It's Raining Meds: Long-Term Care Edition

KATIE DRAGO, MD FACP

PRIMARY CARE REVIEW | FEBRUARY 2026

Session Objectives

- Review how polypharmacy manifests in primary care
- Familiarize ourselves with the different levels of long-term care and impact on function
- Propose medication management considerations for upcoming transitions to long-term care

Medication Number

- > 4 per day (Rx and OTC)
- Threshold at which ADEs and interaction risk increases
- Benefits of >4 agents may outweigh the risks for some (ie. GDMT)

Prescribing Cascade

- Agents causing side effects, whether treated or untreated
- ex. NSAID for arthritis --> elevated BP --> antihypertensive

Polypharmacy

"PIMs"

Potentially Inappropriate Medications - Low Value

- Imparted benefit(s) aren't sufficient to justify continuing
- ex. tight glycemic control, primary prevention statins, STOPPFrail

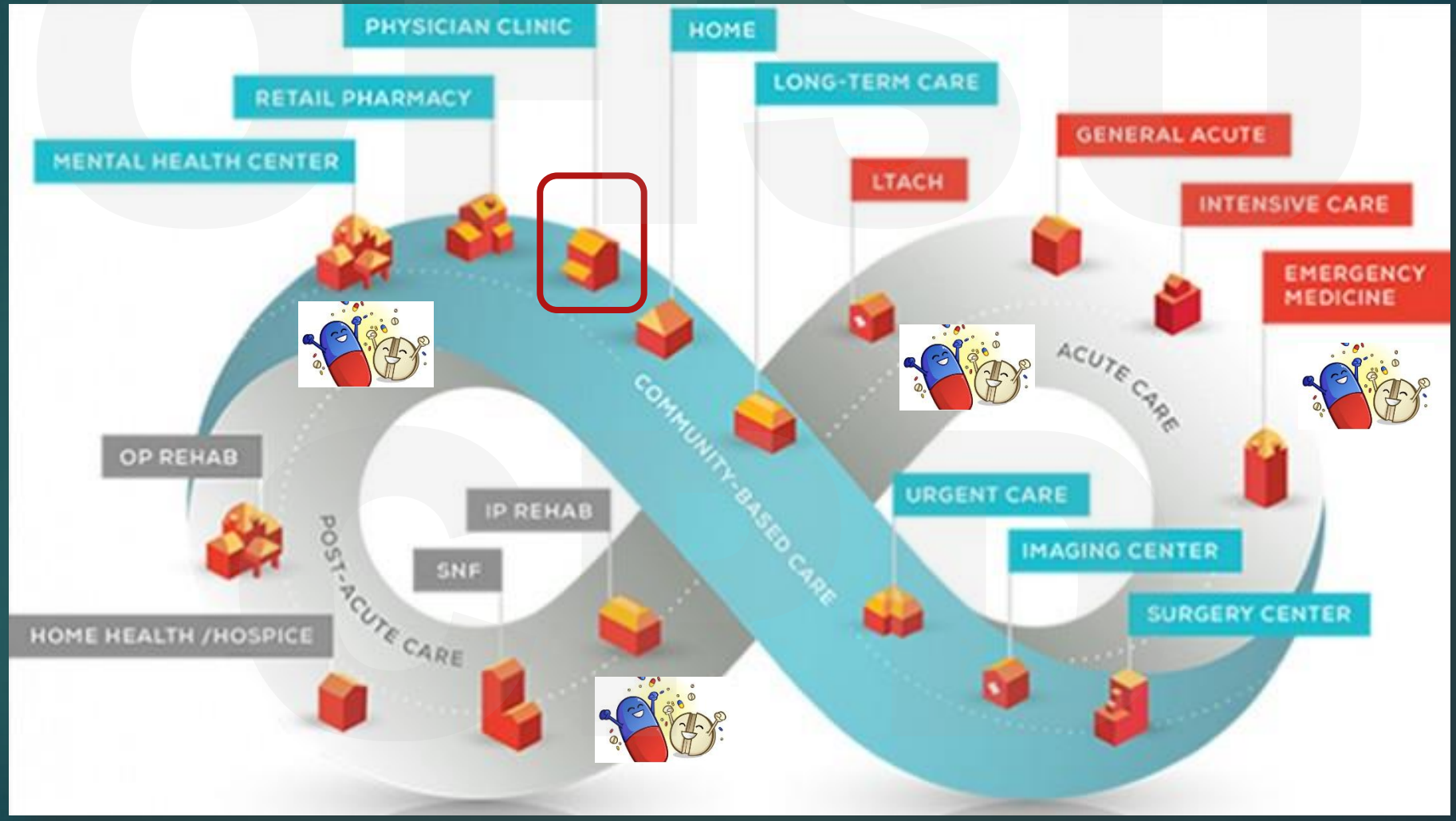
Potentially Inappropriate Medications - High Risk

- Risk (long or short term) outweighs the potential benefits
- ex. Beers List, STOPP criteria

<u>Deprescribing</u>

Planned, supervised process of dose reduction or stopping medications that are causing harm or no longer providing benefit

Polypharmacy is Everywhere



“The [hospital, specialist] put them on [med], so I shouldn’t mess with it”

“That’s not my medication”

“They’ve been taking [med] forever with no issues, so probably fine”

A New Way

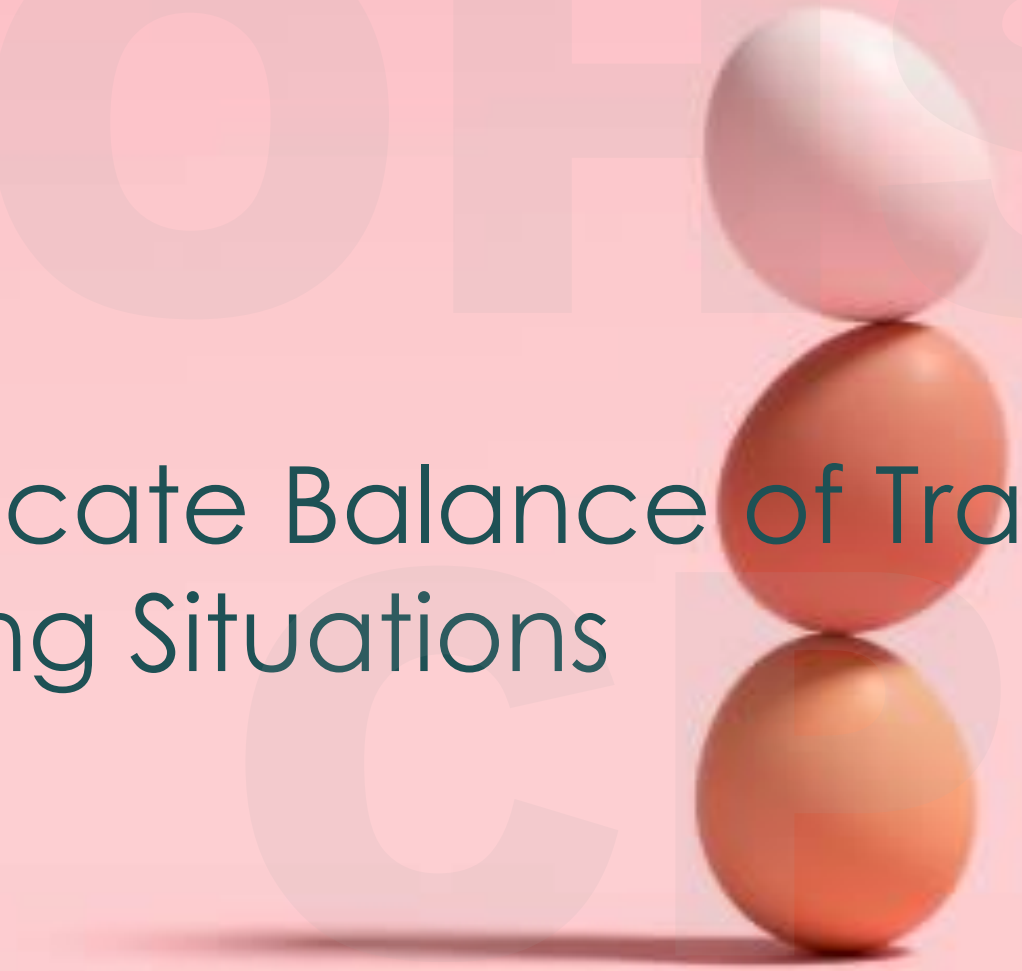
- Medication management is a team effort!
- The prescriber may not have access to information that you have
- You may be the first to be alerted to side effects, changes that make long term treatments more risky
- Aging bodies tolerate meds differently at different stages of life

