal belongings of a cognitively intact resident. Assessing and treating these behaviors is a time-consuming task for nursing staff (Aronson, 1994c).

Many nursing home staff attempt to "manage" problem behavior without first carefully assessing, understanding and treating the underlying behavioral symptoms. This often creates additional problems without solving the original dilemma. For instance, facility staff might attempt to quell the continual screaming of a resident with dementia through commonly accepted (but generally counterproductive) control techniques, or they might threaten to discharge the person from the home without performing a physical and psychiatric exam to determine if medical problems are present, such as pneumonia, urinary tract infection, a bruise or other sources of discomfort or pain.

Many conferees believe the environment of the typical nursing home exacerbates problem behaviors. A nonsupportive environment can accentuate whatever frailty residents enter with—physical illness, mental illness, or both. Attempts to "control" residents, and subtle or blatant disrespect for their individuality and personhood can demoralize them and hasten deterioration. In one study, ethnographic interviews of 156 residents in 40 facilities in 10 states found the following quality of life issues most important to those surveyed: dignity; independence and freedom of choice; self-image; and a sense of purpose and privacy. The researchers found residents wanted to participate in meaningful activities not just ones that "occupied their time," and also wanted to be useful or feel needed. In addition, the study found residents wanted nursing homes to facilitate relationships with family, friends and other residents. They wanted nursing staff to treat them as adult human beings and as friends rather than as objects, children, or tasks. Finally, the study showed that residents with dementia had similar quality of life issues as those without dementia (Teitelbaum, 1995), which confirms what leading dementia-care practitioners have reported (Aronson, 1994b). These findings support the ideas underlying "resident's rights" advocacy, and the 1987 Nursing Home Reform Act and supporting amendments and regulations, e.g., language of "highest practicable" level of mental and physical health.

A positive environment can reduce potential problems by supporting residents' strengths (Alzheimer's Association, 1993; Brawley, 1992; Cohen & Day, 1991; 1993; Coons, 1991; Dunkelman & Dressel, 1994; Lombardo, 1991). Some model nursing homes make the needs of residents the focal point of patient care instead of placing a priority on staff convenience. These facilities have become "resident-directed," with even persons with dementia taking part in activities to the extent of their capacities. Nursing assistants are renamed "residents' assistants" as their role is to assist residents achieve the best possible quality of life given their frailties. Research in other contexts has demonstrated the importance of adequate emotional support and of a sense of purpose and meaning in life to good physical and emotional health (Berkman, 1983; Chopra, 1994: Larson, December, 1995; Larson, Greenwold, & Lyons, 1995; Matthews, December, 1995; Matthews & Larson, 1995).

Unfortunately, some nursing homes deal with behavioral problems mainly by using psychotropic medications and physical restraints. While effective for some residents, these methods can cause additional physical and mental health problems. Other nursing homes use a broader range of methods, emphasizing behavioral assessment including careful observation and creative problem solving, behavior management techniques, and changes in the human and physical environments. Making optimal use of both behavioral and pharmacologic treatments requires proper diagnoses of underlying diseases, careful analysis of the behavioral symptoms, adequate staffing, and training in nonpharmacologic treatment of behavior problems (Aronson, 1994c; Berg, 1994).

Although OBRA '87 has already reduced the amount of inappropriate use of chemical and physical restraints, alternative treatments continue to be underutilized.

Today's payment policies discourage the use of behavioral management and psychotherapy. Behavioral management as a treatment modality is not listed as a separate billing code under Medicare and Medicaid. Physician payment policies have lowered Medicare reimbursement for psychotherapy services and complex geriatric medical consultation while raising reimbursement rates for management of psychotropic drugs (Emerson, Lombardo, Goldman, & Weiss, 1994; Fogel, 1990, 1991). Whether the rapidly growing phenomenon of managed care for medicare beneficiaries will alleviate or exacerbate reimbursement problems remains to be seen (Lawlor, 1995; Weiss, 1996). That several of the managed care for seniors programs emerging in 1995 have minimized or eliminated outpatient mental health benefits is a cause for alarm.

Treatment Gaps

Researchers study large national data sets to get an accurate picture about treatment gaps to mental health services. Unfortunately these are gathered only every few years. It can take several more years to analyze and disseminate data. Several studies that analyzed data from large samples collected in 1985 through 1987 found treatment gaps do occur.

Based on extrapolations and analysis of the 1985 Nursing Home Survey, and that survey's criteria for the presence of an active mental disorder (including dementia), Burns and Taube estimated that in 1986, 789,093 could require some kind of mental health service and only 32,113 received mental health services from either mental health specialists or their own physicians (Burns & Taube, 1990; Burns et al., 1993).[4] Burns and Taube concluded that as many as 95.9% of diagnosed residents did not receive any documented mental health services from a licensed mental health specialist or attending physicians over a one-month period of time; however, some of these residents might have received adequate but undocumented care. Only 17% of residents diagnosed with schizophrenia had seen a mental health professional. Burns further reports that the most likely treatment, if any, is psychotropic medication, which is often prescribed inappropriately by general practitioners (Burns & Taube, 1990; Burns et al., 1993).

In 1993, Penn State University researchers in the College of Health and Human Development, looking at similar issues, but for a longer time period, found that 19% of the mentally ill residents received treatment at least once during their total length of stay. The study (Smyer, Shea, & Streit, 1994), using data from the Institutional Population Component of the 1987 National Medical Expenditure Survey, found that rates of treatment were low in all types of nursing homes, although rates in not-for-profit and government facilities were slightly higher than those in for profit facilities.

In an unpublished study (Shea, Clark, & Smyer, 1995), Boston College and Penn State researchers found that five years after the passage of OBRA '87 which required treatment of mental illness, only 29% of the residents with a mental illness were treated by mental health specialists during the year, with the vast majority (27%) being treated by psychiatrists. Despite changes in Medicare payment policies for psychologists, fewer than 5% of residents with mental illness received treatment from psychologists.

In addition, new unpublished data based on analyses and projections to the national nursing home population of MDS data from a sample of residents in 10 states[5], also

TABLE 1. A Variety of Obstacles Impede Mental Health Treatments

While major strides have been made in research on improving diagnostic tools and in medicine and behavioral treatments, there are still numerous obstacles that keep mentally ill nursing facility residents from receiving needed mental health services. These include:

- **Shortage of Mental Health Professionals.** Access to mental health services is limited by a shortage of mental health professionals trained in geriatrics.
- **Lack of knowledge and Training.** Care in nursing homes is provided primarily by nursing assistants or licensed practical nurses. These staff members, along with the director of nursing, often lack sufficient formal or in-service training to identify or care for residents with behavioral and other problems resulting from mental illness.
- **Lack of Adequate Payment to Facilities.** Medicaid and Medicare payments do not reflect the cost of caring for the behavioral and mental health problems that occur in nursing homes. When per-diem Medicaid rates for nursing homes are too low to cover all needed services, mental health services included or bundled into the rates are often never performed because of lack of funds.
- **Difficulty of Getting Services of Psychiatrists.** Medicare and Medicaid policies discourage frequent visits to nursing facility residents by physicians. Therefore, psychiatric diagnoses often are missed, especially if primary physicians and nurses lack the skills and training required to assess cognitive impairment and other mental disorders.

Source: American Association of Retired Persons, Emerson Lombardo et al.: and Emerson Lombardo Barriers to Mental Health Services for Nursing Home Residents, 1994. *Mental Health Services for Nursing Home Residents,* 1992.

suggests a higher prevalence of both need and treatment than previously reported by Burns (J.N. Morris, personal communication, August 15, 1994; Hawes et al., 1995). This MDS analysis defined presence of a mental health problem in residents if they had any one or more of the following problems: symptom(s) of mood distress, problem behavior(s), resistance to care, hallucinations and delusions, or a diagnosis of anxiety, depression, manic depression, and/or an ICD-9-CM psychiatric diagnosis, not including dementia (Commission on Professional Hospital Activities, 1989). This study found that 62% of the 10 state sample had a mental health problem as defined above and projected that 1.1 million of the 1.9 million persons who were in a nursing home sometime during 1990 had a mental disorder as defined here. (Had functional cognitive impairment been included, the prevalence level for mental disorders would have been close to 90%.) Again projecting from the 10-state sample to the nation, of these persons with mental disorders, a little over 400,000 received behavioral management or psychological therapy (for last 7 days) from any source as reported by nursing home staff. This is a much broader definition than the one used in the Nursing Home Survey which included mental health professionals and primary care physicians only and didn't specify behavioral management therapy in the definition of mental health services. In addition, when treatment by one or more of three types of psychoactive medications (during the last 90 days) is added, about 700,000 residents received one of these three classes of mental health treatment. There was no attempt made in this simple analysis of prevalence levels to look at whether the residents with the more serious symptoms of mental health problems received the appropriate intervention.

These three studies suggest that more analyses are needed to clarify the prevalence of mental disorders, need for treatment and delivery of appropriate treatment. Mean-

while, the conferees believe that the wide gap between the needs for mental health care of people living in nursing homes and the care actually available continues to be a *very serious problem.*

Residents with untreated mental problems endure unnecessary suffering, both physical and mental. Anecdotal stories indicate that mental disorders are often misdiagnosed, and disorders that might be readily treatable often are not recognized, let alone treated adequately. In 1982, a Government Accounting Office report stated that, "Left undiagnosed and untreated, mentally ill residents have limited prospects for improvement, and their overall conditions may decline more rapidly and ultimately place greater demands on the health care system." Twelve years later, most of the conference participants believed this statement is still largely true.

Examples of Model Programs

Although there are many reasons for the treatment gap, innovative mental health programs do exist in some nursing homes. These model programs sometimes receive research or demonstration funds from an array of federal and state agencies, and occasionally from private groups like the Robert Wood Johnson Foundation. According to mental health experts, most model programs are supported by the facilities themselves drawing upon endowment, gifts, free service from college students or volunteers, subsidized services from county, state, or federal government or revenue from private pay patients. No model program discovered to date is supported by routine Medicaid revenues alone, although they may exist.

Here are examples of model mental health programs in operation throughout the nation:

Psycho-Geriatric Units, Interdisciplinary Teams and Training Programs (Jarvis, 1993; Kelly, 1993; J. Kelly, personal communication, August 24, 1995). The U.S. Department of Veterans Affairs (DVA) has undertaken a major effort to improve mental health by introducing psychogeriatric units in its 131 DVA nursing homes. Of the 13,500 residents in these facilities in 1990, about 21% had a primary diagnosis of dementia and 72% had a primary or associated diagnosis of a mental illness (including dementia).

In response to care demands of this group, in the early 1990s, the department sponsored a series of national training conferences to teach 70 teams — composed of psychologists, physicians, psychiatrists, nurses, social workers and nursing assistants — strategies for caring for residents with mental illness. The conferences focused on teaching attendees to conduct comprehensive mental health assessments and how to develop a social and physical environment that would be supportive of the mental health needs of DVA residents with mental illness. The DVA plans to sponsor more training conferences in the future when funding becomes available. A manual was produced to document this training effort (Department of Veterans Affairs, St. Louis Continuing Education Center et al., 1992, September).

