Beyond Medication Regimen Reviews: Quality Measure Focused Consulting in LTC

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Disclosure and Conflict of Interest

Bethany Bramwell has no personal or financial conflicts of interest to disclose.
Pharmacist Objectives

At the conclusion of this program, the pharmacist will be able to:

1. List the skilled nursing facility quality measures.
2. Identify the quality and outcome measures on which a consultant pharmacist can have a direct impact.
3. Discuss the role of the consultant pharmacist in multidisciplinary initiatives aimed at improving quality and outcomes in skilled nursing facilities.
4. Describe methods to evaluate outcomes of initiatives aimed at improving quality measures.
Ensuring quality and improving outcomes in the long-term-care setting is a team effort. Due to their complexity, medication therapy and delivery processes should be continuously monitored and improved. Pharmacists play an integral role in preventing and managing medication errors and adverse events and can have a direct impact on quality and outcome measures. Consultant pharmacists should broaden their responsibilities in skilled nursing facilities beyond medication regimen reviews by taking on roles in quality and performance improvement projects. This session will review the specific quality and outcome measures on which an engaged consultant pharmacist can have a direct impact and discuss types of interventions aimed at improving SNF quality measures.
CMS Short Stay Quality Measures for SNFs

Percent of Residents:
- Who Self-Report Moderate to Severe Pain
- With Pressure Ulcers that are New or Worsened
- Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Assessed and Appropriately Given the Pneumococcal Vaccine
- Who Newly Received an Antipsychotic Medication

Percent of Residents:
• Experiencing One or More **Falls with Major Injury**
• Who Self-Report **Moderate to Severe Pain**
• High-Risk Residents with **Pressure Ulcers**
• Assessed and Appropriately Given the Seasonal **Influenza Vaccine**
• Assessed and Appropriately Given the **Pneumococcal Vaccine**
• With a **Urinary Tract Infection**
• Who **Lose Control of Their Bowels or Bladder**

Percent of Residents who/whose:
• Have/Had a **Catheter Inserted and Left in Their Bladder**
• Were **Physically Restrained**
• Need for Help with **Activities of Daily Living Has Increased**
• **Lose Too Much Weight**
• Have **Depressive Symptoms**
• Received An **Antipsychotic Medication** (excludes residents with Schizophrenia, Tourette’s syndrome, or Huntington’s disease)

Meaningful Measures

Announced November 2017
Identifying the highest priorities to improve patient care through quality measurement and quality improvement efforts.

Promoting Effective Communication and Coordination of Care
• Medication Management
  • Use of High Risk Medications in the Elderly
  • Med Rec Post-Discharge
  • **Drug Regimen Review Conducted with Follow-Up for Identified Issues (SNF QRP)**
• Admissions and Readmissions
• Seamless Transfer of Health Information

[Accessed July 26, 2018]
### SAMPLE CASPER REPORT

#### MDS 3.0 Facility Level Quality Measure Report

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Num</th>
<th>Denom</th>
<th>Facility Observed Percent</th>
<th>Comparison Group State Average</th>
<th>Comparison Group National Average</th>
<th>Comparison Group National Percentile</th>
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<td>21</td>
<td>33.3%</td>
<td>16.0%</td>
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<td>51.5%</td>
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<td>18.4%</td>
<td>14.8%</td>
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# SAMPLE CASPER REPORT

## MDS 3.0 Facility Level Quality Measure Report

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Num</th>
<th>Denom</th>
<th>Facility Observed Percent</th>
<th>Comparison Group State Average</th>
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<th>Comparison Group National Percentile</th>
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<tr>
<td>Antianxiety/Hypnotic % (L)</td>
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<td>65</td>
<td>40%</td>
<td>26.2%</td>
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<tr>
<td>Behav Sx affect Others (L)</td>
<td>10</td>
<td>44</td>
<td>22.7%</td>
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<td>63</td>
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<td>Depress Sx (L)</td>
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<td>43</td>
<td>4.7%</td>
<td>3.2%</td>
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<td>UTI (L)</td>
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<td>Excess Wt Loss (L)</td>
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<td>46</td>
<td>8.7%</td>
<td>8.4%</td>
<td>8.3%</td>
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<td>Inc ADL Help (L)</td>
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<td>34</td>
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<td>16.8%</td>
<td>15.8%</td>
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<td>Move Indep Worsens (L)</td>
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<td>85.7%</td>
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### MDS 3.0 Resident Level Quality Measure Report

