Polymorbidity in the Long Term Care Setting

Taking care of geriatric adults – whom I will refer to as patients – (although we could as easily call them clients, residents, customers, and/or friends) is not for the weak of heart. In the layers of its complexity, doing the best for each individual patient is very difficult, demanding work, and that should never be minimized. If we as a group believe that a society is measured by the way it treats its most vulnerable members, then geriatric patient care is where the rubber meets the road. The people sitting in this room are often their last defense, their brightest hope for the most fitting finale to the chapters of their lives, and in a world of financial pressures and cost containment, sometimes their only visible advocate. This is a weighty responsibility; fortunately, we have help. There are guidelines for what we do in the SNF/LTC setting, and we have each other: we are lucky enough to work within an interdisciplinary team. We will spend some time in the next few minutes looking at the importance and potential pitfalls in the use of clinical guidelines, and review the complementary and integral roles of the interdisciplinary teams involved in the delivery of care to one of those most vulnerable in our society.

In the National Guideline Clearinghouse (http://www.guideline.gov) a site from the Agency for Healthcare Research and Quality, in July, 2012 there were 2,476 clinical practice guidelines, sometimes dozens on the same topic. Today, there are more than 4,000. There is within the site, however, no commentary on the quality of those guidelines, though there are ways to compare them, and any group who wishes to create a guideline is allowed to do so. Guidelines abound, God love ‘em, and anyone can make one.

In a fascinating article in the American Family Physician, 2012 called “How do clinical practice guidelines go awry?” a quite real example is given from the pediatric literature dissecting a comparison of the US Preventive Services Task Force process and development of recommendations for screening pediatric patients for hyperlipidemia. The process of Comparison of the development of the guideline between the USPSTF and the AAP is shown:

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<th>USPSTF</th>
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<td>Clear description of the methods used to ID and analyze scientific data considered?</td>
<td>Yes</td>
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<td>Method of updated literature review that is referenced?</td>
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<td>Standard process for appraisal and grading the quality of evidence?</td>
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Conflict of interest vigorously vetted?    Yes    No
External peer and public review?    Yes    No

Conclusions: USPSTF recommends that there isn’t enough evidence to warrant screening of 12 children with risk factors or a positive family history. The AAP recommends screening. What’s a provider to do? Clearly, in the use of any guideline, some attention must be paid to the quality/rigor of the evidence we use.

Evidence 12(or Eminence) 14 based medicine? In 2009, a review of 14 American Heart Association/American College of Cardiology guidelines revealed that only 11 percent – one in nine – were based on multiple randomized trials or meta-analysis (Level A evidence); nearly half were based on consensus. Consensus, however well intended, is not evidence. Another review of 17AHA/ACC guidelines involving 498 contributors revealed 56% of their guidelines listed an author with a conflict of interest. A 2002 survey of 100 specialty society guidelines demonstrated that 87 percent had ties to the pharmaceutical industry. A British Medical Journal article in 2002 cites a prominent nonprofit organization that received $11M from a pharmaceutical company that appointed six members of their nine person committee with ties to the drug (Alteplase) whose role they were to define in a guideline. No worries here… Good Old Boys Sitting Around A Table (GOBSAT) in its most perfect form.

The IOM has proposed eight standards that should be followed when developing a clinical practice guideline:

1. Complete transparency in guideline creation
2. Conflict-of-Interest disclosure
3. Member composition that is multidisciplinary
4. Systematic review of the literature that meets IOM standards
5. Clear and consistent rating and description of the evidence
6. Recommendations that are articulated in detail and in a standard form
7. External review by the full spectrum of stakeholders
8. Appropriate updating of the guideline*

(RAND Corporation estimates that 90 percent of guidelines are relevant for 3.6 years, but by six years, 50% are obsolete.)
The IOM recommendations (guidelines?) are neither required nor enforced, but may help you make your own decisions. We are often given recommendations by multiple agencies to “help” us with our patients. A review of 33 guidelines (hypertension, hyperlipidemia, and cholesterol screening and cardiovascular prevention) showed that those from specialty groups tended to be less methodologically sound and recommended more aggressive therapy compared with those from primary care organizations.

