

Mental Burden High for Assisted Living Residents

Overall, 24% of patients in the Maryland study met the criteria for depression.

BY KERRI WACHTER
Senior Writer

SAN JUAN, P.R. — Dementia and depression appear to be quite common among residents in assisted living facilities, based on two analyses of facilities in Maryland that were presented at the annual meeting of the American Association for Geriatric Psychiatry.

Both analyses used data from the Maryland Assisted Living Study that included 22 facilities—10 large facilities (more than 15 beds) and 12 small (15 beds or fewer). Assisted living facilities are regulated by each state, and levels of regulation vary widely.

For the Maryland Assisted Living Study, residents of assisted living facilities were evaluated by a geriatric psychiatrist, a nurse (who was experienced with dementia evaluation), and a research assistant specializing in psychometrics. Comprehensive evaluations of residents included information from caregivers and family members, a clinical exam and history, assessment with quantitative scales (function, behavior, depression, medical comorbidity, quality of life, caregiver activity/burden), and neuropsychological battery.

A consensus conference specialist determined diagnoses for residents and assessed whether residents had been worked up and whether they were being treated appropriately. In particular, participants were assessed using the Cornell Scale for Depression in Dementia (CSDD), a 19-item clinician-administered instrument

that uses information from interviews with both the patient and a nursing staff member. Those with scores greater than 7 were considered clinically depressed. The General Medical Health Rating was used to describe comorbidity and health status.

In the first analysis, researchers looked at levels of depression among 196 residents of assisted living facilities. "This is an important study for several reasons, but it is the first comprehensive assessment of psychiatric disease in the assisted living industry," said Dr. Lea C. Watson, professor of psychiatry at the University of North Carolina at Chapel Hill. Subjects were an average of 86 years old, and were primarily women (79%) and white (84%).

Overall, 24% (47 subjects) met the criteria for clinical depression and 8% (15 subjects) met the criteria for severe depression (CSDD score greater than 12). Roughly two-thirds (67%) had dementia. The third of the participants who did not have dementia—those with Mini-Mental State Examination scores greater than 22—were evaluated with the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID IV). Of those, 13 met the criteria for depression.

Bivariate analysis revealed no differences between depressed and nondepressed individuals based on age, gender, number of social visits, or facility size. However, depressed individuals did have a greater number of comorbid conditions, required more assistance with activities of

daily living, spent a greater number of days in bed per month, and participated in organized activities less frequently than did nondepressed individuals.

After controlling for several factors, (global health, supervision of activities of daily living, and social interaction), assistance with activities of daily living alone remained significantly associated with depression (odds ratio 3.8), while medical comorbidity trended toward significance (odds ratio 1.9).

Only 43% of those who were currently depressed were being treated with antidepressants. Likewise, only 40% of those who were severely depressed were being treated with antidepressants. Those with depression were more likely to be treated with antidepressants if they lived in a larger facility (51% vs. 17%).

In the second analysis, researchers looked for any differences between large and small facilities for dementia frequency, detection, and management.

"Large facilities have most commonly arisen out of the hospitality industry and are more likely to be part of a chain," said Quincy M. Samus, a graduate student at Johns Hopkins University in Baltimore, who presented a paper for Dr. Iracema Leroi of the University of Manchester (England). "Small facilities have evolved from the traditional board-and-care homes or group homes," Ms. Samus said.

This analysis included 198 residents (150 from large facilities and 48 from small). Residents in smaller facilities were younger than were those in larger facilities—average age 82 years vs. 87 years. Residents in both types of facilities

were admitted primarily because of functional limitations. Those in large facilities were significantly more likely to be admitted for medical reasons than were those in small facilities.

Significantly more residents in small facilities had dementia than did those in large facilities. Residents in small facilities also were slightly more likely to be diagnosed with Alzheimer's disease, though not significantly so.

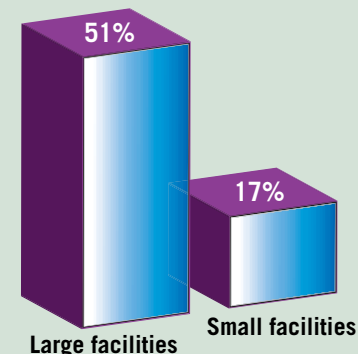
Almost all residents (98%) in small facilities had either dementia or some other psychiatric diagnosis vs. 74% of those in large facilities. Likewise, residents in small facilities had more cognitive difficulties as measured by the Mini-Mental State Examination, with an average score of 13 compared with 20 for those in large facilities.

