DEAR DR. JEFF
By Jeffrey Nichols, MD, CMD

A Better World in the Future: Part 2

Editor’s note
In this month’s column, Dr. Jeff continues to answer the question from the November/December 2020 issue, focusing on deprescribing.

Dear Dr. Jeff: I recently completed a geriatrics fellowship and joined a multispecialty group practice in a small city. A few months ago, I agreed to serve as the Medical Director for a nearby 4-star nursing home. We have survived the pandemic rather successfully, but as I reviewed patient charts, I was pleased by the nursing documentation but appalled at the medical care our residents receive. Our physicians have all been on staff for years and generally have practices in the community. One is even from my group. But polypharmacy, overmedication, and inappropriate medications for the elderly seem like the standard while documentation of actually speaking with residents and families or examining the resident is sparse. Medical orders are largely entered remotely with little time spent in the facility. Our corporate sponsor is beginning a strategic planning process to prepare for the nursing home of the future, but I am not sure we are ready for the nursing home of today. Any suggestions?

Dr. Jeff responds:
Changing outcomes requires changing the systems that produce those outcomes. In my last column, I discussed possible changes in the care delivery system through strengthening the medical staff itself, including adding more providers and more on-site medical presence, particularly those committed to the care of the special demographic living in our facilities.

Over the last decade, nursing homes have been admitting new residents with increasingly complex medical needs and struggling to avoid hospitalization for patients whose medical status is decompensating. The Patient Driven Payment Model (PDPM) adopted by Medicare provides financial incentives for skilled nursing facilities to provide care for higher acuity patients. Hospitals will be encouraged to discharge even “quicker and sicker,” a process that had already begun a decade ago. Those with minimal supportive needs or requiring only custodial care will increasingly go to the assisted living programs of the future or some variant of enhanced home care program, although many already in nursing homes are likely to stay as residents. These changes will be accelerated by the fears of individuals and families stoked by COVID-19 outbreaks in many facilities and the new unfavorable and usually unfair media attention these have elicited. Searching for Allies
Some change is inevitable. But despite occasional nods in the direction of a need to rethink long-term care, there appears very little political will Continued to next page
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to address the complicated changes and major investment that would be required on the national and local levels for any major planned transformation. Responses to the devastation that COVID 19 has produced in many facilities have concentrated on more investment in facilities and higher staffing models with increased training requirements and skill levels for staff.

Despite muttering about the need to eliminate nursing homes, even transformational plans are aimed at alternate (and typically less expensive) care delivery models for those who require less care. There are no serious plans to address the needs of the high-acuity patients cared for in today’s nursing home. Although large numbers of voters have identified health care as their major concern for the 2020 elections, neither party put forward a platform to address the needs of long-term care. Indeed, the Republicans did not even update their health care platform from 2016. With global warming, there might not even be sufficient ice floes to send every nursing home resident out to sea. The proposal that frail seniors sacrifice themselves to the needs of the economy, made openly by Texas Lieutenant Governor Dan Patrick and quietly by all the politicians who have systematically underfunded long-term care for years, is the de facto plan for the future. All these patients deserve patient-centered, goal-concordant care from skilled and knowledgeable practitioners. Unfortunately, few are likely to receive it.

Before you despair of your ability to impact the quality of care, I want to reassure you that committed and knowledgeable medical directors have the ability to significantly improve care in their facilities and have demonstrated this many times in a wide variety of facilities over decades. Moreover, the national organization AMDA – The Society for Post-Acute and Long-Term Care Medicine and your state chapter have abundant resources to help you. These include podcasts and an email discussion forum plus publications like Caring for the Ages and the Journal of the American Medical Directors Association. Other helpful resources include Choosing Wisely recommendations directed at long-term care medical decisions, virtual conferences and lectures (including many archived for review), as well as colleagues and mentors for support and feedback.

Although most geriatrics programs expose their fellows to various sources of academic information regarding the field, some of which do contain useful information regarding quality improvement in long-term care, few programs expose their fellows to the wealth of information and support dedicated specifically to the long-term care space and its particular needs and concerns. The major exception to that has been the participants in the AMDA Foundation Futures program. Academic detailing — using experts in a particular focus of concern — has had only marginal success at best for addressing physician prescribing practices. Distribution of articles or guidelines without individual discussions and reinforcement has been even less successful.

**Pharmacist Allies**

Information by itself will usually not improve care systems. Fortunately, you do have potential allies within your building who can assist you toward your goals. These include your vendor pharmacy, your consultant pharmacist, and the director of nurses along with the nursing staff. Polypharmacy and inadequate documentation can significantly cost your facility in lost reimbursement, medication acquisition costs, and the nursing time required to administer and monitor medications. Administration buy-in and support should be relatively easy to obtain. Although the justification for your quality improvement efforts should not be cost savings per se, but rather improved resident quality of life and reduction in medication side effects, the reallocation of the vast amounts of wasted resources to hire more front-line staff and free up nursing time to more productive care are giant potential benefits. Most dispensing pharmacies provide monthly renewal forms for medications.
and other provider orders. These may be preprinted for facilities that still maintain paper charts or linked into the electronic health record (EHR), which the commonly used EHR systems can accommodate. These pharmacies will typically attach standardized note forms for provider history and physicals, which they will either print on the back of the orders or collaborate with the vendor of the EHR to link with the order. These standardized forms can be individualized to the needs and preferences of your facility but are typically user friendly and comprehensive. From the viewpoint of your providers, they document and justify higher billing levels, but for the facility and resident care they direct provider attention to issues such as weight, cognitive status, and skin integrity, which are often overlooked in spontaneously created notes. They typically offer check boxes for many issues, which increases compliance while decreasing documentation time. Because they are attached to the monthly orders, they encourage routine visits and offer a convenient format to ensure that medication regimens include only therapies that match resident needs and are effective.