In an informative article from January of this year, British researchers discuss the major challenge of clinical guidelines in people with several conditions, despite the fact that multimorbidity is a common phenomenon. Their results confirm that comorbidity and patient adherence were inconsistently accounted for in the guidelines. They noted that recommendations rapidly cumulate to drive polypharmacy, without providing guidance on how best to prioritize recommendations for individuals in whom treatment burden will sometimes be overwhelming.

There are recommendations we confront on a daily basis. You obviously go to conferences, you know stuff. When an insurance company recommends that we subject our patients to blood tests that enhance their reimbursement but do not help our patient – i.e., it does not pass the “smell” test – why do we submit? Is an LDL cholesterol really of benefit to an 80 year old demented patient? Seriously?

Let’s talk about a patient, any patient:

Charles Norton - a 77 year old male admitted to your SNF service after a 3 day stay in a local hospital during which he underwent an elective R TKA for his end stage osteoarthritis. He has a history of a prior athletic injury to that knee in college, is on no meds, has no history of smoking, alcohol or drug use, stays active, and wants to keep playing sports with his grandchildren. Recognize Mr. Norton? Say goodbye. This is now the patient that is and will be cared for either at home with home health services or in assisted living or the adult care home. Twenty five years ago, Mr. Norton would have spent the first week of his postoperative stay in the hospital with a subsequent discharge to an acute rehabilitation facility. Now, we lust for his presence in our SNFs, and our ALF colleagues say this type of patient used to always be in a SNF. (The whining never stops!)

That was a reality check. Let’s try again. Ms. Grant - a 83 year old admitted to acute care with an altered mental status having been found down by a neighbor in the next door apartment. She lives alone, was a long time smoker, has no known alcohol or drug use, has distant family members in another state who are her medical and mental power of attorney, and no PCP. Telephone calls to her POAs at 0100 AM local time go unanswered, and messages are left. On arrival she is arousable but confused, alert, oriented to person, combative, and coughing.
Her BP is 84/56, Temp 96.2 F, HR is 106, RR of 24, and her pulse ox is 72%, improving only slightly with a re-breather mask. She is exhausted, and requires intubation within 20 minutes of her arrival in the ED: cultures are taken, antibiotics and steroids begun for Systemic Inflammatory Response Syndrome, and she ultimately requires wrist restraints, Haldol IM for agitation, and eventually a sitter for her behavior in the ICU. 24 hours before transfer to your facility, neither physical restraints nor a sitter are required, she is extubated, on O2 per oxymizer, still oriented only to person, has a chest CT showing no PE, but a right middle lobe PNA, a receding right sided effusion, and some evidence for CHF.

Ms. Grant transfers directly from the ICU to your SNF after a 7 day hospital stay. Her echo yesterday demonstrates a LVEF of 15-20%, and she comes to you as a demented patient on diuretics, digoxin, diltiazem, beta blockers, ASA, a steroid taper, Haldol prn for behaviors, Lovenox for her DVT prophylaxis, and Xopenex and ipratropium inhalers (albuterol makes her significantly tachycardic) a second round of antibiotics has just ended, and a PPI begun to help stave off the dreaded and inevitable stress ulcers. Ms. Grant is yours for rehab and placement.

On arrival, she is unaccompanied except by ambulance attendants. She is disheveled, disoriented, agitated, uncooperative, old (older than her documented age) and cold (a bad combination). She is on O2 – some of the time – VS are stable, but BP is a little low, and she is slightly tachypneic. A foley catheter, new with this hospitalization, remains in place, a PICC line remains in her R arm, and she refuses meds and food. Her adult diaper contains liquid not particularly foul-smelling stool, the last of several diarrheal bowel movements today. Her coccyx has a documented Stage II blister. Yesterday’s BMP shows Na 133, K 3.4, BUN 26, Cr 1.0, and a glucose of 113.