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<th>Falls</th>
<th>Antipsych</th>
<th>Antianxiety</th>
<th>Behav Sx</th>
<th>Depressive Sx</th>
<th>UTI</th>
<th>Cath</th>
<th>Insert/Left</th>
<th>Wt Loss</th>
<th>Incr ADL Help</th>
<th>Move Worse</th>
<th>Impr Func</th>
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<td>3</td>
</tr>
</tbody>
</table>
Which of the following residents would trigger on the CASPER report for receiving an antipsychotic agent?

A. A 68yo male receiving olanzapine 15mg q HS for schizophrenia
B. An 89yo female receiving quetiapine 50mg q HS for agitation related to Alzheimer’s dementia
C. A 45yo male receiving aripiprazole 10mg q day for bipolar disorder
D. B and C
Pharmacist’s Making a Direct Impact

- Pain
- Immunizations
- Antipsychotic use
- Antianxiety/hypnotic use
- Behavioral symptoms affecting others
- Falls
- Urinary tract infections
- Weight loss

- Depressive symptoms
- Rehospitalization rates
- Pressure ulcers
- Incontinence
- Functional decline/increased ADLs
Performance improvement projects (PIPs) are one of the basic building blocks of an effective QAPI program. PIPs examine and improve care in areas identified as needing attention and should focus first on “high-risk, high-volume” areas related to quality of care and quality of life. Consultant pharmacists are key members of PIP teams targeting falls, pain management, antipsychotic use, weight loss, and preventable rehospitalizations.
Involvement of multiple healthcare providers in the management of LTC residents leads to complex interacting factors and competing priorities. Academic detailing aimed at changing prescribing practices should focus on flexible, facility-tailored interventions, improved communication processes, and a common language across the team.
Multidisciplinary Initiatives

STAFF EDUCATION AND PROVIDER ACADEMIC DETAILING (cont.)

Detailer credibility, a strong relationship with the detailer, and a “third party” perspective have been shown to be important components of engaging providers in LTC initiatives. Consultant pharmacists are uniquely qualified to provide prescriber detailing and facility staff education.
When based on high-quality evidence, standardization of standing orders and care practices may improve the quality, safety, and consistency of care of residents. Examples include admission lab orders, pain management and bowel regimens, and disease and medication-specific monitoring and alert protocols.
Making a Direct Impact – THE BIG 5

- FALLS
- ANTIPSYCHOTIC USE
- PAIN
- WEIGHT LOSS
- REHOSPITALIZATIONS
FALLS

Fall prevention through medication management has consistently been shown to reduce risk of falls. Specific classes of drugs increase the risk of falling and falls can be prevented through interventions that target these medications.
• 50% to 75% of nursing home residents fall annually; 2X the rate of falls in community-dwelling older adults
• Medications are common and potentially modifiable contributors to falls in older residents of long-term care facilities
• Discontinuing unnecessary medications can lower fall risk and the number of falls
• Specific classes of drugs increase fall risk; falls can be prevented through interventions that target specific medications (e.g., benzodiazepines, antidepressants)
• Pharmacists play a key role in reducing medications’ impact on fall risk

Falls are a leading cause of preventable hospitalizations from LTCFs. Polypharmacy and falls-risk medications are potentially modifiable risk factors for falling.

