Dear Dr. Jeff:

Our nursing home has an unwritten policy that we do not accept applicants with a history of alcohol abuse. Talking to friends at other facilities, I have found that this is quite common, although no one seems entirely sure why. Is this a legal practice or discrimination based on a disability? Even if legal, do you think it is a sensible practice or a bizarre car-

Dr. Jeff replies:

It would probably more accurate to say that your facility does not know-

ably admit applicants with prior alco-

hol abuse. Given the high prevalence of alcoholism among seniors and its low level of recognition, it is likely that 10% or more of your current residents have significant alcohol histories, including the probability that it played a role in the acute event that led to their requirement for short-term or long-term placement.

When an older person falls and fractures a femur, there is a much higher chance they were asked about loose throw rugs in the home than the timing of their last drink. Calcium intake and steroid use might be explored, but not the potential role of heavy alcohol use in underly-

ing osteoporosis. Indeed, alcohol abuse interferes with the management of most of the common chronic medical prob-

lems of older patients, including dia-

betic management, warfarin regulation, blood pressure control, congestive heart failure, balance disorders and periph-

eral neuropathies, cognitive impairment, acutely and chronically disturbed bowel patterns, gastric acid disorders including reflux and bleeding, malnutrition, sleep disorders, depression, medication non-

compliance, and chronic liver disease.

Because heavy alcohol use is strongly associated with all these health issues, its prevalence among hospital patients is significantly higher than in community studies. One study estimated alcohol use disorders among elderly emergency department patients at 14%, which rose to 18% among medical inpatients and over 23% in geropsychiatry inpatients (Psychiatr Serv 1996; 47:941–943).

Although surgery patients were not evaluated, the role of alcohol in traumas such as falls and motor vehicle accidents is obvious. Patients with postoperative delirium are frequently alcohol-

dependent, particularly with onset 24 to 48 hours after admission when alcohol withdrawal syndromes would typically present. Because elderly alcoholics are usually single, divorced, or widowed and frequently socially isolated, they are probably overrepresented among

those referred for post-acute care in a skilled nursing facility because they lack the community supports required for home care.

Hospital social histories with “non-

contributory” written next to alcohol and drug use should generally be read as “not asked.” Not only was the pattern of alcohol abuse unknown to the hos-

pitalist, it was also frequently unknown to the community primary care phy-

sician. Callahan and Tierney used the CAGE questionnaire (see box) to screen 4,000 patients older than 60 who were treated in an academic primary care group practice. Although they identified a prevalence of alcohol abuse of 10%, fewer than half of the patients had this diagnosis recognized and documented in the medical chart (J Am Geriatr Soc 1995;43:1378–1383). The misinforma-

tion produced by failure to ask is fre-

quently copied over into nursing home charts. Hospital discharge planners are unlikely to explore an area that will only make discharge more difficult or, if your assessment of local practice is correct, might make a transfer to post-acute care impossible.

Habit vs. Disease

The Philadelphia physician Benjamin Rush, a signatory to the Declaration of Independence, argued in 1808 that “habitual drunkenness should be regarded not as a bad habit but as a dis-

case.” The American Medical Association has accepted this position since the 1950s and included alcoholism in the International Classification of Disease (now ICD-10) under both physical and psychiatric diagnoses. The American Bar Association also endorsed the disease def-

inition for alcohol dependence. In 1988, the Supreme Court allowed the Veterans Administration to deny benefits to vet-

erans with primary alcoholism, which the VA defined as “willful misconduct.” Although explicitly intended as an escape for the VA to avoid the expense, the majority decision acknowledged a com-

mon belief in the disease theory but asserted that ongoing controversy among professionals existed and that the court would not take a position.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) revised the definitions in the process of updating DSM-IV to DSM-5, combining two diagnoses — alcohol abuse and alcohol dependence — into a single diagnosis of alcohol use disorder with various levels of severity based on 11 criteria. However, all these criteria are based on the prior year. Thus, an alcoholic with a year of sobriety would not be diagnosed with an alcohol use disorder despite extensive genetic and anatomical evidence sup-

porting the enhanced risk of relapse.

History of Discrimination

Discrimination against an applicant for nursing home care based solely on the existence of a particular disease would appear to be illegal. It is most certainly immoral and a violation of our medi-

cal responsibility to patients and to our community. Discrimination based on a “history” of a disease seems even worse — either unreasonable and capricious, or a wrong-headed stereotyping of elderly alcohol abusers as “lowlifes and bums” and a remnant of the anti-immigrant prejudices of the temperance movement. German and Irish immigrants in the late 19th century and Italians in the early 20th century faced opposition from Protestant reformers for a combination of religious beliefs and social practices, which included the routine public con-

sumption of alcoholic beverages.

