Dear Dr. Jeff:
My facility is preparing for survey. Many facilities in our state are receiving deficiencies for “unnecessary drugs.” We have found that the average number of prescriptions for our residents has been rising but seem to have little control over this as we don’t employ the physicians and they are doing the prescribing. Aren’t we required to administer medications as prescribed? What should we do to document that all these medications are necessary or to modify the prescribing practices of the medical staff?

Dr. Jeff responds:
The original regulations regarding unnecessary medications date back to the 1980s, the Institute of Medicine report on the quality of nursing home care, and the Omnibus Budget Reconciliation Act of 1987 (OBRA’87). In an era when government solicited expert opinion to inform policy making, a bipartisan coalition including consumer and provider organizations guided the extraordinarily detailed Institute of Medicine recommendations into federal law, signed by then President Ronald Reagan. Nursing home residents acquired the right to be free of unnecessary medications, which were defined as medicines administered without adequate indications, in excessive doses (including duplicate therapy), for excessive durations, without adequate monitoring, or in the presence of adverse effects that indicate the dose should be decreased or discontinued.

The identification of an unnecessary medication leads to a deficiency under F-329, which is a different regulatory section from those related to pharmacy services, medication errors, or self-administration of medications. So, to answer the first part of your question, failure to administer medications as ordered is one category of problems; administering medications that were never needed in the first place is another.

Free Ride
These regulations mandate an extraordinarily high standard of care, but in practice, nursing home physicians and facilities have been given a free ride. For example, antibiotics used for treatment of asymptomatic bacteria in the urine, which experts agree should not be treated, have not been identified as unnecessary medication. Similarly, iron therapy for the anemia of chronic disease, despite its well-known gastrointestinal toxicity in the elderly, has been accepted. One might well ask why residents who are documented to eat all of the food served to them in a diet, which a registered dietician has confirmed to be appropriate and well-balanced, should require supplemental “therapeutic” multiple vitamins. No one questions the routine use of stool softeners in residents without any history suggesting their need.

Medications with an associated diagnosis are generally considered to be “indicated,” even when the diagnosis is simply mentioned in progress notes or repeated from another practitioner’s diagnosis list. Indeed, the process of medication reconciliation for patients transferred from hospital or home to nursing home is often considered done when all the medicines ordered in the previous setting – no matter how ill-advised or inappropriate – have been reordered. Hospitalists often order injectable heparin or low-molecular-weight heparin for prophylaxis against deep vein thrombosis in bedridden patients. Although medical literature tends to support time-limited use in surgical and nonsurgical fracture patients, there is no logic to their use for medical patients who are out of bed and receiving rehab in a post-acute setting. Hospital protocols using prophylactic proton pump inhibitors, finger stick measurements of blood glucose with insulin coverage (especially in nondiabetics), and “as needed” hypnotics for sleep are generally inappropriate in the long-term setting, yet continue unquestioned by surveyors.

What Is Unnecessary?
A thoughtful review of the medication regimens of many nursing home residents would identify medications that most experts would consider “unnecessary.” Even ignoring the controversy around use of statins and cholesterol inhibitors, problematic drug use is common. Consulting pharmacists find large numbers of questionable practices on mandatory monthly drug regimen reviews (DRRs). These are almost never known drug interactions or medications ordered despite known allergies, which are both unusual and typically identified by the dispensing pharmacy. They are often issues regarding monitoring of medication use, and duplicative or excessively prolonged therapies. Pharmacy consultants will question the use of medicines on the Beers Criteria list of medications that are usually inappropriate in the elderly, but very few recommend adjustments of appropriate medications to geriatric dosages. Even fewer would question antibiotic treatment courses of up to 2 weeks for conditions in which 3 days may be appropriate or for infections that are undoubtedly viral in origin. When pharmacy consultant suggestions are not adopted, it is wise to review the chart to ensure that the need for the current practice is adequately documented. Attending physicians and nurse practitioners should use DRRs as a second set of eyes to avoid potential errors (and litigation). Unfortunately, far too many regard this process to be an argument rather than a dialog.

Nursing home staff should become familiar with the details of the guidance to surveyors to avoid potential deficiency citations.

Beyond these basic issues are larger issues regarding goals of therapy. One category would be the actual target values for many chronic conditions, such as hypertension and diabetes mellitus. Residents with genuine, documented hypertension should not be on regimens that lower their blood pressures excessively, and the upper target for systolic pressure has recently been increased to 150. Regimens that achieve “normal” or near-normal glycohemoglobin levels in diabetics expose them to hypoglycemic episodes, which shorten life expectancy and increase the risk of cardiac events and the progression of dementia. Again, these medications are virtually never questioned as “unnecessary.” But all this discussion relates to medications unnecessary to the practitioner’s goals of care. What of the resident’s goals of care? Most nursing home residents are frail seniors near the end of life. Their goals may be primarily palliative. Medications, regardless of effectiveness or risk/benefit ratio, whose primary purpose is to extend life or delay possible disease complications, may very well be regarded as burdensome and unnecessary.

