Psychologists in Long-Term Care: Overview of Practice and Public Policy: Introduction to the Special Series

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With the overall aging of the population and the concomitant need for the provision of mental health care for older adults, professional psychology in long-term care has come of age. Psychologists are now increasingly practicing in such traditional long-term care settings as nursing homes and in less traditional ones such as rehabilitation units, day centers, partial hospitalization programs, and hospices. The practice of psychology in long-term care is strongly influenced by public policy issues relating to Medicare, such as conditions of reimbursement, the rise of managed Medicare, and the continued disparity between payment for mental health and medical diagnoses. Geropsychologists must be flexible in the form of their healthcare delivery to continue to provide quality services. The following articles in this special section on long-term care summarize the research on assessment and interventions for long-term care patients, outline the training opportunities available, and provide a decision-making framework for the common professional ethical/legal issues encountered in long-term care settings.

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It is our pleasure to serve as guest editors for this series of articles on professional psychology in long-term care (LTC). LTC can be broadly viewed as "a range of services that address the health, personal care, and social needs of individuals who lack the capacity of self-care" (Stone, Cafferata, & Sangl, 1987) independent of the site of delivery. We believe this definition should include psychological needs as well.

Until fairly recently psychologists have had a relatively minor impact in LTC service delivery, but the Omnibus Budget Reconciliation Act (OBRA) of 1989 allowed Medicare to directly reimburse licensed psychologists for providing mental health services in all settings, and sparked the entry of increasingly large numbers of psychologists in the field. The OBRA legislation reflected the public's dawning awareness of the aging of Americans by recognizing the fact that medical advances are keeping greater numbers of people alive to an old age, when LTC services are typically needed. Thirteen percent of the population of the United States is over the age of 65 (US Bureau of the Census, 1996). The percentage of those over the age of 85 is growing even faster, and this particularly frail group is the highest utilizer of LTC services, with the average age of nursing home residents approaching 85 years. LTC needs for older adults are expected to double in the next 25 years (National Academy on Aging, 1997). At least 35% of the "oldest-old" have significant cognitive impairment (Evans et al., 1989; Johansson & Zarit, 1995), and a majority of these patients can sometimes display disruptive behaviors that can have intense psychological sequelae for caregivers (Cohen-Mansfield & Kerin, 1986; Zarit, Reever, & Bach-Peterson, 1980).

The time is ripe for practicing psychologists to get a broad overview of the LTC subspecialty within geropsychology, and to discover the professional opportunities available. Psychologists in LTC most commonly practice in nursing home consulting groups. They engage in stan-

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dard assessment and individual treatment activity with residents, conduct family therapy and lead support groups with concerned relatives, train staff in the management of behavior problems of residents with dementia, and consult with nursing home administrators to develop overall plans that address the emotional needs of residents (Qualls, 1995).

Psychologists are now branching out into other nontraditional domains. As hospitals have been eager to reduce their lengths of stay by transferring care to rehabilitation settings immediately after acute medical problems are stabilized, the role of the psychologist in these sites has taken on new importance. Multidisciplinary staff need to have an accurate understanding of the patients' cognitive status to assist in rehabilitation progress and ultimately discharge planning, highlighting the value of assessing cognitive functioning. Research has documented the deleterious effects of untreated depression on recuperation from medical problems (Lichtenberg, 1998; Ormel et al., 1998). Working with other professionals such as occupational therapists to help design treatment protocols so that they address geriatric depression is one of the cutting-edge roles for psychologists in rehabilitation or skilled nursing units (Lichtenberg, 1998). The importance of integrating the physical and behavioral healthcare of patients is striking in rehabilitation and other in-patient settings.

Psychologists are also serving as consultants to Alzheimer day centers to address staff burnout issues, family caregiver burden, and members' adjustment to the new surroundings (Molinari, 1994). Geriatric partial hospitalization programs need qualified geropsychologists to manage the LTC needs of an ever-growing chronic aged psychiatric population. Hospice care also appears to be a prime area where psychologists can intervene to ease the more difficult prolonged grief periods that befall some bereaved families, and to assist dying persons and their families to resolve past unfinished business (Kenan, 1998). Finally, psychologists can provide the expertise in group process to assist organizations such as the Alzheimer's Association with the training of peer support group leaders and with the planning of such novel groups as those for newly diagnosed dementia patients, grandchildren of demented patients, and support groups for Pick's disease.

