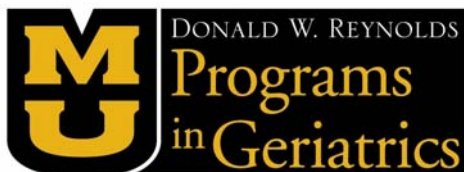


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THE ELDERLY PATIENT with DIABETES

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Type 2 diabetes is a common problem in the elderly population, with various studies showing that 18-25% of people older than 65 have diabetes. Half are unaware of this diagnosis. Diabetes is also a clinically important problem. For those between the ages of 60 and 69, the diagnosis reduces life expectancy by four to five years. For those older than 70, Type 2 diabetes reduces life expectancy by three years. Microvascular disease is the #1 cause of blindness and the cause of half of all non-traumatic amputations. Diabetes results in 25% of new dialysis patients. Even more important, diabetes causes macrovascular disease, resulting in a two- to four-fold increase in the risk of coronary heart disease and stroke. Almost 80% of Type 2 diabetics will die from cardiac or other vascular disease.

Does diabetes have different effects in older vs. young people? One study looked at the effect of diabetes on survival in older patients. Six hundred thirty-five subjects between the ages of 65 and 85 were followed for four and a

half years. Diabetic subjects' risk of dying was nearly five times higher than that of patients with normal glucose tolerance.¹ Diabetes also affects other functional measures. A 1996 study showed that people with diabetes were more likely to suffer disabilities in mobility, activities of daily living (ADL) and independent activities of daily living (IADL), when compared with non-diabetic subjects.²

There are numerous reasons why glucose intolerance develops in older individuals. Postprandial glucose increases by 5 mg/dL per decade after age 30. Glucose absorption slows, and insulin secretion is delayed after meals. Insulin resistance also increases due to a decrease in lean body mass and an increase in body fat. For those who develop diabetes, polyuria and polydipsia are rarely present, due to renal thresholds that increase with age, and an impaired thirst drive. Instead, the elderly diabetic may present with depression, urinary incontinence, pain, falls, cognitive decline, or even coma if hyperglycemia creates a hyperosmolar syndrome.

**Continued:
The Elderly Patient
with Diabetes
Melba Hall, RN**

Long-Term Links

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The diagnosis is made using the same criteria as with younger patients. Those with a fasting blood sugar of >126, or any blood sugar >200, are considered to have diabetes. Those with blood sugars between 127 and 199 have impaired glucose tolerance. In elderly populations, a two-hour postprandial blood sugar may pick up more individuals than a fasting blood sugar of >126.

Most of the data on the benefits of glucose control comes from younger diabetics. The Diabetes Control and Complications Trial (DCCT) demonstrated the benefit of strict glucose control in Type I diabetics, in which patients received intensive therapy in centers with nursing, dietary and social support. The United Kingdom Prospective Diabetes Study (UKPDS) unfortunately excluded patients older than 65 years, but found that good glucose control reduced microvascular endpoints. The UKPDS found that metformin was most effective in controlling both blood sugar and preventing adverse outcomes in obese patients. It also demonstrated the importance of good blood pressure control in all Type 2 diabetes. A study of veterans enrolled 153 patients older than 60 years, and followed them for nearly eight years. Standard treatment was a single morning injection of long-acting insulin. Researchers found that they could improve glycohemoglobin by an average of 2% after 27 months. They found more episodes of hypoglycemia in the intensive treatment group

and similar cardiovascular endpoints. They concluded that a longer-term study was necessary.

There are other issues to consider in the care of each elderly patient with diabetes. It is important to assess the current health status of the patient and life expectancy. Good control will require motivation and commitment on the part of the patient and family members. Social support and financial well-being are helpful. We must also consider the potential benefits and risks of good glucose control vs. hypoglycemia, particularly in those who have cognitive impairment. Will the patient live long enough to benefit from excellent glucose control? The life expectancy of a 65-year-old without major medical problems is nearly 20 years. On the other hand, the risk of hypoglycemia is greater in older patients, and those who live alone, who take sulfonylureas or insulin, who are on multiple medications, or who have cognitive impairment and/or poor social support. Tight control does not likely benefit persons with three or more limitations in ADLs or IADLs. However, we want to avoid glycosuria, which could result in falls, dehydration, skin breakdown, weight loss, urinary tract infection, and fungal infection. Others might benefit from more aggressive care with the goals of achieving euglycemia without hypoglycemia.

