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Trombetta named new program director

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Trombetta

Trombetta will oversee the residency program, which provides post-graduate training in advanced geriatric pharmacy practice.

WILKES-BARRE – Dr. Dominick Trombetta, assistant professor of pharmacy practice in Wilkes University's Nesbitt College of Pharmacy and Nursing, was recently named program director of a new Geriatric Residency Program at Allied Services Rehabilitation Hospital in Scranton.

Trombetta will oversee the residency program, which provides post-graduate training in advanced geriatric pharmacy practice.

Trombetta

TL 8-2-05

Trombetta received a bachelor of science in Pharmacy from Temple University, Philadelphia, and a doctor of pharmacy from Shenandoah University in Virginia. He is recognized as a Board Certified Pharmacotherapy Specialist and Certified Geriatric Pharmacist.

Trombetta has taught at Wilkes since 2001. He resides in Shavertown.

SUNDAY TIMES
SCRANTON, PA
SUNDAY 74,275
JUL 17 2005

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People on the Move

Wilkes University

Dr. Dominick Trombetta, assistant professor of pharmacy practice in Wilkes University in the Nesbitt College of Pharmacy and Nursing, was recently named program director of a new geriatric residency program at Allied Services Rehabilitation Hospital in Scranton. Dr. Trombetta will oversee the residency program which provides post-graduate training in advanced geriatric pharmacy practice. Trombetta received a bachelor of science degree in pharmacy from Temple University, Philadelphia, and a doctor of pharmacy degree from Shenandoah University in Virginia. Dr. Trombetta has taught at Wilkes University since 2001.

Wilkes University CV 1-17-05

Dr. Dominick Trombetta, assistant professor of pharmacy practice in Wilkes University in the Nesbitt College of Pharmacy and Nursing, was recently named program director of a new geriatric residency program at Allied Services Rehabilitation Hospital in Scranton. Dr. Trombetta will oversee the residency program which provides post-graduate training in advanced geriatric pharmacy practice. Trombetta received a bachelor of science degree in pharmacy from Temple University, Philadelphia, and a doctor of pharmacy degree from Shenandoah University in Virginia. Dr. Trombetta has taught at Wilkes University since 2001.

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BETHESDA, MD
24-TIMES/YEAR 39,000
JUL 15 2004

Overview of geriatric pharmacy practice in a rehabilitation facility

DOMINICK P. TROMBETTA

Am J Health-Syst Pharm. 2004; 61:1501-5

The goal of pharmacotherapy in the elderly is to maintain or improve functional abilities to allow them to remain as independent as possible. Persons without any functional impairment at 70 years of age have less medical-related costs compared with those with a minimum of one activity-of-daily-living (ADL) dysfunction.[1] One area that has recently been recognized as being of particular importance is geriatric rehabilitation.[2] Geriatric rehabilitation involves a multidisciplinary approach that primarily aims to restore or improve functional capabilities in the disabled elderly through a variety of therapeutic modalities. Disabilities are defined by the World Health Organization as the presence of one or more impairments causing a diminished level of function.[3] Impairments are losses of certain physical or cognitive function in one or more major organ systems secondary to lack of use, age, or disease. The predicted growth of the elderly population will likely increase the need for geriatric rehabilitation services.

The transition of a patient from an acute hospital to a rehabilitation unit offers clinicians an opportunity to reassess the patient's medical condition, recognize any untreated conditions, and evaluate his or her drug therapy. The elderly often have complex care needs due to acute illness, chronic conditions, and ADL dysfunctions. Many problems identified in the transfer of a patient to a rehabilitative environment are preventable.[4,5] The benefits of clinical pharmacy interventions have been demonstrated and recognized in the acute care, community, and long-term-care environments.[6-12] Pharmacists can also improve the quality of care of geriatric patients in rehabilitation units by reconciling medication orders, collaborating with other health care providers, and assessing medication-related problems.

