Dear Dr. Jeff:

Our facility receives many patient referrals for post-acute care who arrive with a diagnosis of dementia; yet when we admit them, they do not seem to have any significant cognitive impairment. Some of our apparently intact short-term and long-term residents have been receiving cholinesterase inhibitors, while many of our long-term residents with significant confusion have no diagnosis or treatment whatsoever related to their mental status. Do you have any suggestions regarding best practices in dementia screening for nursing homes?

Dr. Jeff responds:

The identification and management of the dementing illnesses are major elements of long-term care. Although many facilities have specialized units designed for the care of individuals with dementia, others attempt to dodge the issue with so-called memory care units. Nearly all long-term care facilities provide care for a substantial number of residents with clinically significant memory loss, some of whom may indeed be admitted for short stays before returning to the community. For many residents, their cognitive deficits determine their need for long-term care, even when dementia per se is not their primary diagnosis. Many residents’ medical problems could have been managed in the community if they retained the ability to follow medical and nursing care instructions and supervise home care aids.

Screening for dementia and diagnosing dementia are two different actions that are frequently conflated but need to be separated to be understood. Every nursing home resident is screened for dementia on admission and at least quarterly per year because the Brief Interview for Mental Status (BIMS) is imbedded in the federally mandated Minimum Data Set (MDS). The BIMS tests immediate recall, orientation, and short-term memory with scores from 0 to 15. Scores of 13 to 15 are considered normal cognitive function. The chief virtue of the BIMS is in the word “brief” — the average administration time is 3.2 minutes (J Am Med Dir Assoc 2012; 13:611–617). The same California residents have been receiving cholinesterase inhibitors, while many of our long-term residents with significant confusion have no diagnosis or treatment whatsoever related to their mental status. Do you have any suggestions regarding best practices in dementia screening for nursing homes?

Making Sense of Dementia Screening

The BIMS was a reasonable selection for a mandatory screening tool, but its use is not common in other settings where the Mini-Mental State Exam (also known as the Folstein), the Saint Louis University Mental Status Examination (SLUMS), or the Montreal Cognitive Assessment (MoCA) is more commonly used, particularly in screening for mild cognitive impairment or early dementia. All three of these screens use 30-point scales, so many clinicians become confused when provided with a BIMS score of 15, which would represent significant impairment on any of the familiar tests.

MDS Shortfalls

Unfortunately, the results of many elements of the MDS, even though they are intended to drive team care planning, are not shared with the physicians and nurses practitioners providing direct care, particularly in the common scenario where the attending physician is not physically present at the care planning meeting. Because the MDS is submitted electronically, the MDS “book” is frequently completed and submitted by specialized MDS nurses; the backup paper copy is eventually brought to the patient care unit where it may be maintained in a separate binder rather than making its way to the patient chart at all. The regulations regarding the timing of MDS submissions are mind-bogglingly complex — with significant financial benefits or losses to the facility billing, depending on the selection of optimized submission dates — so the medical care staff may be unaware that a new MDS has been completed, much less of a change in score.

Medicare requires multiple MDS submissions during the course of a short-term admission. To establish the elements of a safe discharge, patients who return to the community need a more thorough cognitive evaluation than what is available through the BIMS. Unfortunately, nursing notes that read “alert and oriented times 3,” as occurs in the standard note, should usually only read “alert” because orientation is rarely repeated during the course of the stay outside the MDS process. The BIMS does not include any measures of spatial orientation (a key skill for driving, which is frequently lost in early dementia) or of executive function, which is rarely required of permanently placed residents but often is key to a safe discharge.

For example, memory function that includes the name of an immediate family member to call in case of need might be sufficient for a nursing home resident, but in the community that minimal cognitive function would need to be supplemented by finding the telephone number and having the ability to correctly dial a 10-digit number. Meal preparation is more complicated than simply opening and closing the refrigerator and oven, or summoning the strength to stand at the counter and sink for 5 minutes. Independent life at home is filled with multistep tasks, many of which need to be done in proper sequence. Close collaboration with a facility’s physical and occupational therapists will often provide insight on many of these cognitive functions.

The resident who experiences difficulty in remembering two- or three-step therapy instructions or has difficulty sequencing therapy tasks may have significant issues at home, regardless of MDS scores. As with so many issues in geriatric care, functional measures are more important than test scores or laboratory values. Similarly, the resident who requires cueing on the BIMS will probably need cueing for medication compliance when at home.

Screening tests for dementia and actual diagnoses are related but different concepts. The tests were developed to identify a subset of patients who might benefit from more intensive evaluation. “Failing” the BIMS or MMSE does not diagnose dementia any more than a positive urine culture diagnoses a urinary tract infection. Just as many clinicians order inappropriate antibiotics for asymptomatic bacteriuria, far too many will label memory deficits on a single examination as dementia, and may even initiate cholinesterase inhibitors in the hospital setting. Some of these unfortunate seniors will carry this label for life, and their families may make plans accordingly.

All dementia screening tests were designed to be administered to medically stable patients in an unstressed community setting. None have been validated for use in acutely ill adults. Hospitalists are to be commended for attention to the cognitive function of hospitalized patients, but they should shy away from diagnosing “advanced dementia” in patients who all too often turn out to have transient delirium and return to baseline intact cognition after their acute illness. Impaired cognition affects decisions regarding medication regimens, testing, and discharge planning. But all cognitive dysfunction is not dementia.