Residents in small facilities also had a greater number of behavioral symptoms, as measured by the Neuropsychiatric Inventory (17 vs. 10). More residents living in small facilities had psychotic disorders as well (10% vs. 1%). There were no differences in mood or anxiety disorders between the two facility sizes.

Of the 39 residents with dementia in small facilities, the caregiver was slightly more likely to recognize dementia symptoms than were family members. The opposite was true for the 95 residents with dementia in large facilities.

In terms of treatment, small and large facilities were comparable in the percentage of pa-

Patients With Depression More Likely to Get Antidepressants in Large Facilities



Note: Based on a study of 196 residents in 22 assisted living facilities.
Source: Dr. Watson

tients considered completely treated (around 50%).

"Residents who are living in large facilities actually were more likely to have a private duty [caregiver] stay with them," Ms. Samus said. Residents in large facilities also were more likely to undergo physical therapy. Large facilities offered more activities for residents. Small facilities were more likely to use restraints and bedrails.

"Small care providers were actually spending more than 400 minutes a day caring, supervising, or doing activities of daily living with their residents, compared with a little over 100 minutes for the large facilities," Ms. Samus said. The difference may be partly explained by the higher likelihood of having a private-duty caregiver at large facilities.

Residents at small facilities had fewer falls per month (0.13, compared with 0.33). No difference was found in emergency department visits in the last month. ■

Office-Based Intervention Improves Vulnerable Elderly Care

BY JANE NEFF ROLLINS
Contributing Writer

LOS ANGELES — A practice-based, paper-and-pencil-based intervention can improve quality of care for community-based vulnerable elderly patients with dementia or incontinence, Dr. David B. Reuben reported at the annual meeting of the Society of General Internal Medicine.

The Assessing Care of the Vulnerable Elders (ACOVE-2) trial, funded by Pfizer and Rand Health, was implemented in two large group practices in California with patients aged 75 years and older who had dementia or incontinence. The intervention group included 357 patients, and the control group had 287 patients, said Dr. Reuben, director of the multicampus program in geriatric medicine and gerontology at UCLA.

Study sites included a primary care prac-

tice with 30 physicians serving 22,000 patients (67% of whom were in managed care programs) and a multispecialty practice with 100 physicians and 140,000 patients (50% in managed care programs).

The ACOVE-2 sites in the intervention group redesigned their practices to identify eligible individuals, collect data, develop structured visit notes to suggest appropriate care, provide patient education, and link patients to community resources.

The structured visit notes were filled out by the physician. For example, the visit note for preventing falls included check boxes for testing vision, gait, and balance. The dementia visit note included check boxes for long- and short-term memory, a simple math question about making change for a purchase, and a language-related question. After the intervention, overall care patterns improved: 45% of patients at risk for falls received a specialty exam and 89% received

recommendations to improve strength/gait problems, compared with 12% and 58%, respectively, before the intervention.

In addition, after the intervention, 33% of patients with incontinence received a recommendation for behavioral treatment before drug therapy, compared with 4% before the trial. However, there was no significant difference between intervention and control groups in the management of dementia. The structured visit notes included check boxes to minimize the time needed to fill out each section. "If it was quick, we knew doctors would do it. If it took time, doctors wouldn't do it," he said.

Patient education materials for each condition were in each exam room, so the physician didn't have to leave the room and interrupt the flow of the visit. For example, if a patient had problems with falling, the doctor might check the referral box for tai chi classes and pull a list of classes or-

ganized by zip code from the rolling cart that was in every room.

"I think the most interesting and controversial aspect of patient education material was the follow-up sheet," Dr. Reuben said. The follow-up sheet included patient instructions for treatment and a list of questions for the patient to answer as homework before the next visit.

Physicians may encounter problems adapting ACOVE processes to their own practices, Dr. Reuben said. "One thing I can guarantee. If you try to do this exactly how it was done, it won't work or you won't do it. You must ask 'what can I do to tweak it?'" ■

More information about ACOVE, including forms and physician and patient education materials, has been made available at www.geronet.ucla.edu/centers/acove/index.htm.