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Every facility has a consultant pharmacist. As pharmacists whose task is to review and improve prescribing practices in the facility, consultant pharmacists often have a broader perspective on prescribing practices within the facility and how they compare with similar facilities, and most are knowledgeable regarding the specialized pharmacologic issues of a population of frail older adults. They are the logical allies of a committed medical director, particularly as they are reimbursed for the time spent performing monthly reviews of every individual resident’s medication regimen. Medical directors need to check that these reviews are being done and that practitioners are responding to them. Medical directors need to be alerted immediately to any critical issues identified.

Nursing Allies
Most of the suboptimal practices that concern you take a different approach. Regular meetings, whether in person or remotely, will permit you to develop a strategy to work on your goals. I will either print on the back of the orders or collaborate with the vendor of the EHR to link with the order. These standardized forms can be individualized to the needs and preferences of your facility but are typically user friendly and comprehensive. From the viewpoint of your providers, they document and justify higher billing levels, but for the facility and resident care they direct provider attention to issues such as weight, cognitive status, and skin integrity, which are often overlooked in spontaneously created notes. They typically offer check boxes for many issues, which increases compliance while decreasing documentation time. Because they are attached to the monthly orders, they encourage routine visits and offer a convenient format to ensure that medication regimens include only therapies that match resident needs and are effective.

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Nursing Allies
Most of the suboptimal practices that concern you take a different approach. Regular meetings, whether in person or remotely, will permit you to develop a strategy to work on your goals. I will encourage involving the nursing administration in this process. Confirmation from the director of nursing and floor nurses that various medications are no longer needed can encourage practitioners to discontinue them, and most practitioners will be reluctant to discontinue medications that frontline staff consider necessary.

One ideal place to start medication reduction is the near-total elimination of fingerstick glucose measurements with insulin coverage. Despite multiple expert guidelines from the American Diabetes Association, the American Geriatrics Society, and our Society, which condemn management of stable diabetics with this regimen, its use remains surprisingly common in skilled nursing facilities. Sometimes patients with orders for monitoring four times daily with potential coverage for never or rarely received insulin. Sometimes they remain on short-term insulin doses and are never converted to long-acting insulin once daily or have their existing dose readjusted. Some are not even diabetics—they might have had elevated sugars in the hospital because of an acute infection or intravenous dextrose or corticosteroid administration, but these orders continued after transfer to a post-acute setting, where they have been renewed for months or years. For infection control, insulin vials must be individualized to each patient. Irrationally expensive insulin vials, including unused or barely used vials, must be discarded and replaced after 30 days at considerable cost to the health

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Atrial fibrillation (AF) causes one in seven strokes overall, and one in four strokes in people over the age of 80, according to the National Institutes of Health — which makes stroke prevention a pillar of AF management. Yet oral anticoagulation (OAC), which reduces the risk of stroke by one-half to two-thirds in people with AF, is underutilized in the assisted living and long-term care population.

“People are always worried about falls and bleeding [from OAC], but it’s really the ischemic strokes, from clots, that cause the most damage — in physical function, in cognitive function, and in quality of life,” said Midge Bowers, DNP, FNP-BC, an associate professor at Duke University who practices at the Duke Cardiology Clinic and treats long-term care residents. “The impact of strokes in older adults is so profound,” she said in an interview. “One in three nursing home residents who have AF have already had a stroke.”

The most recent guidelines on AF from the cardiovascular community — the 2020 AF guidelines from the European Society of Cardiology (Eur Heart J 2020;ehaa612) — contain a section on the elderly and frail with AF. Dr. Bowers noted, in which it’s stated that “frailty, comorbidities, and increased risk of falls do not outweigh the benefits of OAC given the small absolute risk of bleeding in anticoagulated elderly patients.”

Evidence from randomized controlled trials, meta-analyses, and large registries supports the use of OAC in the frail and elderly with AF, and the newer novel oral anticoagulants (NOACs) appear to have a better overall risk-benefit profile compared with warfarin, the guidelines say.

Meenakshi Patel, MD, CMD, similarly implored her audience at the 2020 Virtual Annual Conference of AMDA — The Society for Post-Acute and Long-Term Care Medicine to “have informed discussions with residents and families” about anticoagulation. “Falls and age are not absolute contraindications to oral anticoagulants,” she stressed at the conference. Research has shown that a high risk of falling increases the risk of intracranial hemorrhage (ICH) by almost twofold, but studies also show “there is no difference in that risk of intracranial hemorrhage whether you’re on warfarin, aspirin, or no antithrombotic therapy... that’s the caveat.”