Of particular note, psychiatrists and psychologists attending these conferences had to commit to continued regular participation in their facility treatment team process. Today, there is an increased involvement of psychiatrists and psychologists in interdisciplinary teams that provide assessments and care planning for residents in DVA facilities.

In addition, significant environmental modifications have been made to DVA facilities to help nursing staff care for residents with more difficult behavioral symptoms. For example, over 40 facilities now have enclosed, secure outdoor and indoor wandering areas and use colors for cueing and orientation.

Finally, 15 special psychogeriatric units are now in operation in DVA nursing homes to care for elderly veterans with mental disorders-associated behavioral symptoms. The environment is tailored to, and facility staff trained to care for, this type of patient.

Mobile Psychogeriatric Team (Fralich, 1993; J. Harmon, personal communication, August 24, 1995). Nursing homes in rural areas are sometimes served through model state-sponsored mental health intervention teams. For instance, in southern Maine, a mobile psychogeriatric team consisting of a psychiatrist, a psychiatric nurse and a clinical social worker provide support upon request to nursing and residential care facilities to treat mentally ill or behaviorally disturbed individuals. In operation for over a year, the team provides assessments, treatment services, medication reviews, and works with staff on the development of care plans and offers training to 23 nursing and 28 residential facilities in the program's catchment area. The program's goal of prevention keeps residents from reaching a psychiatric crisis situation and reduces admissions to the acute hospital setting.

The program works because reimbursement barriers to mental health services are removed since nursing homes are not required to pay directly for the ongoing services. Funding comes from Medicaid and state dollars.

PASARR Screening Agency Works Closely With Health Department (Benson, 1993; W. Mays, personal communications, September 5, 1995). Many states have set up systems to use PASARR Level II screening results to establish treatment plans to improve the mental health care of residents. In Indiana, for example, the PASARR screening agency sends the Indiana Department of Health a list, by nursing facility, of all residents or prospective admissions who receive Level II screening and are judged to be appropriate for facility admission or continued stay and are in need of mental health services.

In this model program, surveyors spot check records of residents to verify that they are receiving the State Mental Health authority's recommended mental health services. If residents don't receive the recommended services, then additional records of PASARR program (Level II) residents in the facilities are reviewed during the survey. Facilities may be cited for deficiencies when they are not providing the appropriate services noted in resident's treatment plans, and they must develop a plan of correction.

Indiana's process links together the mental health system, the public health system and the aging network to effectively implement OBRA and the PASARR program to achieve the optimal results for residents with mental illness. The state's payment system encourages nursing homes to seek mental health services for residents. With a physician's order a facility may obtain mental health services from a qualified Medicaid provider who then bills the Medicaid program directly for reimbursement. This approach removes the financial disincentives for the facility to obtain services.

In a move to reduce health care regulations, the Clinton administration has called for regulatory reforms that would eliminate the annual reassessment of mentally ill or retarded residents. Provider groups and state mental health programs support the President's proposal because resident reassessments (using the MDS) are already required by general nursing facility regulation. But some have expressed concern that

totally repealing the PASARR mandate would be a serious blow for residents who need mental health services. The apparent basis of concern is that without the mandate in PASARR, problems identified by the MDS might not be addressed, and the improvements that have come in identification of mental illness and of service needs during preadmission screening and in provision of community-based services for those not admitted, would be lost.

Facility Creates Mental Health Department (J. Rader, personal communication, September 6, 1995). One of the oldest model mental health programs in a nursing facility was established by the Benedictine Nursing Center in Mt. Angel, Oregon. The facility established a mental health department in 1978, staffed by a psychiatric mental health clinical specialist, and this department is still in operation today. For the past 4 years, the Oregon-based 130-bed nursing facility has been restraint-free.

The part-time director reviews psychotropic medications to ensure appropriateness of drug, dosage and time of administration. During drug review, the director brings her nursing perspective into the problem solving process and develops nursing interventions that can be used in addition to or in place of medications. In addition, she works closely with facility staff to develop alternative interventions and ways of addressing different behavioral symptoms. For instance, staff might provide residents with walkman headphones so they can focus on music they like. Or physical touch can be also used to provide reassurance.

Over the years, the mental health department and facility staff pioneered the development of communication techniques for use with confused residents and for handling wanderers. Currently the department is increasing staff skills in speaking the "language of dementia." For example, persons with dementia may not remember how to sit in a chair. A verbal message combined with a tactile cue such as tapping the back of their knees to show them where to bend can greatly assist them in sitting down.

The Eden Alternative (No author, 1995; Thomas, 1994; Vilbig, 1995). Chase Memorial Nursing Home, an 80-bed skilled nursing facility in upper New York State, has developed one of the newest model programs that some say may revolutionize nursing home care in America. The program was created to reduce loneliness, helplessness and boredom among residents.

The Eden approach emphasizes creating a human habitat that engenders spontaneity and variety to end boredom, provides each resident with companionship of animals or humans to end loneliness and something to care for to end helplessness. Care is redefined as treatment to include "helping the person grow and contribute." The needs of the resident are made first priority and the nursing home is made part of the community to "break down institutional walls and normalize the human habitat."

The original Eden Alternative brings hundreds of birds — plus dogs, cats, rabbits, and even chinchillas—into the facility. Rooms and halls are filled with green hanging plants; residents can plant vegetables and flowers in gardens on the grounds. Children play on-site for several hours most days as part of a day-care program giving residents a chance to mingle with the youngsters. The on-site day-care program allows intergenerational relationships to grow.

Early research findings of the program's effectiveness are promising. Three years after the project began, Eden staff found a 15% drop in its death rate compared to a nearby nursing facility that served as a control. Infections rates have also dropped by about 50%. Most important, staff turnover rates plunged by 26%, saving the facility the

cost of recruitment and training of nursing assistants, about $2,000 per individual. The average number of prescriptions per resident has decreased to 3.01, the national average is 5.6. Medication cost is less than 56% of the U.S. average. Because of these appealing results, at least two states, Missouri and New York, and several individual nursing homes are initiating demonstrations adopting the Eden concept.

Other nursing homes, like the Eden Alternative and the Barkin innovations in California, are establishing programs which emphasize creating meaningful experiences, recognizing the "spirituality" or "spiritual needs" of residents including those with dementia. "Spirituality" relates to meaning, value, and purpose for human beings and is not necessarily related to "religion" (Cohen, 1995; Richards & Seicol, 1991; Seicol, 1995).

Further, several conferees pointed out the importance of family involvement in planning and implementing care to persons with mental disorders including dementia (Gwyther, 1993; Wykle, 1993) echoing many other researchers and practitioners (Gaston, 1994; Lombardo, 1991; Mace, 1990). The Hebrew Rehabilitation Center for Aged in Boston is currently testing a family-staff partnership program with clearly delineated options for constructive family participation in assessment, care planning, activities, assistance with personal care and suggestions for "successful" visiting in special care units in eight nursing homes in New England (Morris et al., 1993).

Other model program elements include working with nursing aides as caregivers with "caring for caregiver" and stress reduction training peer support groups and other methods to improve the mental health of caregivers as necessary to assure the mental health of residents (Wykle, December 1993), conceited efforts to reduce sleep medications (43% reduction in 2 years) and use of exercise, walking and Yoga to reduce behavioral symptoms, improve mood and self-care (Wykle, December 1993), training cultural diversity and on the job clinical supervision and weekly grand rounds to reinforce didactic training.

Various model training programs have been developed which are now available nationally. One leading example is the Geriatric Mental Health Training Series developed with Bureau of Health Professionals funding by Nurses from The University of Iowa and the Abbe Center on Community Mental Health. This series is designed in train the trainer format with all materials included for a nursing home educator to use in training nursing assistants and other staff. The six modules topics are: an overview of mental health and illness in long term care and difficult behaviors; communication with the elderly; control and power issues, dementia, depression and assessing and managing aggression and acting out behaviors (Gaile, 1995; Smith, Buckwalter, & Mitchell, 1990). The group has also written about ways to promote successful training (Mitchell, Smith, & Buckwalter, 1994; Smith, Mitchell, & Buckwalter, 1995).

Nontraditional model mental health programs are increasing across the nation to provide stimulation to residents with mental illness and dementia. Arts, music, culture, and religious programming can be innovative approaches to addressing mental health problems in nursing homes. For example, residents with Alzheimer who learned hymns, prayers and religious rituals in childhood have stored the information in long-term memory even though they forget recent events. These early memories can be very comforting as dementia progresses (L. Gwyther, personal communication, August 14, 1995).

But whatever progress has been made, experts agree that progress is slow and that good mental health care in nursing homes is still the exception rather than the rule.

Systemic Review of Past Policies Needed

Over the years, Congress has passed a variety of legislative initiatives to address the lack of formal services and appropriate nursing care for residents with mental illness. As the following discussion illustrates, laws or administrative actions can have unintended consequences or take years to fully implement or realize intended outcomes. A systematic review of past federal policies affecting mental health of nursing home residents should be undertaken to inform future actions.

OBRA '87, the landmark Nursing Home Reform Law, had multiple provisions which were expected to improve the mental health of residents. The law mandated the use of a standardized Resident Assessment Instrument (RAI), consisting of the MDS and standardized resident assessment protocols (the RAPs), (Morris, Hawes, et al., 1992) as well as PASARR screening of residents with histories of mental illness (with exclusion of those whose primary diagnosis is dementia). The RAI is used by facilities to assess residents upon admission and to develop their plan of care. In addition the RAI is used to assess residents annually after admission and upon any significant change in their health status. Finally, the system includes quarterly assessments used to monitor the effects of the care plan and the need for modifications to the care plan.

According to preliminary findings reported by the researchers contracted by HCFA to evaluate the RAI, significant improvements have been made in the process of care and improved resident outcomes (Phillips, Hawes, Morris, Mor, & Fries, 1994, November). The pre- post-designed evaluation was conducted for 4,000 residents in 269 randomly selected nursing homes in 10 states. Comparisons of process quality and resident outcomes were performed between a pre-OBRA period (1990 and early 1991) and a post-OBRA-RAI implementation period in the spring and fall of 1993. Among the significant and widespread improvements in the process of care were several items relevant to mental health: decreased use of physical restraints; increased participation of families and residents in care plan meetings and decisions; increased use of psychological therapy and antidepressants for residents with depression; increased use of behavior management programs for residents with problematic behavior symptoms (such as wandering). These findings confirm the anecdotal reports of other researchers and practitioners (Berg, 1994; Emerson Lombardo et al., 1994; Cox Post, Krasnausky, Grossman, & Lynch, 1994).

In addition, the study also found that there was a substantial reduction in hospital use (25%), suggesting a potential cost effectiveness of the Resident Assessment Instrument and other parts of OBRA '87 and '90, saving the Medicare program about $2 billion annually. Finally, there was also a significant increase in the accuracy of information available in the medical record and a significant increase in the comprehensiveness of care planning — both of which suggest improved quality of care planning and hopefully of treatment.