On the basis of your chart review (your first 45 minutes with this new patient is of course 24 without the patient), you d/c her Foley at midnight tonight (studies show that this is the time least likely to require replacement), her PICC line soon, consult the wound nurse for a turning program and wound care and you order a low air loss bed and heel floating now, d/c her PPI and begin her on a probiotic, send a stool for c. diff analysis due to her in transient diarrhea, order orthostatic BPs/HRs for in the morning, repeat her CBC, digoxin level, and BMP in the AM, consider Mylanta or sucralfate for dyspepsia symptoms, write an order for recording of “intakes” for the next 48 hours, and then pick up a couple of blankets and go to meet your new charge.

On physical exam Ms. Grant is clinging to the covers, removing your stethoscope from everywhere it touches, quite unhappy to be poked on and prodded, has bipedal edema halfway to her knees, and LE tenderness to touch. In addition to her coccygeal blister, she has DTIs to her bilateral heels, and it is possible that her thin skin actually tents. She believes that she is in New York state, it is 1978 (actually August in Tucson), and it is a really cold summer. She turns to the wall and says “leave me alone, Brute, I am cold” with an East coast accent.
Now, we are in to your comfort zone. This is what we do. Without a CT scanner, believable ultrasound, MRI suite, contrast imaging, stat stat labs, IRB, or a net. Wait a second! Without all of this is it possible for you to do a credible job in rendering the best care to your patient, or are you simply... a pretender?

Let me take a break for a second and talk about Guidelines from AMDA, specifically designed to deal with issues in the long term setting, with an interdisciplinary team, in an evidenced-based manner. There are at least four that apply to Ms. Grant: Dehydration and Fluid Maintenance, Delirium and Acute Problematic Behavior in the Long-Term Care Setting, Heart Failure, and COPD Management in the Long Term Care Setting.

Is she dehydrated?

**Dehydration and Fluid Maintenance AMDA CPG–**

Risk Factors – Older, ill, loss of appetite, dependent on us

What to do?

Dehydration is a loss of body water that causes significant signs and symptoms. The comfort and well-being of every patient is paramount in the decision about what to do in this situation.

Due to inadequate intake of fluids, excessive loss of fluids, or a failure to recognize the need to take in more water; CNS, cardiovascular, urinary, digestive systems, skin, lungs, and endocrine systems are involved. Water accounts for about 2/3 of our body weight, when younger, around 50% in elderly patients. Dehydration can be isotonic, hypertonic (Na>145), or hypotonic (Na < 135).

Disorders of fluid or electrolytes occur more frequently in the elderly: decreased thirst, decreased thirst responses, decreased intake, and decreased ability for the concentration of urine (decreased renin output, decreased aldosterone secretion, renal resistance to vasopressin, and then functional and cognitive decline).

Designated staff members need to be trained to recognize potential issues, intake of fluids, swallowing issues, dislike of fluids offered (I can’t stand water, or this water, or your particular blend of water), medications, diarrhea, refusing fluids because of fear of incontinence, or nighttime trips to the bathroom. It is our role to help educate caregivers, and assuming that they know these not so simple things is not always correct.

Who will teach them if you don’t?
Dying of thirst is an unacceptable concept and tantamount to neglect in some cultures’ view. On the other hand, patients may refuse fluids – they have that right – and should not be forced fluids or hydration artificially.

Lessons from hospice and palliative care have taught us that dehydration does not cause discomfort in terminally ill patients, IV hydration can cause a burden and distress, and there is no evidence that IV hydration therapy prolongs life beyond just a few short hours. In terminally ill and end-stage patients dehydration is an expected outcome and a natural part of the dying process. Federal regulations (Nursing Home Reform Act of 1987) require LTC facilities to maintain adequate hydration for all residents except in select circumstances such as: a disease process that interferes with adequate nutrition and hydration; a new disease process superimposed on a preexisting futile situation, or the patient refuses food and water. Under such conditions, if a patient is sent to acute care, an advance call to the hospital duty physician can be a great service to the patient and provider.

