The Pennsylvania Society for Post-Acute and Long-Term Care Medicine

pmda



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Official Pennsylvania Chapter of AMDA

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President's Message

Giving the Care Our Patients Want

by Deborah Way, MD, CMD
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During the last few weeks, I have had the privilege of attending two very fine conferences. The first was in Chicago for the American Academy of Hospice and Palliative Medicine. While there, in addition to many excellent clinical sessions, I spent an hour in Saturday morning's plenary listening to the words and viewing the images of Candy Chang's work. Ms. Chang is an artist whose work revolves around the phrase "Before I die I want to _____." Her initial efforts were in post-Katrina New Orleans. She painted the walls of an abandoned building with chalkboard paint and stenciled this phrase over and over. Then she left chalk in baskets near the walls. Within a few days, the walls were filled. The project moved from neighborhood to neighborhood, city to city and to places as far away as South Africa, China and Brazil.

This world-wide, cross cultural project has affected so many different people that she has published a book. It is inspiring to see the things small and large that people want to do before they die. The answers range from "laugh more" to "write a book" and so many more. In April, she is bringing her art to Philadelphia in conjunction with the Mural Arts Project. I can't wait to see it.

Although there were numerous topics covered, the particular theme that I found at this conference was **getting our patients the care that they want**. In her presentation, Dr. Diane Meier from the Center to Advance Palliative Care (CAPC) spoke of our community needing five things, which I hope to employ in my own program:

- A common agenda,
- mutually reinforcing activities,
- shared measurement systems,
- continuous communication to build trust, and
- backbone support organizations.

The second conference I participated in recently was the national meeting of AMDA – The Society for Post-Acute and Long-Term Care Medicine, in Orlando. It was not surprising that I saw some faces there that I had just seen in Chicago.

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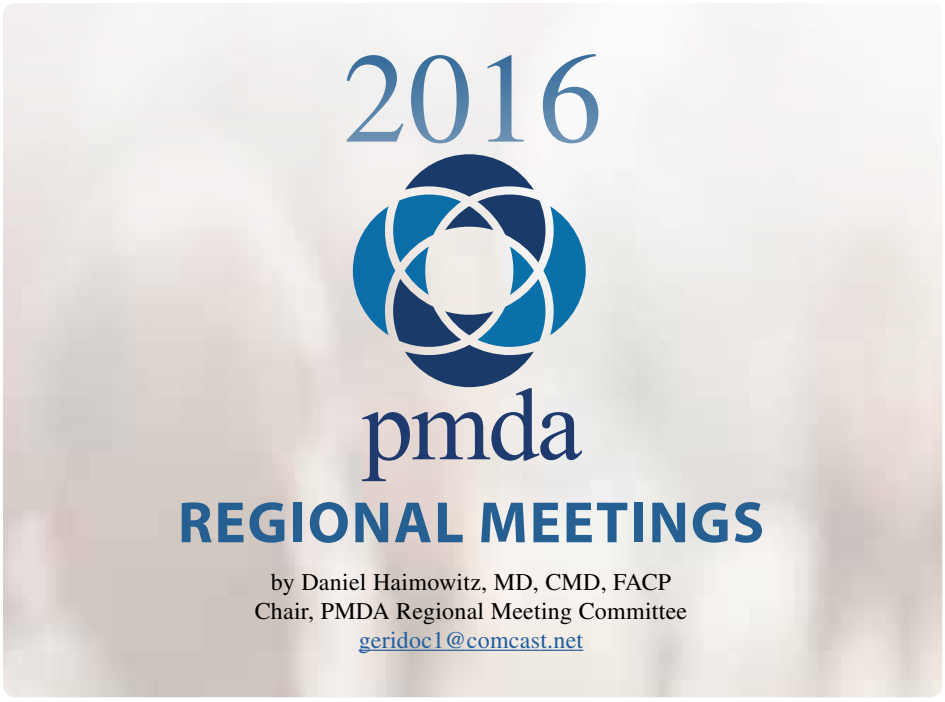

by Daniel Haimowitz, MD, CMD, FACP
Chair, PMDA Regional Meeting Committee
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The PMDA Regional Meeting Planning Committee has been working to develop state-wide webinars on hot topics of interest to PMDA members and other members of the Interdisciplinary Team. The first meeting of 2016 was held at seven locations throughout PA on **Thursday, April 21**.

The topic of the webinar was **"Palliative Care 2.0"** and our distinguished speaker was Robert M. Arnold, MD. Dr. Arnold is professor, Division of General Internal Medicine, Department of Medicine, University of Pittsburgh and University of Pittsburgh Center for Bioethics and Health Law. He is also the director of the Institute for Doctor-Patient Communication and the medical director of the UPMC Palliative and Supportive Institute. Dr. Arnold's presentation focused on palliative care as a model of good care for chronically ill, elderly adults, and reviewed the history of specialty palliative care and the data showing the positive effect of specialty palliative care. He also discussed the limitations of specialty palliative care and the need for primary palliative care. Participants received practical advice on how to have goals of care conversations.