Three years later, OBRA '90 (Omnibus Budget Reconciliation Act of 1990) clarified federal nursing home regulations, requiring facilities to meet the mental health care needs of residents, and allowing for the first time the direct reimbursement by Medicare of mental health services to nursing home residents by psychologists and social workers. OBRA '90 also included the Patient Self Determination Act (PSDA). Under this Act , health facilities, including nursing homes, are required to provide residents with information about their rights under state law to accept or refuse medical

treatment. This law has already triggered an increase in formal competency evaluations and guardianships (Emerson Lombardo, November 1994). A recent study conducted for HCFA found an over 50% increase in use of advance directives in nursing homes (Phillips, Hawes, Morris, Mor, & Fries, 1994, November).

While most policy makers applaud the passage of OBRA '87, and its amendments which mandate more attention to mental health needs and the liberalization of Medicare coverage of mental health services, others fear that lowering the barriers to mental health care will lead to overutilization and misuse of scarce federal dollars (Mace & Emerson Lombardo, 1992). And PASARR has its supporters and critics (Mays, September 1994; Munley, 1994).

Another federal policy, the "Institution for Mental Diseases" (IMD) rule, is thought by many to discourage Medicaid-certified facilities from admitting as residents persons with diagnosed mental disorders. A facility is classified as an IMD if more than 50% of its residents are determined to have mental diseases that require 24-hour residential care, or if the facility advertises itself as a provider of mental health services. Although very few administrators understand the IMD rule (Emerson Lombardo et al., 1992; Emerson Lombardo et al., 1994), many of those who do fear losing their Medicaid certification and federal funding if they qualify as an IMD facility (Mace & Emerson Lombardo, 1992; Robinson, Haggard, & Rohrer, 1990; Mental Health Policy Resource Center, 1993).

Nursing home provider groups and some researchers believe that if mental health services mandated under OBRA '87 are to be meaningful, the IMD classification system must be revised to eliminate the "50 percent" rule to protect nursing homes against the loss of Medicaid certification, if they rigorously identify and treat their current residents with mental and behavioral problems (Robinson, Haggard, & Rohrer, 1990; Mental Health Policy Resource Center, 1993).

Some states are moving away from IMD requirements. As part of the state plan to offer capitated managed mental health benefits, Tennessee and Ohio have already gotten HCFA to waive IMD prohibitions (C. Ross, personal communications, March 8, 1995).

Special Care and Case-Mix Reimbursement

An increasing number of nursing homes are now offering special care units (SCUs) to provide specialized care to residents with dementia. It is not yet known whether dementia SCUs (or special care programs in integrated units) improve residents' well-being more than nonspecialized nursing care (Sloan & Matthews, 1991). A collaborative study at 10 research sites funded by the National Institute of Aging (Holmes, Ory, & Teresi, 1994) may answer this question or at least identify which dementia patients benefit from SCUs, or which patient outcomes improve with this type of care. Further investigations of which state and federal policies help or hinder special care will be needed to determine whether special care improves patients' health. Meanwhile, SCUs certainly function as a way to attract private-pay patients and their families, as well as staff with a special interest in dementia care (Alzheimer's Association, 1995). Consumers and providers are also exploring whether "special care" should be confined to SCUs or be available throughout each nursing home (Alzheimer's Association, July 1992). Those favoring "mainstreaming" suggest use of in-house dementia day care, special

staff training for *all* nursing home staff and primary nursing models (Frazier & Sherlock, 1994).

Another key study based on ethnographic interviews with residents in 10 states reported that cognitively intact residents strongly preferred to be housed in close proximity with residents cognitively and physically similar to themselves. For example, mobile residents do not want to live or room with wheelchair-bound or confused residents. Yet, many of the same residents enjoy voluntarily assisting less able residents off their units (Teitelbaum, 1995).

Several states, including New York, Massachusetts, Maryland, Texas, Kansas, Mississippi, South Dakota, Ohio, Minnesota and Maine, have implemented case-mix reimbursement systems which tie payment rates to each resident's estimated cost of care. The more complex the care, the higher the reimbursement. This cost is based on a standardized resident assessment and classification (Allied Technological Group, 1995; Weissert & Musliner, 1992). Ideally, this system, in contrast to a flat rate system, eliminates facilities' incentives to avoid admitting residents who require complex or expensive care. However, the classification of residents by expected care costs is based on models that were selected in the late 1980's, and there is a pervasive concern that the systems selected were deficient in the area of mental health and dementia care, compared to state-of-the-art facilities. One can hope that with the advent of OBRA '87 current best practice patterning would be significantly different from earlier standards. In the best facilities, staff are much more informed and the conferees expressed concern that best practice standards are not reflected in these reimbursement systems.

At the same time, HCFA is currently reevaluating its RUG III model, and the results of this evaluation are eagerly anticipated. The agency is funding demonstration projects in six states, with an adapted version of RUGs III, to study the effect of the case-mix reimbursement system and of quality-of-care indicators (Zimmerman, 1991; Zimmerman, Gustafson, Sainfort, & Konigsveld, 1990). Researchers used MDS data generated from residents in demonstration states to develop outcome and quality measures, some of which are relevant to mental health issues.

Although the case-mix reimbursement policy is becoming popular, many consumers and some researchers and policy makers are concerned that the payment methodology as implemented in several states could or does discourage the admission of persons with dementia by underestimating the cost of quality or even adequate dementia care (Aronson, Cox, Guastadisegni, Frazier, & Sherlock, 1992; Berg, 1994; Frazier & Sherlock, 1994; Mace & Emerson Lombardo, 1992). Certainly many nursing home administrators as well as many consumers believe that to be the case.

Developers of the HCFA Medicare Demonstration and some of the other contemporary care-mix adjustment systems correctly argue that their cost formulas now take dementia diagnoses, cognitive impairment and behavior problems into account. However, critics still argue that the problem is not with the choice of independent (predictor) and dependent (outcome) variables in the model but with the choice of facilities on which the models are based and with flawed measures. Other consumers think the measurements were carefully calculated, and included direct observations as well as staff reports, and at least some supervision time. The researchers state that self-reporting by staff is quite accurate based on studies comparing self-report results with using bar codes and time stamps. Researchers further report that their ability to obtain large samples significantly aided in their ability to detect and report differences in the cost of caring for residents, whatever their characteristics.

Some consumers have said that the time/motion measurements were not properly designed. Others believe that, based on their personal observations in New York State (C. Rudder, personal communication, April 3, 1995), the time measurements were accurate, reflecting the actual time spent caring for the resident, "either in direct, hands-on care, or indirectly by attention to charting, planning of care, monitoring, discussion with other staff or family" as reported in several published studies (B. Fries, personal communication, March 9, 1995). Yet in spite of these attempts to comprehensibly capture the range of direct and indirect activities, some consumers and providers maintain that researchers were not able to pick up the more elusive "keeping track of" or "worry about" residents with dementia. But the researchers note legitimately it is also not clear why a resident with dementia or other mental illness is substantively different in this regard than one with a medical problem at risk of falling or with another condition, illness, risk factor, temperament, that would require more staff time for monitoring, supervising, or worrying (B. Fries, personal communication, March 9, 1995). Consumer critics of the federal case-mix reimbursement demonstration also suggest that the nursing homes surveyed were not providing the appropriate care to persons with dementia, thus, skewing the measurements. If supervision, monitoring, cueing and other harder to measure aspects of dementia care were properly taken into account, and the sample drawn from facilities with optimal dementia care, the estimated costs might have been different, the critics concluded. The same or similar problems may exist with case-mix reimbursement for other types of mental disorders, such as depression, but no advocacy group as yet has seized upon this issue.

One possible reason for developers and consumers being at odds with each other about the accuracy of the case mix system in capturing time spent and expenses related to caring of persons with dementia is that of perception. Nursing staff perceive care for these individuals to be more time consuming than it actually is, because that time spent is emotionally draining and difficult. Careful studies must be initiated to study differences in supervising, monitoring and caring for persons with and without dementia — this alone will answer the question.

The developers of RUGs III believe that any argument about needs for a differential for persons with dementia should be realistically limited only to those persons who have no Activity of Daily Living (ADL) deficits since the vast majority of those persons with dementia have other comorbidities, including ADL deficits, which receive some weighting—fair weighting they believe—under the case mix system. Research findings show that cognitively impaired residents do, as expected, take more care time than other residents, but that most of the difference can be explained by differences in functional level (Phillips, July 1991). Thus, ADLs can help to explain the differences in cost, regardless of the cause for these ADL deficits (Fries, Mehr, Schneider, Foley, & Burke, 1993). Others, however, argue that one could also ask whether there still should be some premium attached to the dementia itself, even in the cases of comorbidities. Providers argue, for example, that the level of effort required to manage ADLs for a person with dementia exceeds that which is necessary for those who are more cognitively intact (Aronson, Cox, Guastadisegni, Frazier, & Sherlock, 1992; Frazier & Sherlock, 1994).

HCFA adopted the developers' recommendation that a new case-mix group be added for high-functioning cognitively impaired and those with behavioral problems, and added a bonus weighting. Additional subgroups were also added for depression, again after recommendations by Fries and Mehr and others. Even so, consumer groups argued this amount of extra weighting was much too small to represent reality as they and

providers see it, and agreed with the scientists that any extra incentives needed to be earned by proof that providers used the extra funds to improve staff training, and services and programs for the targeted residents (C. Rudder, personal communication, April 3, 1995; Alzheimer's Association, personal communication 1995, Rudder, 1991). Consumers and providers in Pennsylvania have been in an ongoing battle with their state which is attempting to adopt a case-mix system, also based on RUGs III but with lower overall rates than the current federal model (Kaplan & Comstock, 1995; H.A. Comstock, letters to Pennsylvania officials, 1995). A New York State consumer group further suggests that even if all the measures were accurate — if administrators perceive their payment is not commensurate with the time/effort which people with dementia take to care for, then payments should be increased; otherwise persons with dementia will have poor access.

Some have suggested having a panel of clinicians, administrators and consumers reviewing the numbers arrived at by the scientists, and if the general consensus is the numbers don't reflect reality as perceived by a consensus panel, they should be changed. In addition, they argue, access and encouraging good care for a very vulnerable population of impaired elderly should be adopted as goals of the case-mix systems (Rudder, 1991; C. Rudder, personal communication, April 3, 1995). This view is echoed by some researchers (Phillips, July 1991). Over the long run, they suggest, not only does good care provide better quality of life for residents, but it is more cost-effective care, resulting in fewer expensive hospitalizations and acute care professional services.

The developers and researchers of RUGs III and their government sponsors aimed to develop a case-mix reimbursement system that would be budget neutral and that would not specifically concern itself with care quality. In contrast, consumers hoped that the new reimbursement scheme would create incentives for better quality care. The developers measured care inputs based on "acceptable" or "average" practice, without a lot of deficiencies, and not on ideal care. Consumers argue the metric should be based on the highest quality care to create proper incentives. They further argue that the method chosen to be "budget neutral" will actually discourage good care, since the state-of-the-art in general nursing home care has been advancing so rapidly, the RUGs procedure results in freezing into place the past average standards of care or slowing down advancements, even with recalibrations (C. Rudder, personal communication, April 3, 1995).