Rehabilitation services. People 65 years old or older represent approximately 13% of the total population of the United States.[13] By 2011, the baby-boom generation will begin reaching age 65. By 2030, the population of people 65 and older is projected to double, growing to 70 million. The population of people 85 years and older is the fastest growing segment among the elderly. In 2000, they were estimated to represent 2% of the total population; however, by 2050, that number is expected to increase to about 5%. These data are especially important to the health care system since people over 85 years old tend to require more services because of chronic health conditions and the inability to perform ADLs. Chronic diseases are illnesses or impairments that are rarely cured and are often the causes of ADL dysfunction. An individual may have more than one chronic disease. Examples of chronic diseases affecting the elderly are diabetes, heart disease, hypertension, cerebrovascular disease, cancer, and chronic obstructive pulmonary disease. These diseases negatively affect the patient's quality of life and ability to function in the community.

Rehabilitation helps patients to achieve their highest level of functioning. Rehabilitation services in acute care hospitals are not as comprehensive as those offered in free-standing centers. Rehabilitation services in long-term-care centers primarily consist of physical therapy and restorative nursing. Outpatient rehabilitation centers provide many of the same services as inpatient centers. Rehabilitation services are reimbursed through Medicare.[14] Patients must have one of the following primary diagnoses to qualify: amputation, brain injury, burns, congenital deformity, femur fracture, multiple trauma, neurologic disorders, polyarthritis, stroke, and spinal cord injuries.

The primary goal of rehabilitation services is to maximize a patient's level of independence. As such, three disciplines play a major role in the care of such patients: physical therapy, occupational therapy, and speech therapy. The primary role of the physical therapist is to restore physical function. Progressive gait training is one way to increase muscle strength and balance, a cardinal goal

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of physical therapy. The Functional Independence Measure (FIM) can be used to evaluate changes in mobility and transferring to the toilet and bath or shower.[15-17] Occupational therapists' primary focus is to optimize the performance of the patient's daily activities. These ADLs include grooming, eating, dressing, and the ability to transfer to the toilet and bath or shower for personal hygiene. These activities are quantitatively scored using the FIM as rehabilitation services progress. Conservation of physical and emotional energy must be considered because fatigue is very common in the elderly. Speech therapists or speech pathologists evaluate and treat patients with dysphagia, dysarthria, aphasia, and apraxia. Patients who have had a stroke or brain injury are at increased risk for impaired swallowing. The consequences of this impairment may include aspiration, dehydration, obstruction of the airway, and nutritional deficiencies. Assessment and management of food and liquid intake are vital for adequate nutritional support during aggressive physical and occupational therapies. Speech assessment and language impairments are additional areas covered by the speech therapist.

The rehabilitation needs of patients 65 years of age and older are significantly different from those of younger patients.[18] Aging is associated with increased functional disability and diminished physical capabilities. Acute hospitalization itself can have negative effects on elderly patients, independent of their primary acute illness, including disorientation, delirium, insomnia, psychosocial dysfunction, disruption in social support, adverse drug reactions, and physical deconditioning. Rehabilitation allows for the reassessment of medical status, and comprehensive geriatric assessment has been shown to increase cognitive and functional abilities, allow patients to return home, and reduce mortality.[19]

The goals of geriatric rehabilitation are to (1) offset or minimize any disability caused by an acute illness (e.g., joint replacement, hip fracture, or cerebrovascular accident) and (2) prevent further functional decline secondary to decreased physiological reserve. Exercise programs that improve gait, balance, flexibility, endurance, and muscle strength can accomplish this. Common complications encountered in geriatric rehabilitation include incontinence, insomnia, pain, anxiety, depression, delirium, orthostatic hypotension, dehydration, and fatigue. Medication-related geriatric rehabilitation issues include preventing adverse drug effects, reducing unnecessary medication use, and educating patients to improve compliance.

Additional information resources for geriatric rehabilitation are listed in the appendix.

Role of the pharmacist. Pharmacists who practice in the rehabilitation setting must be knowledgeable about the needs of geriatric patients. Pharmacists must consider the patient's level of functional impairment (as defined by FIM scoring) on admission, goals of the multidisciplinary team, comorbidities, family support and resources, and discharge placement. The pharmacist first thoroughly reviews the patient's medication history and discusses it with primary care practitioners and specialists who have been directly involved with a patient's care. Prescription drug records and refills are sometimes needed from the patient's community pharmacy medication profile to assess compliance. Drug-related problems as defined by Strand et al.[20-22] can be used to optimize drug therapy. For example, the pharmacist within the rehabilitation setting can identify patients who have sustained either hip or fragility fractures who are not receiving any pharmacologic interventions to increase bone mineral density and make recommendations to initiate therapy. Osteoporosis has recently been identified as undertreated.[23-25] Given the disability and high mortality associated with hip fractures, the initiation of therapy during rehabilitation should be a high priority. A pharmaceutical care plan should be developed in a SOAP note format (subjective, objective, assessment, plans) to document pharmacist interventions and recommendations. Implementation of specific interventions must be carefully discussed with appropriate team members to avoid untoward outcomes.