- All medications are “our” medications

Why do people move to LTC?

- Progressing illness burden with changing functional support needs
- Important trigger for med review & deprescribing

Delicate Balance of Transitioning Living Situations



A High-Risk Time

People Factors

- People with physical & cognitive impairments alongside progressing medical conditions
- Increasing fragility with vulnerability to more minor insults
- Reliance on routines & surroundings being the same

Environmental Factors

- Disrupt or eliminate the routines that supported peak function
- Need to replace "mental maps" of their surroundings
- Building care relationships with all new caregivers
- Acclimating to meals, ambient sounds, etc

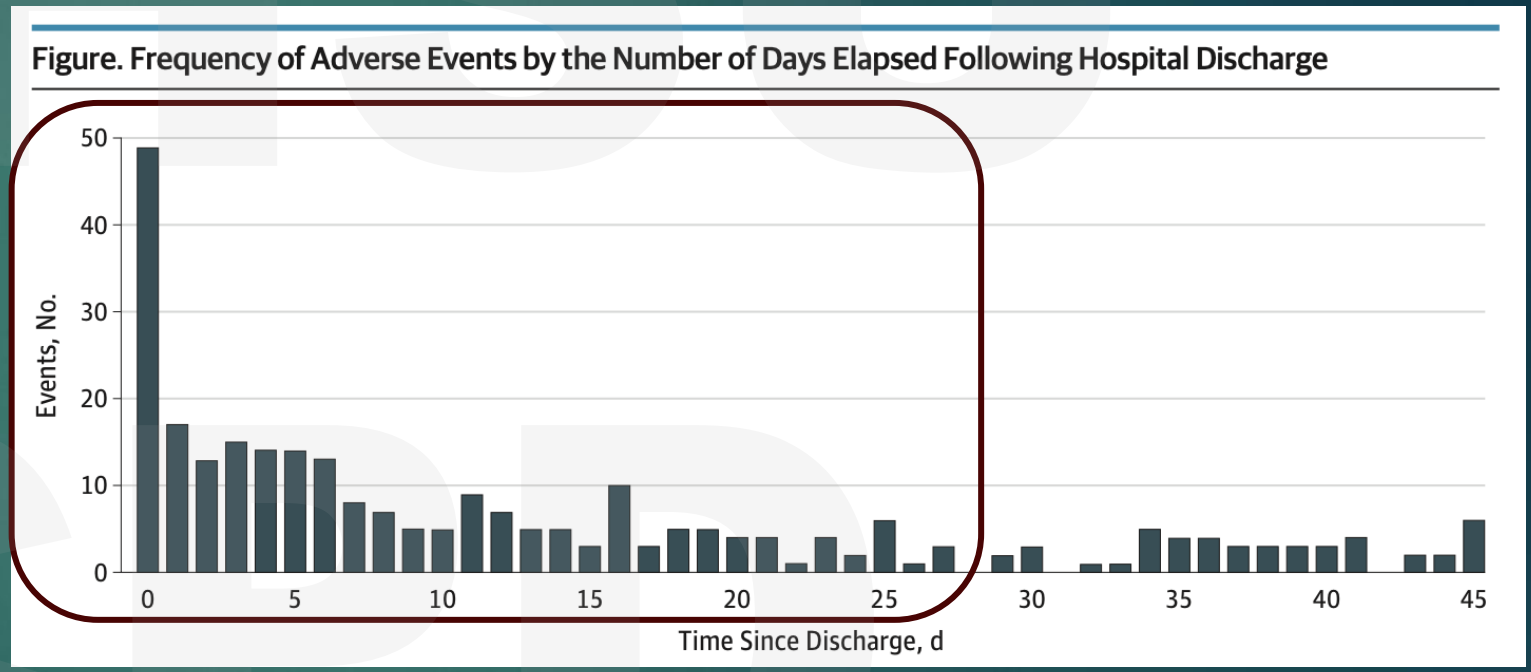
What happens with LTC transitions?

~50% related to "resident care"

- Falls, skin events, pressure injuries

~28% healthcare acquired infections

Remainder due to medication issues



Highest risk period is in the first few weeks of residency

Kapoor A, Field T, Handler S, et al. Adverse events in long term care residents transitioning from hospital back to nursing home. JAMA Int Med. 2019;179(9):1254-61

What happens while living in LTC?

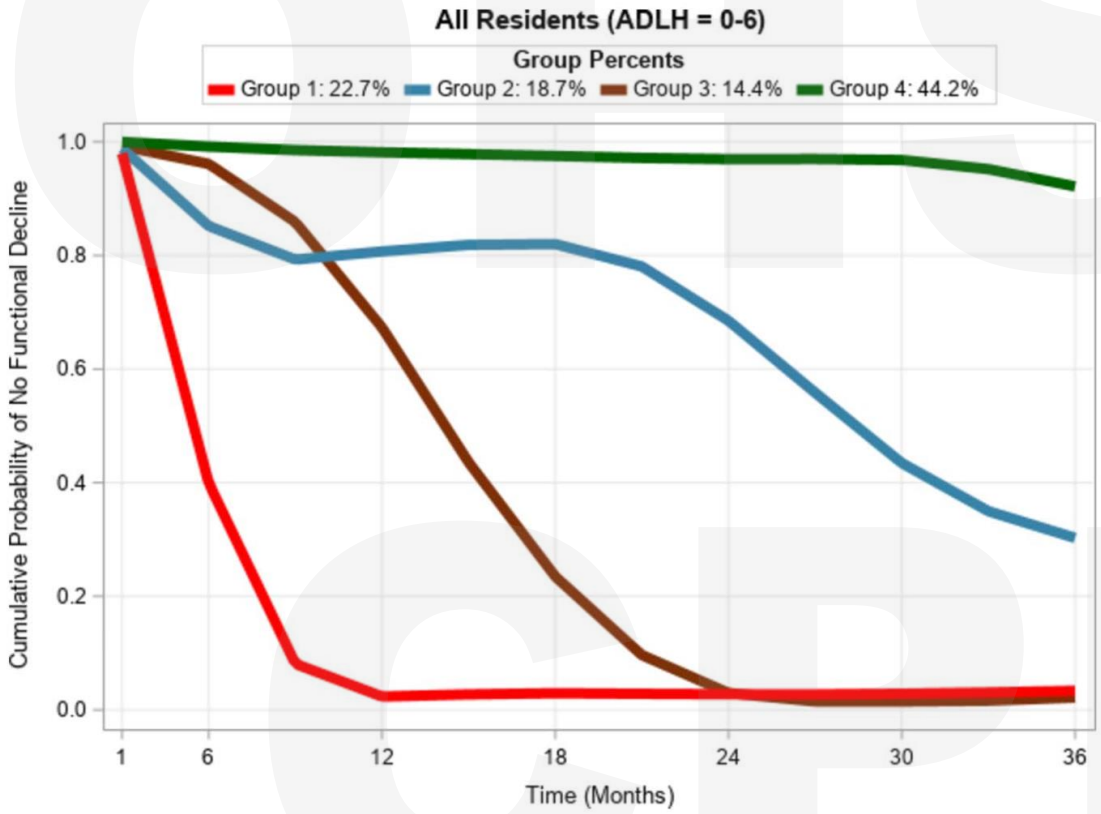


Figure 1. Best Fitting Functional Decline Trajectory Pattern Identified by the GBTM Technique 2015–2021, n = 204 036.