As experience to date of controversy at both the state and national level demonstrates, any case-mix reimbursement system that does not give significant weight to active mental illness or to the multiple or complex needs of residents with dementia (whether or not behaviorally complicated) is likely to be challenged. The challengers will have to be persuasive about the overall benefits of readjusting things in the direction they desired, since augmenting payments for one segment of the nursing home population automatically withdraws resources for the care of all residents without this condition, including, for example, those in nursing homes with very serious medical conditions, severe functional disabilities, and so forth (B. Fries, personal communication, March 9, 1995). If Medicaid is replaced by block grants as proposed by Congress, nursing home reimbursement will be even more of a zero sum game than it is now.

An evaluation of the HCFA case-mix demonstration has been awarded to Abt Associates, Inc., and its completion should help inform this debate. Ultimately, there

are significant gaps in the research and program literature on model programs in nursing homes, and with the advent of standardized MDS information, considerable progress can be expected on this topic in the years to come.

Unexpected Policy Outcomes Occur

Although many federal legislative initiatives have been developed with good intentions, their outcomes may contradict one another. Recent changes in how Medicare reimburses physicians, for example, effectively lowered Medicare reimbursement for psychotherapy services and for complex geriatric medical consultation (Fogel, 1992). These incentives favor pharmacologic over nonpharmacologic treatment for behavior disorders. At the same time, OBRA '87 discourages inappropriate psychotropic drug use and mandates efforts to maximize psychosocial well-being through thorough assessment, individualized care planning and implementation.

Nonpharmacologic, nonrestrictive behavior management techniques continue to be underutilized by many facilities. Psychologists and psychiatrists in many areas are discouraged from using behavioral management as a treatment because it is not listed as a separate billing code under Medicare or Medicaid (Omnibus Budget Reconciliation Act of 1987; Emerson Lombardo et al., 1992; Goldman, Cohen, & Davis, 1995; Sharfstein & Goldman, 1989; Emerson Lombardo, Goldman, & Weiss, 1994). Other reasons include inadequate staff training and lack of direct reimbursement of mental health specialists for liaison work, i.e., training nursing home staff in how to implement behavioral treatments.

An example from an early attempt at case-mix reimbursement highlights why reimbursement policies particularly need to be scrutinized to avoid creation of incentives adverse to good care or access to services by deserving clients. Pre-OBRA, the state of Maryland's case-mix nursing home reimbursement system was looking for an objective tag for heavy-care patients and chose the use of physical restraints. Because nursing homes received higher reimbursement rates for patients in restraints, the use of restraints in that state went from about 25% to 70% in the first few years of the new system (Lombardo, 1991).

PASARR. While many effects of most major policies are still largely unknown, researchers are beginning their attempts to study the systemic effects of mental health policies (Robinson, 1990). For example, when the federal government mandated that PASARR assessments be performed in nursing homes, groups opposing the screening requirement expressed concern that the policy would force the inappropriate removal of residents with dementia from nursing homes. As a result, they lobbied for and secured the passage of an amendment to exempt these individuals from the screening process (Mace & Emerson Lombardo, 1992). Thus incentives were created for emphasizing diagnoses of dementia and underdiagnosing primary mental illness. Yet most dementia patients suffer from mood problems and/or psychotic symptoms, and people with primary mental illness such as schizophrenia or depression are at least as vulnerable to developing Alzheimer's disease or another dementia as anyone else.

Notwithstanding, a 1992 nationally representative survey of nursing home operators showed that many believe that PASARR has increased the accuracy of diagnosing individuals with mental illness, as well as those with dementia (Emerson Lombardo et al., 1992; Emerson Lombardo et al., 1994; Emerson Lombardo, 1993). In these administrators' view the PASARR process had not had a deleterious effect on dementia

admissions nor has it resulted in more discharge of mentally ill residents. A survey of geriatric psychiatrists revealed mixed opinions (Emerson Lombardo, December 1993). However, many suggestions have been made about improving the PASARR process to make it more cost effective and reduce unnecessary effort (Munley, 1994). At a minimum, conferees proposed that potential benefits from PASARR could be greatly expanded if states were required to pass on individual's screening results to the nursing homes admitting them.

How Do Some Homes Provide Adequate Mental Health Care?

Despite a lack of financial incentives for mental health services in nursing homes, some facilities succeed in providing adequate or even excellent mental health care. While the determinants of mental health care quality in the long-term-care setting have not been adequately studied, and there may be legitimate disagreement on how to rank different facets of quality in order of importance, there is still informal consensus on some factors common to homes providing good quality care. This consensus was elicited at the December 1993 national conference. The elements, not all of which are necessary in every case, include:

1) Funding beyond Medicaid only—with some funds specifically devoted to mental health services and training;
2) a fixed liaison with one or more mental health specialists who monitor and guide the staff, who are consulted and heeded by attending physicians, who are involved in training staff, and/or who actively help staff develop individual plans of care;
3) a senior nurse with knowledge, skill and interest in mental and behavioral areas who serves as a role model and opinion leader on issues related to mental health;
4) some formal training in mental and behavioral issues for nursing assistants and their supervisors, and if possible all facility staff;
5) specific attention to mental and behavioral issues in formal assessment, care planning and supervision of staff;
6) training nurse supervisors in management and supervisory skills;
7) proper job design, specifically permanent assignment of residents to nursing assistants; and
8) systematic monitoring of results of behavioral and psychopharmacologic interventions, including a periodic review, multidisciplinary if possible, of medication lists with consideration of mental, behavioral, and functional effects of prescription drugs of all kinds.

Mental Health Services May Be Cost-Effective

Policy makers involved in health care reform have raised concerns about the feasibility of fully covering mental health services in a national health care plan. Undoubtedly, broader coverage of mental health services will increase total care costs in the short run. However, in the longer run, timely treatment of mental health problems may avert other costly medical treatments. The "cost offset effect" may be greatest in the frail elderly, who have a high burden of chronic disease that can be aggravated by concurrent mental

illness and/or behavioral symptoms (Lave, 1990). A Penn State University study (Shea & Smyer, 1993) estimated that the annual costs are somewhere between $480 million and $1.34 billion to provide monthly psychotherapy and pharmacological management to the mentally ill in nursing homes—with the costs varying according to the estimated size of the target population and the low- vs. high-cost estimates for each type of service.

Another recent study found that total care for persons with a primary diagnosis of mental illness residing in nursing homes, excluding those with Alzheimer's disease and other dementias, cost more than $12 billion[6]. From 1977 to 1987, the number of persons with a mental illness in state and county facilities fell by 38% while the number in nursing homes rose by 108%. As a result, the private share of payments for long-term care of persons with a mental disorder went from 20 percent to 34 percent, as the percent from public sources went from 80% to 66% (Shea, 1995).

During the 1994 congressional debates on how to best overhaul the nation's health care system, the Congressional Budget Office (CBO) was not confident that it could develop good cost estimates for proposed mental health services for all frail elders from available data. Consensus and anecdotal evidence scattered throughout the research journals are not enough to satisfy CBO's high standards. The federal agency can only develop realistic cost estimates if its staff are provided with data including length and scope of treatment, costs of treatment, utilization rates, and the size of the eligible population.

During the health care reform debates, as for any legislation, proposals with uncertain costs are automatically designated by CBO to have high costs. As a result, such proposals are especially vulnerable to deletion from any consensus legislative package, especially if they include mental health services. Health care reform as framed by most major proposals in 1994 omitted coverage of nursing home care. The community-based long-term-care provisions, which appeared in only some bills, were also somewhat vulnerable but did show surprisingly good staying power until the reform effort stalled altogether in the fall of 1994.

During the recent federal budget debates in fall of 1995, many consumers were not aware of how the proposed deep Medicaid cuts and the block granting of the program could jeopardize the continued Medicaid funding of the care of hundreds of thousands of nursing home residents, most of whom have either dementia or another mental illness or both. Many providers and consumers were unaware that House and Senate proposals to reduce and block grant Medicaid rescinded OBRA '87 and that law's later amendments. With Medicaid and other third-party payors, coverage of mental health treatment virtually always has a lower priority than traditional medical treatments of physical illness. Any cutbacks in Medicare and Medicaid would be expected to have a disproportionately larger impact on funding of mental health treatments.

Some proponents of the block granting of Medicaid call for managed care and capitated rates for mental health clients, using rates based on case load, severity of illness and inflation combined with a state plan which waives "arbitrary" federal coverage rules. Some propose "carving out" mental health benefits with separate capitations. Others call for mental health care for nursing home residents to be "carved in" or integrated with physical health care. However, at this time many mental health experts conclude that there are too few data to determine what would be best for residents needing mental health treatments (Coalition on Mental Health and Aging, 1995; Eisdorfer, 1995; Wetle & Mark, 1990). In either case, many health maintenance

organizations limit coverage of treatment for mental illness in even more dramatic ways than earlier fee-for-service insurance arrangements. Although there is a growing number of robust scientific findings about the importance of treating mental/emotional illness as a necessary concomitant of treating physical illness, reimbursement of mental health treatments is increasingly jeopardized by trends in both private and public payment systems.

Congress and the president are currently in conflict over whether Medicaid should remain an entitlement program, and more generally over the appropriate role of the federal government in financing health care. However, even the most minimal conception of the federal role is compatible with government efforts to identify and disseminate best practice and to fund geriatric mental health and health service research — both basic and applied (Benson, March 1995). In addition, Medicare and state Medicaid reimbursement rules could be changed along the lines recommended in this policy brief.

CONFERENCE CONCLUSIONS

The conference consisted of 11 panel discussions, 5 workshops, and a final plenary meeting. Panel presenters and attendees, representing a wide range of professional backgrounds, political views and philosophies of treatment, showed a remarkable consensus in defining the nature and scope of the obstacles facing mentally ill or behaviorally disturbed nursing home residents. The disciplinary conflicts and philosophic differences expected from such a diverse group surprisingly did not result in disagreement on either the scope or seriousness of the problem or on the first steps needed to address it specifically; for example, no one gave a high priority to increased specialist services to serve individual residents. The conferees acknowledged that mental health and well-being are *primary* concerns for most nursing home residents, and that their formal caregivers, whatever their discipline or specialty, must understand mental health problems and their treatments.

The conference in plenary session accepted the recommendations of each of the five workshops listed at the end of this policy brief as well as the following conclusions which integrate the major thrusts of the more specific, operational and unprioritized recommendations listed by workshop topic areas: financing, reimbursement, treatment and practice, service delivery and quality management.

Mental Health Is Primary Care for Many Nursing Home Residents. For many residents, mental and behavioral symptoms are the primary cause of disability, so their identification, assessment and treatment is an essential part of residents' primary care. Therefore, mental health professionals must become more actively involved in a regular and routine way in both care planning and staff training in facilities. At present, most nursing home residents are viewed as being in the facility on account of a physical disability, even though a majority have a combination of physical and mental impairments, and some suffer only cognitive losses. While residents with disruptive behaviors get some kind of attention, those with quiet distress or excess disability may go unrecognized and unserved. For example, a survey of geriatric psychiatrists by HRCA, revealed that while they *were* consulted regarding disruptive behavior and suicidal depression, they *wanted* to be consulted more for such issues as failure to thrive, withdrawal, delirium, suspected toxicity of prescription drugs, and well as having the

opportunity to detect one of the most challenging conditions in psychogeriatrics, i.e., unrecognized or subtle, but functionally significant, depression (Emerson Lombardo et al., 1994; Emerson Lombardo, Sherwood, & Fogel, 1991). There is a 50% increase of one-year risk of mortality for those with depression (Cohen, 1995).

