Doctors Without Borders Lends a Gloved Hand to U.S. Nursing Homes

By Christine Kilgore

Doctors Without Borders/ Médecins Sans Frontières (MSF), the medical humanitarian care organization that has worked for 50 years in conflict zones and on infectious disease outbreaks throughout the world, for the first time in its history has stepped into more than 750 long-term care facilities during the COVID-19 pandemic — including dozens of nursing homes in Michigan and Texas.

MSF has provided on-site support to improve infection prevention and control (IPC) as well as mental health and wellness for caregivers. And in keeping with the communication aspects of its mission, the organization has briefed state and federal officials in the United States about the need for increased wellness support for staff, a more collaborative oversight process, and more on-site support for implementing effective IPC during the COVID-19 pandemic and beyond.

“Our job is to look for society’s most vulnerable and disproportionately affected, and [in the COVID-19 crisis], we found it in these nursing homes, both in the staff and in the residents,” said Heather Pagano, an operational analyst with MSF based in Belgium and the organization’s emergency coordinator in Michigan.

MSF’s involvement in nursing homes began in northern Italy last spring and spread to Belgium, France, and several northern European countries. As the pandemic’s epicenter shifted to the United States, MSF applied an additional lens to selecting its work sites, looking for areas of “structural exclusion and disparities,” Ms. Pagano told Caring.

A staff member at Advantage Living Center in Roseville, Michigan, volunteers to demonstrate safe personal protective equipment practices during training on infection prevention and control conducted by MSF.

To Prescribe or Deprescribe Statins, That Is the Question

By Jeanne Manzi, PharmD, BCGP, FASCP

The treatment of elevated cholesterol, particularly with β-hydroxy β-methylglutaryl-CoA (HMG-CoA) reductase inhibitors, commonly known as statins, is measured by the Centers for Medicare & Medicaid Services in various different ways. Statin Use in Persons With Diabetes (SUPD), a new Medicare Part D star measure in 2019, was listed as measure D14 in 2020; it calculates the percentage of patients between 40 and 75 years old who received at least two diabetes medication fills and also received a statin medication during the measurement period. Only patients who are enrolled in hospice or have an end-stage renal disease diagnosis are excluded (Caring for the Ages 2018;19[4]:8). So what about patients who are over 75 years old? The first statin, lovastatin, was approved in the United States by the Food and Drug Administration in 1987. Currently there are seven statins on the market in the United States that are available as a single-source product or in fixed-dose combinations with other drugs: atorvastatin, fluvastatin, lovastatin, pitavastatin, pravastatin, rosuvastatin, and simvastatin. There are almost 20,000 studies found on PubMed from the last two decades.
confirming the efficacy of statins in treating hypercholesterolemia, preventing atherosclerotic cardiovascular disease (ASCVD), and reducing mortality. But there are also risks associated with their use.

The FDA has published several safety alerts about statins in the last decade (search on the recalls, market withdrawals, and safety alerts at the FDA site: https://bit.ly/35PTryQ), including reports of adverse events such as:

- Increased muscle injury
- Loss of appetite
- Upper belly pain
- Dark-colored urine
- Yellowing of the skin/whites of the eyes (jaundice)
- Memory loss
- Confusion
- Abnormal fatigue
- Weakness
- Increased Hgb A1c
- Cytochrome P-450 3A4 drug interactions

Most adverse effects subside when statin therapy is discontinued, and the FDA has determined that the cardiovascular benefits of statin therapy outweigh these risks and prescribers should monitor patients. When reviewing the product labeling for the seven statins, severe adverse reactions that are noted include:

- Rhabdomyolysis
- Acute renal failure
- Pancreatitis
- Anaphylaxis
- Thrombocytopenia
- Stevens-Johnson syndrome
- Hemolytic anemia

Lower doses of statins are recommended for patients with decreased renal function and patients with a mild to moderate decrease in hepatic function. Prescribers should always check individual drug prescribing information (available online) for the dosing parameters. People older than 65 and women have a higher risk of developing adverse events from statins, so in these populations it would be prudent to start therapy with a low dose and increase slowly when titrating to therapeutic doses.