These are exciting times for psychologists in LTC. In particular, there has been a dramatic increase in the number of consulting firms run by psychologists who contract with nursing homes. However, with these opportunities come responsibilities to assure that services are provided ethically as well as competently. A few highly publicized cases of fraud by psychologists in nursing homes (e.g., billing for group therapy with severely demented patients, or doing extensive psychological testing on patients with no demonstrable need) have called attention to the need for psychologists practicing in these settings to be adequately trained. Standards of practice for psychologists in LTC settings have recently been published that delineate state-of-the-art psychological practice (Lichtenberg et al., 1998). But it is unfortunate that at this time most APA-approved graduate programs in professional psychology do not proffer coursework or clinical practica in working with older adults. Although internship programs are now increasingly offering at least minor rotations in geriatrics (American Psychological Association, Division 12, 1997), there is still a distinct possibility that one can graduate from an APA-approved program and not be exposed to the ever-widening knowledge base in developmental research and clinical geropsychology. Surprisingly, despite the long-time awareness of the leaders in geropsychology about the demographic trends and the need to train a cadre of specialists in this area, there remain only a handful (perhaps less that 20) of postdoctoral programs in geropsychology (Karel, Molinari, & Gallagher-Thompson, 1999), and only a few of these offer extensive exposure to LTC sites.

There is a particular need for psychologists practicing in the field of LTC to understand how their work with older adults fits into a broader public policy context. Psychologists should keep abreast of the latest developments in the field and acquire an understanding of how current legislative initiatives and regulation changes affect service delivery. The following is a broad overview of the public policy domain. For more detailed analysis, additional readings can be found in the reference list (Hartman-Stein, 1999a,b; Norris, Rosowsky, & Molinari, 1998).

CATCH 22: AS MORE SERVICES ARE BILLED UNDER MEDICARE, GREATER RESTRICTIONS RESULT

Mental health services account for less than 3% of the total Medicare budget (Norris et al., 1998). This surprisingly small percentage is the current federal spending constraint in which we currently must function as behavioral healthcare providers under Medicare. As the demands for geriatric mental health services and the number of Medicare

beneficiaries increase, the volume of claims for mental health services rises, creating a major "geriatric catch 22." The catch is that when the number of mental health care claims exceed volume performance standards set by the Health Care Finance Administration (HCFA), greater scrutiny of claims occurs. For example, in 1997 performance standards for mental health utilization exceeded expected levels, and at the same time audits conducted by the Inspector General's office showed that psychologists and psychiatrists were the second greatest offenders in so-called erroneous billing practices, next to podiatrists (Hartman-Stein, 1998a). The end result is that HCFA has put pressure on the Medicare insurance carriers to tightly scrutinize claims and in effect place more restrictions on mental health practice, especially in nursing home, rehabilitation, and partial-hospitalization settings.

No one can disagree that fraud and abuse in behavioral health care need to be weeded out. However, even painstakingly conscientious and ethical clinicians have been caught unaware of some of the requirements for documentation and billing procedures, resulting in monetary penalties. For example, the trend is that each and every psychotherapy treatment session must have documentation that shows its "medical necessity." Carriers in some regions have denied payment for psychotherapy services for patients who carry dementia diagnoses, and mental health claims of nursing home patients beyond 20–30 in a 2-year time period have triggered payment denials or audits. When using neuropsychological testing codes the examiner who uses *DSM-IV* diagnostic codes rather than ICD-9 codes may be audited if the code chosen lacks specificity or does not indicate that a neurological condition exists (Hartman-Stein, 1999b).

Both prepayment and postpayment reviews of claims for mental health services have become commonplace in many regions of the country. Medicare carriers are creating profiles of their providers, resulting in audits of mental health specialists who perform services in excess of what is typical of peers in their geographic region. The ever-increasing restrictions on clinicians will result in disincentives to provide behavioral healthcare services to older adults covered under traditional Medicare plans.

MANAGED MEDICARE

The number of older Americans enrolled in managed Medicare plans is growing at a fast pace. In 1990 about 3% of Americans age 65 and over were enrolled in health maintenance organizations, while in 1998 about 16% were in managed care plans. Predictions are that by 2002 more than 25% of the Medicare population will be covered under some type of managed care plan (Dallek, 1998). For the mental health practitioner who has become a provider on managed Medicare panels, there are some distinct advantages. First, there is automatic access to patients; that is, individuals covered by the plan have a limited number of clinicians from which to choose. Psychologists with geropsychology expertise need to let the care managers for the plan as well as the panel primary care physicians know of their interest and background, thereby encouraging referrals.

In managed-Medicare plans, from the time of the initial referral the clinician knows the number of service units that are preauthorized. Therefore, there is rarely any concern about pre- or postpayment audits that result in demands for monetary paybacks. Treatment plans and chart notes that meet the individual plan's requirements must be kept, but many managed care plans make the documentation requirements clear.