The Regional Meeting Committee appreciates the efforts of the facilitators in each of the regions. They are all available for any questions or additional details. The committee has reached out to the PA Chapter of the American College of Healthcare Executives, in particular Vice-Chair Mary Kender, to seek input and involvement of facility administrators. **All interdisciplinary teams are encouraged to attend regional meetings!**

Planning is now in progress for the second regional meeting of 2016, which will take place **Wednesday, September 7**. The topic will be **"Transitions of Care,"** with at least partial focus on the transition of residents out of the nursing home to the community. It is anticipated that in addition to the sites listed above, there will be an additional location in the Scranton/Wilkes-Barre area. Details will be announced as soon as they become available. As always, you can check the PMDA website for updates. We look forward to seeing you!

APRIL 21ST LOCATIONS

Bethlehem

ManorCare Chapel Meeting Room

(Facilitator Dr. Sean Heffelfinger)

Erie

County Medical Society

(Dr. David Kruszewski)

Harrisburg

PinnacleHealth Brady Building Susquehanna

(Dr. Sarah Noorbaksh)

Lancaster

Mennonite Home Juniata Room

(Drs. David Fuchs and Leon Kraybill)

Muncy

Muncy Valley Hospital

(Dr. Dilip Elangbam)

Pittsburgh

UPMC Passavant Hospital Donor Hall

(Ms. Tracy Polak and Taafoi Kamara; Dr. Daniel Steiner)

Southeastern PA

Boyd-Horrox Funeral Home Norristown

(Dr. Daniel Haimowitz)

Advance Care Planning Codes: Finally a Reality

by David A. Nace, MD, MPH, CMD and Zachary Simpson, MD, CMD
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In October 2015, the Centers for Medicare and Medicaid Services (CMS) approved two long-awaited advance care planning (ACP) codes as part of its 2016 Physician Fee Schedule. Both AMDA and PMDA advocated for inclusion of these codes in the final fee schedule, a step which we believe will play a major role towards conducting meaningful conversations about a given patient's care wishes.

The two codes and payment rates are listed in the tables to the right. Table 1 lists the fee schedule for the codes when provided outside a facility. Table 2 lists the fee schedule when services are provided within a facility. Both codes require a face-to-face meeting with either the patient, family or surrogate for "the explanation and discussion of advance directives such as standard forms (with the completion of such forms, when performed), by the physician or other qualified health professional."

Physician Fee Schedule Amount - Non-Facility Settings (Service Provided in Outpatient Setting)			
Code	Descriptor	Metro Phila Area	Rest of PA
99497	First 30 Minutes	$90.50	$83.85
99498	Each Additional 30 Minutes	$78.67	$73.28

Table 1.

Physician Fee Schedule Amount - Facility Settings (Service Provided in a Facility)			
Code	Descriptor	Metro Phila Area	Rest of PA
99497	First 30 Minutes	$83.49	$77.86
99498	Each Additional 30 Minutes	$78.28	$72.95

Table 2.

FREQUENTLY ASKED QUESTIONS

Regarding the ACP codes (members are reminded they must check with their billing services and insurance carriers for accuracy of information and specific details):

1. **Can the codes be used in the nursing home or assisted living setting?**

   YES – The ACP codes are not site restricted. They may be used in hospital, outpatient and long-term care settings.

2. **Can nurse practitioners and/or physician assistants use these codes?**

   YES – The codes may be used by any qualified health professional.

3. **Can we bill for ACP that is less than 30 minutes, but more than 15 minutes?**

   YES – The CPT® time rule applies for any service in the CPT manual unless otherwise stipulated. The CPT® time rule convention states, "A unit of time is attained when the mid-point is passed." The 99497 code is used to report the first 30 minutes of face-to-face time. Using the CPT® time rule, if a visit is > 16 minutes and < 31 minutes, then the 99497 code may be billed. PMDA believes that advance care planning discussions are complex ones and should not be rushed. Thus, for most discussions, we would anticipate the time required to be closer to the 30-minute mark. Note: Some carriers may require documentation of the specific start and stop times when using time-based codes. Members should consult with their local carriers.

4. **Can the ACP codes be billed on the same day as office or nursing facility Evaluation & Management (EM) codes?**

   YES – Practitioners may bill both an EM code and one or more ACP code on the same day. For example, a practitioner may perform a federally mandated visit to a nursing home resident for purposes of reviewing the resident's overall plan of care. It may be determined there is a need to address advance care planning and this service is provided in addition to the scope of the federally mandated visit. The practitioner would bill a nursing facility EM code which reflects the time/intensity of services provided as well as one or more ACP codes which reflect the additional time spent addressing advance care planning. Time identified in the ACP codes should not be included in the time necessary to complete the EM services.