Regulations require that residents not be prescribed medications that cause adverse effects severe enough to require dosage reduction or discontinuation. This assertion is particularly interesting and challenging. In fact, any resident receiving more than seven different medications is probably experiencing at least one side effect or drug-drug interaction. Many residents receive 20 or more medications with additional as-needed medications added on. When the diuretic produces hypokalemia, leading to prescribed potassium supplements, which produce nausea, leading to a histamine-2 blocker, which produces insomnia, which leads to a hypnotic, which produces anxiety and memory loss, leading to a cholinesterase inhibitor and a benzodiazepine, which --- this all-too-common sort of cascade is the opposite of good geriatric care. When residents elect hospice, if only truly palliative medications are continued, the resident often becomes dramatically more alert, with improved appetite. “Hospice honeymoon” is a vivid demonstration of the negative role that polypharmacy can play in resident quality of life. Yet again, probably none of those medications would have been described by surveyors as unnecessary.

Pitfalls of Psychotropics
Most deficiencies for F-329 unnecessary medications are triggered by the use of psychotropic medications, particularly antipsychotics, for residents with dementia. They are, in essence, the low-hanging fruit of unnecessary medications. Unlike all the examples of potentially unnecessary medications listed previously, specific guidelines have been issued to surveyors to walk them through the decision process, which the Centers for Medicare & Medicaid Services has determined to be appropriate to justify the administration of psychotropic medications. Because these guidelines essentially describe the activity that every other discipline – including nursing, social work, and therapeutic recreation – should do before considering medication, surveyors feel comfortable that they are not “practicing medicine,” but rather evaluating appropriate dementia care.

Psychotropic drugs for residents with dementia are only considered necessary when reasonable nonpharmacologic approaches have been tried and failed, or briefly in emergency situations until nonpharmacologic strategies can be used. They must only be used to treat specific target symptoms likely to benefit from their use, and their efficacy must be monitored. Efforts must be made for gradual dose reduction or total elimination, consistent with the known biology of the behavioral complications of dementia or other psychiatric diseases.

No one argues that medications are superior to nonpharmacologic approaches when those approaches can be identified. Just as no one would consider appropriate the use of an incontinence medication when the solution could simply be assisting the resident to the toilet or eliminating a nocturnal diuretic, appropriate use of antipsychotics must be founded on a thoughtful evaluation of the underlying causes of the resident’s behaviors.

Effective collaboration with your pharmacy consultant combined with quality data should help you to avoid a deficiency for unnecessary medication. Remember, a survey is a test

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Hospitalization for Pneumonia Raises CVD Risk

BY MARY ANN MOON

Among older adults, hospitalization for pneumonia raises the short-term (1-month) and long-term (10-year) risk of cardiovascular disease events to a degree comparable to those of smoking, diabetes, and hypertension, according to a report published online in JAMA.

“Our findings suggest that hospitalization for pneumonia should be considered an independent cardiovascular risk factor” and “should prompt clinical trials to test targeted strategies” to prevent the disease in this patient population, said Vicente F. Corrales-Medina, MD, of the University of Ottawa and the Ottawa Hospital Research Institute.

The risk of CVD events within 30 days of severe infections, mainly those involving the respiratory tract, is well established, but the more lasting effects are uncertain. In what the researchers described as “the first study to document the temporal variation in the long-term risk of CVD ... using rigorous methods to adjust for many potential confounders,” they analyzed data from two multicenter population-based cohorts that were followed for 21 years. The 591 participants in the Cardiovascular Health Study were 65 years of age or older and had been hospitalized for pneumonia. When researchers compared their outcomes with 1,182 matched controls without pneumonia, they found that in the pneumonia group the rate of CVD events was fourfold higher at 30 days, dropped to twofold higher throughout the rest of the first year, and leveled out at 1.5-fold higher for the remainder of the decade.

Researchers then verified this risk pattern in a cohort of 680 pneumonia patients aged 45-64 years and 1,360 matched controls in the Atherosclerosis Risk in Communities study. The increased risk conferred by hospitalization for pneumonia persisted after the data were adjusted to account for demographic traits, preexisting CVD risk factors, and measures of patient frailty; it also was robust to numerous sensitivity analyses, the researchers said [JAMA 2015 Jan. 20 [doi:10.1001/jama.2014.18229]].

Moreover, the magnitude of risk conferred by hospitalization for pneumonia “was similar or higher, compared with the risk of CVD associated with traditional risk factors such as smoking, diabetes, and hypertension,” wrote Dr. Corrales-Medina and his associates.

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of compliance, not quality. The larger issue, eliminating truly unnecessary medications, will require larger effort. Practitioners need to be educated regarding effective geriatric care. Families and residents need to be informed about the actual risks and benefits of their drug regimens. Consultant recommendations need to be reviewed skeptically, but considered. Drug regimens carried over from prior settings, such as proton pump inhibitors from the hospital, need to be scrutinized as to their appropriateness for the resident’s current status. Principles of palliative care need to be infused into standard care for residents in their final years. The benefit from these admittedly difficult tasks would be fewer falls, more available nursing time to devote to resident needs, decreased weight loss with improved appetites, and happier residents.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Comment on this and other columns at www.caringfortheages.com under “Views.”