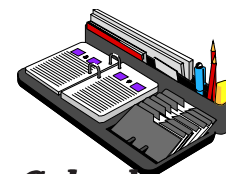
There are many medication choices for the older diabetic. Sulfonylureas increase insulin production and

act rapidly. Glyburide is eliminated more slowly in the elderly patient and may be more likely to cause hypoglycemia. Glipizide might be a better choice, using smaller doses than in younger diabetics. Repaglinide is absorbed rapidly, is quickly eliminated, and enhances insulin response to meals. The risk of hypoglycemia is lower than with sulfonylureas, but it must be taken prior to meals to be effective. Metformin is associated with good glucose control and, commonly, with weight loss in obese patients. It lowers triglycerides and LDL cholesterol, and is the only agent proven to decrease cardiovascular events and mortality. Furthermore, it rarely causes hypoglycemia. However, its onset of action is slower – usually one to two weeks – and it can cause nausea and diarrhea in many patients. Metformin is a bad choice in those with renal impairment or those with congestive heart failure. The thiazolidinediones (TZDs) reduce insulin resistance and enhance peripheral insulin sensitivity, but unfortunately are often associated with weight gain. Rosiglitazone appears to be effective in elderly patients compared with younger patients, with an average 1.5% reduction in glycohemoglobin. However, edema and anemia were more likely to occur in elderly patients than in middle-aged patients. Glargine (Lantus) insulin has a glucose-lowering effect comparable to human insulin. Its absorption is slow and there is no pronounced peak; it lasts for 24 hours. However, cost may be a factor.

The nursing home population has special needs. Prevalence of diabetes is twice that of the general population, with a significant degree of functional impairment. Life expectancy is markedly reduced and malnutrition is common, as are many comorbidities. Diabetes management depends in large part on the knowledge of the nursing home staff. The goals set for glycemic control should include everyone – patient, family members and staff. However, high-functioning patients should be able to achieve good control with monitored meals, minimal variations in activities, insulin given on a schedule, and the possibility of regular glucose monitoring.

In summary, Type 2 diabetes is very common in the elderly, and many of the lessons learned in managing younger patients apply. However, our goals must be individualized to consider the functional status, life expectancy, and medical comorbidities often present in the older patient. There are very few clinical trials to guide us in the care of older patients, but we should at minimum strive for symptomatic control and in the healthy elderly person, do all we can to reduce the likelihood of both the micro- and macrovascular complications of Type 2 diabetes.

References for this article can be found on Page 7.



For your Calendar

Midwest Regional Conference on End-of-Life Care, November 14-15, 2005. Hyatt Regency Crown Center, Kansas City MO. For more information call (816) 350-7702 or e-mail cindy@mohospice.org.

8th Annual Scientific Meeting, Gerontological Society of America, Nov. 18-22, 2005. Hilton New Orleans Riverside http://www.eshow2000.com/geron/about_the_meeting.cfm

17th Annual Gerontology Nursing Conference, "Clinical Update for Gerontology Healthcare Professionals in Hospitals, LTC Facilities, Home and Community Settings." **Dec. 1-2, 2005.** Peachtree Banquet Center, Columbia MO. For info, e-mail NursingOutreach@missouri.edu or call (573) 882-0215.

American Medical Directors 29th Annual Symposium, "Mastering the Challenges Across the Spectrum of Long-Term Care." **March 23-26, 2006.** Hyatt Regency, Dallas TX.

Changes in MALTCP Leadership

Carl Bynum, DO, MPH, Medical Director at Primaris, Missouri's Medicare Quality Improvement Organization, was chosen President of the Missouri Association of Long-Term Care Physicians at their annual meeting on Aug. 26, 2005. Jeff Kerr, DO, moved to the office of Past President. David Thomas, MD, of the Division of Geriatric Medicine at Saint Louis University, was elected to the Board of Directors.