1 = Catastrophic decline
2 = Rapid decline with some recovery
3 = Progressive decline
4 = No / minimal decline

Most predictive factor is level of function upon admission

Egbujie BA, Turcotte LA, Heckman G, et al. Trajectories of functional decline and predictors in long term care settings: A retrospective cohort analysis of Canadian nursing home residents. Age Ageing. 2024;53:https://doi.org/10.1093/ageing/afae264

What happens while living in LTC?

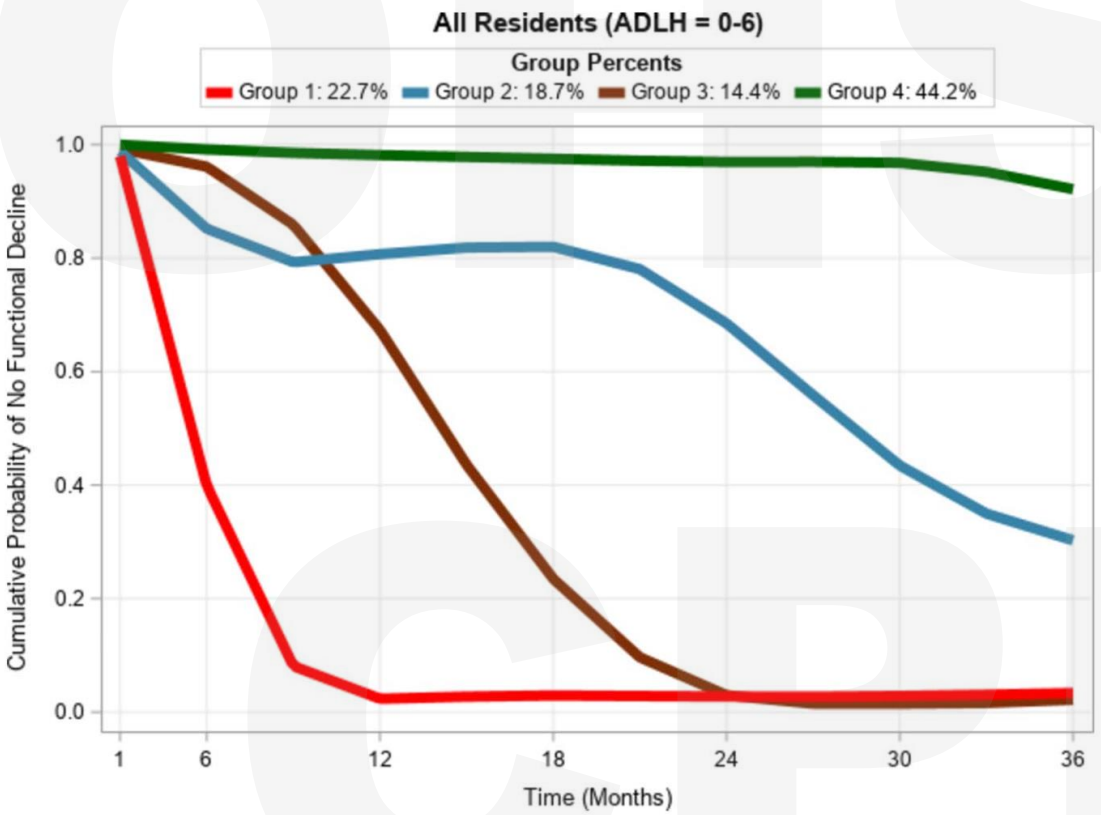


Figure 1. Best Fitting Functional Decline Trajectory Pattern Identified by the GBTM Technique 2015–2021, n = 204 036.

1 = <u>Catastrophic decline</u>

- Less impaired, intact cognition
- Recent falls, severe vision loss, cancer
- Mild to moderate multi-morbidity
- Motor predominant neurologic conditions (ie. PD, ALS, etc)
- More to lose!

Egbujie BA, Turcotte LA, Heckman G, et al. Trajectories of functional decline and predictors in long term care settings: A retrospective cohort analysis of Canadian nursing home residents. Age Ageing. 2024;53:https://doi.org/10.1093/ageing/afae264

What happens while living in LTC?

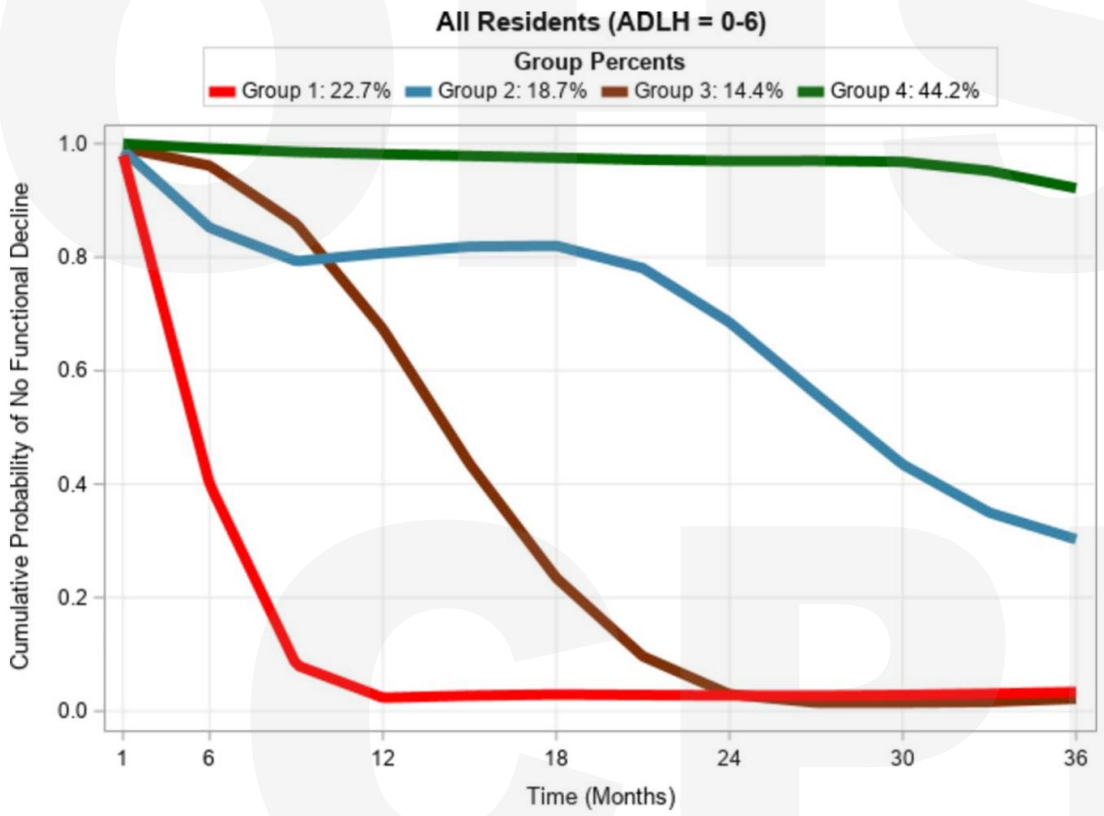


Figure 1. Best Fitting Functional Decline Trajectory Pattern Identified by the GBTM Technique 2015–2021, n = 204 036.