In 1884, Samuel D. Burchard, a prominent Presbyterian minister, attacked the Democratic Party at a meeting of the Religious Bureau of the Republican National Committee as the party of “Rum, Romanism, and Rebellion.” The combination was apparently popular enough to help elect Democrat Grover Cleveland as president. Prohibition in the United States was a product of an early alli-

ance between the Republican Party and Protestant religious leaders, enacted during the 12 years of Republican rule in Washington, DC, from 1920 to 1932 and promptly repealed after Teddy Roosevelt’s election. Nursing homes in the United States are the descendants of the old parish poorhouses and old people’s homes, which were intended to support the “worthy” poor. Policies to exclude alcoholics or other substance abusers (even when the facility is part of a national for-profit chain) are obsolete remnants of those old traditions distin-

guishing our “righteous and worthy” poor elders from “sinners and the will-

fully sick.” These policies are generally unwritten and often unacknowledged because they will not withstand legal examination or legal scrutiny.

There are, however, valid reasons to reject individual potential residents with particular medical and psychological diagnoses or even categories of patients. These reasons would be based on the capability of your facility to meet the specific needs of that applicant. A facility licensed for adults should reject an infant applicant due to the lack of equipment or expertise to manage the patient. This would, of course comply with licensing regulations and not represent age dis-

crimination. A similar example would be a ventilator-dependent patient apply-

ing to a facility without ventilators or staff trained to manage them, without the ability to monitor blood gas lev-

els, and without a physician skilled in the management of such patients. Similarly, a facility might reasonably reject an 800-pound man if there were no beds that could support his weight or no equipment to transfer him out of bed. A patient with active tuberculo-

sis should not be accepted by a facility unless it has a negative pressure room and suitable protective equipment for staff. Applicants with recent physically aggressive behavior should be carefully reviewed as potential threats to other residents. However, none of these concerns should apply to most patients with alcohol abuse disorders and certainly not to those with a history of prior alcohol abuse who are now in remission.

Thorough Screening

New admissions to a post-acute or long-

term care facility should be screened on admission for alcohol and substance abuse. As an absolute minimum, the standard questions regarding prior use of tobacco, alcohol, and other drugs should be repeated and any positives given appropriate follow-up. Even light to moderate alcohol use may be a health issue if it decreases cardiac contractility, interferes with medications, worsens an underlying balance disorder or mild cog-

nitive impairment, or induces dang-

erous swings in blood pressure. Short-term patients, especially, need to have these issues addressed before returning to the community.

Screening for active alcohol abuse disor-

der is desirable. The CAGE questionnaire

CAGE QUESTIONNAIRE

1. Have you ever felt you needed to Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt Guilty about drinking?
4. Have you ever felt you needed a drink first thing in the morning (Eye opener) to steady your nerves or to get rid of a hangover?
CMS Finalizes Payment, Policy Updates for Medicare Hospital Admissions

The Centers for Medicare & Medicaid Services issued the fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, which updates 2018 Medicare payment and policies when patients are discharged from hospitals. The final rule relieves regulatory burdens for providers, supports the patient-doctor relationship in health care, and promotes transparency, flexibility, and innovation in the delivery of care for Medicare patients.

In the final rule, CMS is increasing the amount of uncompensated care payments made to acute care hospitals by $800 million to approximately $6.8 billion for fiscal year 2018. CMS is also providing further clarification about discounts given to uninsured patients who meet the hospital’s charity care policy.

In relieving providers of administrative burdens and encouraging patient choice, CMS is finalizing a 1-year regulatory moratorium on the payment reduction threshold for patient admissions in long-term care hospitals. CMS is also finalizing provisions that reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records.

Due to the combination of payment rate increases and other policies and payment adjustments, acute care hospitals will see a total increase in Medicare spending on inpatient hospital payments of $2.4 billion in fiscal year 2018. Based in part on the changes included in the final rule, overall payments to long-term care hospitals will decrease by $110 million in fiscal year 2018.

For a fact sheet on the Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, visit www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html. The final rule (CMS-1677-F) can also be downloaded from the Federal Register at: www.federalregister.gov/public-inspection.