Medicaid Reform Commission Announced

The commission is made up of five senators and five representatives from the General Assembly. They are: Sen. Charlie Shields, R-St. Joseph; Sen. Jon Dolan, R-Lake St. Louis; Sen. Chuck Purgason, R-Caulfield; Sen. Patrick Dougherty, D-St. Louis; Sen. Rita Days, D-St. Louis; Rep. Jodie Stefanick, R-Ballwin; Rep. Bryan Stevenson, R-Joplin; Rep. David Sater, R-Cassville; Rep. Margaret Donnelly, D-St. Louis; and Rep. Yaphett El-Amin, D-St. Louis.

The directors of the Departments of Social Services, Health and Senior Services, and Mental Health will serve as ex-officio members. Sen. Purgason said that although the committee will have to formally determine their mission, they were formed to come up with new and innovative ways to deliver Medicaid in Missouri. The state's current Medicaid system will shut down in 2008.

The commission is expected to report to the General Assembly next year with goals and an outline on how to reach them, Purgason said. It will be a "basic blueprint" of what will change within the program, but getting to that point will depend on how fast the federal government cooperates with state officials, he said.

CMS Sends Wrong Info on Part D to Dual Eligibles in SNFs

CMS and the Social Security Administration (SSA) have begun to send a letter to every dual eligible person in the country stating that starting Jan. 1, 2006, Medicaid will no longer pay for their medications, but Medicare will. The letter further states that when Medicare assumes coverage, the person "will need to pay a small copayment for each prescription." That information is INCORRECT for dual eligible nursing facility residents. Congress mandated that dual eligible residents of long-term care institutions be exempt from any copays under Part D. The problem has been brought to CMS' attention, but they were unable to fix it before letters were printed and mailings begun.

See the letter at [http://www.cms.hhs.gov/medicarereform/11132Dual Letter.pdf](http://www.cms.hhs.gov/medicarereform/11132Dual%20Letter.pdf).

Nursing Home Fines Going Uncollected

The federal government collected only 42% of civil penalty fines levied against the nursing home industry for quality-of-care problems during a two-year period, says a report from the Office of the Inspector Gen-

eral (OIG) for the Department of Health and Human Services. The report, made at the request of Sen. Kit Bond, R-Mo., is part of a series now underway by the OIG.

Discounts offered to nursing homes for agreeing not to appeal -- and delays collecting payments -- were pinpointed as the main causes, the report says. It reviewed civil monetary penalties levied in more than 4000 cases in 2000 and 2001. By the end of 2002, only \$34.6 million had been collected of the \$81.7 million levied. Civil monetary penalties can be imposed when health inspectors find quality of care problems. Fines range from \$50 to \$10,000, depending on the severity of the problem. The report found:

- ◆ An automatic 35% reduction in the amount of the fine is allowed when nursing homes agree not to appeal. That accounted for \$11.8 million, or 14% of the total amount of imposed fines.
- ◆ Another 14% of fines remained uncollected at the end of the period, primarily caused by bankruptcies and inconsistencies in the collection process.
- ◆ The median per-day fine imposed for the most serious problems, which include injuries or death, was about \$4000, well below the \$10,000 maximum. For less severe problems, the median per-day fine was \$250 out of a possible range of \$50 to \$3000.

News & Notes items on this page were reprinted from the Missouri Association of Homes for the Aging Hotline newsletter

Residents' Rights in a Nursing Home

- ♦ The right to exercise rights, or to appoint another person to exercise rights in your behalf.
- ♦ The right to be informed.
- ♦ The right to manage financial affairs.
- ♦ The right to choose a physician and participate in planning, care and treatment.
- ♦ The right to privacy and confidentiality of personal and clinical information.
- ♦ The right to voice grievances without discrimination or reprisals.
- ♦ The right to examine survey results and plans of correction.
- ♦ The right to perform or refuse to perform services for the facility.
- ♦ The right to send and promptly receive mail that is unopened.
- ♦ The right to have visitors.
- ♦ The right to use a telephone without being overheard.
- ♦ The right to retain and use personal possessions.
- ♦ The right to share a room with a spouse.
- ♦ The right to self-administer drugs if the interdisciplinary care team decides this is safe.
- ♦ The right to refuse a transfer to another room under certain conditions.
- ♦ Transfer and discharge rights -- right to remain in a facility unless certain conditions warrant otherwise.
- ♦ The right to receive notice of bed-hold policy and readmission.
- ♦ The right to equal access to quality care regardless of source of payment.
- ♦ The right to refuse or waive Medicare or Medicaid.
- ♦ The right to be free of physical or chemical restraints.
- ♦ The right to freedom from mistreatment, neglect, and abuse (verbal, mental, sexual, physical, corporal punishment, involuntary seclusion).
- ♦ The right to dignity.
- ♦ The right to self-determination and participation.
- ♦ The right to participate in resident and family groups.
- ♦ The right to participate in other activities.
- ♦ The right to accommodation of needs.
- ♦ The right to participate in an ongoing program of activities.
- ♦ The right to social services.
- ♦ The right to have a safe, clean and comfortable environment.