One of the downsides of Medicare-managed care systems is that many provider panels are closed. Well-trained geropsychologists may not be allowed membership on the panel if they had not applied at the time the panel was open for applications (Hartman-Stein, 1998b). Unless the plan determines that there is a shortage of behavioral health clinicians in a given area, no amount of geropsychology postdoctoral training will ensure access to the older adults enrolled in the managed care plan.

ADDITIONAL PUBLIC POLICY FORCES

Congress has mandated the revision and study of all 6500 clinical procedure treatment codes in the near future, a process that occurs every 5 years (Hartman-Stein, 2000). The impact on future allowable charges for mental health services under the Resource-Based Relative Value Scale (RBRVS) remains unclear. In 2000 a survey of psychiatric Current Procedural Terminology codes seems likely. Only if the psychologists who are randomly polled are cooperative in filling out the survey will the profession have an opportunity for increased recognition of the work value of psychological services.

Political forces in Congress are encouraging the continued integrity of the Medicare system with proposed increases in spending in one large area: medications. Even the most recent White House Conference on Mental

Health emphasized biological treatments of mental disorders as the first line of treatment (Saeman, 1999). Behavioral health services such as psychotherapy continue to be the stepchild of mental health interventions. As in the old Avis commercial, we have to try harder to prove our added value, pointing to the need for more medical cost-offset research in the geropsychology field.

The justification for the disparity between payment for mental health conditions and medical conditions has been debated in recent years. Currently there is a 50% copayment for the client for psychotherapy services in the Medicare system, in contrast to only a 20% copayment for medical services. Some argue that this disparity is yet another barrier to accessing needed services, especially for older adults without supplementary insurance plans. Grassroots political efforts with lawmakers are occurring across the country to lay the groundwork for legislative changes in the future. Caution must be taken, however, not to be overly strident in this cause, which could result in pricing ourselves out of the insurance plan coverage altogether. Other professionals such as social workers and licensed professional counselors who have been willing to be reimbursed at lower rates have argued that they can provide psychotherapy services that are just as efficacious as those conducted by doctoral-level psychologists. No study known to date has shown consistently better therapy outcome conducted by doctoral-level psychologists.

The need for greater expertise in geriatric mental health is clear. However, given the limits with which we must perform our services under the Medicare system, psychologists must learn to practice in innovative ways. Therapy must be focused, with appropriate homework assigned to our clients to propel them toward agreed-upon goals of treatment. Group treatment modalities need to be utilized whenever possible, including design of disease management treatment protocols conducted in groups. Neuropsychological testing must be brief in most cases (about 2 hours of testing), with a focus on providing concrete treatment recommendations (Lichtenberg, 1999). Psychologists must incorporate outcome measures as part of their standard operating procedure whenever they are providing geriatric mental health services (Frazer, 1998).

Geropsychologists cannot be rigid if we are to survive as valued healthcare professionals in the 21st century. We must keep up with the discoveries of the biological sciences that enhance healthy aging and work to creatively improve our methods of service delivery to the ever growing-population of older adults.

Fortunately, there is now an expanding list of resources available that psychologists can turn to that provide overviews of working with older adults in general (American Psychological Association, 1998) and more specifically in the area of LTC (Lichtenberg, 1993, 1998; Molinari, 2000). Also, Psychologists in Long Term Care (PLTC), a professional organization started in 1983 and dedicated to the understanding and delivery of high-quality psychological services in LTC sites, has seen a distinct membership rise. The authors of the following articles are all members of PLTC and leaders in the field.

In the first article, Peter Lichtenberg and Michael Duffy discuss assessment and training in LTC and document the growing corpus of clinical and research findings in the field. With proper evaluation and sensitivity to the special needs of this frail population, psychologists can effectively address many of the psychological and behavioral problems affecting residents in LTC settings. Next, Dolores Gallagher-Thompson, Erin Cassidy, and Steven Lovett discuss the training of psychologists for work in LTC sites. They highlight exciting professional opportunities now available, discuss the varied levels of training, and identify a growing number of resources for those interested in furthering their education. Finally, Jennifer Moye and Martin Zehr provide a conceptual overview to assist clinicians in managing the more common ethical dilemmas that are encountered when working with LTC patients. They provide good practical guidelines to assist practitioners in making sense of the complex array of ethical principles and laws that they confront. All of the articles are suffused with the energy of a new and exciting field, and are guided by the principle that increasing the number of well-trained professional psychologists in this area will have a dramatically positive impact on the quality of life for LTC residents.

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