Hospital-based, case-control study of patients ≥65 years hospitalized from LTCFs:

- No association between polypharmacy and fall-related hospital admissions (adjusted OR 0.97, 95% CI 0.63-1.48)
- Adjusted odds of fall-related hospital admissions increased by 16% for each additional falls-risk medication (95% CI 3-30%)
- Medications that cause orthostatic hypotension (OH) were associated with fall-related hospital admissions (adjusted OR 1.25, 95% CI 1.06-1.46)
- Psychotropics were not associated with fall-related hospital admissions (adjusted OR 1.02, 95% CI 0.88-1.18)
- The association between medications that cause OH and fall-related hospital admissions was strongest among residents with polypharmacy (adjusted OR 1.44, 95% CI 1.08-1.92)

Ryan-Atwood TE et al. Medication Use and Fall-Related Hospital Admissions from Long-Term Care Facilities: A Hospital-Based Case-Control Study. Drugs Aging. 2017 Aug;34(8):625-633.
Falls and Dementia

Higher fall rates in LTC residents with dementia are associated with a combination of:

- Impaired Mobility
- Indicators Of Disinhibited Behavior
- Diabetes
- Analgesics
- Beta Blockers
- Psychotropics

ASCP-NCOA Falls Risk Reduction Toolkit:
A Companion to CDC’s Stopping Elderly Accidents, Deaths & Injuries (STEADI) Tool Kit

- Designed to focus on falls risk factors in older adults identified to be at increased risk using screening tools
- Guides clinicians through a comprehensive assessment of falls risk inducing medications and medical conditions
- Conveys the importance of an interprofessional approach to falls risk detection and management
- Medications and chronic conditions are often implicated as a risk factor for falling - the role of the pharmacist in falls risk reduction is emphasized
Number of medications (Rx, prn, OTC, vitamin, supplement, herbal)
Recent medication regimen change

Falls risk Medication-Related-Problems detected:
- Suboptimal dose*
- Interactions between medications, food, medical conditions
- Allergies and intolerances within current regimen
- Dose too high**
- Lacking medication therapy for all medication-requiring indications
- Unnecessary medication
- Safer evidence-based therapy available
- Difficulty administering any medication (eye drops, inhalers, large dosage forms)

*Suboptimal dose - based on renal and hepatic function
**Dose too high** - causing adverse effects and/or unnecessary risk
ASCP-NCOA Falls Risk Reduction Toolkit

Medication Assessment

- Anticholinergics
- Antihypertensives/CV meds (especially α-blockers, nitrates)
- Dopaminergic agents
- Opioids*
- Anticonvulsants*
- Antipsychotics
- Hypoglycemia agents
- Sedative/hypnotics*

- Antidepressants*
- Benzodiazepines*
- Muscle relaxants
- OTC: diphenhydramine, doxylamine

*Beers Criteria medications to avoid with a history of falls or fractures
Strategies For Reducing Falls In LTC

Requires a comprehensive approach:
• Identifying conditions that predispose to falls
• Plan interventions to reverse or address each risk factor identified

“More than 90% of patients are willing to stop a medication if their doctor says it is possible.”

Improvement requires thorough root cause analysis, including tracking trends for falls:
• When, where, and how the fall occurred
• Number of falls per unit, per shift
• Staff members present

Question #2

A secondary outcome of reducing falls would be most likely to occur with a successful performance improvement project aimed at the following Quality Measure:

A. Antipsychotic Use
B. Depressive Symptoms
C. Urinary Tract Infections
D. Pressure Ulcers
Multidisciplinary Strategies For Reducing Falls

- **Prevent Syncope**
  - Common causes include carotid stenosis, orthostatic hypotension (OH), postural orthostatic tachycardia syndrome, and diabetes
  - Offending agents: Diuretics, calcium antagonists, angiotensin-converting enzyme inhibitors, nitrates, antipsychotics, antihistamines, central nervous system agents (eg, levodopa), narcotics
  - Errors in assessing OH are common
- **Recognize Pain, Prevent Boredom**
  - To remain seated, residents must be comfortable and engaged
- **Consider Vitamin D**
- **Promote Appropriate Exercises**
- **Address Staffing Issues**