Residents' rights are guaranteed by the Federal Nursing Home Reform Act, which was part of the Omnibus Budget Reconciliation Act of 1987. All nursing homes must meet the requirements of the Nursing Home Reform Act to participate in Medicare or Medicaid.

♦ *Reprinted from AMDA's Caring for the Ages newsletter*

Home Health Goals -- 2005-2007

The Centers for Medicare and Medicaid Services (CMS) has a vision for quality healthcare in which every patient receives the right care at the right time. The “right care” corresponds to the six Institute of Medicine (IOM) aims as outlined in *Crossing the Quality Chasm* (2001). CMS wants providers to undergo transformational change in order to meet IOM aims for safe, effective, efficient, timely, patient-centered and equitable care. CMS believes that achieving transformational change in home care over the next three years can be accomplished through the application of four strategies:

| Transformational Change Strategy | Home Health Activity |
|-------------------------------------|---|
| Measure and report performance. | Improve two clinical performance measures: Key Measure: Reduce acute care hospitalization (required) Plus one additional measure: Improvement in bathing Improvement in transferring Improvement in ambulation Improvement in the management of oral medications Improvement in pain interfering with activity Improvement in the status of surgical wounds Improvement in dyspnea Discharge to community |
| Adopt health information technology | Implement or utilize telehealth as a tool to reduce acute care hospitalization rates. (Includes both phone monitoring and telemonitoring.) |
| Redesign care processes | Increase the number of agencies that include assessment of adult immunization status in their initial comprehensive assessment. |
| Transform organization culture. | Survey home health agency culture related to how agency leads care quality, how employees within the agency work together and how the agency approaches the delivery of safe quality care. Implement a plan to improve the culture area targeted as an opportunity by survey results. |

♦ Courtesy of Primaris
 The Medicare Quality Improvement Organization of Missouri

Missouri Association of Long-Term Care Physicians Minutes of the 14th annual meeting ♦ Aug. 27, 2005

The The 14th Annual Meeting of the Missouri Association of Long Term Care Physicians (MALTCP) came to order at 5:20 PM.

Dr. Jeff Kerr, MALTCP President, introduced AMDA president Dr. David Smith, who provided an AMDA update. Dr. Smith discussed:

- ♦ MMA (Medicare Modernization Act): AMDA had significant input for improvements and streamlining for patients.
- ♦ The AMDA website has been updated with information on Medicare Part D and new medical director F-tags.
- ♦ He stressed the importance for AMDA members to become knowledgeable and helpful in the roll-out of Part D.
- ♦ AMDA is working to improve communication with state chapters.
- ♦ AMDA is working to improve quality in long-term care.

Dr. Kerr introduced Katherine Gill from Primaris, who provided a fact sheet on CMS (Center for Medicare and Medicaid Services) goals for home health in 2005-2007. Primaris' challenge from CMS is to improve home care -- the current hospitalization rate is 26% for those persons in Medicare home care. Primaris will be working closely with home health agencies to bring the rate nearer the goal of >20%. There was discussion about the cur-

rent lack of incentives to decrease hospitalizations. Comments were made that there will be significant financial interest in the future with pay-for-performance expectations to decrease hospitalizations. Additional discussion ensued about the role of telehealth and tele-monitoring, working on strategies to identify problems early, and to provide better care. Vigorous discussion occurred regarding current pitfalls in patient care by home health. There was skepticism that this could work outside a closed system where there is no incentive or payment for physician time for managing home care.