Increased Funding Is Essential. Medicare and Medicaid payment policies must be amended to provide adequate funding to support regular, ongoing visits of mental health professionals to nursing homes. For years, payments for mental health services under these programs have taken a low priority as compared with funding for general medical services. For example, Medicare typically reimburses 50% of approved rates for ambulatory mental health services compared to 80-to-100% for other medical services. Medicaid in most states also reimburses at relatively low rates for mental health services, and some states do not reimburse at all for some mental health services or for the services of mental health providers other than psychiatrists. The program's payments do not reflect the cost of caring for behavioral and mental health problems that occur in nursing homes. When per-diem Medicaid rates for nursing homes are too low to cover all needed services, mental health services included or bundled into global rates are often never performed because of the lack of funds. Medicaid rates must no longer be set so low that it is difficult for staff to individualize care. Looking to the future, managed care plans should also properly reimburse and facilitate mental health treatments (Eisdorfer, 1995; Emerson Lombardo et al., 1994; Emerson Lombardo et al., 1992; Emerson Lombardo, Goldman, & Weiss, 1994; Weiss, 1996; Wetle & Mark, 1990).

Staff Training and Education Is Crucial. There was also strong agreement that an important nonfiscal barrier to treating mental problems is insufficient education and training of nursing home staff and primary care physicians on how to recognize, understand and respond to mental and behavioral challenges good training programs are available and can be cost-effective (Brannon & Smyer, 1994; Frazier & Sherlock, 1994; Gaile, 1995; Mitchell, Smith, & Buckwalter, 1994; Smith, Mitchell, & Buckwalter, 1995; Smith et al., 1994).

Job Design and Supervision Is Also Crucial. Although the training of direct care staff is critical to achieve quality of care, their supervisors must be trained to understand mental health issues and to better deploy, supervise and support staff. Training the supervisors (LPNs and RNs) in supervisory skills is important and can reinforce the effects of in-service training on mental health topics. A strong and skilled supervisor (well trained in mental health issues) may be at least as effective as a formal training program for dealing with many behavioral issues. In addition, "primary nursing," or permanent assignment of residents to nursing assistants, rather than rotating assignments, is key to facilitating consistency of behavioral and other mental health interventions (Frazier & Sherlock, 1994; Streit & Brannon, 1994).

OBRA Should Be Fully Implemented. Nursing homes have demonstrated a responsiveness to OBRA mandates that require reduction in restraints and inappropriate use of antipsychotics and benzodiazepines—both of which are under their control. Antidepressant prescription drug use has increased since OBRA was implemented in part because less toxic antidepressants have become widely available. However, behavioral regimens that require coordination of staff actions, or an approach to avoiding inappropriate polypharmacy that involves multidisciplinary dialogue that includes the attending physician, have been much less widely adopted though model programs do exist

(Cohen, Smyer, & Horgas, 1994). Moreover, while federal law requires the use of the MDS or RAPs which help staff identify treatment needs, neither law nor regulations meaningfully compel treatment of mental disorders even when the efficacy of treatment is well established. Some nursing home staff do not properly use the MDS and RAPs for either assessment or care planning. On the other hand, progress has been reported by some states as they implement state plans to provide active treatment to residents who pass Level II PASARR screens and are thus determined to need both nursing home placement and active mental health treatment.

Studies of the original MDS suggested that nursing home staff had much greater difficulty in accurately recognizing depression or delirium than any other common resident problem. The second version of the MDS, recently adopted by HCFA, appears to do a better job of operationalizing the definition of delirium and depression and may improve accuracy of staff assessments.

The new MDS 2.0 version is designed to be responsive to user needs. The tool does not presume staff can recognize depression or delirium but instead asks them to state the frequency of occurrence of several specific observable symptoms and creates an algorithm for provisional diagnosis in the problem identification section of the MDS system (the Resident Assessment Protocols or RAPs) (Morris et al., 1995).

Federal and State Surveys Should Give More Weight to Mental and Behavioral Health Care. Over the years, it has been possible for nursing homes to pass the federally-mandated survey and certification process without having to make serious efforts to identify, assess and treat residents' mental and behavioral problems. Regulators should no longer give passing grades to facilities that do not actively promote their residents' mental and behavioral symptoms. HCFA is encouraged to complete and implement its plans to have quality of care/life indicators using MDS data available to federal and state surveyors.

Enhancing Mental Wellness Is Key to Quality Care. Quality of care is achieved only when residents are helped to function at the highest physical and cognitive level, given the constraints of their physical and mental illnesses, individual values, and cultural identity. Nursing homes should address not only diagnosed mental disorders and emotional problems, but also their residents' realistic, practical concerns about their living environment and how they are being treated by staff. Care plans, and the actions of all staff, should encourage residents to use positive coping mechanisms and to participate actively in their health care and in other purposeful activity. HCFA's plan for adding more quality of life measures to survey protocols should be encouraged.

More Research Is Needed to Identify Effective Treatments and Target Them More Precisely. Various studies have shown the effectiveness of a variety of treatments for depression and other mental illnesses. Many persons with dementia and agitation can be helped without drugs, while others have markedly positive responses to some drugs but not to others. The choice of treatments for individuals even when described in the scientific literature, involves trial and error, and some problems remain difficult to understand and treat. Much more research is needed now to increase effective assessments and to evaluate effectiveness of therapies for various types of people (including differential effects for various age, gender, racial, and ethnic groups) and to match residents and therapies. Research is also needed to evaluate the effectiveness of "traditional," "alternative or complementary modalities for treatment of mental and behavioral symptoms (Coalition on Mental Health and Aging, February, 1995). In

addition, research is needed to investigate issues of disease course and outcomes, impact of heterogeneity and comorbidity, and methods to optimize functioning and prevent excess disability. Furthermore, mental health measures and mental health services utilization and cost measures should be incorporated in all studies of long-term-care systems for the elderly. Special attention should be given to such studies in managed care models with the aim of determining any cost-offset effects and for identifying opportunities for prevention of excess disability due to neuropsychiatric and other mental health issues (Robinson, 1990; Wetle & Mark, 1990). Further managed care highlights the urgency of the need to develop clear protocols for treatment which do not ignore heterogeneity and comorbidities as well as reliable outcome measures and cost-monitoring programs which capture cost effects. Studies of integrated physical and mental health treatment modalities vis à vis separated modalities are also needed. In addition, research is needed to determine the types of service delivery and financing systems that provide best quality outcomes at a reasonable cost.

Other Important Considerations. The cultural, ethnic, and racial diversity of residents and caregivers must be respected. Access to service and funding for the mainstream culture is unsatisfactory, but access for minorities, especially for Native Americans, is even more abysmal. For example, there are only 16 tribally operated nursing homes with 600 beds for 170,000 elderly Indians from 500 Indian tribes (Baldridge, March 1995). It is very important for nonIndian-managed facilities to allow traditional healers to visit their Indian residents and to facilitate connection with nature, which is central to Indians' physical, mental and spiritual well-being. Other ethnic minorities in the U.S. have similar needs to allow traditional and modern Western medical therapies to complement rather than exclude each other.

Finally, nursing assistants and other direct care staff also must be full and active participants in assessing mental health problems, and in the planning and implementation of mental health interventions. They need not only training, but also ongoing supervision that takes residents' mental health and well-being seriously and reinforces concepts learned in training. In-service education and supervision on mental and behavioral issues is also likely to reduce staff turnover and staff injuries, and to prevent abuse and neglect of residents.

OBRA '87 and subsequent amendments set worthy goals for federal health policy makers to reach. If this legislation is to be fully implemented, financing, regulation, research and education must finish what federal legislation has begun.

RECOMMENDATIONS

After two days of panels, workshops in each of five areas — financing, reimbursement, treatment and practice, service delivery and quality management — and informal discussions, the conferees developed a set of recommendations for improving the treatment of mental health of nursing home residents. Although not all conferees agreed on every point, a broad consensus developed on many issues and these recommendations were read and accepted informally at a concluding plenary session. Further, the recommendations and earlier drafts of this policy brief were reviewed for accuracy and completeness by nearly half of the participants. Listed below are recommendations the conferees asked policy makers to consider. They are not prioritized and some duplication exists. We combined reporting of the financing and reimbursement workshops

since they were two aspects of the same issue area. Potential cost implications have to be considered, although conferees felt that cost reductions in acute and chronic medical and long term care would be greater than the total cost of the recommended actions.

Financing and Reimbursement

Benefit Design and Scope of Services

- Eliminate exclusionary and discriminatory elements in long-term-care insurance and Medicare reimbursement relating to cognitive and mental impairment.
- Cover Medicare beneficiaries for mental health services with the same copayments as apply to other health services.
- Correct the imbalance of Medicare benefits for mental health care. The program still favors inpatient psychiatric care over community-based outpatient and nursing home-based services that are often less costly and equally effective.
- Determine if expanding the scope of publicly funded mental health services to nursing home residents would be cost-effective through demonstration projects with evaluation that fully accounts for cost-offset effects (i.e., determining whether decreases in nonmental health service costs outweigh any increases in mental health service costs, for example, whether a decrease in hospital use offsets higher costs for mental health care in the nursing home).
- Any improvements in mental health benefits, including those that may be incorporated into any health care reform package signed into law, should also be made accessible to minorities and incorporated into the Indian Health Service.
- Authorize and directly fund the Indian Health Care Delivery System (IHS) to deliver an expanded scope of mental health and long-term-care services to older Native Americans living on reservations.

Funding and Payment for Services

- Parity: Lower Medicare copayments for all mental health services to be the same proportionate share as those for medical management of psychotropic drugs and medical and other services to treat physical illnesses. (Parity in reimbursement for services would mean an 80% reimbursement level for all approved mental health service billings instead of the current 50% level for most types of mental health services delivered to nursing home residents.)
- Improve Medicaid and Medicare reimbursement to nursing homes for mental health liaison services.
- Reimburse with separate billing codes for behavioral management services.
- Unbundle mental health services provided by facilities from nursing home per-diem reimbursement. The services either could be reimbursed separately or could be specified in separate budgets.
- Increase reimbursement levels to cover the costs of providing holistic care of individuals with Alzheimer's disease and other dementias. It is recommended

that HCFA fund demonstration projects to determine the cost effectiveness of special care units or programs and to modify reimbursement formulas if results so indicate.

- Refine case-mix reimbursement adjustments to take better account of staff time devoted to supervising, monitoring and cuing residents with cognitive impairment, behavioral or other mental health problems (e.g., comforting residents with anxiety or pain, and encouraging residents with depression or apathy), both as measured by researchers and as perceived by providers. Develop reimbursement formulas by studying facilities that follow best practice rather than provide usual care.
- Assure that all states are adequately funded for the implementation of the nursing home reform provisions in OBRA '87 and OBRA '90.
- Provide additional funding for education and training of surveyors about the needs of residents with mental illness or mental disease, basic principles of mental health care, and how to measure mental health status and mental and behavioral care.