In our buildings fluid maintenance must be a concern every day (fluid rounds, one to one help, records of intakes +/- outputs), caregivers must be able to assess, and treat dehydration, and must appreciate family and patient preferences. Contact and communication with family members is essential.

Dehydration is underdiagnosed and undertreated, and more common than we know. It is part of everyone’s job. In today’s jargon, it is considered a sentinel event, and reportable. Ms. Grant does accept food and fluids, fed at first, and then more on her own. She seems to want to get better. Her PICC line is pulled.

Recognition: decreased food or fluid intake/output; AMS, weight loss of 3-5% in 30 days, constipation, medications; Dry eyes or mouth, thrush, odynophagia, fever, N/V/D, postural hypotension, lo BP, tachycardia, UTI, dark urine in the afternoon, dizziness, should be a red flag to alert caregivers to alert providers. Anticipate and reduce risk as much as possible. If dehydration is suspected by the clinical situation (2 signs or symptoms are present, and a BUN/Cr ratio of 25 to 1, orthostatic bp changes or tachycardia present) the diagnosis is clinically dehydration. Review diagnoses, risks, V5s, labs, meds, fluid restrictions, etc. Treat cause(s). If treatment is indicated, do so as part of an interdisciplinary team action. Treat the pneumonia, stop the antibiotics and the PPIs causing the diarrhea, stop or decrease the diuretics or ACE inhibitors, and address the deficits. It takes time to do this. Offer po sustenance, oral rehydration solutions: IV access can be difficult, and hypodermoclysis can help and is still used. Consider NG or PEG tube if other means are not feasible, but make it time or goal limited. Monitor frequently. Unstable patients may need to be sent out, depending on patient’s wishes and advance directives.
The patient arrives from acute care with the diagnosis of dementia, no prior records, and is 31 on antipsychotic meds begun in acute care. Is Ms. Grant demented?

**Delirium and Acute Problematic Behavior in the Long-Term Care Setting AMDA CPG**

Delirium refers to a medical illness of acute or sub-acute onset that presents with psychiatric symptoms, including a disturbance of consciousness and attention with a change in cognition and/or perceptual impairments. This she has.

Organ systems that can influence behavior include blood, CV, digestive, endocrine, musculoskeletal, neurological, reproductive, respiratory, skin and urinary tract. Problematic behavior and altered mental function are symptoms or syndromes needing careful evaluation; common responses to problematic behavior are to a. try to hospitalize the patient, b. call the police, 3. defer to psychiatric consultants, or 4. all 3.

Overreliance on psychiatric input can be harmful if it delays recognition in management of medical causes of AMS. Delirium is dangerous for your patient; it can last from days to months. It may be superimposed on dementia. Delirious patents have more complications, are more likely to be readmitted to acute care, and up to 25% die within 30 days. The Confusion Assessment Method can help sort out delirium from other disorders. 1. The change in mental status is acute and seems to fluctuate. 2. Difficulty focusing is a feature. 3. Speech may be disorganized or incoherent. 4. Level of consciousness may be altered.

Identify the patient’s current MAJOL. (Mood, affect, judgment, orientation, intellect). Work with your multidisciplinary team to identify the problematic behavior (aggression, sexually inappropriate behavior, restlessness) and altered mental function. Hx, symptoms (change in LOC, confusion, delusion, disorientation), diagnoses (hypovolemia, infection, fever, lo BS, abnormal LFTs/ TFTs, hypoxia, anemia, HTN, High Calcium, lo B12 or folate), meds (especially anticholinergic). Be specific: a description of “agitation” does not help. Restlessness, aggression, screaming, ruminating, resistance to care, disinhibition, and wandering might. Baseline mental status (Ask family? Friends?). Medical records, review of current orders, talk with PCP. Nature of behavior, severity, course.