4 = No / minimal decline
- More ADL impairment
- Less to lose!

3 = Progressive decline
- Cognition predominant neurologic conditions (ie. AD, other dementias)

Egbujie BA, Turcotte LA, Heckman G, et al. Trajectories of functional decline and predictors in long term care settings: A retrospective cohort analysis of Canadian nursing home residents. Age Ageing. 2024;53:https://doi.org/10.1093/ageing/afae264

What happens while living in LTC?

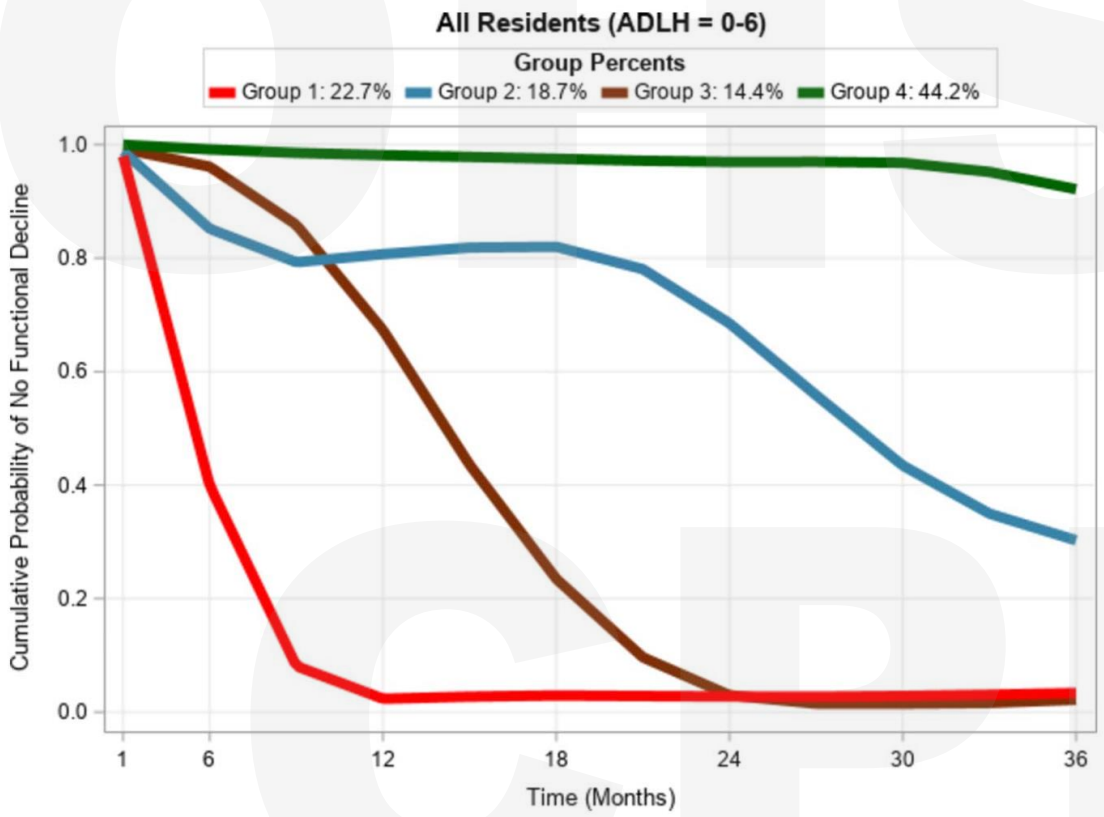


Figure 1. Best Fitting Functional Decline Trajectory Pattern Identified by the GBTM Technique 2015–2021, n = 204 036.

2 = Rapid decline with some recovery

- Cognitively intact
- Severe but correctable vision & hearing impairments
- Schizophrenia dx

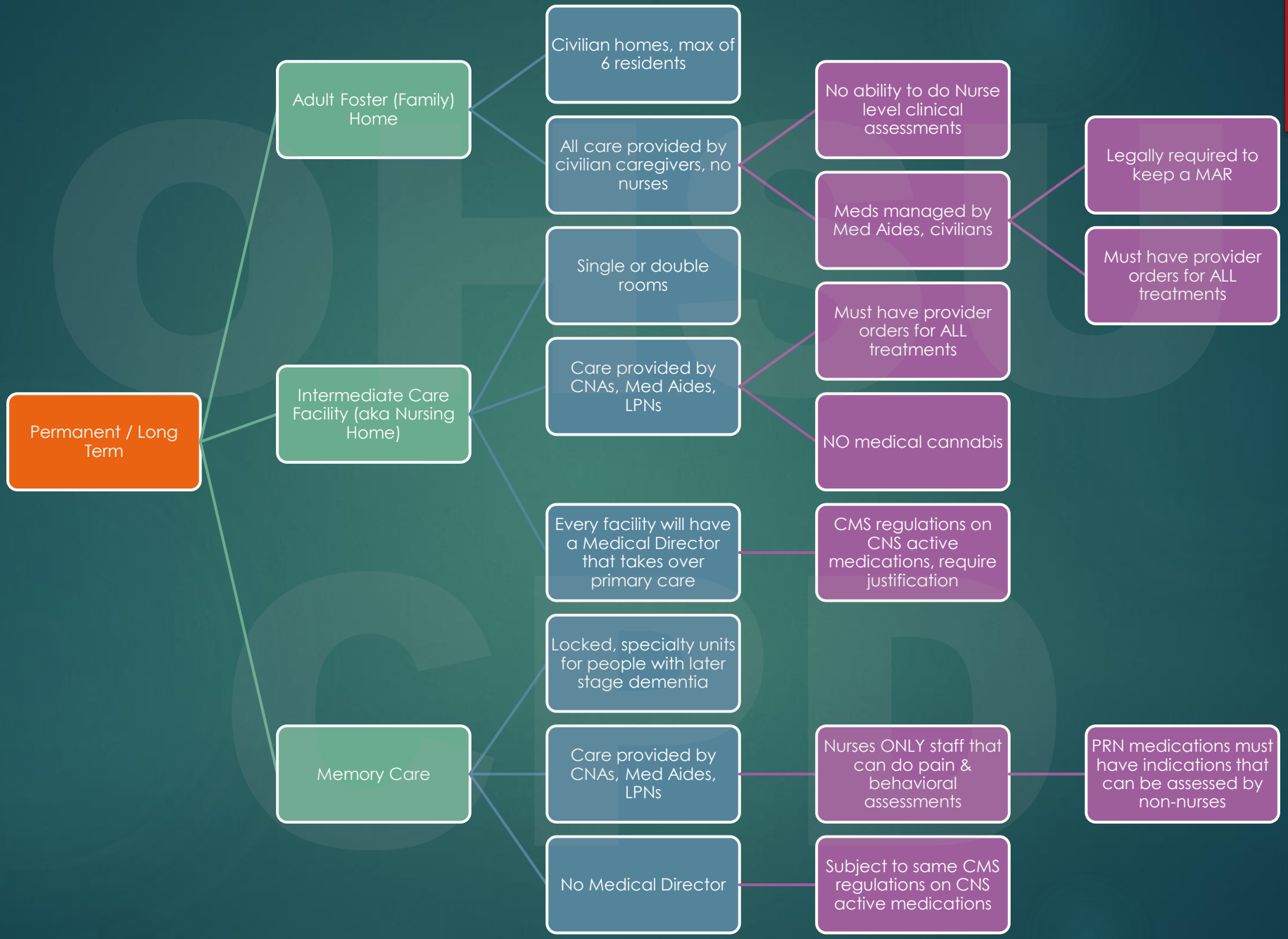
- Generally treatable, correctable deficits show promise of meaningful recovery