Confounding Factors

Among the list of confounding factors for misdiagnosed patients, certainly the most common confounder is delirium. Although many clinicians associate delirium with agitated and hyperactive behaviors, the majority of delirious seniors appear calm or even withdrawn (hypactive). However, difficulty with attention, which is the hallmark of delirium, will certainly produce low scores on any cognitive assessment. Friends and family are frequently more sensitive than medical professionals to the subtle changes that may resolve slowly after acute stresses to the brain, such as fever, hypoxia, electrolyte disturbances, and general anesthesia. For instance, see the study on the confusion assessment method–family assessment method (CAM-FAM) in post-acute care by Nina Flanagan, PhD, and Gale Spencer, PhD, of the Decker School of Nursing at Binghamton University in Binghamton, NY (Int J Older People Nurs 2016; 11:176–183). Their observations deserve attention.

Medications also contribute to in-hospital cognitive impairment, particularly the commonly used hypnotics and antihistamines or multiple medications with anticholinergic properties. Medication reconciliation in the post-acute setting should include efforts to eliminate these medications whenever possible.

Other common confounding factors include hearing impairment, language barriers, and pre-existing cognitive issues such as intellectual disabilities or developmental deficiencies (IDDD). Incorrect answers to misheard questions are common. Experienced older patients often do not bring their hearing aids to the hospital, anticipating the potential loss of these expensive devices. Additionally, questions asked in a language other than the patient’s native tongue may not produce reliable responses. Although several of the common screening tests are available in translations that have been validated for several languages widely used in the United States, such as Spanish or Cantonese, the individual administering the test might not speak those languages or appreciate the need for their use. With the dramatically enhanced life expectancy for IDDD patients, their presence among senior populations is increasing, and community-based programs lead to hospital admissions from home rather than institutional transfers. Chronic stable deficits may be mistaken for a dementing disease.

Dementia is, by definition, a category of illnesses characterized by progressive cognitive decline, including memory loss and decline in at least one other...
Federal guidance issued to state survey agencies last summer is expected to reduce inconsistencies in the issuance of civil monetary penalties (CMPs) and to curb what the nursing home industry has decried as a growing and unreasonable use of retroactively applied per-diem fines.

David Gifford, MD, MPH, senior vice president of quality and regulatory affairs at the American Health Care Association, said that per-diem CMPs were created to incentivize swift and sustained compliance with federal health and safety requirements in cases of immediate jeopardy (IJ) citations. “But over time, regional offices and [the Centers for Medicare & Medicaid Services] started issuing per-diem CMPs retrospectively for problems [found during annual survey visits] to have existed months ago,” he said.

“You could have two facilities with the same problem and in one facility the problem happened 1 month ago and in the other it happened 6 months ago, and their fines could vary from $30,000 to $180,000,” he said. “There was no equivalency between them.”

Now, according to a revision to CMP policies that CMS updates the CMP “analytic tool” used by regional offices to calculate fines, CMPs should not be applied on a per-diem basis for noncompliance and citations found to have occurred in the past, unless, as Dr. Gifford said, “there’s clear evidence of continued ongoing non-compliance.”

This change, he emphasized, “is only the change we have asked [CMS] for.”

In its policy memo issued in July 2017, CMS calls the per-instance CMP the “default for non-compliance that existed before the survey,” and the per-diem CMP the “default for non-compliance existing during the survey and beyond.”

There are exceptions in each category, however. For instance, CMS has said a per-diem CMP will still be used retroactively when “a resident suffers actual serious harm at the immediate jeopardy level” or was abused, or “if the facility had persistent deficient practices.” And per-instance CMPs will be made for noncompliance existing at the time of the survey and beyond “for facilities with good compliance histories.”

Dr. Gifford said nursing homes should feel the impact of these changes this year. “We’re still looking at the data [for signs of more consistency],” he said, “but it [appears] that we won’t [continue] to see huge variations of fines for the same problem.”

AHCA is also continuing to monitor an “apparent increase” in IJ citations in some areas of the country, Dr. Gifford said.

Dramatic Increase in Citations

Officials from LeadingAge Kansas and LeadingAge Washington told Caring last year that they were seeing “dramatic” and “inexplicable” increases in IJ citations — and resultant increases in CMPs and drops in Five-Star ratings (Caring for the Ages 2017;18(3):1,16,17).

Asked about this, Dr. Gifford said that AHCA is investigating the trend. “We’re trying to figure out whether it’s warranted or not,” he said. “There are clearly some examples of IJs that don’t appear to be related to serious harm or to any immediate risk. But we’ve also seen cases where there probably should have been an IJ citation but wasn’t.”

More change regarding the use of IJ citations — and fines for IJ citations — may be on the way. A separate draft memo issued by CMS in October 2017 says that noncompliance may occur for a variety of reasons, and that “the CMS regional offices, [in selecting remedies], should consider the extent to which non-compliance is a one-time mistake or accident, the result of larger systemic concerns, or a more intentional action or disregard for resident health and safety.” For IJ citations that do not result in serious injury, harm, impairment or death, fines “may be imposed but are not required,” the draft memo says.

Moratorium for Phase 2 Regs

CMS recently issued an 18-month moratorium on the use of CMPs for some of the new phase-2 regulations that became effective in November 2017. (The 2016 Requirements for Participation have a three-part phase-in of implementation dates over 3 years.) Among the F-tags included in the moratorium are F655 (Baseline Care Plan), F838 (Facility Assessment), F881 (Antibiotic Stewardship Program), and F758 (Psychotropic Medications, related to PRN Limitations).

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