Medication therapy can significantly affect the ability of the geriatric patient to participate in vigorous rehabilitation routines. Many medications can compromise a patient's ability to participate in physical therapy. Pharmacists must scrutinize prescriptions that may cause sedation and hypotension. Often, simply changing times of administration of antihypertensives can alleviate symptomatic hypotension during therapy sessions.

Pain management presents both challenges and opportunities in the geriatric rehabilitation patient. Analgesics need to be administered routinely prior to physical therapy for most patients. Around-the-clock administration schedules help patients participate in physical therapy; however, excess sedation and inadequate pain control must be monitored for and remedied. Opioids and nonsteroidal antiinflammatory drugs (NSAIDs) are routinely prescribed for this population. Excess opioids can cause sedation, increase the risk of falls, and limit the patient's ability to participate in physical therapy sessions. NSAIDs can cause gastrointestinal bleeding or worsen renal impairment in some patients. Through careful dosage adjustment and ongoing monitoring, pharmacists can ensure therapeutic goals are met.

Providing patient and family education is an important part of a pharmacist's responsibilities. Drugs that

require particular attention at patient discharge counseling include warfarin and insulin. Warfarin is used frequently in geriatric patients to prevent complications caused by temporary immobility secondary to orthopedic surgery or permanent risk factors, such as atrial fibrillation. Individual instruction for glucose monitoring, insulin injection, and neuropathic pain is necessary for patients with diabetes mellitus.

Providing continuity of care is extremely important. Pharmacists must compare medications taken before hospital admission with discharge prescriptions after rehabilitation and avoid drug duplication, inappropriate dosages, and drug interactions. Counseling a patient and family members provides the final link in the continuity of patient care. Medication therapies for patients with multiple comorbid conditions are extremely complex. Pharmacists can ensure that the patient understands any medication changes and avoids potential adverse events. Discussion with all providers to coordinate medication regimens is time-consuming but necessary.

FIM. Rehabilitation involves ongoing measurements of progress. One of the instruments used to assess the outcomes of geriatric rehabilitation is the FIM.[15-17] The FIM is a reliable and sensitive measure of function in the elderly. The following domains are assessed by FIM: grooming (mouth care, hair care, washing face and hands, applying cosmetics, and shaving), bathing (cleanses, rinses, and dries the body from the neck down in a tub, shower, or sponge bath in bed), dressing (above and below the waist dressing and undressing and the application of prosthesis or orthosis devices), eating (utilization of utensils and the ability to masticate and swallow food from the tray placed in front of them), toileting (manipulating clothing and sustaining personal hygiene after bedpan, commode chair, urinal, and toilet), bladder management (proportion of support and sphincter control), bowel management (proportion of support and sphincter control), transfers (chair, bed, toilet, tub, shower, and wheelchair), locomotion (walking, wheelchair, stairs), comprehension (visual and auditory), expression of language (verbal, nonverbal, writing), social interaction (interactions with personnel, patients, and family), problem solving (ADLs), and memory (recall and recognition necessary to execute daily activities). Different healthcare professionals are responsible for evaluating and treating particular domains in the FIM. For example, the physical therapist evaluates a patient's locomotion. The FIM identifies levels of assistance, ranging from complete independence to total assistance.

A number of classes of medications have the potential to adversely affect FIM scores. It is important for pharmacists to monitor both therapeutic and adverse effects of medications on the functional capacity of the patient as reflected by FIM scores. Table 1 identifies the specific classes of medications, mechanisms by which they can adversely affect the patient, and daily activities affected. Benzodiazepines, barbiturates, sedatives–hypnotics, opioids, antidepressants, antipsychotics, and parkinsonian medications have the most significant impact on FIM scores.