For “most patients with frequent falls, including injurious falls, the benefits of anticoagulation outweigh the risks of bleeding,” said Dr. Patel, a practicing geriatrician at Valley Medical Primary Care in Centerville, OH, and assis tant professor or geriatrics at Wright State University Boonshoft School of Medicine in Dayton.

In an American College of Cardiology 2016 registry study of more than 210,000 AF patients at moderate-high risk for stroke, almost 40% were treated with aspirin alone without OAC (Am Coll Cardiol 2016;67:2913–2923). The findings are disheartening, Dr. Patel said, because antiplatelet therapy is recommended as an option only for those at low risk of stroke.

Dr. Bowers found the findings from a LTC study published in 2020 just as frustrating. Almost 10% of 44,373 long-stay residents with AF had OAC discontinued — most often in association with a recent fall, and other times in association with severe activity of daily living dependency and other geriatric conditions (J Am Geriatr Soc 2020;68:717–724). Notably, she said, the CHA₂DS₂-VASc stroke risk score (congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, stroke, or transient ischemic attack, vascular disease, age 65–74 years, sex category) was not predictive of discontinuation. (The specific anticoagulant used in the study was not known.)

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Newer Anticoagulants

The CHA₂DS₂-VASc scoring system — which is recommended for stroke risk assessment and anticoagulation decision-making by the European Society of Cardiology and the American Heart Association/American College of Cardiology/Heart Rhythm Society guidelines on AF — puts almost all older residents into moderate-risk or high-risk categories by virtue of their age and gender alone.

It advises OAC for individuals who have a score of 2 or more, or a prior stroke/transient ischemic attack. An age of 75 or older earns 2 points, as does an age of 65–74 plus female gender. Still, using this tool in combination with a structured bleeding-risk assessment tool — such as HAS-BLED (Hypertension, Abnormal renal/liver function, Stroke, Bleeding history or predisposition, Labile international normalized ratio, Elderly [≥65 years], Drugs/alcohol concomitantly) — can be very helpful for decision-making that takes into account the risks and benefits, said Drs. Patel and Bowers.

“Anticoagulation really isn’t a cardiology decision — we need to be going over the pros and cons and making these decisions with patients and their families,” said Dr. Patel in an interview after the Society’s conference. “It’s a discussion that needs to happen.”

NOACs (also called direct oral anticoagulants) carry less risk of ICH compared with warfarin, and they do not require regular monitoring. “Almost all [NOACs] can be used in patients with reduced creatinine clearance, and they’re better than warfarin for stroke or systemic embolism risk, regardless of creatinine clearance or age,” Dr. Patel said at the meeting. “And now there are reversal agents for all these drugs.”

Jonathan Shaatz, MS, RPH, FASC, director of pharmacy for the Four Seasons Nursing and Rehabilitation Center in Brooklyn, NY, and the founder of a pharmacy consulting practice, told Caring that fluctuating international normalized ratios (INRs) in patients on warfarin signal a possible opportunity for switching to a NOAC. “Once we see that the INR is around 2.5, in the lower end of the therapeutic range, we can stop the warfarin and start the NOAC,” he said. He noted that the newer blood thinners are now considered standard therapy by pharmaceutical benefit companies.

NOACs decrease the risk of ICH but increase the risk of gastrointestinal bleeding compared with warfarin, Mr. Shaatz noted. “It’s a matter of asking which one is the lesser of two evils.” Rate control with beta-blockers and sometimes calcium channel blockers is the other main pillar of AF management in the elderly, he said. (Rhythm control is challenging, with antiarrhythmic drugs unlikely to maintain sinus rhythm in the older patient.)

Good rate control is essential for optimal functional status and participation in activities and therapies, Dr. Bowers said. “Look for subtle signs of worsening AF — breathlessness with either rest or activities, for instance, or more fatigue,” she said. “And continue to treat other conditions that may potentiate AF. By treating the hypertension, the sleep apnea, and the diabetes, you may actually help in controlling AF or reducing episodes.”

Future Changes

Dr. Bowers and Dr. Patel are both watching for insights into the role that OAC may play in the prevention of cognitive impairment. Thus far, research (largely observational studies) has suggested that OAC can reduce or protect against cognitive impairment in patients with AF. “A couple of studies suggest that the NOACs do a better job,” Dr. Patel said at the meeting. Randomized controlled trials of OAC with cognitive function as an end point are underway.

The potential for screening for silent AF with mobile or wearable devices — as well as detecting suboptimally managed AF — has been gaining attention in the cardiology community and is of huge interest for long-term care, they said. “Often we don’t see AF until there’s an event,” Dr. Patel said. “I think that with smart watches [and other digital technology], we’re finding out there’s a lot going on [asymptomatically].”

Christine Kilgore is a freelance writer based in Falls Church, VA.

Oral Anticoagulants for Atrial Fibrillation: Benefits Outweigh Risks for Older Adults

By Christine Kilgore

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