Ms. Grant is oriented only to self, confused, and has been quite ill, and medically now well-travelled. Dig level is normal, C. diff. is positive.

The American Psychiatric Association notes that delirium is often a direct physiological consequence of a general medical condition, intoxication or withdrawal, toxin exposure, medication SE or combination of the above. Avoid conditions that promote delirium: Foley catheters, IV catheters, restraints, electrolyte imbalances, medications with CNS SE’s, infectious diseases, anemia, sleep issues, unnecessary infectious isolation or restriction practices.
Her C. diff is treated. Within 3 days, Ms. Grant (Dr. Grant, actually, Ph.D. in Art History from Columbia University) is conversing normally, able to give her history with precision up until the time she became ill.

Some situations require urgent evaluation: unstable VS (SBP< 90, HR>120 or <50, RR >30), 38 respiratory distress, new condition – CVA, etc. Escalating physically aggressive behavior or threats, may imply intermittent or persistent danger to self or others.

Abrupt MS changes in a demented patient are presumed to be from another cause until 39 ruled out. Prior psychiatric illness – schizophrenia, bipolar depression, mood disorder – may be the cause and need treatment.

So may unmet comfort needs, environmental extremes (noise, temperature, lack of sleep), 40-2 physical impairments (aphasia, HOH, blindness), disappointment and frustrations, confrontations with others, and nonspecific behaviors related to dementia. Urine studies 43 should be viewed with caution, and are uncommonly associated with physical and/or verbal aggression in demented patients.

Other causes should be researched as well, every time. Medications, even those used for long 44 periods without adverse effects, should be reviewed in light of changes in a patient’s condition. “Antis”: arrhythmic, cholinergic, convulsants, depressant, emetics, histamines, hypertensives, 45 neoplastics, manic, Parkinson’s, psychotics, anxiety, muscle spasms, as well as steroids, narcotics, and hypnotics. Psychosis (common symptoms of which include illusions, delusions, hallucinations, paranoia) can be a feature of delirium, schizophrenia, schizoaffective disorder, major depression, dementia, bipolar affective disorders, and mania. Major depress- 46 sive disorders can cause a problematic behavior or AMS. Personality disorders – enduring 47 patterns of behavior that are pervasive and inflexible, with an onset typically in adolescence or young adulthood – can coexist with other conditions including delirium or dementia. These can be more likely in patients who are aware of their behavior and can rationalize it. BPSD - Behavioral Symptoms of Senile Dementia implies that no other cause is identified. Restless- 48 ness, aggression, delusions, hallucinations, repetitive vocalizations, and wandering. Modifying environmental or other factors may help some. To treat, define the problem. Why do we 49 need to intervene? What’s the cause, and how was that determined? Will the intervention help? Will it help the patient? Explain this all to staff and families. Hospitalization for these problems 50 is risky for the patient: hospital personnel have not had the privilege of getting to know the 51 patient over time, they frequently omit vital supportive care or very relevant non-pharmacologic interventions resulting in undesirable changes in the patient’s regimen. Identifying the causes of a behavior suggests the changes that might be of benefit. Non-pharmacologic interventions 52-3 include addressing pain, minimizing sleep disruption, encouraging independence, providing activities, involving the patient differently, maintaining a structured routine, using different
approaches to bathing, feeding, other ADLs. A diagnosis of delirium allows for the possibility of diagnosis of a treatable cause of the patient’s AMS. This affects their decision making ability, their desired scope of medical interventions, the need for substitute decision making. If a patient’s delirium or psychosis is severe, short term treatment with oral or IM antipsychotic medication often relieves associated symptoms. All patients should also receive environmental and supportive interventions as well. Apathy affects over 70% of patients with dementia. Apathy (a lack of motivation) is not depression (related more to mood, dysphoria, hopelessness). Apathy may be treated with methylphenidate or modafinil. Depression can respond to non-pharmacologic interventions alone or with medications. Antipsychotics are not approved to treat dementia or delirium. Clonazepam may help patients who are sensitive to the side effect of antipsychotic medications (PD or those with Luey body dementia). Short half-life benzodiazepines are best avoided due to over-sedation and rebound side effects. Aggression may respond to anti-epileptics or antipsychotics when accompanied with delusions. There are no medicinal “magic bullets”, i.e., meds that can be used with consistently predictable benefits in every situation.

