**Focus on Hospice**

**Hospice** is “a way of helping the dying and their loved ones maintain the dignity and humanness of the dying process, receiving sophisticated medical and nursing care. For hospice, the focus is on helping the dying live as fully as possible, rather than on the disease process. It is the disease of dying that hospice care seeks to eliminate through the control of symptoms.” Douglas McKell

Hospice shifts the focus from curing to caring. When patients and families agree to participate in hospice services they elect to forgo aggressive and curative measures in return for supportive and palliative therapy. For many years hospice has fought to find a place in society due to the nature of the human soul to reject the thought of dying. However, hospice can provide many benefits and services to not only patients, but their family members during the last months of life and help the patients live these last days comfortably and with a great deal of satisfaction. Hospice agencies are on call 24 hrs/day 7 days a week.

Hospice services becomes the provider and payer of all services.

- DME products
- Medical supplies
- Prescription Drugs
- Nursing
- Physician
- Medical
- Social work
- Counseling (spiritual, dietary, bereavement)
- Home health aide
- Volunteers
- PT, OT, ST
- Labs and diagnostic procedures that are related to terminal illness

To initiate hospice services, first the attending or primary physician of the patient must write an order that hospice may evaluate and admit the patient if appropriate for services. Then a nurse will come and visit the patient, review medical records and assess the patient and make a recommendation to the agency if the patient is truly “hospice appropriate”.

The average length of stay is 21.3 days in a hospice unit. Patients elect to forgo aggressive and curative measures in return for supportive and palliative therapy. Most hospice facilities are unable to afford expensive therapies and measures such as chemotherapy and radiation unless very large in size and receive considerable donated funding. Criteria for admission into a hospice facility includes having a terminal process with expected prognosis < 6 months.
Impaired nutritional status is not an expected part of normal aging. It may be associated with an increased risk of mortality and other negative outcomes such as impairment of anticipated wound healing, fluid and electrolyte imbalance/dehydration, and unplanned weight change. The early identification of residents with, or at risk for, impaired nutrition, may allow for development and implementation of interventions to stabilize or improve nutritional status before additional complications arise. Due to the high risk for adverse effects from medications in the elderly population, consultant pharmacists can help identify medications that affect nutrition by altering taste or causing dry mouth, lethargy, confusion, constipation, nausea, weight gain, and weight loss.

In addition to the consultant pharmacist’s Medication Regimen Review, other helpful information regarding a resident’s nutritional status can be obtained from the MDS (Section K: Resident’s Oral/Nutritional Status) and in the facility’s Quality Indicator (QI) report. Careful monitoring of residents’ nutritional status will improve overall quality of life, prevent “avoidable” deleterious status changes, and can ultimately eliminate unwanted F-tags (i.e. F-325 (Nutrition) & F-329 (Un-necessary drugs).

<table>
<thead>
<tr>
<th>In looking at Nutritional Status, Malnutrition can have many causes. Those to be most familiar with include:</th>
<th>It is also important to be mindful of those medical conditions that require an increase in caloric intake, such as:</th>
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<tbody>
<tr>
<td>• Chemotherapy</td>
<td>• Cancer and its treatment</td>
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<td>• Nutrient/medication interactions</td>
<td>• Burns</td>
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<tr>
<td>• Laxatives and antacids</td>
<td>• COPD</td>
</tr>
<tr>
<td>• Medication-induced anorexia</td>
<td>• Wandering and pacing</td>
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<tr>
<td>• Altered ability to taste or smell food</td>
<td>• Pressure Ulcers</td>
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<tr>
<td>• Reduced ability to feed oneself due to: arthritis, contractures, vision problems, decreased ADLs, loss of voluntary arm movement, lethargy, behavior problems that keep a resident from concentrating on eating (such as depression, delirium, dementia), the inability to communicate hunger or food preferences, GI problems, and ill fitting dentures</td>
<td>• Infection</td>
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</table>

In 1999, CMS incorporated the use of QIs in the nursing facility survey. Some of these QIs are designed to directly evaluate the use of medications in the facility while others can be impacted by drug therapy. The quality indicators are calculated by combining data elements from all the residents in a facility in order to provide information about patterns of care. A total of 24 QIs are incorporated into the survey process. QI 13 is triggered by residents with weight loss. A number of medications can cause or exacerbate weight loss. The consultant pharmacist should alert the physician or facility staff, as appropriate, when it appears that medications might be contributing to undesired weight loss in a particular resident. QI 15 is triggered by residents with signs/symptoms of dehydration. Diuretics and laxative are examples of medications that have the potential to cause or impact dehydration. As dehydration is considered a “sentinel event” indicator, the consultant pharmacist should assist the facility in investigating the etiology of such episodes and determine if medications might be a contributing factor.
Suggested parameters for evaluating significance of unplanned and undesired weight loss are:

<table>
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<tr>
<th>Interval</th>
<th>Significant Loss</th>
<th>Severe Loss</th>
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<tbody>
<tr>
<td>1 month</td>
<td>5%</td>
<td>Greater than 5%</td>
</tr>
<tr>
<td>3 months</td>
<td>7.5%</td>
<td>Greater than 7.5%</td>
</tr>
<tr>
<td>6 months</td>
<td>10%</td>
<td>Greater than 10%</td>
</tr>
</tbody>
</table>

The following formula determines percentage of weight loss:

\[
\% \text{ of body weight loss} = \left( \frac{\text{usual weight} - \text{actual weight}}{\text{usual weight}} \right) \times 100
\]

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### Medications Associated with Weight Loss

#### Anorexiants (CNS Stimulants/ sympathomimetics/ psychostimulants)
- Diethylpropion (Tenuate, Dospan, generics)
- Phentermine (Adipex-P, generics)
- Sibutramine (Meridia)
- Dexetramphetamine; amphetamine, benzphetamine (Didrex), methamphetamine (Desoxyn)

#### Gastrointestinal lipase inhibitor
- Orlistat (Xenical, Alli)

#### Diuretics (Due to fluid loss)
- Thiazide: HCTZ, metolazone(Zaroxylon)
- Loop: Furosemide (Lasix), ethacrylic acid
- Potassium-Sparing Diuretics: spironolactone, triamterene, amiloride

#### Hormone replacement therapy
- Thyroid hormone: Synthroid, levothroid, levothyroxine
- Fertility agents: Human Chorionic Gonadotropin (HCG, Novarel, Pregnyl)

#### Hypoglycemics
- Amylin analogs: Pramlintide (Symlin)
- Incretin Mimetics: Exenatide (Byetta)

#### Anticonvulsants
- Zonisamide (Zonegran)
- Topiramate (Topamax)

#### Antidepressants
- SSRI: Fluoxetine (Prozac)
- SNRI: Venlafaxine (Effexor)
- OTHER: Buproprion (Wellbutrin SR, generics)

#### CNS-selective carbamate-type cholinesterase (ChE) inhibitor
- Rivastigmine (Exelon)

### Medications Associated with Weight Gain

#### Atypical antipsychotics
- **First Generation:** Chlorpromazine (Thorazine), Fluphenazine (Prolixin), Haloperidol (Haldol), Perphenazine (Trilafon), Thioridazine (Mellaris), Thiothixene (Navane), Trifluoperazine (Stelazine)
- **Second Generation:** Aripiprazole (Abilify), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine (Seroquel), Risperidone (Risperdal), Ziprasidone (Geodon)
- Clozapine (Clozaril) and olanzapine (Zyprexa) are the most likely to cause weight gain—apiprazole (Abilify) and ziprasidone (Geodon) are the least.

#### Mood stabilizers
- Up to 20% of patients on lithium gain 20 pounds or more. About half of patients on valproic acid have a 10% increase in weight (Females= Males); suggest carbamazepine or lamotrigine if possible for less weight gain.

#### Antidepressants
- The most likely are MAO inhibitors: isocarboxazid (Marplan), phenelzine (Nardil), tranylcypromine (Parnate)
- **Tricyclics:** amitriptyline (Elavil), Clomipramine (Anafranil), Desipramine (Norpramin), Doxepin (Sinequan), Imipramine (Tofranil), Maprotiline (Ludiomil), Nortriptyline (Pamelor), and mirtazapine (Remeron)
- **SSRIs** may cause weight gain if used for more than 6 months (citalopram (Celexa), fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft)); Suggest bupropion (Wellbutrin), venlafaxine (Effexor), or duloxetine (Cymbalta) if weight gain is a concern.

