Medications Prescribed by Specialists in Nursing Homes

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The existence of specialty prescribers is challenging.1 Multiple prescribers have been identified as a risk factor for treatment with medications considered to be “inappropriate.”2 The use of “inappropriate” medications, in turn, has been associated with adverse outcomes such as hospitalization and death.3 In my experience, specialty prescribed medications include muscle relaxants for spasticity induced by upper motor neuron lesions (tizanidine, baclofen, and dantrolene), antiseizure medications (phenobarbital, carbamazepine, phenytoin), and the anti-arrhythmic (amiodarone).4,5 Other examples include immunomodulating agents for rheumatoid arthritis and psychiatric medications. Primary physicians may be uncomfortable determining if these “specialty” medications are indicated or the lowest effective dose. Unfortunately, office-based specialty consultants may not be aware of the “big picture.”6 The urology consultant may focus on a single problem such as urge incontinence and give little attention to systemic anticholinergic effects.7,8 The neurology consultant may advance the dose of medications for Parkinson’s disease in an effort to maintain ambulation without awareness of hallucinations and agitation triggered by the medications.9

Psychiatry consultants vary considerably in training, experience, and approach to frail residents with multiple medical problems. A psychiatrist with an outpatient practice managing major psychiatric illness will have difficulty projecting outpatient approaches to nursing home residents. Behaviors such as crying, apathy, fear, anger, or hallucinations are often triggered by delirium, focal brain disease, and/or dementia rather than major psychiatric illness such as depression or schizophrenia.10

The psychiatrist is often consulted to manage agitation (shouting, aggression). Psychiatrists who practice in multidisciplinary settings are expected to prescribe medications. Unfortunately, there are no Food and Drug Administration (FDA)-approved medications for this indication. The best-studied medications, the atypical antipsychotics, have limited efficacy and are associated with greater mortality.6,11–13 Therefore, the medical treatment of an individual with agitation should be considered uncharted territory in which adverse effects may overshadow benefits. For example, some medications may cloud the mind (delirium) more than they calm the mind.1,11,12 Medications that further cloud the mind can make the condition worse with a temptation to use even more mind-clouding medication. I support monitored medication trials in conjunction with behavioral/environmental adaptations and maximizing medical status (pain control, hydration, medication review, etc.). However, the primary physician likely has a better grasp of the “big picture” than the consultant including medical illnesses and potentially life-threatening dysfunctions (dysphagia, fall risk, bowel and bladder emptying) that could deteriorate during treatment.6 The monitored medication trial must track specific agitated behavior(s), as well as global function. The primary physician must be fully engaged and aware of the details of dose titration, ready to intervene and actively collaborate with the specialist if the resident deteriorates or fails to improve.

The management of acute illness is especially challenging since the specialist is unlikely to assess the resident in the nursing home during the illness. A resident may “get by” or tolerate a certain dose of medication when the resident is in their usual state of “health.” However, the dose may become excessive when a new medication is added or in the face of dehydration or hypoxia with adverse effects on renal and hepatic drug elimination. The primary physician may be wary of temporarily tapering/holding potentially mind-clouding medications prescribed by a specialist in the face of acute mental status changes or sedation that interferes with swallowing, hydration, or postural stability. Optimally, telephone consultation with the specialist should be pursued in this situation or advanced planning with the specialist should include parameters for dose titration during acute medical instability. Rapid tapering or withdrawal of some medications, however, may precipitate seizures or withdrawal syndromes, while nonconvulsive seizures might require a higher dose of antiseizure medication.

A potentially worse scenario may develop if the specialty prescriber is no longer following the resident. This may occur because of distance or disability if the resident requires specialty stretcher transportation or 1:1 supervision by a nursing assistant. Specialty follow-up may “fall through the cracks” at the time of nursing home admission. The primary physician may be uncomfortable changing the dose of a medication prescribed by a specialist or substituting a “modern,” better-tolerated alterna-
tive. One of my colleagues referred to these medications as “orphan drugs.” In the case of carbamazepine, there is evidence that lamotrigine and other antiseizure medications may be better tolerated for new-onset epilepsy. In addition, some of the newer antiseizure medications have fewer drug interactions. Specialists are often quick to use newer drugs.

The problem of specialty medications without specialty follow-up may be addressed as a continuous quality improvement (CQI) project during the Medication Review process. The consulting pharmacist can identify residents who are using “specialty medications.” Then the individual who tracks appointments with outside specialists can determine if specialty consultation is occurring. The attending physicians can then be made aware of the specialty medication without specialty follow-up with a suggestion that the primary physician become fully familiarized with the medication or refer the resident. I suggest that facilities have a program to identify specialty medications without specialty follow-up so that attending physicians can be prompted/empowered to actively manage dosing or to refer for specialty follow-up.

The Centers for Medicare and Medicaid Services (CMS) guideline for pharmacy providers (F329) states, “It is important that the facility clearly identify who is responsible for prescribing and identifying the indications for use of medication(s), . . . and for monitoring the resident for the effects and potential adverse consequences of the medication regimen. This is also important when care is delivered or ordered by diverse sources such as consultants, . . . hospice or dialysis programs.” Facilities should, therefore, consider sending an explicit statement to attending physicians informing them that they have final authority and responsibility regarding the indication, monitoring, and dosing of all medications, including those prescribed by specialists.

REFERENCES