Was Dr. Grant in CHF?

Thigh high TED hose were applied; she improved as she felt better clinically.

**Heart Failure AMDA CPG** —congestive heart failure is defined as the inability of the heart to pump blood to the body at a rate commensurate with the body’s needs. CHF is one of the most common reasons for admission or readmission to hospitals in persons over 65 years of age. Most likely are females over 80, with multiple co-morbidities, who have been offered the opportunity to complete an advanced care directive. The following goals for each individual pertain: prolongation of life, prevention of exacerbations, improvement of QOL, palliative care.

Identify patients with a h/o CHF, CAD, HTN, DM, and find copies of CXRs, EKGs, and echocardiograms. Identify patients who have CHF by signs (tachycardia, S3, increased JVP, + HJR, bilateral rales, peripheral edema not due to venous insufficiency), laterally displaced apical impulse, weight gain) or symptoms (DOE, dyspnea, orthopnea, PND, fatigue, decreased exercise tolerance, cough, especially at night, delirium, abdominal pain or distention, decreased food intake, decline in status). Decide if the burden of a workup is too great.

Reversible etiologies include arrhythmias, pulmonary emboli, accelerated HTN, thyroid disease, valvular heart disease, unstable angina, high output failure, renal failure, medication induced problems, severe anemia. Treat the underlying cardiac conditions. No-added-salt diet, no alcohol, psychosocial and spiritual support, restricting fluids for edema, treat obesity, pneumococcal vaccines and annual influenza vaccines.
Treat systolic dysfunction (fluid volume overload) with loop diuretics, ACE inhibitors if not contraindicated and if not volume depleted by diuretics, starting with a low dose, or start ARBs if ACE inhibitors are not tolerated. Beta blockers, started low and increased carefully improve LV systolic function, and reduce hospitalizations and mortality in patients with all classes of CHF. Digoxin is recommended for CHF patients who are receiving ACE inhibitors, loop diuretics, and beta blockers who are in a sinus rhythm. Aldosterone antagonists have been shown to decrease mortality in Class III-IV CHF patients under age 80.

If EF is >40%, with pulmonary congestion and other CHF symptoms, diastolic dysfunction is implied. Options for treatment include diuretics, nitrates, calcium channel blockers, beta-blockers, and ACE inhibitors in an attempt to decrease fluid volume overload and treat elevated filling pressures. Advance directives, dietary counseling, rehabilitation consultation, and education for the patient and their family need occur.

Aggressive interventions that adversely affect quality of life may be withdrawn as patients near the end of their lives. Monitoring response to any treatment is imperative; BMP’s, functional status (ADLs and participation in activities) and if not improving document why, and what is the next step. If goals cannot be reached state why and use consultants as necessary.

As a long time smoker, does Dr. Grant have COPD?

Albuterol is listed by the hospital as an allergy, so the pharmacy questions the use of Xopenex – you call them back and reassure them that it is a matter of side effects, not allergy. Then her Xopenex then does not come because the insurance company refuses to authorize it until you fill out the appropriate forms.

**COPD Management in the Long Term Care Setting AMDA CPG** – COPD is a chronic, progressive disease characterized by airflow limitation that is not fully reversible; it usually encompasses features of both emphysema and chronic bronchitis, with obstruction to air flow. It is the 4th leading cause of death after heart disease, cancer and stroke. Unrecognized early disease is common: it is estimated that as many as 50% of persons with COPD are undiagnosed, and is expected to affect more than 16 million people in the US. COPD increases with age among Caucasians, and is an important predictor of hospitalizations and re-hospitalizations in the US, with sufferers more likely than others to be discharged to SNFs rather than home. FEV1s decline twice as fast in smokers as the normal aging population, and FEV1 is a predictor of death from COPD, heart disease, CVA, lung cancer and all-cause mortality.