Treatment and Practice

- Educate and train all nursing home staff as well as family and the residents themselves in mental health care and mental self-care (e.g., self-awareness, stress management, relaxation, communication skills) and reinforce learning by using peer support groups and other strategies. All nursing home staff are de facto mental health staff who can contribute to or undermine residents' mental health, and who are more likely to help residents' mental health if they are in good mental health themselves. Training programs should be implemented on a facility-wide basis rather than directed at a limited number of designated staff members or "specialists."
- Amend OBRA '87 to require increased staff training on mental and behavioral issues.
- Encourage physician involvement in nursing homes by including service in nursing homes as a payback for publicly funded clinical training.
- Retain a mental health coordinator for every nursing home to provide staff training on care of individuals with mental illness. This professional would develop prevention programs to foster a culture of mental wellness in the facility. The coordinator would also support a resident-oriented rather than task-oriented approach to care of older residents.
- Use a comprehensive approach to treating residents with mental and behavioral challenges that makes use of activities, nursing interventions and family involvement as well as medication when needed.
- Encourage attending physicians to obtain consultation from mental health specialists when planning the medical care of mentally ill residents or when responding to problems with impairment of mood, behavior, motivation or cognition.

- Promote the use of plans for the prevention or treatment of mental health problems which recognize residents at high risk for mental health problems, or those with past history of mental illness or those with cognitive impairment as well as those with possible early symptoms of major mental illness. Encourage all care plans to address possible mental health aspects of residents' well-being.
- Increase family involvement in the care of all residents, including those with mental illness.
- Use reimbursement incentives to implement practice recommendations. Explore assigning various behavior intervention procedure codes to effectuate reimbursement.
- Use the Minimum Data Set to monitor prescription drug use and record any change in physical or mental status, along with positive and negative effects on function, cognition, behavior and mood. Consider repeating the MDS prior to beginning a new behavioral or environmental treatment or a new trial of medication, as well as after a reasonable trial period to assess its effect.
- Assess efficacy of various treatment interventions by means of demonstration projects and controlled trials. Fund research to evaluate the effectiveness of an expanded range of therapies for various types of people (including differential effects for various age, gender, racial, and ethnic groups) and to match residents and therapies. Fund research to investigate issues of disease course and outcomes, impact of heterogeneity and comorbidity, and methods to optimize functioning and prevent excess disability.
- Disseminate best practice models to nursing home administrators, nursing directors, program staff, medical directors, attending physicians and others. Support rigorous evaluation of alternative practice models, including demonstrations as needed.

Service Delivery

- Remove funding and financing barriers to appropriate care by bundling resources and integrating financing of long-term care, subacute care and acute care, especially for people with chronic illness.
- All states should provide the data and recommendations from preadmission screenings, including PASARR Level II, to the nursing homes that admit or provide care for the screened patients.
- Collect information to determine whether residents with mental illnesses are receiving the services they need: Federally mandated resident status data should be computerized. Patient advocates, families and clinicians should work together to develop preselected outcomes that can be measured over time in order to answer questions about efficacy in quality of care and quality of life.
- Assess the role that managed care plays in influencing the access of elderly patients to mental health specialists.
- HCFA should require the collection of standardized data on health services received and outcomes of patients who receive PASARR assessments to

determine the effectiveness of the policy. While some states compile data on residents they screen, along with the results of the PASARR assessment, there is no comprehensive follow-up database on whether the PASARR recommendations were implemented and what the outcomes were. In addition, all states should follow the lead of those states which make the preadmission mental health assessments and recommendations developed under PASARR available to the nursing homes where screened individuals are admitted.

- Collect data on mental health service needs and services received by nursing home residents who are under age 65. Future federally sponsored surveys, such as the next National Medical Expenditure Survey, should incorporate questions on the subject.
- Systematically disseminate relevant health service research results to nursing home administrators, medical directors, and directors of nursing.
- Adopt a public health (population-based) approach to care for elderly persons with mental disorders.
- Clarify the roles of community mental health centers as service providers to nursing homes and facilitate the organization and funding of "wrap around" mental health services to nursing homes.
- Facilitate recommended changes in assessment, treatment, practice, education and training by eliminating or revising the federal Institution for Mental Diseases rule so that it no longer serves as a disincentive to facilities to admit, recognize and treat persons with mental health problems.
- Revise the IMD requirement to ensure that the requirement does not inhibit care.

Quality Management

- Involve the whole team in the assessment and care process including families and residents. Change the survey and certification criteria so that mental health services and mental well-being are evaluated and given weight.
- Initiate a broad consumer education campaign on the basic principles of good nursing home care. Empower consumers to evaluate the quality of care received by their friends and relatives,
- Using the MDS, develop or select quality care indicators for mental health and provide results to consumers.
- Develop "Best Practice" guidelines based on identified excellent practices.
- Develop "Best Practices" model centers and clinical trials to develop better ways to treat all types of mental problems. Share results with consumers, health care providers third party payors and nursing home surveyors.
- Require Medicaid to pay incentives to facilities that provide outstanding care, including mental health services. Detailed case mix or adjusted quality benchmarks would be used to determine who receives the incentive payments.
- Initiate industry and advocate consensus clinical guideline panels set up by the government (Agency for Health Care and Policy Research (AHCPR), National Institute of Mental Health (NIMH), National Institute of Aging (NIA) or Center

for Mental Health Services (CMHS), including elements of "best practice" in mental health care.

NOTES

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[2]Unless otherwise noted, the information and ideas within this issue brief are derived from conference and workshop transcripts, group discussion in preparation for a press conference immediately following the event, and solicited comments on earlier drafts of this paper from 50 conference participants. Those who reviewed the earlier drafts have greatly improved the final version and facilitated the authors' efforts to build upon the conference proceedings with more recent developments and publications.

[3]Using PASARR and Nursing Home Reform Act (NHRA) regulatory definitions of primary and secondary and mental illness and data from the 1987 NMES survey which allows two primary and seven secondary diagnoses, using ICD-9-CM definitions. This study also reports 27. 1 % of residents, or about 287,000, with a "primary" diagnosis of mental illness - and no primary diagnosis of ADRD; this number also excludes over 50,000 "organic psychotics"—ICD-9 codes 290XXX-294XXX which are exempted from PASARR Screening. About 39,271 had primary or secondary diseases of mental illness. (Shea & Smyer, 1993).

[4]This estimate was derived from the National Center for Health Statistics 1985 National Nursing Home Survey (NNHS). The rate of mental health treatment (2.45%) was applied to the 1980 nursing home population age 65 and over. The rate is based on any contact with a mental health professional during the past month.

[5]Using a Resident Instrument Evaluation Sample, created by the Research Triangle Institute for the Health Care Financing Administration (HCFA).

[6]This cost estimate is based on prevalence rates projected from the 1987 NMES survey. An estimated 475,000 current residents in 1995, or 31% of nursing home residents were estimated to have *a primary* or secondary diagnosis of mental illness (an ICD-9 code between 290-316, except almost all dementias, but would include about 85,186 organic psychotic disorders) (290XXX-294XXX) (Shea, 1995).

REFERENCES

Allied Technology Group. (1995). *Multistate nursing home case-mix and quality care demonstration project*. Rockville, MD: Author.

Alzheimer's Association. (1992, July). *Guidelines for dignity: Goals of specialized Alzheimer's/dementia care in residential settings*. Chicago: Author.

Alzheimer's Association. (1995). *Alzheimer's special care in nursing home—Is it really special? A survey of families and professional advocates*. Chicago: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Aronson, M. K. (1994a). Overview of dementia and the nursing home. In M. K. Aronson (Ed.), *Reshaping dementia care: Practice and policy in long-term care* (pp. 1-14). Thousand Oaks, CA: Sage Publications, Inc.

Aronson, M. K. (1994b). Dementia care: Program and staff variables. In M. K. Aronson (3rd ed. rev.) (Ed.), *Reshaping dementia care: Practice and policy in long-term care* (pp. 31-42). Thousand Oaks, CA: Sage Publications, Inc.

Aronson, M. K. (1994c). Strategies for management of behavioral problems. In M. K. Aronson (Ed.), *Reshaping dementia care: Practice and policy in long-term care* (pp. 81-93). Thousand Oaks, CA: Sage Publications, Inc.

Aronson, M. K., Cox, D., Guastadisegni, P., Frazier, C., & Sherlock, L. (1992). Dementia and the nursing home: Associated care needs. *Journal of the American Geriatrics Society, 40,* 27-33.

Baldridge, D. (1993, December). Conference transcript.

Baldridge, D. (1995, March). Presentation at Gerontological Society of America, Symposium on Achieving Mental Health Care for Nursing Home Residents, Atlanta, GA.

Beck, A. T. (1976). *Cognitive therapy and the emotion disorders*. New York: International Universities Press.

Beck, A. T., Rush, A., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Gilford Press.

Benson, B. (1993, December). *Key note address.* Presented at Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care, Washington, DC. Conference transcript, 33-52.

Benson, B. (1995, March). Presentation at Annual Meeting of American Society on Aging, Symposium on Achieving Mental Health Care for Nursing Home Residents, Atlanta, GA.

Berg, L. (1994). Current challenges in dementia care: A Physician's Perspective. In M. K. Aronson (Ed.), *Reshaping dementia care: Practice and policy in long-term care* (pp. 15-30). Thousand Oaks, CA: Sage Publications, Inc.

Berkman, L. (1983). *Health and ways of living*. New York: Oxford University Press.

Brannon, D., & Smyer, M. A. (1994, Fall). Good work and good care in nursing homes. *Generations,* 34-37.

Brawley, E. (1992). Alzheimer's disease: Designing the environment. *American Journal of Alzheimer's and Related Disorders Care & Research, 7*(1), 3-8.

Broadhead, W. E., Blazer, D. G., George, L. K., & Tse, C. K. (1990). Depression, disability days, and days lost from work in a prospective epidemiologic survey. *Journal of the American Medical Association, 264,* 2524-2528.

Burns, D. P. (1992). *Feeling good: The new mood therapy*. New York: Avon.

Burns, B. J., Wagner, H. R., Taube, J. E., Magaziner, J., Permutt, T., & Landerman, L. R. (1993). Mental health service use by the elderly in nursing homes. *American Journal of Public Health, 83,* 331-337.

Burns, B. J., & Taube, J. E. (1990). Mental services in general medical care and in nursing homes. In B. S. Fogel, A. Furino, & G. L. Gottlieb, (Eds.), *Mental health policy for older Americans* (pp. 63-84). Washington, DC: American Psychiatric Association.

Burrows, A. B., Satlin, A., Salzman, C., Nobel, K., & Lipsitz, L. (1995). Depression in a long-term care facility: Clinical features and discordance between nursing assessment and patient interviews. *Journal of the American Geriatrics Society, 43,* 1118-1122.

Chopra, D. (1994). *Ageless body timeless mind.* New York: Random House.

Coalition on Mental Health and Aging. (1995, February). *White House mini conference: Emerging issues in mental health and aging.* Washington, DC: Author.

Cohen, G. (1995, March). Presentation at Annual Meeting of American Society on Aging, Symposium on Achieving Mental Health Care for Nursing Home Residents, Atlanta, GA.