#### Hormone Replacement Therapy (HRT)
- Oral contraceptives can initially increase weight due to edema…but long term gains aren’t likely. Depo-Provera can lead to about 11lbs increase over 5 yrs. Tamoxifen, SERMs (Evista), Estrogen, Progestin

#### Hypoglycemics
- Meglitinides: Nateglinide (Starlix), Repaglinide (Prandin)
- Sulfonlyureas: Chloropropamide (Diabinese), Glimipiride (Amaryl), Glipizide (Glucotrol), Glyburide (Glynase), Tolbutamide (Orinase)
- Insulin: Thiazolidinediones: Pioglitazone (Actos), Rosiglitazone (Avandia)

#### Antihistamines & corticosteroids
- **H1 Blockers:** Cetirizine (Zyrtec), Diphenhydramine (Benadryl), Fexofenadine (Allegra), Hydroxyzine (Vistaril)
- Recommend intranasal or inhaled steroids to limit weight gain.

#### Anticonvulsants
- Carbamazepine (Tegretol), Gabapentin (Neurontin), Pregabalin (Lyrica), Valproic Acid (Depakote), Lithium (Eskalith, Lithobid)

#### Anti-hypertensives
- **Alpha-blockers:** Prazosin (Minipress), Terazosin (Hytrin)
- **Beta-blockers:** Atenolol (Tenormin), Propranolol (Inderal)
- **Centrally Acting Agents:** Clonidine (Catapres), Guanabenz (Wytensin), Guanethidine (Ismelin), Methyldopa (Aldomet)
- **Vasodilators:** Minoxidil (Loniten)

#### Appetite Stimulant
- Megestrol (Megace)

It is important to remember that if at any time a medication’s use is in question, evidence/rationale for the continuation of that particular medication should be charted.

*Article by Keely Ray, Pharm D*
Alzheimer’s disease is a debilitating and fatal disease that affects 5.2 million Americans. The underlying cause of this disease is not fully understood. One prominent and well-characterized feature of Alzheimer’s disease is a progressive region-specific decline in cerebral glucose metabolism. Under normal conditions, the human brain relies almost exclusively on glucose for fuel. Most of the glucose absorbed is oxidatively metabolized for adenosine-triphosphate, or ATP, synthesis. ATP fuels basic cellular functions and synaptic activity. The glucose hypo-metabolism found in Alzheimer’s patients leads to low ATP levels and loss of synaptic function.

Although the brain cannot use most of the usual alternative energy sources, it can use ketone bodies. Axona® (caprylic triglyceride) is for the clinical dietary management of glucose-hypometabolism. It is absorbed from the gastrointestinal tract after oral administration and is metabolized by the liver into ketone bodies. These are released into the blood stream for use by brain cells. Ketone bodies can provide up to 60% of the energy requirements of neurons even if glucose is present. It takes three metabolic steps to metabolize a ketone body into ATP. Once the ketone bodies are converted into ATP, brain cells can use this energy to successfully transmit messages across the synapse. This illustrates that the ketone-body derived energy source, provided by Axona®, can theoretically return the hypometabolic neurons to a functional state.

Axona® was tested in a double-blind randomized placebo controlled study of 152 patients with mild to moderate Alzheimer’s disease. By day forty-five, a statistically significant improvement in cognitive function was seen. By day ninety, the patients maintained a slight cognitive improvement from baseline, compared to the placebo group which declined in cognitive function. Further studies are required to determine if Axona® will prove to have a clinically significant impact on cognitive function and activities of daily living.

Axona® has been deemed as safe and effective. It is given once daily mixed in 4-8 ounces of water, juice, milk, or soft foods such as applesauce or ice cream. After mixed, it may be stored in the refrigerator for twenty-four hours. Minor adverse effects include: diarrhea, flatulence and dyspepsia. These effects can be lessened by beginning Axona® gradually. It is recommended to give one tablespoon on days one and two of treatment. Increase the dose to two tablespoons on day three and four. Increase to three tablespoons on day five and six. Increase to four tablespoons on day seven and eight. Then from day nine forward, the dose is one packet (40grams). GI effects can also be lessened by giving Axona® 15-30 minutes after breakfast or lunch.

Axona® is kosher and gluten free. One packet is 217 calories. It should not be used in those allergic to milk, milk products or soy. It should not be used in those with uncontrolled diabetes, those at risk of ketoacidosis, those with a history of gastro inflammatory disease or severe liver or kidney dysfunctions. Axona® is a prescription only product and it can be used to complement current Alzheimer’s treatments. The average cost for a box of 30 packs ranges from $83.00 to $110.00.
Focus on Hospice

However, guidelines for admitting and keeping patients in an acute generalized hospice in-patient unit are different. These units often have several nurses and CNA’s on staff along with social workers, chaplains and volunteers in the building to help provide the high level of acute care these terminal patients and family members need in a crisis situation.