Required skills of rehabilitation pharmacists. Clinical practice experiences in the growing arena of rehabilitation should be offered to pharmacists interested in geriatrics. The geriatric rehabilitation pharmacist must be cognizant of several key concerns. First, the goals of pharmacotherapy must be congruent with those of the rehabilitation team. The pharmacist must actively participate with the multidisciplinary team. For example, if a therapist reported a decline in the patient's level of functioning, the pharmacist would thoroughly review any potential medication-related cause and discuss the issue with all therapists involved to further evaluate, identify, and resolve any drug-related problems. Second, the pharmaceutical care plan must take into account the patient's global functional status. Recommendations to initiate or modify medication regimens should be based on a careful assessment of the impact of those changes on ADLs. More importantly, the pharmaceutical care plan must be practical to execute after discharge, regardless of discharge placement status. Patients who cannot self-inject medications or are unreliable cannot receive the same recommendations for treatment as more reliable and self-confident patients. For many patients, the rehabilitation process is an opportunity to regain their independence and return to their homes by demonstrating the ability to safely perform self-care activities. Therapeutic interventions are tailored to allow patients to meet their goals. Patients with parkinsonian symptoms who are trying to maintain their independence do not have three or four weeks to wait for a dopamine agonist to reach optimum effectiveness. In these situations, levodopa–carbidopa dosages must be maximized and monitored closely. A patient's risk of falling, in addition to other factors, may determine whether they receive warfarin for long-term thromboembolism prophylaxis. Patients with a high risk of falling are not good candidates to receive long-term anticoagulation therapy.

Finally, the pharmacist must understand how different medications can affect FIM scores. If patients with initial FIM scores of 6 or 7 on any particular activity decline to 4 or 5, a medication-related cause should be ruled out. Conversely, appropriate medication use can help patients participate in therapy, resulting in improved FIM scores.

Oral and written communication skills are also important in rehabili-

Table 1.
Drugs That May Affect FIM Scores in Geriatric Patients[a]

Drug Class(es)	Mechanism	FIM Affected
Antidepressants, antipsychotics, barbiturates, benzodiazepines, opioids, sedatives/hypnotics	Central nervous system depression	Grooming, bathing, dressing, eating, toileting, bladder management, bowel management, transfers, locomotion, comprehension, expression of language, social interaction, problem solving, memory
Nonsteroidal antiinflammatory drugs	Dizziness, confusion	Transfers, locomotion, problem solving, comprehension, memory, social interaction
Diuretics	Diuresis, orthostatic hypotension	Bladder management, transfers, locomotion
Antihypertensives	Orthostatic hypotension	Transfers, locomotion, bathing, dressing, toileting
Parkinsonian drugs	Psychiatric disturbances, motor fluctuations, dyskinesias, orthostatic hypotension	Grooming, bathing, dressing, eating, toileting, bladder management, bowel management, transfers, locomotion, expression of language, social interaction
Cardiac glycosides	CHF, nocturia, visual changes, confusion	Bladder management, transfers, locomotion
Insulin, hypoglycemics	Hypoglycemia	Transfers, locomotion, comprehension, problem solving, memory, social interaction
Antiepileptics	Central nervous system depression	Transfers, locomotion, social interaction, expression of language, comprehension, problem solving, memory
Laxatives/stool softeners, colchicine, antibiotics	Diarrhea	Bowel management, toileting
Anticholinergics, antihistamines	Confusion, constipation, urinary retention	Bladder management, bowel management, social interaction, comprehension, expression of language, problem solving, memory, toileting

[a]FIM = functional independence measurement, CHF = congestive heart failure.

tation care. Pharmacists do not always have the opportunity to directly observe patient care or discuss with individual therapists a patient's progress. The pharmacist is best suited to suggest medication changes but only within the context of knowing the patient's comprehensive global assessments and through monitoring their plans of care. Communication with all team members is important to ensure any medication change or intervention will not negatively impact other domains of rehabilitation. Pharmacists should understand that the amount of useful information obtained from the medical chart is limited and how to obtain vital patient information through other sources. For example, most patients appreciate speaking to pharmacists. Because a plethora of diagnostic testing has occurred before rehabilitation occurs, pharmacists need to consult with the patient's primary care provider to determine if a particular test has been recently completed and, if so, secure the results. This differs from an acute care practice where information is more readily available. For example, the results of an echocardiogram are helpful in deciding which medications to add or possibly discontinue for a patient. The pharmacist may need to inquire if such a test has been performed and where it was conducted. The pharmacist would then have to request that those results be faxed to the rehabilitation facility. The results would then be communicated with all health care providers involved in the care of the patient and incorporated into the pharmaceutical care plan. Good writing skills are necessary for the documentation of clinical interventions and the rationale for any changes.