5. **Is there a copayment for the ACP codes?**

   YES – There is a separate copayment which applies to use of the ACP codes, with the exception of situations in which the ACP codes are provided on the same day as an annual wellness visit (outpatient setting). If used in conjunction with an annual wellness visit, copayments are waived. *Note: If both an EM service and an ACP service are billed on the same day (outside of a wellness visit), the patient will be subject to two copayments.*

Reference:

CMS Physician Fee Schedule

Criminal Neglect in Personal Care Homes — Is the Doctor at Risk?

by Duncan S. MacLean, MD
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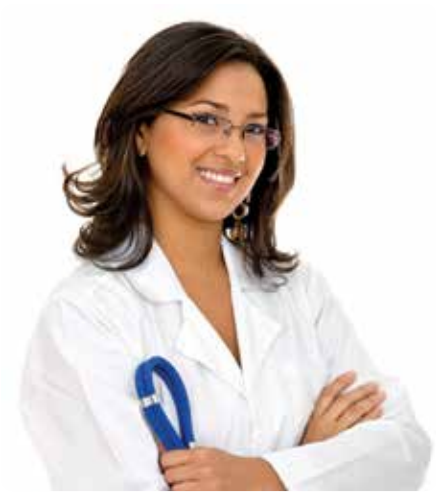
Monday morning call from GoodCare personal care home: "Mrs. Smith returned from ER last night. Small right elbow skin tear, steri-stripped. X-rays negative. Vital signs normal. Eating breakfast and back to her baseline." Mrs. Smith is an 82-year-old woman with stable dementia, mild CHF and controlled diabetes. She has resided at GoodCare for a year, and had been thriving until she tripped and fell 6 weeks ago. She had another fall in the bathroom last month. After that, she plateaued in physical therapy. Your exams have shown only a pleasant frail elderly woman with slow gait and no cogwheel rigidity. Your follow-up phone call today elicits staff's report that she "forgot" to use her walker out in the day room yesterday. They promise to remind her about the walker, but admit that they can't always watch her when she is alone in her room.

What is the facility's responsibility in this case? What is the physician's responsibility? What are the differences between a personal care home (PCH) and a nursing facility (NF)? What is the potential civil negligence liability? Is there criminal neglect liability? How can the risk be managed?

David Hoffman, Esq. and I covered abuse and neglect in long-term care at the Fall 23rd Annual PMDA Symposium. PMDA has requested more in-depth discussion of issues specific to PCH settings. *Disclaimer: this general review is for education only; please consult an attorney and physician for specific cases.*



Background

In 1987, OBRA proclaimed that all residents in any NF that receive federal funds would have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion (F Tag 223). All residents would have the right to receive care to maintain their highest practicable level of well-being (F Tag 309). But, as recently as the mid-1990s, there were still NFs that were horribly neglecting their frail residents.

Three notorious cases came to light in 1991 at Cobbs Creek and Care Pavilion nursing homes in Philadelphia, both operated by the Geri-Med Corporation. These three frail victims lost weight, shriveled with contractures and suffered pressure sores penetrating through their viscera and out the opposite side of their torso. The Philadelphia District Attorney and Pennsylvania Attorney General joined forces to prosecute these cases, but they could not convict any corporate officer simply because there was no law to do so. Thus came about Act 28, the Care Dependent Adult Protection Act, passed unanimously in 1995 and now in place as Title 18 Pa. (Crimes Code) §2713. This law defines neglect of a care-dependent person and holds responsible any person who is an owner, operator, manager, or employee of a nursing home, personal care home, domiciliary care home, community residential facility, intermediate care facility for the intellectually disabled, adult daily living center, home health agency, or home health service provider whether licensed or unlicensed; provides care to a care-dependent person in the setting described in the introductory paragraph; or has an obligation to care for a care-dependent person for monetary consideration in the settings described in the introductory paragraph or in the care-dependent person's home.

The law very explicitly includes corporate officers and administrators. It also includes physicians and broadly covers all institutional, community and home settings.

Fortunately, owing both to OBRA and the neglect law, criminal neglect and abuse has now largely been driven out of nursing homes throughout Pennsylvania and the nation. Admittedly, there are still individual instances of rough handling, care lapses or emotional intimidation that may occur. And yes, though not as serious as the Geri-Med abuses, these mistreatments must be eliminated from nursing homes and replaced with a culture of dignity – affirmation of social worth, support of authentic autonomy, celebration of individuality

of residents, and compassionate care, as discussed at the 2015 PMDA Symposium.

Neglect in Personal Care Homes

Unfortunately, residents in PCHs are not covered by the abuse protections of OBRA '87. There are no federal regulations for the Assisted Living (AL) industry. Castle et al. from the University of Pittsburgh reported statistics about mistreatment in PCHs in a recent Journal of Applied Gerontology (2015; 34:407–443):

- 15% of staff had reported witnessing verbal abuse in AL (2002)
- In Pennsylvania in 2009, 8% (i.e., 116) of 1,441 complaints received by the State Ombudsman and 6% (i.e., 1,231) of 20,550 incident reports were from AL residents

A personal communication from Pennsylvania Attorney General Department indicates that all criminal neglect cases they have reviewed in the last 10 years under §2713 originated in PCHs, not NFs.

Negligence and Neglect

Neglect is the failure to provide care, goods, service, or treatment with resultant harm. The elements of neglect are well known to PMDA members and are the same for both civil negligence and criminal neglect:

- duty,
- breech,
- injury, and
- causal connection between breech and injury.

The difference between civil and criminal culpability hinges on intent. For civil culpability, it is sufficient to demonstrate a simple failure to provide care that meets a prevailing standard. However, to show criminal culpability the prosecutor must prove "intentional, knowing or reckless" intent. Reckless intent can be shown by a pattern of inattentiveness; a single lapse of care is usually not sufficient.