Guidelines for Acute GIP admissions
- Sudden onset or new manifestation of symptom(s) such as pain, intractable nausea and vomiting, dyspnea, psychoactive disturbances such as delirium, agitation, anxiety, severe decubiti, wounds or other skin lesions.
- Other modalities in other settings to control symptoms were ineffective.
- The patients often have frequent adjustment of meds by physician to control symptoms to bring the patient to a higher level of comfort and ease during the dying process or disease process.
- Patient is actively in the dying process.

Reimbursement to acute GIP facilities is $600 per patient day and records are heavily audited and reviewed to ensure patients qualify and meet criteria for acute GIP placement according to state and federal regulations.

Patients admitted to the GIP unit may be discharged back home once stable if they are not actively in the dying process, whether the home environment be their permanent residence, family member home, ALF, SNF, etc.

Hospice in LTC Facilities

In the long-term care facility setting, more than 600,000 patients die annually and less than 1/3 receive hospice services. Only 6% of nursing home patients elect the hospice benefit. The usual LTC patient who elects hospice coverage is an older female, unmarried and dually eligible. LTC patients typically have longer episodes of hospice care and see high rates of dementia and debility as the diagnosis.

Hospice coverage in the nursing home cannot be used while the patient is receiving skilled Medicare Part A days.

Nursing homes are paid 100% for the care of the hospice patient by the hospice company, however the hospice company only receives 95% reimbursement from Medicare and Medicaid or managed care. Services covered for hospice patients in the LTC facility include room and board, supplies, DME equipment, medications, specialist RN, nurse aide, social worker, chaplain and volunteer services.

Hospice use in Long-term facilities has many benefits and advantages for the patient, family and facility.

- Hospice patients in LTC facilities experience 24% hospitalization rates, vs 44% if not hospice. They also see less ICU stays, ER visits and decreased days in the hospital if admitted.
- Hospice patients in LTC facilities receive better pain assessments and pain management regimens.
- Hospice patients in LTC facilities receive more comfort for themselves and their family and higher overall satisfaction rates.
- Hospice patients in LTC facilities have higher survival rates.
- Hospice patients in LTC facilities have increased survival with opioid use.
- Families are relieved of drug and supply costs if patients are private pay or dual eligible.
- Hospice patients in LTC facilities are less likely to be restrained.
- Hospice patients in LTC facilities are less likely to receive IVs, have feeding tubes placed, receive IM injections, and less routine lab work. Medications are reviewed by the pharmacist for appropriateness with hospice care and prognosis.
- Facilities/Families experience an average cost savings of $2300 per patient during the last few months of life (this cost savings is higher for cancer patients).
- Facilities can see increased care available for non-hospice patients due to provision of nurse aide coverage.
- Hospice supplements the LTC facility with counseling services (due to chaplain and social work visits) to help with emotional, spiritual and bereavement needs.

An advantage to utilizing hospice for terminal patients in the assisted living setting is that is helps to avoid the Medicaid spend down needed to qualify for Medicaid services. It also provides help with medication costs and supplies, not to mention the aide care provided and nursing assessments.

What’s the difference between hospice care and palliative care?

Palliative care is care that accompanies the patient throughout their disease process, from diagnosis, treatment and hope for cure to hospice and hope for care. Hospice care is acknowledging and recognizing that the patient has exhausted all medical treatments and has accepted the finality and terminality of their disease. It is the opposite of the aggressive or curative modalities in conventional care. Palliative care is part of hospice care, but one does not have to receive hospice care in order to receive palliative care. For example, a patient can be diagnosed with breast cancer and receive palliative care while undergoing chemotherapy and radiation to help manage and treat symptoms. The breast cancer can be curable and treatable and therefore not hospice appropriate.

Article by Bobbie, Hall, Pharm D, CGP

Neil Medical Group – Pharmacy Services Division
HOT TOPICS

Survey Trends

After noting increased citations by CMS on the cleaning of glucometer devices between patients, CMS released the below clarification:

- Point-of-care devices, such as blood glucose meters, can become contaminated with blood and, if used for multiple residents, must be cleaned and disinfected after each use according to manufacturer’s instructions.
- If the manufacturer does not specify steps for cleaning and disinfection between uses of a point-of-care device, then the device generally should not be used for more than one resident. In the case of point-of-care devices where there are no manufacturers’ instructions for cleaning between uses, we strongly advise nursing homes not to share the devices among residents. In such cases involving sampled residents (or when triggered for further investigation) where there are no manufacturer’s instructions, surveyors will inquire as to the methods used for cleaning and disinfection between shared uses and will cite a deficiency for such a practice unless the nursing home can clearly establish that commonly accepted safe infection control practices are being followed (through authoritative references to published research, CDC recommendations, recommendations of professional societies, or similar references to commonly accepted professional practices).