Egbujie BA, Turcotte LA, Heckman G, et al. Trajectories of functional decline and predictors in long term care settings: A retrospective cohort analysis of Canadian nursing home residents. Age Ageing. 2024;53:https://doi.org/10.1093/ageing/afae264

Alphabet Soup of Long-Term Care

NOT ALL FACILITIES ARE 'SNF'


Temporary
Skilled Nursing (SNF)
For short term post-hospital rehab
Medical Director manages all meds, medical issues
Paid by Medicare
Permanent / Long Term
Independent Living
Studio, 1 or 2 bedroom apartment
No medication support
Assisted Living
Studio, 1 or 2 bedroom apartment
Care provided by caregivers, Med Aides, no nurses
"Meds and meals"
Residents can elect to manage their own medications
Medical cannabis is allowed but with restrictions
Legally required to keep a MAR
Residential Care (aka Group Home)
Single rooms with similar support to ALF
Specific for chronic mental illness


Permanent / Long Term
Adult Foster (Family) Home
Civilian homes, max of 6 residents
All care provided by civilian caregivers, no nurses
No ability to do Nurse level clinical assessments
Meds managed by Med Aides, civilians
Legally required to keep a MAR
Must have provider orders for ALL treatments
Intermediate Care Facility (aka Nursing Home)
Single or double rooms
Care provided by CNAs, Med Aides, LPNs
Must have provider orders for ALL treatments
NO medical cannabis
Every facility will have a Medical Director that takes over primary care
CMS regulations on CNS active medications, require justification
Memory Care
Locked, specialty units for people with later stage dementia
Care provided by CNAs, Med Aides, LPNs
Nurses ONLY staff that can do pain & behavioral assessments
PRN medications must have indications that can be assessed by non-nurses
No Medical Director
Subject to same CMS regulations on CNS active medications

What This Means for Primary Care

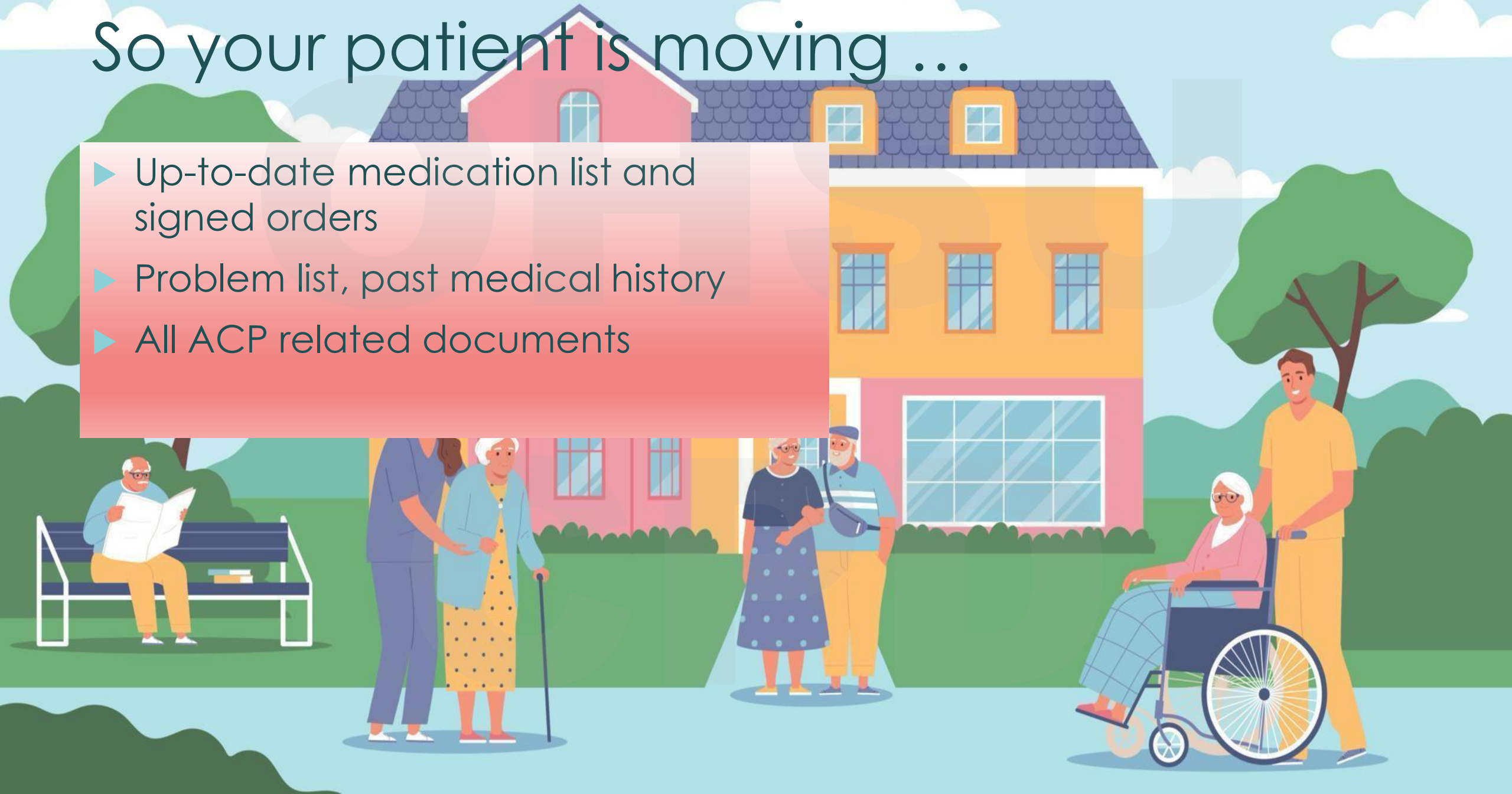
- You already care for people living in settings that do NOT include a house provider:
  - Assisted Living, Adult Foster Home, Residential Care, Memory Care

- It's critical to know what level of care patients reside in
- Ask for a MAR to reconcile medications & treatments
- All those faxes … they're really important