What Is Different in PCHs?

OBRA '87 is a plaintiff attorney's dream because of its hundreds of specific regulations, each one spelling out a clear-cut duty in NFs, just waiting to be breeched. Annual NF licensure surveys flush out poor-performing facilities and serve them up to firms like Riddick Moss in Alabama and Wilkes & McHugh in Florida. According to Provider magazine (September 2015), tort liability adds $1,910 to the annual cost of each NF bed in Pennsylvania, and as high as $5,730, $6,950 and $9,220 annually per bed in Florida, West Virginia and Kentucky, respectively. In NFs, then, federal and state inspectors constantly scrutinize quality of care, with tort lawyers close behind them.

However, as noted, PCHs are not federally regulated. PCHs and Assisted Living Communities (ALCs) are licensed in Pennsylvania by the Department of Human Services (formerly Public Welfare), not by the Department of Health, which licenses and inspects NFs. Pennsylvania posts its regulations in Title 55 for PCHs in Chapter 2600 and somewhat stricter ones for ALCs in Chapter 2800. While both are technically an "assisted living" in the broad sense, the majority are licensed in Pennsylvania as PCHs and will be referred to by the latter term for the remainder of this article.

PCH regulations are much more limited and general than OBRA regulations. Furthermore, PCHs do not involve the state and federal governments as silent financial partners, unlike NFs, who must comply with federal nursing home conditions of participation to qualify for Medicare and Medicaid payments. Rather, PCHs have only a two-way contract between the facility and the resident. There are no federal dollars involved, only private pay. The only duty for PCHs is to fulfill the contract, meet the modest state regulations and legally, little more.

Of course, there are many reputable PCHs who maintain high standards of LTC clinical and business practices. But residents in PCHs have become increasingly frail and care-dependent with numerous chronic diseases. Sadly, less ethical PCHs can easily victimize these elders, who often are vulnerable due to some degree of cognitive impairment. These facilities can claim that they were respecting the resident's legal right to sign the contract, and can hide under the pretense that the PCH had no knowledge of the resident's cognitive impairment. They can claim it was solely the resident's responsibility to identify any lapses under the contract. There are no state Department of Health or federal inspectors to advocate for them, as in NFs. The LTC Ombudsman is available to PCH residents, but only if the victim or responsible party knows when and how to call.

Personal Care Home Regulations

The key regulations pertaining to resident care in PCHs are:

- Requirement for resident assessment, both by the facility and by a provider (physician, PA, or CRNP), initially, annually and for "significant condition change," which is not defined further in these regulations. (55 Pa Code 2600.225)
- Determination by both the facility and provider that the patient does "not require the services in or of a licensed long-term care [nursing] facility." (55 Pa Code 2600.1 (c))
- Requirement for a resident-

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Criminal Neglect

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facility contract that provides a contingency discharge plan in case either the facility or provider determine that "the resident's needs cannot be met in the home." (55 Pa Code 2600.25 (c) (3))

The Assisted Living regulations at Chapter 2800 by contrast do not necessarily require discharge to another level of care, even in the case of increasing resident care need. The ALC regulations permits as an alternative to the implementation of a "supplemental support plan," at additional cost, providing it meets the resident's needs, as determined by the facility administrator, LPN or RN (55 Pa Code 2800.227).

Managing the Risk

The conclusion from this analysis is that PCH residents are not protected by federal law and regulation. Their health, safety and welfare are protected only by

- themselves or their family, monitoring the fulfillment of the contract;
- "the kindness of strangers," namely the facility and its staff. But facility and staff have a built-in conflict of interest, making it necessary to "trust but verify;" and/or
- the attending provider (physician, PA or CRNP).

Thus responsibility for the fundamental process of care falls largely to the physician or provider – assessing, care planning, implementing, and monitoring. PCHs have diminished responsibility to ensure highest practicable well-being and care under their regulations. A facility can claim a limited duty to assess and plan care only to the extent of the contract, and can escape responsibility by saying "the doctor did not tell us." PCH regulations do not even require a licensed practical nurse on staff, though most do have one.

It may fall mainly to the physician or provider to recognize "significant changes" that necessitate reassessment and further care planning. Providers must review supplemental "support plans" when contracted services are not sufficient. And they must determine when the facility can no longer adequately care for problems like frequent falls, pressure sores or recurrent aspiration pneumonia.

I have dealt with some facilities that have asked for a hospice referral when the PCH could no longer fully meet the patient's needs. Hospice can be a valid means to supplement care in a PCH, as long as the patient and family agree on hospice goals, and providing the patient does meet formal hospice enrollment criteria. Hospice care, however, might not be able to assure safe care for residents if the PCH does not have adequate staff resources.

And so it is physicians and providers who must ultimately watch over the rights and care of residents in PCHs. The law can hold providers culpable for neglect of a care-dependent person if they don't. In the case of Mrs. Smith at GoodCare, accordingly, the next step would be for the provider to call the administrator to start a discussion about transfer to a higher level of care, and to ask the administrator in turn to approach the patient and family.

What If the Family Refuses?