Best Practices

How many times have you been pushing the med cart down the hall at 8 or 9:00am and find the next patient on your medpass was supposed to get Reglan before breakfast....and breakfast was served at 7:00am? Or, have you ever been pulled to another hall to pass meds and find yourself halfway down the hall at 9:00am, only to find the next patient was supposed to get KCl 20meq “with breakfast”…..and she had breakfast over an hour ago? Do either of these scenarios sound familiar? Well, each of these cases would constitute a medication error.

Such med errors could easily be avoided with a “Medpass Cheat Sheet”. Take a few minutes to list out those patients on your hall that require any of the following:

- Fingersticks/insulin
- “AC meds” – meds to be given before a meal, such as Reglan, Prilosec, Prevacid, and certain diabetic medications
- Meds that need to be given with a meal or with food, such as KCl, NSAIDS, and certain diabetic medications
- “PC meds” – meds to be given after the meal, such as Flomax that needs to be given 30 minutes after the same meal each day.

Place this list in the front of your MAR to be available for all nurses passing meds on that hall. This can help eliminate such surprises and potential medication errors. This “Medication Cheat Sheet” is extremely helpful for new nurses, nurses that are used “PRN” or float between units, and agency staff.
When dealing with litigation in long term care, documentation is an important factor in having a substantial defense against medical malpractice claims. We are in the process of reviewing the ten most common charting mistakes with a goal of improving overall documentation and thus minimizing the risk of litigation.

One area of concern in LTC documentation is failing to record that a medication has been given. “Holes” on the MAR have been an issue in long term care facilities for many years and the question often arises, ‘Is it just poor documentation or actual poor care?’

We have all heard the old phrase…."If it wasn’t charted, it wasn’t done". This statement is definitely true when it comes to litigation. Whereas a hole or two on the MAR might seem insignificant, the pattern of such can point to “sloppy” documentation and possible substandard care. I was once asked to give a deposition in a case dealing solely with documentation. Although the family was suing the facility over dropping their mother with a hoyer lift, the attorneys were trying to strengthen their case of substandard care by pointing out “holes” on the MAR, treatment sheets, VS sheets and Blood Glucose Monitoring Sheets.

In addition, MAR omissions can be a red flag for surveyors. I recently had an instance where I had reviewed a chart for three months in a row and noted that the monthly B-12 injection had not been charted. I had dutifully noted this in my report for 2 months. By the third month, I decided to do what a state surveyor told me that he did in similar circumstances: I called the pharmacy to verify the last date of refill. Indeed, the last refill date on the B-12 was 3 months prior….proving that the “hole” on the MAR was an actual dose omission/medication error vs a documentation oversight. Although surveyors cannot make such global conclusions on most medications, the monthly or weekly administered medications are good targets.

<table>
<thead>
<tr>
<th>10 COMMON CHARTING MISTAKES</th>
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<tbody>
<tr>
<td>1. Failure to record pertinent patient information.</td>
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<tr>
<td>2. Failure to record nursing actions.</td>
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<tr>
<td>3. Failure to record drug reactions OR changes in condition.</td>
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<tr>
<td>4. Recording information in the wrong patient’s chart.</td>
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<td>5. Writing illegible or incomplete orders.</td>
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<td>6. Failure to properly document a discontinued medication.</td>
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<td>7. Transcribing orders improperly or transcribing improper orders.</td>
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<tr>
<td>8. Failure to record that medications have been given.</td>
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<tr>
<td>9. Failure to follow a specific physician order.</td>
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<tr>
<td>10. Inappropriate use of abbreviations.</td>
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Write it Right! Tip

Check you MAR at the conclusion of you medication pass to make sure that all doses have been signed for. It is also good practice, when giving report between shifts, to have the oncoming nurse “scan” the MAR for holes to assure all charting is accurate. Two sets of eyes are better than one!
And so……

We are winding down another year and Volume 13 of Pharm Notes. Long term care continues to evolve and give us all a few more gray hairs (except me who was driven totally gray years ago by my 20+ years involvement in LTC). As this newsletter goes to print, I will be on a (much needed and much anticipated) vacation to Italy. I promise to eat enough pasta for ALL of you.

For now, I will leave you with an Italian blessing....

“Lei possa vivere cento anni”
(May you live one hundred years)

Until next time,
Cathy Fuquay
Pharm Notes Editor