Med Management & LTC Transitions

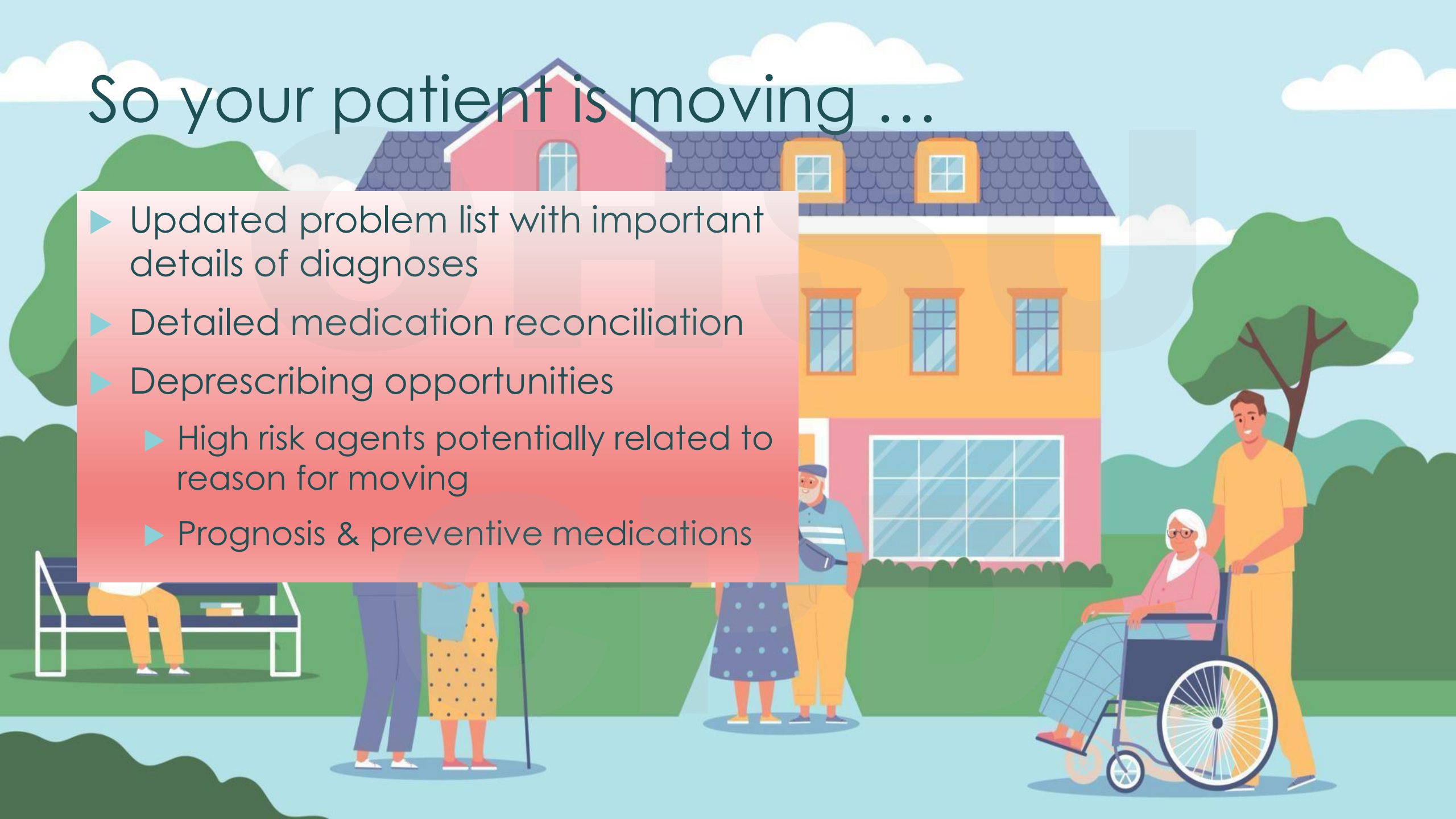
So your patient is moving …

- Up-to-date medication list and signed orders
- Problem list, past medical history
- All ACP related documents



So your patient is moving …

- Updated problem list with important details of diagnoses
- Detailed medication reconciliation
- Deprescribing opportunities
  - High risk agents potentially related to reason for moving
  - Prognosis & preventive medications



Let's talk about Med Rec

- Ideal time for a brown bag medication review
  - If moving from home to facility or have been managing their own medications
  - Prescriptions, OTCs, supplements

- If moving between facilities:
  - Indication of advancing illness, declining function, progressing frailty
    - All change the appropriateness of a variety of medications!
  - Time to review and reconcile with the building MAR
    - Pay attention to how often doses were held or declined

Deprescribing Opportunities

High risk agents

- Anticholinergics
- Antihistamines
- Muscle relaxants
- Sleepers
- Benzoes
- Chronic opioids
- Dopaminergics for RLS
- And more

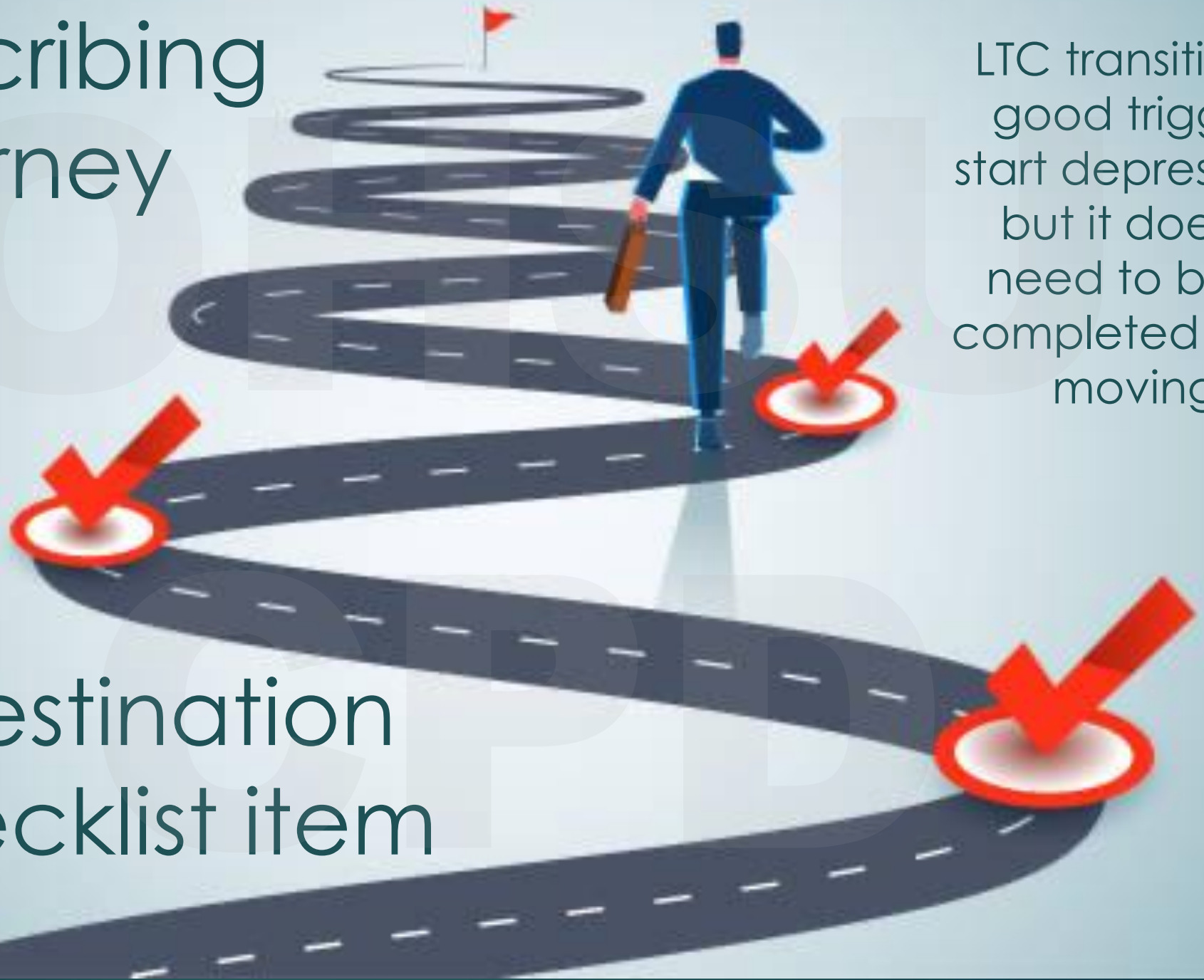
Low value agents

- Tight control of BPs, blood sugars
- Primary prevention aspirin
- Primary prevention statins
- Metoprolol for HTN
- Bisphosphonates
- AChE inhibitors