An internet literature search for statin deprescribing can produce guidance and tapering recommendations that are safe and do not increase mortality. One randomized clinical trial of statin deprescribing included palliative care patients with a limited life expectancy, recent deterioration in functional status, and statin use for primary or secondary coronary artery disease prevention, with no active cardiovascular disease (JAMA Intern Med 2015;175:691–700). The primary outcome was proportion of deaths at 60 days. Several secondary benefits that were observed while deprescribing statins included improvements in quality of life, less nonstatin medication use, and decreased medication costs. This study concluded that statin discontinuation was safe and did not increase mortality.

The Choosing Wisely campaign is an initiative of the American Board of Internal Medicine. The goal of this initiative is to promote conversations between clinicians and patients by helping patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

It calls upon leading medical specialty societies and other organizations to identify tests or procedures commonly used in their field whose necessity should be questioned and discussed with patients (ABIM Foundation, Choosing Wisely, Feb. 1, 2018; https://bit.ly/2HS20Ku).

The Choosing Wisely campaign — an initiative of the American Board of Internal Medicine to reduce the use of interventions of questionable necessity — suggests that adults age 75 and older may not need statins. Statins are often prescribed to prevent heart disease in older patients who have hypercholesterolemia. However, for older adults there is no clear evidence that high cholesterol leads to heart disease or death, and some studies show the opposite — that elderly patients with the lowest cholesterol have the highest mortality after adjusting for other risk factors. In addition, a less favorable risk-to-benefit ratio may be seen for patients older than 85, where the risks from statin drugs outweigh the benefits.

Limited studies are available that have evaluated the safety and efficacy of statins in older adults. A 2020 study by Ariela Orkaby, MD, and colleagues evaluated the role of statin use in mortality and primary prevention of ASCVD in U.S. veterans aged 75 and older (JAMA 2020;324:68–78). Of the 326,981 participants, 97% were male, and 91% were white, with a mean body mass index of 27.5 and average age of 81. The primary outcomes were all-cause and cardiovascular mortality. The participants were followed for almost seven years. The study concluded that in the individuals who were free of ASCVD at baseline, new statin use was significantly associated with a lower risk of all-cause and cardiovascular mortality. However, the study did not assess known adverse effects of statins such as myalgias, an increased risk of diabetes, postulated decline in cognition, drug-drug interactions, and polypharmacy. The investigators did state, however, that previous research had shown a slightly elevated risk of type 2 diabetes with high-potency statin use in the Veterans Health Administration setting. There remains a need for longitudinal studies of statin use in a diverse population of older adults, including women and people of color.

There is no simple answer regarding when to initiate or discontinue statin therapy in older patients. The best practice is to start low and go slow. For patients residing in a SNF, consultant pharmacists will identify tests or procedures already received, not duplicative of other tests or procedures, free from harm, and supported by evidence. The health care team should monitor each patient’s tolerance and educate patients and caregivers about common and serious side effects of the medication. Prescribers are advised to perform baseline and periodic laboratory tests to guide dosage increases and decreases as well as to evaluate the efficacy of the medication.

Using practical lipid end-point goals, prescribing the lowest effective dose possible, and deprescribing statin therapies when the risks outweigh the benefits are key points to consider when treating elevated cholesterol in older adults. If necessary, providers should investigate other pharmacologic and nonpharmacologic cholesterol-lowering therapies where appropriate.

If a decision is made to initiate statin therapy in an older individual, the best practice is to start low and go slow.

The Society’s Guide to Post-Acute and Long-Term Care Coding, Reimbursement, and Documentation contains documentation requirements and Society-developed coding vignettes for each of the nursing home family of codes as well as Chronic Care Management (CCM), Advance Care Planning (ACP), and Behavioral Health Integrated (BHI) services. For more information or to order your copy, please visit paltc.org.