Updates in Sepsis Management Show Thoughtful Approach
By Christine Kilgore

The strengthening of protocols for close monitoring, active surveillance, and goals of care (GOC) discussions during the pandemic have likely positioned more nursing facilities to confidently recognize and initiate early management for residents with sepsis or suspected sepsis.

“The positive of COVID is that facilities that might have questioned their ability to create such a standard of care and manage sick patients in accordance with their wishes have realized they’re capable of doing it,” said Swati Gaur, MD, MBA, CMD, chair of AMDA – The Society for Post-Acute and Long-Term Care Medicine’s Infection Advisory Committee and medical director of New Horizons Nursing Facilities with the Northeast Georgia Health System. “The protocols and frameworks that facilities put in place to manage COVID were not one-off functions,” she said. “We can use the competencies we had to develop for COVID to do well in other areas of patient care.”

Dr. Gaur has advocated at the Society’s conferences for PALTC providers to embrace feasible elements of the “hour-1 bundle” introduced by the Society of Critical Care’s Surviving Sepsis Campaign (SSC) in 2018, such as obtaining blood samples to send for culture, administering crystalloid fluids in residents who are hypotensive, and administering broad-spectrum antibiotics when indicated.

In a 2018 JAMDA editorial, Robin L.P. Jump, MD, PhD; Susan M. Levy, MD, CMD; and Wayne S. Saltsman, MD, PhD, CMD, urged nursing homes to serve as first responders by developing a sepsis protocol tailored to its institution and by stocking an “S-Kit” with pertinent supplies (J Am Med Dir Assoc 2019;20:275–278).

Now, updated international guidelines from the SSC will further shape early management in long-term care (Intensive Care Med 2021;47:1181–1247; Crit Care Med 2021;49:e1063–e1143). Issued in October 2021 as an update to 2016 recommendations, the new guidance draws a distinction between sepsis and septic shock in addressing treatment and care.

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California Requires All Skilled Nursing Facility Medical Directors Be Certified
By Karl Steinberg, MD, CMD, HMD, and Michael Wasserman, MD, CMD

On October 6, 2021, Governor Gavin Newsom signed California’s AB 749 into law after it sailed through the state’s Assembly and Senate with minimal opposition. The bill requires almost all nursing facility medical directors to be certified through the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) by 2027. The California Association of Long Term Care Medicine (CALTCM), which is the state affiliate of AMDA – The Society for Post-Acute and Long-Term Care Medicine, was the sponsoring organization for this bill.

In 1974, in response to identified quality-of-care problems, the federal government began to require that all skilled nursing facilities have a physician serve as medical director and be responsible for the medical care provided. One year later, a group of concerned medical directors formed the California Medical Directors Association (now called CALTCM) and immediately began

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nursing home staff want to use “antipsychotics to manage dementia” but also want to “avoid penalties and sanctions by mislabeling residents with a diagnosis that makes sense for the medication, but not for the patient.”

Misdiagnosing patients is a question of medical ethics. “Clinicians that misdiagnose residents as schizophrenic ... are putting their licenses at risk,” Dr. Juman said. “Purposefully skirting a regulation in order to prescribe a drug is not only harmful but fraudulent. It also leads to fraudulent billing for services related to a diagnosis that was not rendered.”

Appropriate Prescribing Practices

Ms. Hoffman detailed four key areas that impact her decision on whether to prescribe an antipsychotic without the CMS-approved diagnosis. She looks at the impact of symptoms on daily life, rules out other drugs without effect, assesses physical harm to the patient’s self or others, and rules out underlying medical conditions. She stressed the importance of proper documentation and ensuring that staff are charting “mood and behaviors to support psychotropic use.” She stated that it is good practice to use “the lowest effective dose” while monitoring for side effects, quality of life, and physical mobility and re-evaluating the need for medication as needed.

Regulatory and Educational Reform

Dr. Kaylee Mehlm, PharmD, a member of the American Society of Consultant Pharmacists and owner of Germed Senior Care Consulting, stated that while the New York Times article “has highlighted some of the very negative, abusive uses of antipsychotic agents, it also highlights shortcomings of the current regulation.” She noted that the three approved diagnoses for antipsychotic use per the CMS regulations are schizophrenia, Tourette’s syndrome, and Huntington’s disease. There are also antipsychotics approved by the Food and Drug Administration for conditions such as bipolar disorder and treatment-resistant depression, but the current regulations “do not allow for appropriate use of antipsychotics for conditions like bipolar disorder without penalty in both ratings and reimbursement from CMS” although such conditions are “enduring and progressive and require continued treatment in our elderly population.”

The New York Times article has uncovered a real issue with the current regulatory process. Among this interdisciplinary group of medical professionals was a consensus that significant changes were needed. They advocated for an entire psychopharmacology regulatory review and allowance for the use of FDA-approved antipsychotics with proper diagnosis when antipsychotics are deemed appropriate and when the benefits clearly outweigh the risks. Also, they identified the need for training requirements for staff, and all of them encouraged the use of nonpharmacological interventions, particularly because these have been proven to be more effective at treating the behaviors associated with dementia than psychotropics.