Prescribing Cascades

- Calcium channel blockers → loop diuretics
- Thiazides → K, Ca, allopurinol
- High dose beta blockers → SSRIs
- PPIs → B12

Deprescribing is a Journey



LTC transition is a good trigger to start deprescribing but it does not need to be fully completed prior to moving in

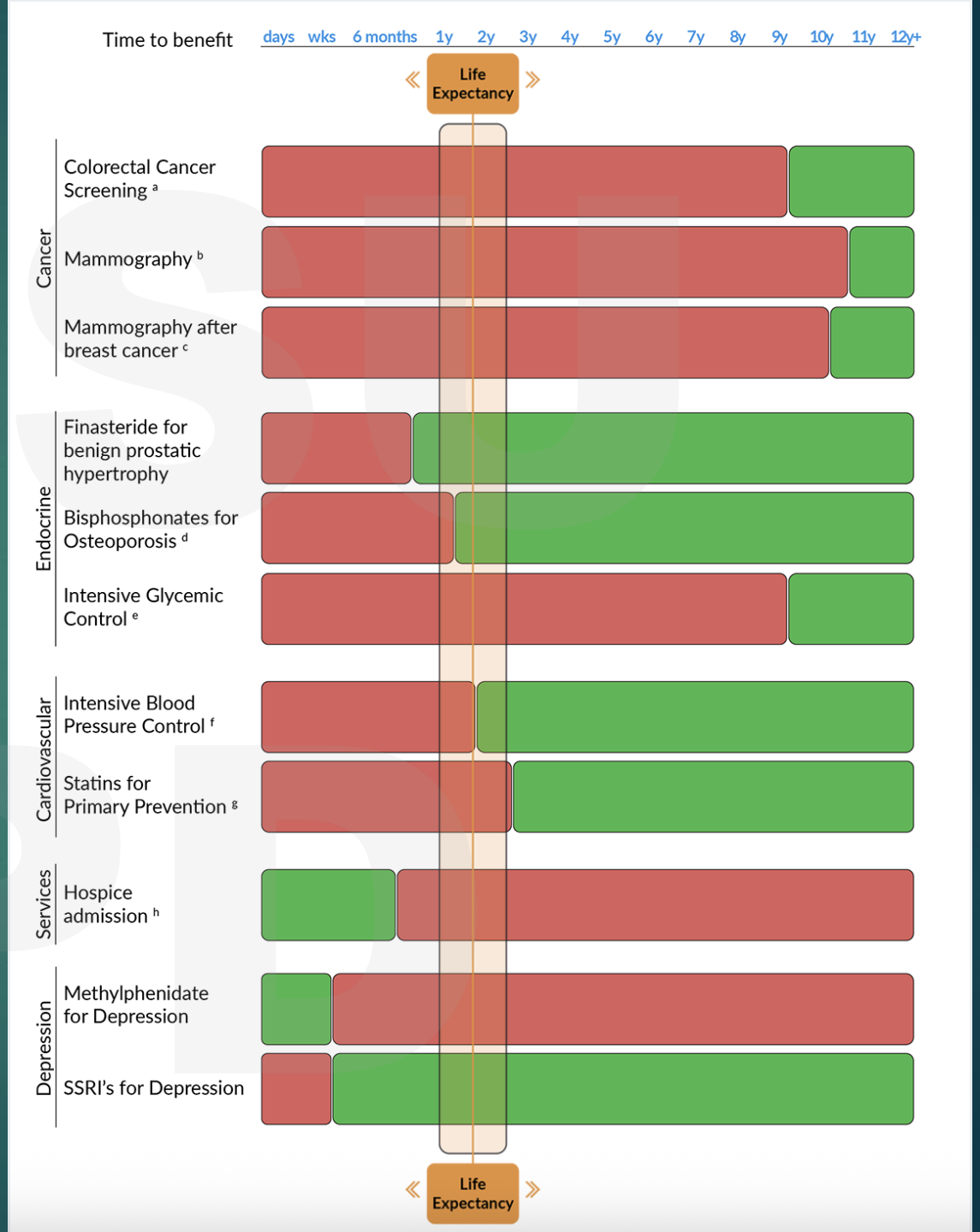
Not a destination or a checklist item

Preventive Medications at LTC Transition

Moving into or between LTC settings is a sign of increasing fragility

Changes the potential benefit of preventive medications with a long lag time to benefit