Cohen, M. D., Smyer, M. A., & Horgas, A. L. (1994). *The ABCs of behavioral change: Skills for working with behavior problems in nursing homes.* State College, PA: Venture Publishing, Inc.

Cohen, U., & Day, K. (1991). *Holding on to home: Designing environments for people with dementia.* Baltimore: The Johns Hopkins University Press.

Cohen, U., & Day, K. (1993). *Contemporary environments for people with dementia.* Baltimore: The Johns Hopkins University Press.

Commission on Professional and Hospital Activities. (1989). *Annotated ICD-9-CM: International classification of diseases* (9th revision, clinical modification, Vol. 2). Ann Arbor, MI: Author.

Comstock, H. A. (1995, July 21). Letter to Feather O. Houstown, Secretary, Department of Public Welfare, State of Pennsylvania.

Comstock, H. A., & Mandelbaum, K. C. (1995, September 19). Letter to Frank Comerford, Jr. Independent Regulatory Review Commission, Commonwealth of Pennsylvania.

Consumer Reports. (1995, October). Mental health: Does therapy help? *60*(11), 734-739.

Coons, D. H. (Ed.). (1991). *Specialized dementia care units.* Baltimore: The Johns Hopkins University Press.

Cox Post, D., Krasnausky, P., Grossman, H. D., & Lynch, D. (1994). The reduction of restraint use in the nursing home. In M. K. Aronson (Ed.), *Reshaping dementia care: Practice and policy in long-term care* (pp. 94-108). Thousand Oaks, CA: Sage Publications, Inc.

Department of Veterans Affairs, St. Louis, Continuing Education Center & Office of Geriatrics and Extended Care. (1992, September). *A report on caring for the mentally ill nursing home patient - 1993.* Publication No. 1B 18-7A.

Dunkelman, D. M., & Dressel, R. C. (1994). The nursing home environment and dementia care. In M. K. Aronson (Ed.), *Reshaping dementia care: Practice and policy in long-term care* (pp. 60-68). Thousand Oaks, CA: Sage Publications, Inc.

The Eden Alternative: The nursing home of the future. (1995). *The Brown Long-Term Care Quality Letter, 7,* 1.

Eisdorfer, C. (1995). Managed care and mental health services. Presentation at the Annual Meeting of the American Society on Aging. Atlanta, GA.

Ellis, A. (1994). Rational-emotive therapy approaches to overcoming resistance: III. Using emotive and behavioral techniques of overcoming resistance. *British Journal of Cognitive Psychotherapy,* 11-26 (from *Psychological Abstracts,* 1884, *71,* Abstract No. 31926).

Emerson Lombardo, N. B. (1993). *Nursing home reform law and PASARR: Findings from the AARP study.* A paper presented at Achieving mental health of nursing home residents: Overcoming barriers to mental health care. December 5-7, 1993, Washington, DC.

Emerson Lombardo, N. B. (1994, November). *Increases in advanced directives and guardianships reported by nursing home administrators.* Poster session presented at the annual meeting of the Gerontological Society of America, Atlanta, GA.

Emerson Lombardo, N. B. et al. (1994). *Barriers to mental health services for nursing home residents.* Washington, DC: Public Policy Institute, American Association of Retired Persons. (Available from AARP)

Emerson Lombardo, N. B., Belleville-Taylor, P., Fogel, B. S., Levine, D., Morris, J. N., Morris, S. A., Mace, N. L., Murphy, K. M., Muse, D. N., Ooi, W. L., & Sherwood, S. (1992). *Mental health services for nursing home residents,* Unpublished report prepared for the American Association of Retired Persons. (Available from HRCA Research and Training Institute, 1200 Centre St., Boston, MA 02131.)

Emerson Lombardo, N. B., Goldman, H., & Weiss, H. (1994). Overcoming Reimbursement Barriers. *Dimensions, 1,* 4.

Emerson Lombardo, N. B., Sherwood, S., & Fogel, B. S. (1991). *Survey of geriatric psychiatrists on mental health care in nursing homes.* Unpublished report prepared for the American Association of Retired Persons. (Available from HRCA Research and Training Institute, 1200 Centre St., Boston, MA 02131.)

Evans, D. (1990). Estimated prevalence of Alzheimer's disease in the United States. *The Milbank Quarterly, 68,* 2.

Fogel, B. S. (1990). Physician payment reform. In B. S. Fogel, A. Furino, & G. L. Gottlieb (Eds.), *Mental health policy in older Americans: Protecting minds at risk* (pp. 109-124). Washington DC: American Psychiatric Press.

Fogel, B. S. (1991). Implications of the new Medicare physicians fee schedule for access to mental health services in nursing homes. Unpublished report prepared for the American Association of Retired Persons. (Available from HRCA Research and Training Institute, 1200 Centre St., Boston, MA 02131.)

Fogel, B. S. (1993). *Models of mental health practice and their impact on outcomes: Consultation vs. liaison: Tradition vs. medical psychiatry.* A paper presented at Overcoming Barriers to Mental Health Care for Nursing Home Residents Conference, Dec. 5-7, 1993, Washington, DC.

Fogel, B. S., Gottlieb, G. L., & Furino, A. (1990). Minds at risk. In B.S. Fogel, A. Furino, & G. L. Gottlieb (Eds.), *Mental health policy in older Americans: Protecting minds at risk* (pp. 1-22). Washington, DC: American Psychiatric Press.

Fralich, J. (1993). Presentation at Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care, Washington, DC. Conference transcript, 150-153.

Frazier, C., & Sherlock, L. (1994). Staffing patterns and training for competent dementia care. In M. K. Aronson (Ed.), *Reshaping dementia care: Practice and policy in long-term care* (pp. 109-126). Thousand Oaks, CA: Sage Publications, Inc.

Fries, B. E., Mehr, D. R., Schneider, D., Foley, W. J., & Burke, R. (1993). Mental dysfunction and resource use in nursing homes. *Medical Care, 31,* 898-920.

Furino, A., & Fogel, B. S. (1990). The economic perspective. In B.S. Fogel, A. Furino, & G. L. Gottlieb (Eds.), *Mental health policy in older Americans: Protecting minds at risk* (pp. 23-36). Washington, DC: American Psychiatric Press.

Gaile, S. (1995, November). Geriatric Mental Health Training Series (Book review). *Journal of the American Geriatrics Society, 43*(1), 1328-1329.

Gallagher-Thompson, D. (1994). Clinical intervention strategies for distressed caregivers: Rationale and development of psychoeducational approaches. In E. Light, G. Niederehe, & B. D. Lebowitz, *Stress effects on family caregivers of Alzheimer's patients* (pp. 260-277). New York: Springer Publishing Company.

Gaston, P. (1994). Families as an integral part of dementia care. In M. K. Aronson, (Ed.), *Reshaping dementia care: Practice and policy in long-term care* (pp. 69-80). Thousand Oaks, CA: Sage Publications, Inc.

Georgotas, A., & McCue, R. C. (1988). Overall treatment strategies for depression and manic states. In A. Georgotas & R. Cancro (Eds.), *Depression and mania* (pp. 335-343; 344-549). New York: Elsevier Science Publishing.

German, P. S., Rovner, B. W., Burton, L. C., Brant, L. J., & Clark, R. (1992). The role of mental morbidity in the nursing home experience. *The Gerontologist, 32,* 152-158.

Goldman, H. H., & Frank, R. G. (1990). Division of Responsibility Among Payers. In B. S. Fogel, A. Furino, & G. L. Gottlieb (Eds.), *Mental health policy in older Americans: Protecting minds at risk* (pp. 85-95). Washington, DC: American Psychiatric Press.

Goldman, H. H., Cohen, G., & Davis, M. (1995). Changes in Medicare outpatient coverage for Alzheimer's disease and related disorders. *Hospital and Community Psychiatry, 36,* 939-942.

Gwyther, L. (1993, December). Presentation at Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care, Washington, DC, Conference transcript, pp. 274-277.

Hawes, C., Morris, J. N., Phillips, C. D., Mor, V., Fries, B. E., & Nonemaker, S. (1995). Reliability estimates for the minimum data set for nursing home resident assessment and care screening. *The Gerontologist, 35,* 172-178.

Hollman, P. (1993). In search of the perfect behavior measurement scale. *The Brown University Long-Term Care Quality Letter, 5,* 1.

Holmes, D., Ory, M., & Teresi J. (Eds.). (1994). Special dementia care: Research, policy, and practice issues. *Alzheimer Disease & Associated Disorders, 8* (Suppl. 1).

Jackson, M. E., Spector, W. D., & Rabins, P. (1993, November). *Risk of behavior problems among U.S. nursing and personal care home residents.* Paper presented at the Gerontological Society of America Annual Meeting, New Orleans, LA. See Abstract in *Gerontologist, 33,* SP(1): 193.

Jarvis, R. (1993, December). *VA models of mental health care in nursing homes.* Paper presented at Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care, Washington, DC.

Kamholz, B., & Gottlieb, G. L. (1990). The nature and efficacy of interventions for depression and dementia. In B.S. Fogel, A. Furino, & G.I. Gottlieb (Eds.), *Mental health policy in older Americans: Protecting minds at risk* (pp. 37-62). Washington, DC: American Psychiatric Press.

Kaplan, M., & Comstock, H. A. (1995, July 23). *RUG III case-mix reimbursement: The threat to Alzheimer's care.* Paper presented at the Fourth National Alzheimer's Disease Education Conference.

Katz, I. R., Parmelee, P. A., & Streim, J. E. (1995). Depression in older patients in residential care: Significance of dysphoria and dimensional assessment. *American Journal of Geriatric Psychiatry, 3,* 161-169.

Katz, I. R., Simpson, G. M., Curlik, S. M., Parmelee, P. A., & Muhly, C. (1990). Pharmacologic treatment of major depression for elderly patients in residential care setting. *Journal of Clinical Psychology, 51*(7S), 41-47.

Katz, I. R., Simpson, G. M., Jethanandani, V., Cooper, T., & Muhly, C. (1989). Steady state pharmacokinetics of nortriptyline in the frail elderly. *Neuropsychopharm, 2,* 229-236.

Kelly, J. (1993, December). Presentation at Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care, Washington, DC. Conference transcript, 306-312.

Lair, T., & Lefkowitz, D. (1990). *Mental health and functional status of residents of nursing and personal care home residents.* Rockville, MD: Agency for Health Care Policy and Research.

Larson, D. B. (1995, December 3). Spirituality and medical outcomes-II. Paper presented at Conference on Spirituality and Healing in Medicine. Harvard Medical School Department of Continuing Education. Boston, MA.

Larson, D. B., Greenwold, M., & Lyons, J. S. (1995). Spiritual assessment in clinical research. Unpublished manuscript. Rockville, MD: National Institute of Health Care Research.

Lave, J. R. (1990). The cost-offset effect. In B. S. Fogel, A. Furino, and G. L. Gottlieb (Eds.), *Mental health policy for older Americans.* Washington, DC: American Psychiatric Press.

Lawlor, E. F. (1995). Is Medicare managed care the answer? *The Public Policy and Aging Report, 6*(5/6), 1-4, 15-19.