Families usually do refuse a transfer at first, or drag their feet, both because they typically don't acknowledge the resident's deterioration and because of money issues. The facility administrator, who may be under financial pressure regarding occupancy rates, may also have an incentive to downplay the deterioration and to delay plans for transfer.

LTC physicians must consequently not only muster our clinical and prognostic acumen, but also must mobilize our negotiating skills to understand all the emotional and practical barriers to a transfer. We must start early to sow the seeds for recognition for the need for transfer. The regulations give us a "big stick" indeed to leverage transfers, since we can legally determine the resident as no longer fit for personal care (as recognized in the introductory paragraph), but usually "speaking softly" works best. We have communication skills to explain the resident's decline. We understand the system dynamics of PCHs. We have the diplomatic skills to work with facility administration and we have connections with social services to help the family come to terms with an impending clinical tipping point.

There are some PCHs that have had the foresight to employ medical directors. Unlike in NFs, there is no federal requirement for this position in AL. A skilled, involved medical director may be able to work with the PCH administration to help provide improved care for the residents, and may be able to take an active role in transition of care issues.

The Real World

This analysis of criminal culpability sounds dire and overwrought. In reality, however, any provider who is a member of PMDA and has read this piece will never get within a country mile of a criminal prosecutor. Long before patients would deteriorate to the condition of the Geri-Med residents in 1991 we would have already taken steps to ensure their good care. I am aware of no LTC providers prosecuted under 18 Pa. C.S. §2713.

At the same time, there are challenges in persuading a PCH or family to transfer their loved one from a PCH to a NF for a higher level of care (unless done within a multi-level continuing care system). Usually the PCH resident must come to a clinical crisis and a hospitalization – another fall, another pneumonia, a worsening pressure sore, etc. At that moment, it finally becomes clear to all clinicians and family that nursing home placement or hospice is needed. In the end, the seed planted earlier by the doctor then sprouts without any further cultivation.

Conclusion

The message for LTC providers is to reemphasize our role in upholding the rights and well-being of our patients in PCHs and to embolden us to communicate forthrightly with our facility administrators. We must

- carefully assess patients' appropriateness for PCH,
- oversee support plans (especially for needs not covered by contract),
- monitor for signs that residents need a higher level of care,
- tell families and facilities when signs of decline emerge, and
- promote OBRA-style rights and dignity in the absence of federal protections.

Pennsylvania has underscored this expectation in law, even to the point of criminal culpability if we grossly abdicate this responsibility. However, it will not be the fear of criminal prosecution that motivates us to fulfill our duty, but rather our dedication under our Oath.

The author acknowledges and thanks Daniel Haimowitz MD, CMD, for reviewing this article and making helpful suggestions.

PMDA'S WEBSITE MAKEOVER

In mid-February, PMDA launched its newly redesigned website! If you haven't done so already, please take a minute to try out the now super user-friendly . We hope for this to be a valuable asset to our members that will conveniently display information on the latest Society's events, news and resources.

This is your website and we encourage you to share your suggestions and welcome web content submissions. Please provide us feedback at .

WELCOME NEW MEMBERS!

PMDA welcomes the following individuals who have become PMDA members since January 2016:

Heather Cox, MD
Amy Andreassi, CRNP
Chery Goff, NP
Nancy Dunphy, CRNP
Roxanne Sides, CRNP
Colleen Hughes, CRNP
Jennifer Weber, DO
Robert Druckenmiller
Christopher Pitsch, DO
Elizabeth Dohan, DO

President's Message

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There were many similar themes. Additionally, was this question:

"How do we help our patients get the care that they want?" First we have to know what they want. Then we also need to know what to tell them.

One of the sessions was on "prognosis." We all know of the research that shows medical providers are not skilled at prognosis and we know that the longer the relationship we have with our patients, the less accurate are prognoses. This session was very interactive. The bottom line was that there are various tools for prognosticating, but this skill is not based on an exact science. Many of us struggle with knowing how to answer "How long do I have, doc?"

The bottom line is not really about how long our patient "has" but how do they want to spend that time? Our task is to communicate how the course of illness will go over what probable time course. Is it curable, stable or progressive? What symptoms or complications can be expected? What effect will treatment have and what side effects can be expected? What is important to our patients and their families?

The good news is that CMS has now created billing codes for having these conversations. The better news is that providers are being reimbursed for these conversations. On page 3 of our newsletter you will find an article by Drs. Nace and Simpson that explains how this coding and reimbursement process is done. **Go forth and communicate!**

PMDA Listserv: An Underutilized Member Benefit

by David E. Fuchs, MD, CMD
defuchs@comcast.net

We all encounter situations in clinical practice or as medical directors that leave us wondering, "What would my colleagues do?" All members of PMDA are entitled to sign up for the listserv, an email only forum to post questions to which other members can respond. PMDA has many experienced members who are likely to have encountered your issue in the past. Here are a few examples of recent questions and answers, edited for the sake of brevity:

1. **Q:** The administrator at my facility is continually telling Medicare Part A skilled residents that they cannot go outside the facility for specialty medical follow-up appointments as the administrator will deny payment. Can he do this?