PAIN

Initiatives shown to improve pain management include needs assessments, educational workshops for facility staff and clinicians, adoption of standardized nursing assessment, documentation, and prescriber communication tools.
Pain

- Pain is underrecognized and undertreated in LTC
- 45% to 80% of older adults in LTC experience significant chronic pain
- Poorly managed pain negatively affects cognition and function and impairs overall QoL
- Disability, dementia, comorbidities, and communication difficulties among LTC residents complicate efforts to assess and manage pain
- AMDA—The Society for Post-Acute and Long Term Care Medicine has developed clinical practice guidelines to address barriers to pain management in the LTC
- Systemic barriers make consistent application of guidelines difficult:
  - Drug costs
  - Formulary restrictions
  - Staffing challenges
  - Lack of care coordination
## MDS 3.0 Section J

### Section J | Health Conditions
---|---
**J0100. Pain Management** - Complete for all residents, regardless of current pain level  
At any time in the last 5 days, has the resident:

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Received scheduled pain medication regimen?</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>1. Yes</td>
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<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Received PRN pain medications OR was offered and declined?</th>
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<tbody>
<tr>
<td></td>
<td>0. No</td>
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<tr>
<td>1. Yes</td>
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</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Received non-medication intervention for pain?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>

### J0200. Should Pain Assessment Interview be Conducted?  
Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0. No (resident is rarely/never understood)</th>
<th>Skip to and complete J0800, Indicators of Pain or Possible Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes</td>
<td></td>
<td>Continue to J0300, Pain Presence</td>
</tr>
</tbody>
</table>

### Pain Assessment Interview

#### J0300. Pain Presence
- **Ask resident:** "Have you had pain or hurting at any time in the last 5 days?"
  - 0. No → Skip to J1100, Shortness of Breath
  - 1. Yes → Continue to J0400, Pain Frequency
  - 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain

#### J0400. Pain Frequency
- **Ask resident:** "How much of the time have you experienced pain or hurting over the last 5 days?"
  1. Almost constantly
  2. Frequently
  3. Occasionally
  4. Rarely
  9. Unable to answer

#### J0500. Pain Effect on Function
- **Ask resident:** "Over the past 5 days, has pain made it hard for you to sleep at night?"
  0. No
  1. Yes
  9. Unable to answer
- **Ask resident:** "Over the past 5 days, have you limited your day-to-day activities because of pain?"
  0. No
  1. Yes
  9. Unable to answer

#### J0600. Pain Intensity - Administer ONLY ONE of the following pain intensity questions (A or B)

**A. Numeric Rating Scale (00-10)**
- **Ask resident:** "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00 -10 pain scale)
- **Enter two-digit response. Enter 99 if unable to answer.**

**B. Verbal Descriptor Scale**
- **Ask resident:** "Please rate the intensity of your worst pain over the last 5 days." (Show resident verbal scale)
  1. Mild
  2. Moderate
  3. Severe
  4. Very severe, horrible
  9. Unable to answer

---

**CRITERIA TO TRIGGER:**

1 or 2

≥ 5

≥ 2

---

Which of the following residents would trigger on the CASPER report for Self-Reported Moderate to Severe Pain?

A. A 61yo female with borderline personality disorder receiving fentanyl 100mcg/24h and PRN oxycodone/acetaminophen 10/325mg reporting that her pain is frequently 10 out of 10.
B. A 92yo female with Alzheimer’s disease who has received 2 doses of PRN acetaminophen in the past 5 days for headaches reporting occasional mild pain with a maximum pain score of 4 out of 10.
C. A 56yo male with paraplegia due to spinal cord injury who receives hydrocodone/acetaminophen 5/325mg QID routinely reporting frequent pain; the worst pain in the last five days is noted at a 6 out of 10.
D. A and C
Pain QAPI Initiative

Methods, Development & Implementation:

• Needs assessment to identify areas for improvement
• 2-hour educational workshop for facility staff and local clinicians
• A pre- and post-survey (significant improvement in knowledge of pain management and confidence the ability to recognize and manage pain)
• To measure the effectiveness of the QI initiative charts reviewed at baseline and at 3 and 8 months after the session to evaluate pain assessment and management
Pain QAPI Initiative

**Results:**
Post-workshop chart reviews showed significant improvement in:
- Consistency of documentation of pain characteristics (ie, location, intensity, duration)
- Use of targeted pain assessments for residents with cognitive dysfunction

**Conclusion:**
QI initiative is an effective way to improve pain care practices in the LTC setting
 Resident with Pain

Physician

Nursing

Pharmacist

CNAs

MDS Coordinator

PT/OT

Social Services
Interventions shown to reduce inappropriate antipsychotic and anxiolytic/hypnotic use include nursing educational programs, provider academic detailing, prospective reviews, and implementation of quantitative behavior monitoring.
• Review response to non-drug interventions prior to use of an antipsychotic (AP)
• Risks and benefits should be assessed by the physician and discussed with the resident/family prior to initiation of an AP
• If there is no significant response after a 4-week time period, the medication should be tapered and withdrawn
• In residents with an adequate response treatment, an attempt to taper and D/C the AP should be made within 4 months of starting
• In residents whose AP is being tapered, symptoms should be assessed at least every month during tapering and for at least four months after the medication is discontinued

Rues V, et al. The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia. Am J of Psychiatry May 2016
A systematic review of antipsychotic deprescribing in patients receiving them for BPSD failed to demonstrate negative outcomes resulting from deprescribing.

For adults with BPSD (including psychosis, aggression, agitation) treated for at least 3 months (symptoms stabilized or no response to adequate trial):

**Taper and stop antipsychotics slowly in collaboration with the patient and caregivers:** eg, 25%-50% dose reduction every 1-2 wk (strong recommendation, moderate-quality evidence)
Suggested Antipsychotic Tapering Strategies

• Reduce to 75%, 50%, and 25% of the original dose on a biweekly basis before stopping
• Or, reduce the previous dose by approximately 50% every week down to 25% of the initial dose, then stop
• In addition, for patients with severe baseline BPSD symptoms or long-term use of antipsychotics:
  • Slower tapering
  • Close monitoring for withdrawal symptoms
  • Establish a clear intervention plan emphasizing use of nonpharmacologic approaches first, for increased severity or recurrence of symptoms
• Tapering may need to be individualized depending on the starting dose, available dosage forms, and how tapering is tolerated

The HALT Project

Multidisciplinary initiative for deprescribing antipsychotics in LTC, two interventions:
#1 Deprescribing: 50% reduction in AP every 2 weeks
#2 Education:
  • Prior to deprescribing, training provided for staff on how to reduce and manage BPSD using person-centered approaches
  • Academic detailing for providers

*Primary outcome measure:* reduction of antipsychotics without use of substitute psychotropic medications
*Secondary outcome measures:* NPI total and domain scores, Cohen-Mansfield Agitation Inventory scores, and adverse events, including falls and hospitalizations.

Results:
• 133 residents started deprescribing
• 126 completed deprescribing
• 26 were represcribed
• At the end of 12 months, 81.7% of residents were off of antipsychotics
• No change in total NPI score over time
• No change in total agitation/aggression over time

Take-aways:
• Study recruited 1 to 2 RN champions per NH
• Assessed residents 2 months before intervention
• 12 weeks of training for nurses in psychosocial management of behaviors
• Avoided replacement with other drugs
• Monitored for effects of withdrawal and re-emergence of behaviors
The HALT Project - Challenges

