Long-Term Care Survey Alert

Drug Management: Your Rx for Enhanced Survey Results: Make Medication Management a Priority

Beware the feds' broad new definition of "psychotropic."

Take note: The feds have infused the phrase "medication management" with new meaning under the proposed rule for long-term care facilities participating in Medicare and Medicaid. To fare well, providers should review their approaches to managing a number of drug classes flagged in the proposed rule, namely, antipsychotics, pain medicines, antibiotics, and anticoagulants, as well as drugs related to the treatment of diabetes.

Background: The 103-page proposed rule, Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities, mentions "medication" no fewer than 90 times and "drug" 143 times.

One very important change is the shift in the feds' definition of psychotropic drug to include "any drug that affects brain activities associated with mental processes and behavior," says **Dr. Cheryl Phillips, MD,** senior vice president of public policy and advocacy for Leading Age. For starters, that includes all anti-psychotic, antidepressants, anti-anxiety drugs, hypnotics, and opioid analgesics.

The addition of opioid drugs to this class is especially noteworthy, says Phillips. Including opioids under the psychotropic umbrella could be problematic, she notes, given a provision requiring that residents who receive psychotropic drugs to "receive gradual dose reductions" in an effort to discontinue use of the drugs.

The "gradual dose reduction" requirement for psychotropic drugs is prudent, experts agree, potentially sparing residents serious effects such as parkinsonian symptoms and other movement disorders, dizziness, and mood instability. But calling too broadly for dose reductions once a patient stabilizes may not be beneficial.

"For opioids, for example, gradual dose reductions may well not be the best course," Phillips points out particularly in light of the proposed rule's new focus on the management of pain among long-term care residents.

She advises providers to balance the gradual dose reduction requirement with the proposed rule's "special needs" requirement that "facilities must ensure that residents receive necessary and appropriate pain management."

The **American Society of Consultant Pharmacists** (ASCP) echoes Phillips' concerns about categorizing opioids as a psychotropic drug.

"Pain management must be evaluated on a frequent basis, and should not be subject to the rule and restrictions of the psychotropic medication drug class," the group cautions in its comments to the feds.

It's vital that providers grasp the degree to which the **Centers for Medicare and Medicaid Services** (CMS) expands survey rules now in place for antipsychotic drugs, says **Reed Smith attorney Carol C. Loepere.**

In addition to expanding related safeguards to antidepressants, anti-anxiety drugs, hypnotics, and opioid analgesics, the new regulatory catch-all "psychotropic" label applies to "any other drug that results in effects similar to the drugs listed" earlier.

Also potentially problematic is the proposed rule to limit "as needed" PRN orders for psychotropic drugs to 48 hours. Limiting PRN orders to 48 hours could potentially result in adverse clinical outcomes for long-term care residents, says Loepere.

A Call for Collaborative Care

For psychotropic drugs and other "red flag" medicines mentioned in the proposed rule, expect that medication management will soon become more complex and a more multi-disciplinary exercise. Specifically, the proposed rule has the potential to extend the oversight role of the consultant pharmacist including greater access to residents' medical records.

For example, according to the rule, the pharmacists must at least "periodically review the resident's medical record concurrently with the drug regimen review." In particular, the pharmacist is called on to review the medical chart upon each resident's admission, at least every 6 months thereafter, and when a resident returns from a hospital or is transferred to another institution. In addition, monthly medical chart review is required under the proposed rule for all residents who are taking a psychotropic drug (including opioids and potentially other pain medications), antibiotic, or any drug the facility's quality assurance committee has requested be included in the pharmacist's monthly drug review. CMS specifically flags anticoagulants and anti-diabetic medications as drugs that may warrant closer scrutiny at the provider level.

Resource: The publication Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries is a report from the **Office of Inspector General** (OIG) OEI-06-11-00370 that highlights concerns about adverse events related to drugs in the SNF setting.

Significantly, the consultant pharmacist is on the front line in flagging so-called drug regimen "irregularities," such as a medication given for an atypical duration or a drug prescribed without adequate documentation of clinical need in the resident's medical record.

Once an irregularity has been identified, the ball is in the court of the attending physician, who is called on to "document in the resident's medical record that he or she has reviewed the identified irregularity and what, if any, action they took to address it," according to the proposed rule.

Remember: CMS is increasingly looking to clinical guidelines and other evidence-based standards to guide its survey enforcement. If an attending physician is seemingly out of step with current practice or industry initiatives to limit the use of certain drugs documentation must make a strong case that the resident requires the medication in question.

From Admission to Discharge

In its comments to CMS regarding the proposed rule, the ASCP supports a greater role for consultant pharmacists including a role in the care planning process.

"Inclusion of the consultant pharmacist aligns the health care team in providing person-centered care, the group contends. "We recommend that the consultant pharmacist be notified upon admission, and at that time have access to the full medical record."

One overarching provision calls for facilities to include in each resident's discharge summary a reconciliation of all discharge medications with the resident's pre-admission medications, both prescription and over-the-counter.

In addition to reconciling the medication lists, providers, partnering with the consultant pharmacist, may find that under the forthcoming final rule they play a more active role in educating a resident's family members about the drugs they are taking.

The bottom line: Impeccable documentation about medications will be essential to keep survey findings clean and resident care on track.