Dr. Zweig discussed MALTCP finances and measures being taken to improve them. Thanks were given to Dr. Bynum and Primaris for rescuing the MALTCP website. Drs. Rosen and Thomas suggested merging Missouri AGS and MALTCP. Dr. Zweig offered to give information packets to members for distribution to drug representatives when they visit, asking for unrestricted grants to MALTCP for recognition in *Long Term Links*.

Dr. Kerr discussed hearings being held on reform of Medicaid. Members were encouraged to contact state representatives. Initiatives are underway to decrease nursing home admissions and shift Medicaid dollars from seniors to younger folks. Dr. Kerr also discussed the creativity of

attorneys in finding and using loopholes in the law to get elders on Medicaid. Members thanked Dr. Kerr for his service as MALTCP President.

No financial update was available. Officers and board members were elected. Dr. David Thomas and Dr. Jeff Kerr (immediate past-president) were elected to the Board of Directors for 3-year terms. Dr. Randy Huss was re-elected Treasurer for a 2-year term. Dr. Carl Bynum, president-elect, was elected to serve a two-year term as President beginning 2005.

The meeting was adjourned at 6:18 PM.

- ♦ Respectfully submitted,
David D. Cravens,
MD, MSPH, CMD

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The Elderly Patient with Diabetes

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2005-06 Flu Season Soon to Arrive!

The Centers for Disease Control and Prevention (CDC) has recently issued two informative newsletters with resource and planning information regarding the soon to arrive 2005-06 influenza season. The article "Influenza Vaccine Bulletin #1: Influenza Season 2005-06" is available at www.cdc.gov/flu/professionals/bulletin/2005-06/bulletin1_062905.htm.

The "Immunization Works" electronic newsletter can be accessed at <http://www.ced.gov/nip/news/newsltrs/imwrks/2005/200506.htm>.

Also, please note this update on Medicare payment for purchase/administration of influenza vaccine:

- ♦ Based on Medicare's 2005 Physician Fee Schedule, the average payment rate for administration of influenza and pneumococcal polysaccharide vaccines to Medicare beneficiaries has increased substantially from an average of \$8.21 per dose to \$18.57 per dose. Rates vary by locale and range from \$14.82 to \$31.01. To find the rate in your locale, go to www.cms.hhs.gov/.
- ♦ Medicare's 2005 payment rate for influenza vaccine has not yet been determined but is expected to rise proportionally in response to the price increases observed this year. (The payment for vaccine is in addition to payment for its administration.)

Change in Nursing Facility Level of Care

In response to action taken by the 93rd General Assembly, the Department of Health and Senior Services is in the process of promulgating rules to raise the Level of Care (LOC) point count required to meet nursing facility level of care. Effective 7/1/05, the requirement to access Medicaid in a certified Medicaid facility increased from 18 to 21 points. Likewise, this change was implemented July 1, in determining eligibility for persons who receive long-term care in the home and community-based care settings.

AHRQ Website: Source for Patient Safety Findings/Resources

The Agency for Healthcare Research and Quality (AHRQ), which leads the federal government's effort to improve patient safety and reduce medical errors, has announced a new website. AHRQ's Patient Safety Network, or PSNet, is the first comprehensive effort to help healthcare providers, administrators, and consumers learn about all aspects of patient safety. Visit <http://psnet.ahrq.gov> to learn more.

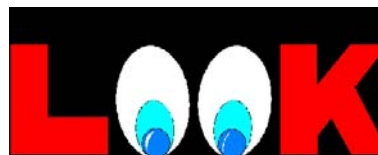


Nursing Home Administrators in Short Supply

The American College of Health Care Administrators (ACHCA) gave members of Congress a heads-up this summer about the dwindling number of nursing home administrators. Speaking before the National Commission for Quality Long-Term Care, ACHCA Chair Sara Sinclair described the 40% fall in the rate of those taking the administrator exam for certification. She produced a study showing the higher quality outcomes of SNF's led by certified administrators and asked Congress for three things to stop the decline -- a study of the reasons for high administrator turnover, standardized qualifications for all SNF administrators, and funding to train those wanting to become administrators. In turn, ACHCA's press release stated, the commission asked ACHCA for help developing a nationwide scorecard to measure nursing home quality.



Take a



at MALTCP's new website!

www.maltcp.org