<table>
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<th>Difficulty recruiting, Change in processes</th>
<th>Facility Level</th>
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</thead>
<tbody>
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<td>Difficulty recruiting, Fear of deprescribing</td>
<td>Families</td>
</tr>
<tr>
<td>Difficulty recruiting, Fear of deprescribing, Lack of education</td>
<td>Providers</td>
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<td>Care Staff</td>
</tr>
<tr>
<td>Recruiting “champions”, Presence of “nurse led” prescribing, Task oriented care, Changing processes, Addressing family expectations</td>
<td>Nursing</td>
</tr>
</tbody>
</table>

Deprescribing Initiatives

- Consultant pharmacists are well positioned to lead deprescribing programs
- Initiatives should align with facility’s mission, goals, and values
- Build on current organizational strengths
- Identify and address barriers within the current processes
- Partner with interdisciplinary champions in the development, implementation, and evaluation of initiatives
Question #4

Which of the following challenges to an antipsychotic deprescribing initiative could be anticipated based on the results of the HALT Project?

A. A nurse requesting the prescriber increase an antipsychotic dose after a recent dose reduction due to increased agitation and combative behaviors.
B. A daughter declining a reduction in an antipsychotic dose for her father with Parkinson’s disease due to her fear of his hallucinations returning.
C. A physician documenting the rationale for not reducing an antipsychotic dose in a patient with dementia with behavioral disturbances as “patient is stable”.
D. All of the above
WEIGHT LOSS

Common modifiable causes of unintended weight loss in the elderly include drug-induced weight loss, psychiatric disorders, and endocrine disorders. Quality improvement initiatives should target the root cause of weight loss and focus on evidence-based interventions to treat unintended weight loss.
# Modifiable Factors Associated with Weight Loss

<table>
<thead>
<tr>
<th>Physiologic factors</th>
<th>Psychological factors</th>
<th>Social factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease-related</td>
<td>Depression</td>
<td>Reduced social activity</td>
</tr>
<tr>
<td>Medication-related</td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiac d.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benign GI d.</td>
<td></td>
</tr>
</tbody>
</table>

### Common Causes of Unintentional Weight Loss in Older Adults

<table>
<thead>
<tr>
<th>Category</th>
<th>Cause</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Induced</td>
<td>May account for only about 2% of cases</td>
<td>2%</td>
</tr>
<tr>
<td>Psychiatric Disorders</td>
<td>Especially depression 9-42%</td>
<td>9-42%</td>
</tr>
<tr>
<td>Endocrine Disorders</td>
<td>Especially hyperthyroidism 4-11%</td>
<td>4-11%</td>
</tr>
<tr>
<td>Unidentified Cause</td>
<td>In 25% of cases, a specific cause cannot be identified</td>
<td>25%</td>
</tr>
</tbody>
</table>

Medications and Weight Loss

**Cardiac**
- Digoxin
- Aspirin
- ACE inhibitors
- Calcium channel blockers
- Hydralazine
- Loop diuretics
- Hydrochlorothiazide
- Spironolactone
- Statins
- Nitroglycerin

**Neurologic and psychiatric**
- SSRIs
- Tricyclics
- Neuroleptics

**Bones/Joints/Analgesics**
- Benzodiazepines
- Anticonvulsants
- Lithium
- Levodopa
- Dopamine agonists
- Donepezil
- Memantine

**Endocrine**
- Levothyroxine
- Metformin

**Other**
- Anticholinergics
- Antibiotics
- Decongestants
- Antihistamines
- Iron
- Potassium
- Alcohol
- Nicotine

Addressing Unintended Weight Loss

Nonpharmacologic Interventions
- Screening for dementia and depression
- Remove dietary restrictions (diabetic, low-salt, etc.)