Lechner, H., Bertha, G., & Ott, E. (1988). Results of a five-year prospective study of 94 patients with vascular and multi-infarct dementia. In J. S. Meyer, H. Lechner, J. Marshall, & J. F. Toole (Eds.), *Vascular and multi-infarct dementia* (pp. 101-111). Mt. Kisco, NY: Futura Publishing Co.

Lewinsohn, P. M., Munoz, R., Youngren, M. A., & Zeiss, A. M. (1986). *Control your depression* (Rev. ed.). Englewood Cliffs, NJ: Prentice-Hall.

Lombardo, N. E. (1991). Cognitive Impairment: Policy implications for service design. *American Journal of Alzheimer's and Related Disorders Care & Research, 6,* 2, 4-18.

Mace, N. L. (1990). *Dementia care: Patient, family and community.* Baltimore: The Johns Hopkins University Press.

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Matthews, D. A. (1995, December 3). Spirituality and Medical Outcomes I. Paper presented at Conference on Spirituality and Healing in Medicine. Harvard Medical School Department of Continuing Education, Boston, MA.

Matthews, D. A. & Larson, D. B. (1995). (Vol. 3) The Faith factor: An annotated bibliography of clinical research on spiritual subjects. Rockville, MD: National Institute of Health Care Research.

Mayeux, R., Maestre, G., Ottman, R., Stern, Y., Gurland, B., Chun, M., Tang, M-X, Shelanski, M., & Tycko, B. (1994). Genetic heterogeneity & environmental interaction in the association between alzheimer's disease and apolipoprotein-E. *Neurobiology of Aging, 15,* Abstract No. 300, S73.

Mental Health Policy Resource Center. (1993). *Policy issues in mental health coverage: A review of issues.* Appendix A: Institutions for Mental Disease [IMDs]. Washington, DC: Author.

Mitchell, S., Smith, M., & Buckwalter, K. (1994, summer). Ways to promote successful training. *The Journal of Long-Term Care Administration.*

Morris, J. N., Hawes, C., Murphy, K. M., Nonemaker, S., Phillips, C., Fries, B. E., and Mor, V. (1992). *Resident assessment instrument training manual and resource guide.* Natick, MA: Elliot Press.

Morris, J. N., Murphy, K. M., Emerson Lombardo, N. B., Morris, S. A., Belleville-Taylor, P., Rada, P., & Gwyther, L. (1993). *Family partnership program staff manual and family care giver manual.* Boston: HRCA Research Training Institute.

Morris, J. N., Nonemaker, S., Murphy, K. M., Hawes, C., Fries, B. E., Mor, V., & Phillips, C. (1995). *A commitment to change: Future revisions of HCFA's RAI.* Manuscript submitted for publication.

Munley, E. F. (1994). Modifying PASARR might reduce unnecessary screening. *PASARR: An interdisciplinary perspective.* Providence, RI: Manisses Communications Group, 24.

Omnibus Budget Reconciliation Act of 1987. P.L. 100-203. Subtitle C. The Nursing Home Reform Act. 42 U.S.C. 1395i-3(a)-(h)(Medicare); 1396r (a)-(h) (Medicaid).

Omnibus Budget Reconciliation Act of 1990. P.L. 101-508, Sections 4206 & 4751 (Medicare and Medicaid, respectively), 42 U.S.C. Section 1395cc(a)(I)(Q), 1395mm(c)(8),1395cc(f), 1396a(a)(57),(58), 1396a(w).

Parmelee, P. A., Katz, I. R., & Lawton, M. P. (1989). Depression among institutionalized aged: Assessment and prevalence estimation. *Journal of Gerontology, 44,* M22-29.

Parmelee, P. A., Katz, I. R., & Lawton, M. P. (1992). Incidence of depression in long-term care settings. *Journal of Gerontology, 47,* M189-M196.

Parmelee, P. A., Katz, I. R., & Lawton, M. P. (1993). Anxiety and its association with depression among institutionalized elderly. *American Journal of Geriatric Psychiatry, 1,* 46-58.

Phillips, C. D. (1991, May). *The Rug-II system and cognitively impaired residents.* Unpublished background paper prepared for the Nursing Home Community Coalition of New York State.

Phillips, C. D. (1991, July). *Resource use, ADL functional level, and cognitive impairment.* Unpublished background paper prepared for the Nursing Home Community Coalition of New York State.

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Rabins, P. (1992, November). Paper presented at the Annual Meeting of the Gerontological Society of America, Washington, DC. See Abstract. *The Gerontologist, 32,* (SP1).

Reifler, B. V. (1986). Mixed cognitive-affective disturbances in the elderly. *Journal of Clinical Psychiatry, 47,* 354-356.

Richards, M., & Seicol, S. (1991). The challenge of maintaining spiritual connectedness for persons institutionalized with dementia. *Journal of Religious Gerontology, 7,* 3.

Robinson, G. K. (1990). The Psychiatric Component of Long-Term Care Models. In B. S. Fogel, A. Furino, & G. L. Gottlieb (Eds.), *Mental health policy in older Americans: Protecting minds at risk (pp.* 157-177). Washington, DC: American Psychiatric Press.

Robinson, G. K., Haggard, L., & Rohrer, C. F. (1990). *Nursing home reform and its implications for mental health care.* Washington, DC: Mental Health Policy Resource Center.

Rovner, B. W., German, P. S., Brant, L. J., Clark, R., Burton, L., & Folstein, M. F. (1991). Depression and mortality in nursing homes. *Journal of the American Medical Association, 265,* 993-996.

Rovner, B. W., German, P. S., Broadhead, J., Morris, R. K., Brant, L. J., Blaustein, J., & Folstein, M. F. (1990). The prevalence and management of dementia and other psychiatric disorders in nursing homes. *International Psychogeriatrics, 2,* 13-24.

Rubin, E. H., Zorumski, C. F., & Bourke, W. J. (1988, October). Overlapping symptoms of geriatric depression and Alzheimer-type dementia. *Hospital and Community Psychiatry,* 39(10), 1074-1079.

Rudder, C. (1991, August). *Modifying RUGs: Responding to consumer concerns in New York State.* New York: Nursing Home Community Coalition of New York State.

Seicol, S. (1995, July). Creating spiritual connectedness for persons with dementia. *Proceedings of the providers educational conference.* Chicago: Alzheimer's Association.

Shadish, W. E., & Bootzin, R. R. (1981). Nursing homes and chronic mental patients. *Schizophrenia Bulletin, 7,* 478-488.

Sharfstein, S. S., & Goldman, H. (1989). Financing the medical management of mental disorders. *American Journal of Psychiatry, 146,* 345-349.

Shea, D. G. (1995). *Nursing homes and the costs of mental disorders.* Unpublished manuscript. University Park, PA: Penn State University.

Shea, D. G., Clark, P., & Smyer, M. A. (1995, November). *Treatment of persons with a mental illness in nursing homes after OBRA '87.* Paper presented at the Annual Meeting of the Gerontological Society of America, Los Angeles, CA.

Shea, D. G., & Smyer, M. A. (1993). Mental health services for nursing home residents: What will it cost? *Journal of Mental Health Administration, 20,* 223-235.

Sloane, P. D., & Matthew, L. J. (1991). *Dementia units in long-term care.* Baltimore: The Johns Hopkins University Press.

Smith, M., Buckwalter, K., & Mitchell, S. (Eds.) (1990). *The Geriatric Mental Health Training Series.* New York: Springer Publishing Company.

Smith, M., Mitchell, S., & Buckwalter, K. (1995). Nurses helping nurses: Development of internal specialists in long-term care. *Journal of Gerontological Nursing, 21*(3), 25-31.

Smith, M., Buckwalter, K., Garand, L., Mitchell, S., Albanese, M., & Kreitner, C. (1994). Evaluation of a geriatrics mental health training program for nursing personnel in rural long-term care facilities. *Issues in Mental Health Nursing, 15,* 149-168.

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Strahan, G. W., & Burns, B. J. (1991). Mental illness in nursing homes: United States, 1985. In *Vital & Health Statistics, 13,* 105. Hyattsville, MD: National Center for Health Statistics. DHHS Pub. No. 91-1766.

Streit, A., & Brannon, D. (1994). The effect of primary nursing job design dimensions on caregiving technology and job performance in nursing homes. *Health Service Management Research, 7,* 271-281.

Teitelbaum, M. (1995). *Evaluation of long-term care survey.* Unpublished report under review by the Health Care Financing Administration. Cambridge, MA: Abt Associates.

Thomas, W. (1994). *The Eden Alternative: Nature, hope and nursing homes.* Sherburne, NY: Author.

U.S. General Accounting Office. (1982). *The elderly remains in need of mental health services.* Washington, DC: American Psychiatric Association.

Vilbig, P. (1995, January 20). Welcome to the nursing home of the future. *The Repository* in Canton, OH, D-2.

Valle, R. (1988-1989). Outreach to ethnic minorities with Alzheimer's disease: The challenge to the community. *Health Matrix, 6,* 13-27.

Valle, R. (1989). Cultural and ethnic issues in Alzheimer's disease in family research. In E. Light & B. Lebowitz (Eds.), *Alzheimer's disease treatment and family stress* (pp. 122-154). Washington, DC: U.S. Government Printing Office.

Weiss, H. P. (1996). Mental health's forgotten constituency: New report on nursing homes. *Aging Today, 17*(2), 1.

Weissert, W. G., & Musliner, M. C. (1992). *Access, quality and cost consequences of case-mix adjusted reimbursement for nursing homes: A critical review of the evidence* (Report No. 9109). Washington, DC: American Association of Retired Persons.

Wells, K. B., Stewart, A. L., Hays, R. D. et al. (1989). The functioning and well-being of depressed patients: Results from the medical outcomes study. *Journal of the American Medical Association, 262,* 914-919.

Wetle, T., & Mark, H. (1990). Managed care. In B. S. Fogel, A. Furino, & G. L. Gottlieb (Eds.), *Mental health policy in older Americans: Protecting minds at risk* (pp. 221-238). Washington, DC: American Psychiatric Press.

White House Conference on Aging. (1995). *Official 1995 White House Conference on Aging: Adopted resolutions.* Washington, DC: Author.

Williams, J. W., Kerber, C. A., Mulrow, C. D., Medina, A., & Aguilar, C. (1995). Depressive disorders in primary care: Prevalence, functional disability, and identification. *Journal of Geriatric Internal Medicine, 10,* 1, 7-12.

Wragge, R. E., & Jeste, D. V. (1989). Overview of depression and psychoses in Alzheimer's diseases. *American Journal of Psychiatry, 146*(5), 577-587.

Wykle, M. (1993, December). Presentation at Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care, Washington, DC: Conference transcript, 300-305.

Zimmerman, D. R. (1991). The potential impact of new regulations and data sources on nursing home quality of care. In *Mechanisms of quality in long-term care: Service and clinical outcomes*, Proceedings of the 7th Annual Conference. New York: National League for Nursing Press.

Zimmerman, D. R., Gustafson, D., Sainfort, F., & Konigsveld, V. (1990). The Quality Assessment Index (QAI) for Measuring Nursing Home Quality. *Health Services Research*, 25.

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