Oncology patients present a special challenge within the rehabilitation environment. Asthenia and fatigue are common in many patients with cancer, as are physical impairments and psychological or social issues. There are data to illustrate the benefits of rehabilitation in this patient population.[26] However, both asthenia and fatigue limit a patient's ability to participate in therapy. Pharmacists can intervene by reviewing the patient's current medications and recommend interventions to reduce lethargy and fatigue. The patient's level of dyspnea and vital signs, including pain assessment, should be monitored.

The need for geriatric rehabilitation services will inevitably grow with the aging population. Pharmacy educators should consider forming affiliations with inpatient rehabilitation facilities for training pharmacy

students. The provision of pharmaceutical care in the rehabilitation center can serve as a unique learning opportunity for senior pharmacy students. Students can greatly benefit from the multidisciplinary and collaborative care planning in which the skills of the pharmacist are utilized to improve the quality of care for geriatric patients. The opportunity to provide pharmaceutical care is the capstone of the educational process.

Conclusion. The rehabilitation environment presents practicing pharmacists with opportunities to provide pharmaceutical care to geriatric patients in an inpatient environment.

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Appendix—Information resources for geriatric rehabilitation services

1. Administration on Aging (www.aoa.gov/).
2. American Academy of Physical Medicine and Rehabilitation (www.aapmr.org).
3. American Medical Rehabilitation Providers Association (www.amrpa.org).
4. National Institute on Aging (www.nia.nih.gov).
5. National Rehabilitation Information Center (www.naric.com).
6. The American Geriatrics Society (www.americangeriatrics.org).

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ALUMNI News

Go To Page 2 >>>

Trio has a classic impact on bluegrass

Three SU alumni bridged their classical training with bluegrass when they performed with Rhonda Vincent and "The Rage" in March at the legendary Birchmere music hall in Alexandria, Va.

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Full Story>>>

Alumni SUCCESS Stories

Robin Higginbotham ('90) is as well known as ever on campus as she often returns to be part of Shenandoah Summer Music Theatre. During the 2005 season, the SU theatre alumna played Roxy Hart in "Chicago," choreographed "Guys and Dolls" and served as assistant director of "Disney's Beauty and the Beast." Higginbotham lives outside New York City, where she has performed in "All is Full of Love" and "Wallenburg." She toured with Kenny Rogers in "Christmas From the Heart" and was in the off-Broadway production of "Take it Easy." Shenandoah not only has a place in her

Dominick Trombetta ('01) ,assistant professor of pharmacy practice at Wilkes University's Nesbitt College of Pharmacy and Nursing, in Wilkes-Barre, Pa., was recently named program director of a new geriatric residency program at Allied Services Rehabilitation Hospital in Scranton, Pa. Dr. Trombetta will oversee the residency program, which provides post-graduate training in advanced geriatric pharmacy practice. He is recognized as a board certified pharmacotherapy specialist and certified geriatric pharmacist. Trombetta taught at

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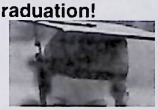

heart, but in her husband's. Higginbotham married alumnus Michael King '96, whom she met one summer performing in SSMT.

Wilkes since 2001. He resides in Shavertown, Pa., with his wife Dr. Susan (Czekalski) Trombetta '01.

students attain their goals? Are you interested in continuing to help your university grow stronger? There are many ways for alumni to get involved at SU.

The Office of Alumni Affairs is accepting applications for membership on the Alumni Association board of directors.

Applications are for the 2006 nominating committee. Contact the Office of Alumni Affairs at (800) 786-4802 or alums@su.edu.

The Alumni Association hosted On July 18 a dinner at Castiglia's Restaurant for alumni participating in the Shenandoah Summer Music Theatre. They had a great time relaxing on their day off.

(Front row) Andrew Livingston '03, Dan Miller '05, Matt Gose '93, Jessica Moryl '04, Robin Higginbotham King '90, Hilary Stevens '05, Jennifer Ellerby '03. (Back row) Brian Curl '03, Lanny Warkentien '01, Jeff Klein '90, Jeff Mueller '94, Rick Wesley '88

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