Pharmacologic Treatment
- Should be used only after all underlying causes of weight loss are assessed and treated; minimal evidence to support use of pharmacologic agents
- Initial treatment should be targeted at addressing identified risk factors, although evidence of benefit is limited
- Treatment of depression may, in and of itself, cause weight gain.
- Medications that are not clearly required and that may be contributing to the weight loss should be discontinued or appropriate alternatives considered

Resident with Weight Loss

- Physician
- Dietician
- Pharmacist
- Speech Therapist
- Social Services
REHOSPITALIZATIONS

Mismanagement of medications and adverse drug events are leading causes of preventable rehospitalizations. Polypharmacy and use of potentially inappropriate medications (PIMs) are consistently associated with increased all-cause hospitalizations. Multifaceted, multidisciplinary interventions including transitions of care programs that incorporate identification of high-risk residents and medication reconciliation have been shown to reduce rehospitalization rates.
Rehospitalizations

October 2017

CMS published the SNF 30-Day All-Cause Readmission Measure (SNFRM) on Skilled Nursing Compare

October 2018

SNFs with higher than expected readmission rates will be subject to financial penalties
Rehospitalizations

- Adverse drug events (ADEs) can lead to emergency department (ED) visits and hospitalizations -- many ADEs are preventable
- Factors leading to use of PIMs and drug-drug interactions (DDIs):
  - incomplete information
  - poor understanding
  - time constraints
- High-risk medications should be reviewed and potential DDIs should be reviewed and avoided when possible.
- Programs which may be helpful in preventing DDIs and use of PIMs include:
  - medication therapy management
  - transitional care nursing
High-dose influenza vaccination reduces hospitalization. A RCT demonstrated that high-dose influenza vaccination reduced all-cause hospitalization compared with standard-dose vaccination (risk ratio [RR] 0.93; 95% confidence interval [CI] 0.88-0.98).

Polypharmacy and PIMs are consistently associated with increased all-cause hospitalization.
Four studies suggested polypharmacy and PIMs increased all-cause hospitalization.
Inconsistent associations found between psychotropic medications with all-cause and cause-specific hospitalizations (11 studies).
Warfarin, NSAIDs, pantoprazole, associated with all-cause or cause-specific hospitalizations in single studies of specific resident populations.

Polypharmacy Assessment

- Medication Appropriateness Index (MAI)
- Measures appropriate prescribing based on 10-item list and 3-point rating scale
- Higher scores associated with higher rates of hospitalization and emergency room visits
- Higher risk of adverse drug reactions
- Compared to Beers criteria, IPET and HEDIS: best at detecting prescribing improvement over time, most time consuming to use

HEDIS = Healthcare Effectiveness Data and Information Set; IPET = Improving Prescribing in the Elderly Tool

Interventions to Reduce Rehospitalizations

Standardized Treatment/Monitoring Protocols

- Diabetes Management: standing orders for CBGs; admission, routine, sick days; alert parameters for CBGs
- Warfarin Therapy: standing orders for INRs; admission, antibiotic therapy
- CV Therapy: alert and withholding parameters for abnormal vitals; weight alert parameters for HF patients
- Standardized Nursing Assessments for Residents Suspected of Having an Infection (e.g., Infection SBAR)

Admission Medication Regimen Reviews

Transitions of Care Medication Reconciliation
“Beginning in 2018, nursing homes will be penalized for frequent avoidable re-hospitalizations, increasing the demand for collaboration among pharmacists, prescribers and caregivers to optimize medication therapy and patient safety. In this patient-centered care reimbursement model, providers will be rewarded for positive outcomes. A pharmacist role in reducing a patient’s length of stay while simultaneously reducing re-hospitalizations is a better measure of a positive performance than the lowest cost of medication per patient day.”

- Frank Grosso, ASCP 2017
Consultant pharmacists and long-term care 101
Resources

1. ASHP The Pharmacist’s Role in Quality Improvement Available at: www.ashp.org Accessed: June 26, 2018
2. CMS Quality Initiatives Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/ NHQIQualityMeasures.html Accessed June 26, 2018
3. NCPA Pharmacists’ Impact on Quality Measures and Opportunities for Pharmacy Enhanced Services Available at: http://www.ncpa.co/issues/APMAY17-CE.pdf Accessed: June 26, 2018
7. CMS QAPI at a glance: A step by step guide to implementing QAPI in your nursing home. Available at: CMS.gov Accessed: July 2, 2018
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