In long-term care settings, COPD ‘gets no respect’ because staff may be unaware of the prevalence, no standardized screening tool exists in LTC facilities, it is often a co-morbidity, smokers may not be forthcoming about their history, shortness of breath has many causes, the
diagnosis may not be communicated from prior settings, or caregivers inherently believe that there may be no cure.

Staff need training to recognize COPD, staff who administer inhaled medications need training and regular assessment, half of COPD exacerbations begin with a viral or bacterial infection and staff must be sensitized to protect these patients by wearing masks, getting immunized themselves, and not coming to work when ill. Facility wide smoke free policies can also help patients as well as staff. Appropriate outcomes might be measured by decreased smoking, earlier identification of patients, education of patients regarding their disease, better symptom control, increased patient function, decreased anxiety and depression, more appropriate use of resources including medications, oxygen, and acute care, fewer lung infections, better immunizations, better understanding of comfort care and palliative care in patients with end-stage COPD.

Recognizing COPD – More than 90% are cigarette smokers or former smokers- cigar, pipe, and passive smoking count. Chronic cough, dyspnea, activity intolerance, weight loss (nutritional problems) or gain (associated CHF), use of bronchodilators, steroids, etc., oxygen use, vital signs, with emphasis on HR and RR (and effect of exercise), length of time needed to expel air, abnormal breath sounds, anxiety or depression, and cognitive problems associated with poor oxygenation and/or hypercarbia. Few symptoms differentiate COPD from other respiratory diseases such as asthma or CHF, but exposure to risk factors may be helpful, pattern of symptom development, documentation of comorbidities, impact of the disease on the patient’s life, and possibilities of reducing risk factors, particularly smoking. CXRs are important for ruling out other diagnoses.

Spirometry is required for a definitive diagnosis of COPD (FEV1/FVC ratio of less than 70%), but may be quite difficult for long-term care patients to do. Asthma and COPD may have significant overlap, but may be separated by the stage of life when symptoms first became apparent, and a history of other allergic symptoms for the asthmatic. Assessment of the severity of COPD guides the treatment interventions. Mild COPD reflects an FEV1 50-75% predicted. Moderate 35-49%. Severe<35%. A history of the frequency and severity of exacerbations, precipitating factors and premonitory symptoms can be of help. An alteration in mental status is particularly worrisome and warrants immediate evaluation. Acute exacerbations require emergent treatment to prevent progression and deterioration of the patient’s status.

Decide on the goal in LTC: rehabilitate, maintain, or comfort care. Progressive intolerance to activity may warrant a medical reevaluation or restorative therapy or both. The goal of treatment is to prevent further lung damage and to optimize pulmonary function.
Plan: stop smoking, relieve reversible airway obstruction, control cough and secretions, prevent infections (exposure and immunizations), address comorbid conditions, avoid aggravating factors, relieve depression and anxiety, maximize exercise tolerance, avoid futile therapy, and educate the patient. As a medical director implement facility wide programs and policies to encourage smoking cessation and smoke free buildings, and spread the message up close and personal as well. The average smoker makes 3-4 attempts to stop before they succeed. Counseling, education, energy conserving exercises, instructions on devices and breathing exercises all help. 27% of patients with COPD are malnourished; healthy food, good dentition, a daily MV are recommended. An exercise program is recommended when clinically stable. Supplemental O2 when appropriate, especially when exercising; >18 hours/day of O2 increases survival. Try to avoid isolation caused by immobility.