   A: The motivation is probably to reduce costs and increase profits, but the administrator is overstepping his authority as ascertaining the need for outside medical consultation is the responsibility of the attending physician. The administrator could be accused of denying access to medical care; this is a dangerous practice which is dead wrong and must be reversed. Work with your administrator to let him know that you will cancel truly unnecessary appointments (like PCP follow-up outside the facility) and approve only those that are medically necessary.

2. **Q:** What is the legality of using POLST? Can the emergency department (ED) physician ignore the resident's requests for care on their POLST?

   A: Although there is no specific POLST law in PA, other PA law provides the opportunity for patients to declare themselves a DNR here and now, without having a terminal illness or being permanently unconscious (the two criteria for invoking an advance directive). Having advance care planning discussions with residents and their families may help prevent the EMT from being summoned in the first place. When summoned, EMTs seeing a POLST may communicate with their command ED physician and confirm it is okay to omit CPR. In reality, for this to work, it is most important to have your entire medical community, hospital emergency departments, EMTs, and long-term care facilities, all embracing POLST together.

3. **Q:** Can a CRNP perform the admission history and physical on a skilled nursing admission?

   A: No, per CMS regulation, the attending physician must perform the admission history and physical examination within 30 days of admission or sooner if facility policy dictates. However, the CRNP may see the resident prior to the physician and bill an E&M code for that visit.

4. **Q:** Is anyone adopting the Quantiferon testing for TB screening on new residents or health care workers?

   A: Some use it but expense is an issue. Another responder then raised the issue of what to do for follow-up screenings for those who are positive. The CDC recommends that for residents or staff members with a positive tuberculin skin test or positive Quantiferon test, follow-up screenings should be done annually with only a symptom assessment, and further evaluation (e.g., chest x-ray) performed if symptoms suggest infection.

Recently, a physician from PA wanted to know if anyone knew of a good geriatrician in a town in New Jersey, and a response was quickly received. Another wondered how others handled a particular deficiency cited by the Department of Health on the recent annual survey visit.

This wonderful communication device is under utilized. I encourage you to sign up by sending an email to pmda@pamedsoc.org. Then you can begin posting your questions and being enlightened by the responses. To post a question you may follow the link on the PMDA website or send an email to pmda@pamedsoc.org.

NEW CMDS IN PA

PMDA congratulates the following individuals for recently obtaining their CMD certification:

Faina Caplan, MD
Joseph P. Chollak, Jr., MD
Jerry Cohen, DO
James R. Harty, MD
Steven C. Lewis, DO
Madhu Menon, MD
Robert J. Thurick, II, DO
Vincent Trapanotto, DO

When to Pop or Drop: Medication Reduction in Older Adults with an Intellectual Disability

by Don Bastian, RPh, MS, CGP
Board Certified Geriatric Pharmacist, President, DB Pharmacy Consultants LLC, Wescosville, PA
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A recent study described the morbidity and mortality characteristics among older adults with an intellectual disability. "The main finding was that although individuals in the current generation of older adults with intellectual disability still normally die at an earlier age than do adults in the general population, many adults with intellectual disability live as long as their age peers in the general population."(1) The results suggest that the longevity of adults with intellectual disability is progressively increasing including longevity for adults with Down syndrome. Furthermore, the study revealed the cause of death was strikingly similar to those of the general older population with cardiovascular, respiratory and neoplastic diseases among the most prominent causes of death. It was suggested that clinical practices be implemented that deter the onset and lessen the impact of older age related diseases and secondary conditions. This article will highlight some important considerations regarding safe medication use in older adults regardless of the intellectual disability with emphasis on those medications that should be modified, added and/or dropped to prevent dangerous drug side effects and interactions.

The geriatric population is a fragile age group from a pharmaceutical perspective since renal function declines with the aging process. Most drugs and their metabolites have a significant renal mode of elimination; therefore, special attention needs to be given to senior drug selection and dosing. Commonly used drugs in the geriatric population that require renal dosing consideration include Neurontin, Lyrica, Bactrim, Macrobid, Metformin, Zantac, Digoxin, Dilantin, Cipro, Levaquin, Celexa, Aricept, Effexor, Namenda, Actonel, Fosamax, Remeron, Seroquel, Allopurinol, and this is just the tip of the iceberg of renal sensitive pharmaceuticals. If renal dosing guidelines are not utilized, significant drug side effects are inevitable in older adults and many of these drugs should be dropped (i.e., Metformin is contraindicated if SrCr >1.5mg/dl in males or >1.4mg/dl in females).

There are many drugs on the market that when used in older adults can cause dementia, Alzheimer's-like symptoms and/or significant cognitive impairment. The reasons these drugs cause dementia are twofold. Many directly affect the central nervous system and brain causing a variety of symptoms that mimic Alzheimer's including agitation, memory loss, delirium, depression, and hallucination. Other drugs can indirectly cause cognitive impairment by accumulation in the body to toxic levels due to the inability to metabolize the drugs in the aging liver.(2) One example of a drug class with cognitive issues and commonly used in older adults are the statins (e.g., Lipitor, Crestor) whereby cognitive problems are the second most common side effect after muscle pain and weakness. There are a significant number of cases of statin-induced memory loss and transient global amnesia reported to MedWatch, the FDA's adverse-event reporting program. Other drugs that can cause cognitive impairment include the following drug classes and examples; beta-blockers (e.g., Atenolol), benzodiazepines (e.g., Valium), anti-histamines (e.g., Benadryl), tricyclic antidepressants (e.g., Amitriptyline), anticonvulsants (e.g., Neurontin), muscle relaxants (e.g., Baclofen), and sedative hypnotics (e.g., Ambien). These drugs should be dropped or never initiated for treating older adults due to the likelihood of precipitating cognitive impairment. There are safer alternative agents that should be used. Use caution however, when dropping since abrupt withdrawal on some of the above drugs can be devastating.