Dr. Watson also suggested a solution “would be to link all prescriptions back to the specific prescriber and make them accountable for the order, not to laying the blame at the facility level only.” Of course, as Dr. Watson also pointed out, many facilities are doing the right things: “We have spent an inordinate amount of time and energy educating frontline staff about nonpharmacologic interventions with much success.”

All these professionals pointed out that a more patient-centered approach to care and treatment without regulatory burden is necessary. As Dr. Mehlm said, this includes studying the benefits versus the risks of medication and specifically considering quality of life and comfort for the patient.

In sum, education and training on appropriate diagnoses and antipsychotic medication is needed at all long-term care facilities and across the interdisciplinary team. The Society’s position is that diagnoses should follow the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), collateral information should be obtained, and other potential diagnoses should always be ruled out. Diagnosis should never be justified only to meet prescribing regulations. Advocacy should continue through organizations such as Project Pause, which pushes for reform, and by an emphasis on collaborative approaches to treatment across the interdisciplinary team.

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allows for a “more thoughtful approach” to decision-making and management of suspected or early sepsis, Dr. Gaur told Caring.

The guidance is “still saying time is of the essence, but they’re allowing for the right things: ‘We have spent an enormous amount of time and energy educating frontline staff about nonpharmacologic interventions with much success.”’

Another pertinent item is the suggestion that survivors who have received mechanical ventilation for more than 48 hours or had an intensive care unit stay of more than 72 hours be referred to a posthospital rehabilitation program. This sometimes will be a nursing home, Dr. Gaur said. “We need to be prepared,” she said, “to provide comprehensive care for these patients.”

Screening for Sepsis

Screening for sepsis remains a challenge, particularly for long-term care facilities. The updated SSC guidelines take a twist and recommend against using the quick Sequential Organ Failure Assessment (qSOFA) compared with the Systemic Inflammatory Response Syndrome (SIRS) criteria, the Modified Early Warning System (NEWS), or the National Early Warning Score (NEWS) as a single-screening tool for sepsis or septic shock. (The latter two are used commonly in the United Kingdom.)

The qSOFA, a tool employed in some long-term care facilities, is less sensitive than the SIRS criteria.

More important for nursing facilities, said Bernardo J. Reyes, MD, CMD, AGSF, of the Charles E. Schmidt College of Medicine at Florida Atlantic University, will be the development of new ways to screen for sepsis using changes in vital signs and other measures rather than set published values. “We need to create scoring systems that work for older people in nursing homes,” he said.

The concept of “vital parameters” was first discussed in a 2019 paper by Dr. Reyes and colleagues (Am Geriatr Soc 2019;67:2234–2239), and it is currently under discussion by a group from the Florida Medical Directors Association (FMDA) Quality Advocacy Coalition. The group aims to develop goals and guidance on sepsis identification and early management.

“With [electronic medical records], we have access to an enormous amount of data that we didn’t have before.” Dr. Reyes told Caring. “And current technology allows us to do machine learning [so we can know] what is abnormal for specific individuals.”

A growing number of facilities have the capability to treat patients with suspected sepsis in-house, he said, noting that point-of-care technology has changed the equation along with on-site nursing and in-house intravenous fluids and antibiotics.

Dr. Levy, coauthor of the first-responder editorial in JAMA, agreed. “Many facilities have upped their clinical ability,” she said; but even facilities with limited resources can still “get the ball rolling” with frequent monitoring and other aspects of early management. “It’s not all or none,” she said.

Ms. Coniglio is the president, CMO, and a founding member of Psych360 (http://Psych360.org) and a member of the Behavioral & Mental Health Advisory Council of AMDA – The Society for Post-Acute and Long-Term Care Medicine.

More “Thoughtful” Management, Important Downstream Issues

Prior guidelines recommended the initiation of broad-spectrum intravenous antimicrobials as soon as possible after recognition or within 1 hour for both septic shock and sepsis without shock. The 2021 guidelines present a more stratified framework for approaching antibiotics; they recommend immediate administration in cases of possible septic shock or a high likelihood for sepsis but advise rapid assessment of infectious versus noninfectious causes of acute illness in cases of possible sepsis without shock.

“For adults with possible sepsis without shock, we suggest a time-limited course of rapid investigation and if concern for infection persists, the administration of antimicrobials within 3 hours from the time when sepsis was first recognized,” the new guidelines say. “For adults with a low likelihood of infection and without shock, we suggest deferring antimicrobials while continuing to closely monitor the patient.”

The guidance is “still saying time is of the essence, but they’re allowing for the thoughtfulness that we hope and expect with our good antimicrobial stewardship programs,” she said.

In a section on long-term outcomes and GOC, the SSC recommends addressing GOC within 72 hours for patients with sepsis or septic shock and integrating the principles of palliative care into the treatment plan if appropriate. “They’re recognizing the high-risk nature of critical illness and the fact that outcomes are poor ... and that, in addition to treating the condition, we need to be able to treat the patient,” Dr. Gaur said.

The new recommendation to assess survivors of sepsis or septic shock for physical, cognitive, and emotional symptoms after hospital discharge “is a nod to trauma-informed care and has bearing on what we [see and do] in long-term care,” she said. “We have to be able to screen for and understand the complications ... and how to manage them appropriately.”

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