- Time between starting a therapy and when the effects are realized



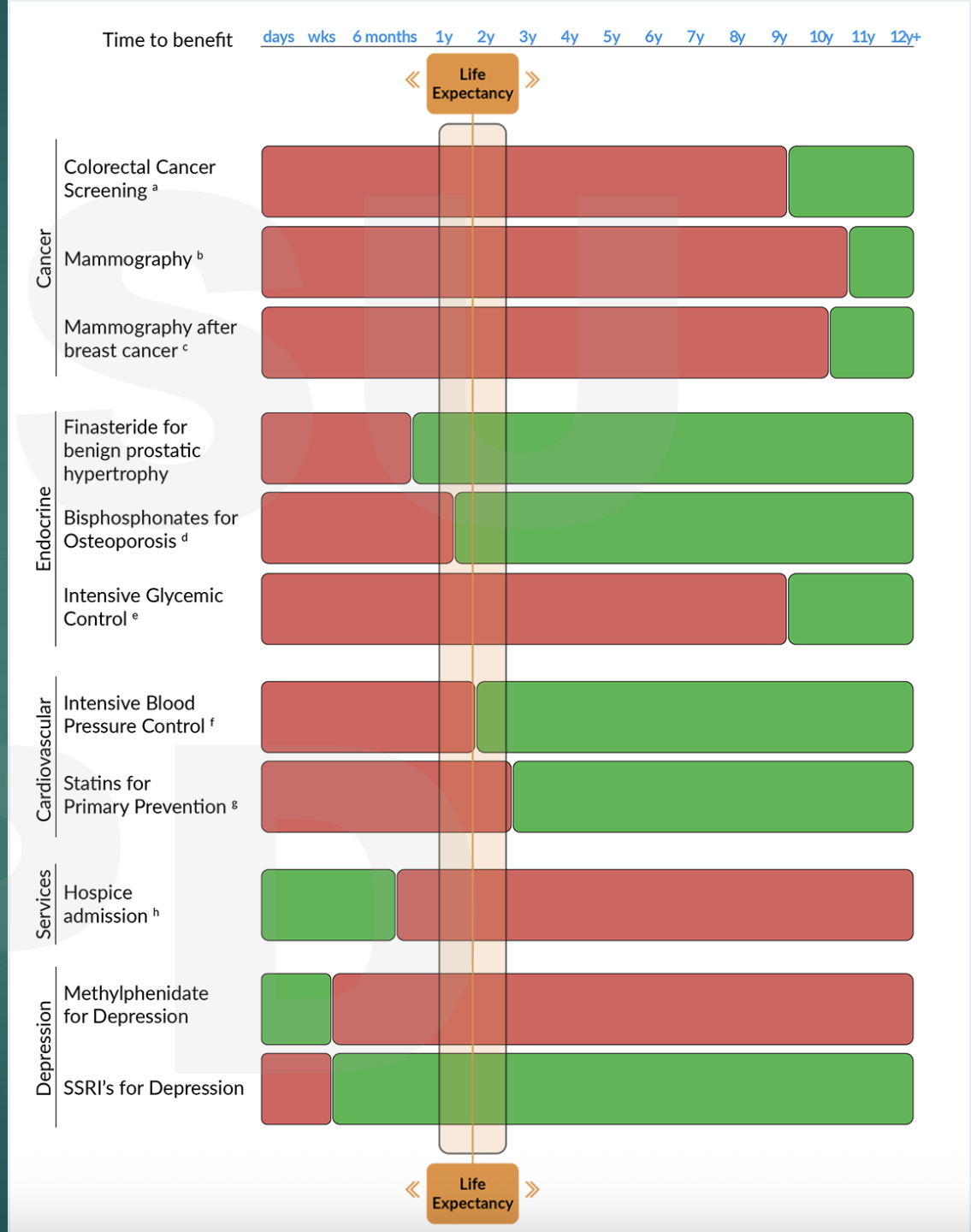
Life Expectancy at LTC Transition

Individual factors matter but …

Average mortality at:

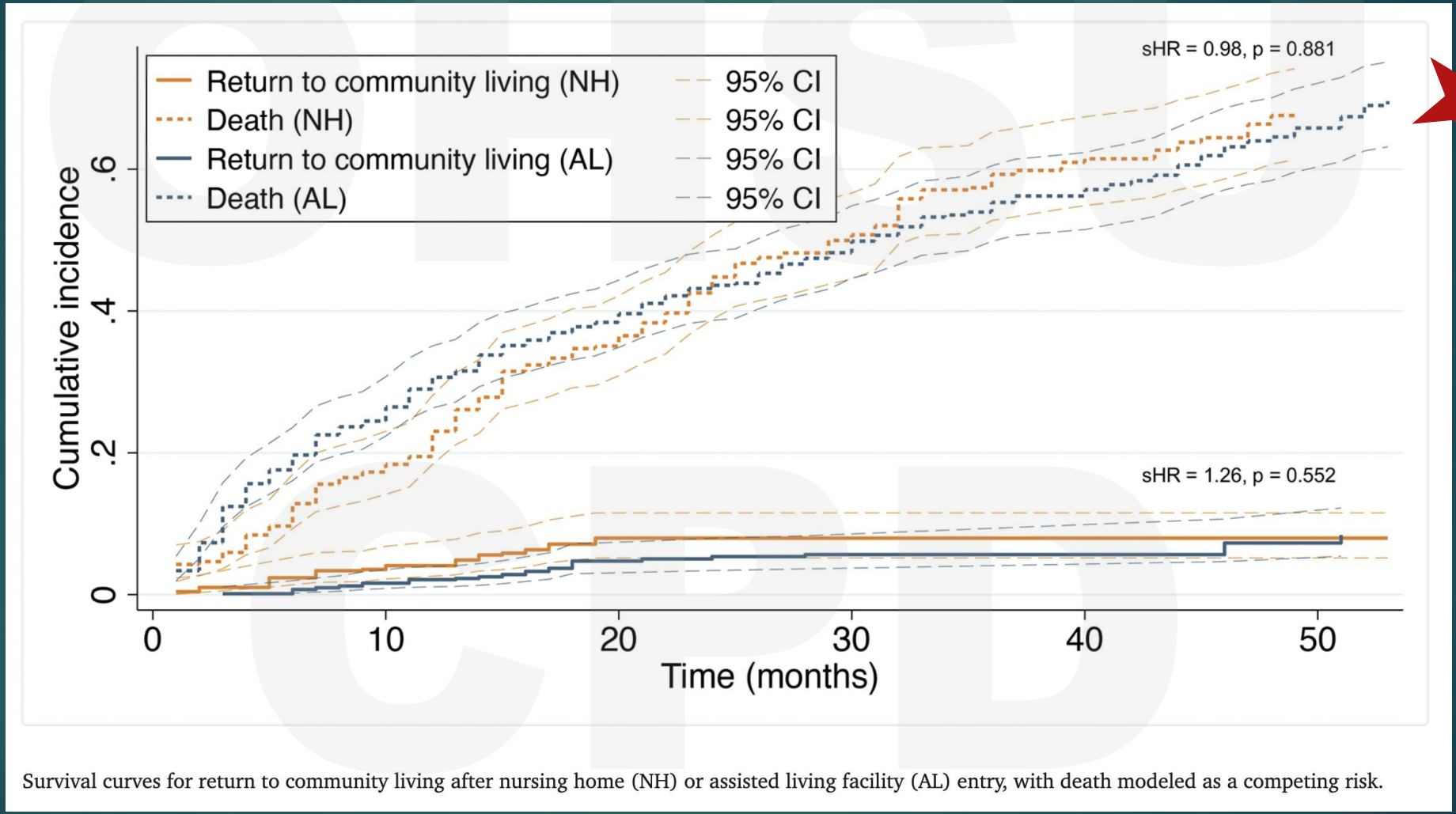
- 1 year → 28%
- 2 years → 44%
- 4 years → 66%

Average life expectancy upon LTC transition = 2.2 years



Lam K, Cenzer I, Covinsky K. Return to community living and mortality after moving to a long term care facility: a nationally representative cohort study. J Am Geriatr Soc. 2022;71(2):569-576

Assisted Living vs ICF / AFH



Survival curves for return to community living after nursing home (NH) or assisted living facility (AL) entry, with death modeled as a competing risk.

Lam K, Cenzer I, Covinsky K. Return to community living and mortality after moving to a long term care facility: a nationally representative cohort study. J Am Geriatr Soc. 2022;71(2):569-576

Curation of medications for the road ahead

HIGH-RISK AGENTS

High Risk Agents

- Transition to LTC is an opportunity to peel back high-risk agents
  - Consistent caregiver presence might make lower risk therapies more accessible (ie. Stretching classes in ALF, topical agents, local massage, etc)
  - Medication tapers can be supported and monitored by staff
  - More supportive, engaging environment affects how people experience various symptoms
    - Anxiety, loneliness, boredom, chronic pain, sleep disturbances

High Risk Agents

- Transitioning between levels of care may be due to issues affected by decreased tolerance of high-risk medications
  - Ex. Increasing frequency of falls
  - Minimizing or stopping contributory medications can help reduce the risk of falling in those first few weeks
  - Assessing for orthostatic hypotension

  - Ex. New or progressing cognitive impairment
  - Pruning CNS active meds in the run up to a transition can make transitions easier … figuring out new spaces and new routines

Tips for Writing Orders

- Write clear, concise orders that include indications for every medication and treatment
  - Ex. Duloxetine for depression or chronic pain?
  - Ex. Heating pad to low back TID
- Use descriptive, behavioral terms for PRNs
  - Ex. Norco PRN calling out, restlessness
- Include hold parameters for vasoactive medications
- Write out taper schedules in the med order
- Include an AVS copy with the visit packet
  - Great place to type orders along with communicating clinical info

Individual curation is the key

THERE IS NO ONE SIZE FITS MOST TO MED MANAGEMENT AROUND LTC TRANSITIONS