One of the most dangerous drug classes for older adults is the nonsteroidal anti-inflammatory drugs or NSAIDs. Unfortunately, these drugs are commonly used by seniors to treat their problems associated with aging including joint stiffness, arthritic and muscle pain. This class of pharmaceuticals is available both as prescription (e.g., Ibuprofen, Naproxen, Celebrex) and readily available over-the-counter (e.g., Advil, Aleve). NSAIDs are often the ingredients of many pain, cold and sleep medications thus compounding the use and problems of NSAIDs. The problems with NSAIDs are multifold including gastro-intestinal irritation leading to GI bleeding and

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When to Pop or Drop

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death, platelet dysfunction/prolonged bleeding time, blood pressure elevation, increased risk of heart attacks and strokes. The FDA recently strengthened existing label warnings for all NSAIDs about the risk of heart attack and stroke. Geriatric patients are at an increased risk of NSAID-related adverse events due to body system frailties. Patients of advanced age do not tolerate GI ulceration or bleeding well, and most cases of reported fatal GI events occur in this population. Older adults shouldn't take NSAIDs and they should be dropped from their drug profiles since so many non-NSAID analgesics are available that work just as well but without the risks.

Proton pump inhibitors (PPI) are thought to be ranked second for worldwide sales for a single class of drugs. They are also one of the most dangerous drug classes especially when consumed for extended time periods by older adults. The powerful acid suppression drugs were a big breakthrough following the discovery of histamine-2 blockers (e.g., Tagamet). Now for the first time, thanks to PPIs (e.g., Prilosec, Prevacid, Protonix, Aciphex, Nexium), you can actually slow down the production of acid from the stomach. PPIs are approved for a variety of uses including GERD, duodenal/gastric ulcer, dyspepsia, heartburn, esophagitis, Zollinger-Ellison syndrome, and used to prevent GI bleeds with the use of NSAIDs. Unfortunately, studies have shown that at least half of all people taking PPIs don't have a condition that the drug was designed to treat.(3) To further complicate matters, PPIs were tested and approved for short-term treatment of GERD, yet many people take them for much longer periods of time or greater than the recommended 4-8 weeks. Long-term use of PPIs by the elderly is associated with a variety of serious issues including: Vitamin B12 deficiency, bone fractures, hypomagnesemia, increased risk of pneumonia and C. difficile, increased risk of adenocarcinoma, and interactions with over a hundred other medications. Now for the worst news, trying to stop or get off of a PPI is very difficult. Studies have shown that if individuals taking PPIs for a month or more then stop, they make even more stomach acid than before starting the drug.(4) This effect, known as rebound hypersecretion of gastric acid, requires patience and multiple attempts of gradual dose reduction. Simpler non-drug alternative diet and lifestyle changes such as; raising the head of the bed, weight loss, eating smaller and less spicy meals, and eating earlier in the day are all reasonable fixes if bothered by heartburn or acid reflux.

A class of drugs widely prescribed to older adults for osteoporosis is the bisphosphonates (e.g., Fosamax, Boniva, Actonel, Reclast). This class of pharmaceuticals is often featured in magazine and TV ads as the cure-all or miracle drug as Sally Field claims in the ads for Boniva. What the ads fail to describe are the very serious and irreversible adverse effects of bisphosphonates. The FDA issued a warning that bisphosphonate drugs may lead to severe, chronic and permanent pain in muscles, joints and bones. The most common adverse effects of bisphosphonates are gastrointestinal including esophagitis, heartburn, acid reflux, ulcerations, and even cancer of the esophagus. While these drugs are intended to treat osteoporosis, ironically they are associated with atypical bone fracture of the femur. The most severe and devastating adverse reaction is osteonecrosis of the jaw. The long-term effects of bisphosphonates are unknown and the duration of therapy remains undefined by the manufacturers. The Surgeon General issued a comprehensive report in 2004 outlining the best ways to promote bone health and prevent osteoporosis and fracture. The report included sensible approaches such as supplementation with calcium, vitamin D and weight bearing exercise (e.g., walking). Considering the risk versus benefit of bisphosphonates, dropping them from the older adult drug profile should be given serious consideration especially if used for three or more years.