Start medications only when non-pharmacologic interventions have proved insufficient, and add them to those measures. Start with meds with the fewest side effects and the lowest dose and then go up before adding the next medication. If the latest addition does not help, considering discontinuing it. Spacer attachments must be used with MDIs and make them as effective as SVN in some cases. Dry powder inhalers (DPIs) may be easier for patients to use. Start with bronchodilators as the cornerstone of treatment: anticholinergic agents for maintenance, Beta 2 agonists if they do not cause side effects, short acting for rescue, long-acting if rescue agents are required often, theophylline is controversial in the elderly due to its toxicity, susceptible to liver and cardiac issues and interactions with many drugs, and finally steroids. Inhaled corticosteroids are appropriate only for those COPD patients who have a documented spirometric increase to these agents. Anti-inflammatory agents, anti-tussives, beta blockers, CCBs, digitalis, diuretics have been shown to be of little benefit. Antihistamines and ephedrine are contraindicated. In acute exacerbations, anti-cholinergics should be increased, systemic steroids may be of benefit (inhaled - not particularly), broad spectrum antibiotics if there seems to be a bacterial infection, evaluate for other conditions with CBC and CXR. Hospitalization is warranted when RR>28 persistently, ventilatory support is required, new arrhythmias, failure to respond, nursing competence/confidence is exceeded, or overall prognosis and care goals so dictate. Pulmonary referral might be indicated for patients with rapid severe progression, progressive symptoms, acute events or multiple exacerbations, severe dyspnea, uncertainty regarding the diagnosis. A patient is considered end-stage when SOB is disabling, there are increased visits to acute care without long term improvement, low oxygenation at rest, progressive weight loss, resting HR is >100 beats/min. In end of life care balancing the respiratory depressive effects of opiates and benzodiazepines given to relieve dyspnea and anxiety may be a source for discussion with staff and family.

**In summary:** You and your staff are taking care of patients in the SNF that used to have 63 another name: they were called hospital inpatients. With the social/placement disposition
issues of patients in the SNF, what you do is more 3 dimensional than acute care medicine. To do this requires a multidisciplinary team. You are fortunate that you have one. The case can be made that SNFs are the most challenging arena in which to practice medicine today: that of chronic multiple interacting problems in a frail patient population with every right to have their needs heard and honored. One of the very clear upsides of this challenge is that we get to eventually meet a different patient than providers in acute care, like Dr. Grant, and learn at least as much as we want to know about Picasso’s blue period. You have the privilege of getting to know these patients longer, and eventually better.

I want to take just one second to reiterate some points earlier made.

Paraphrasing the oft quoted words of Christopher Robin:

**You (we) are braver than you (we) believe.**

We are the advocates for our patients. We must stick up for them, and protect them from the ravages of things like inappropriate acute care stays and tests that offer them no benefit. We are resourceful - we will get everything our patients need, and even most of what they want – but sometimes you have to stick your neck out.

**You (we) are stronger than you (we) seem.**

This work is complex and formidable and important. But we have help. We have patients and families who for the most part want to get better. We have an important interdisciplinary team whose skills complement each other and we must lean and depend on each other to get our work done. Our patients have earned our best. We are better as a team.

**You (we) are smarter than you (we) think.**

Give yourself credit. With the resources we lack, this is the hardest job in health care. It is the work we have chosen and are privileged to do. There are guidelines that can help us in the right direction, but every patient is an individual and we are smarter than guidelines, especially multiple guidelines. That is the way it is, and actually, the way it is supposed to be.

It is the end of that quote and that part of our calling that I find particularly reassuring for our patients, and for us as we someday eventually will all become a patient: “**but the most important thing is... I’ll always be with you.**”

References:


Relationships between authors of clinical practice guidelines and the pharmaceutical industry. JAMA, 287:5, 2002.


AMDA CPG - Dehydration and fluid maintenance

AMDA CPG – Delirium and acute problematic behavior in the long-term care setting

AMDA CPG – Heart failure

AMDA CPG – COPD management in the long-term care setting

Christopher Robin: “If ever there is tomorrow when we’re not together.. there is something you must always remember. you are braver than you believe, stronger than you seem, and smarter than you think. but the most important thing is, even if we're apart.. i’ll always be with you.”