The top selling class of pharmaceuticals in the US is the statins and atorvastatin (i.e., Lipitor) is the top selling prescription drug. This class of drug is endorsed by the American College of Cardiology, the American Heart Association and other organizations, and often promoted by many internists that everybody over 40 years old should be on a statin. But are the statins as safe and useful in the older adult population as promoted by speakers paid for by big pharma? When older patients complain of muscle pain, fatigue and weakness, statins are often the likely cause. Muscle weakness and aches have the potential to progress to a statin induced rhabdomyolysis and eventually lead to kidney damage and/or failure. When the statins are combined with other fibrates, used to lower triglycerides, the risk of muscle damage increases dramatically. In June 2011, the FDA issued a warning that the use of simvastatin (i.e., Zocor) in doses of 80 mg should be avoided due to the risk of muscle damage. The second most common problems with statins are the cognitive ones as discussed above. Cognitive issues including memory loss, forgetfulness, amnesia, memory impairment, confusion, and depression have all been associated with the use of statins. Statins may

increase other risks including, developing diabetes, hemorrhagic stroke and many drug interactions since statins are metabolized by the liver enzyme CYP3A4. Use of statins in the elderly is ill advised, according to Danish researchers who concluded, "There is not sufficient data to recommend anything regarding initiation or continuation of lipid-lowering treatment for the population aged 80+, with known cardiovascular disease (CVD), and it is even possible that statins may increase all-cause mortality in this group of elderly individuals without CVD."(5)

All the drugs indicated for Alzheimer's disease including Aricept, Razadyne, Namenda, and Exelon, have the same geriatric precaution regarding duration of therapy as defined in the Federal Omnibus Budget Reconciliation Act (OBRA). According to OBRA regulations, the continued use of these medications for the treatment of a cognitive disorder should be reevaluated as the underlying disorder progresses into advanced stages. All the drugs indicated for Alzheimer's disease have numerous potential adverse reactions ranging from psychiatric effects (i.e., hallucinations, agitation and depression), confusion, drowsiness, gastrointestinal, cholinergic, skin reactions, and Stevens-Johnson syndrome. If the beneficial or stabilizing effects of the drugs are no longer evident then it's time to drop the drug.

The above suggestions of medication reduction in older adults regardless of intellectual disability can serve as a rough guide to refocus attention on some commonly used pharmaceuticals. When complaints or symptoms of discomfort are expressed, think about the potential drug related causes. For those older adults with intellectual disabilities and those that are unable to articulate discomfort, this article will hopefully stimulate your thoughts of possible causes and how to avoid drug related problems.

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The AMDA Foundation Futures Program —
It's Time for Advanced Practice Clinicians to Get Involved!

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Once again The AMDA Foundation dedicated a full day to the foundation's Futures Program at the 2016 AMDA – The Society for Post-Acute and Long-Term Care Medicine Annual Symposium, in Orlando, welcoming new Futures participants and Futures alumni. The Futures Program is dedicated to providing education, networking opportunities and on-going mentoring to physicians, fellows, residents, and advanced practitioners who are interested in devoting their careers to post-acute and long-term care.

Each year at the AMDA Annual Symposium, the Futures Program begins with a one-day intensive session. During this session, geriatric leaders and Futures alumni mentor Futures participants by sharing wisdom, expertise, numerous career opportunities, and the dedicated work that occurs in post-acute and long-term care. Additionally, participants learn how to take full advantage of the AMDA sessions and networking opportunities for the remainder of the annual meeting. This spirit of mentoring continues to resonate year after year, creating life-long relationships for providing advice, answering questions and offering guidance between Futures participants and alumni.

The Futures Program is an excellent opportunity to share your expertise, experiences and partake in the growing community of post-acute and long-term care! The ADMA Foundation is committed to fully funding the Futures Program through donations and gifts. For more information on how to participate in the Futures Program, please visit the AMDA Foundation website.

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Changes to Nursing Home Compare and the Five-Star Quality Rating System Begin April 2016

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On March 3, 2016 CMS released plans to update the nursing home Five-Star program. The plans call for the public reporting of six new quality measures beginning in April 2016 (via the nursing home compare website): four specific to the short stay (post-acute) population and two specific to the long stay (long-term) population. Five of these measures will be incorporated into the 5-star rating calculation beginning July 2016. The only measure which will not be incorporated into the 5-star calculation is the percent of long stay residents who receive an anti-anxiety/hypnotic medication. CMS has excluded this measure at present due to uncertainty in establishing specific thresholds.

The changes are being made in recognition of the fact there are at least two distinct populations served by nursing homes – short stay and long stay residents. Up to this point, most quality measures have focused on the long stay residents. There is a strong need to measure quality of care for the short stay population. In addition, the measures address quality areas not covered by existing measures, such as readmissions, emergency department visits and discharges to the home setting. Three of the six measures will be claims-based which CMS believes will improve accuracy.

References:

CMS Five-Star Quality Rating System

CMS Further Improvements to the NHC Five-Star Quality Rating System PDF

The quality measures are summarized in these tables:

2 New Long Stay Measures

Percent of Long Stay Residents
• whose **ability to move independently worsened** *(MDS-based)*
• received an **antianxiety or hypnotic** medication *(MDS-based)*

4 New Short Stay Measures

Percent of Short Stay Residents
• successfully **discharged to the community** *(Claims-based)*
• had an outpatient **emergency department visit** *(Claims-based)*
• were **re-hospitalized** after a nursing home admission *(Claims-based)*
• made **improvements in function** *(MDS-based)*