CALTCM 45th ANNUAL MEETING

CALTCM Summit for Excellence

Leading the Future of Post-Acute and Long-Term Care

Promoting quality patient care through medical leadership and education

April 5-6, 2019

CALTCM
California Association of Long Term Care Medicine

45th Annual Meeting & Pre-Summits:

CALTCM Summit for Excellence:

Leading the Future in Post-Acute and Long-Term Care

April 4-6, 2019

Omni Los Angeles Hotel at California Plaza
Los Angeles, California

CALTCM 45th Annual Meeting
CALTCM Summit for Excellence
Leading the Future of Post-Acute and Long-Term Care

April 5-6, 2019

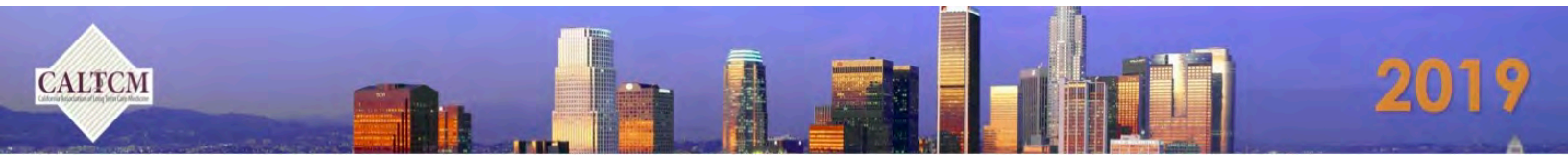
Program Overview

The CALTCM Summit for Excellence has been designed to engage and benefit direct care practitioners - all members of the interdisciplinary team and administrative leadership. This event will help you stay current on best practices to be the driver of quality, patient safety and person-centered care. The CALTCM Annual Meeting has been rebranded as the CALTCM Summit for Excellence, harnessing our mission and vision to Lead the Future of Post-Acute and Long-Term Care! Exciting sessions for the entire interdisciplinary team, clinical hot topics, and two “In The Trenches” sessions give you the opportunity to individualize your experience.

Program Learning Objectives

At the completion of this training participants will be able to:

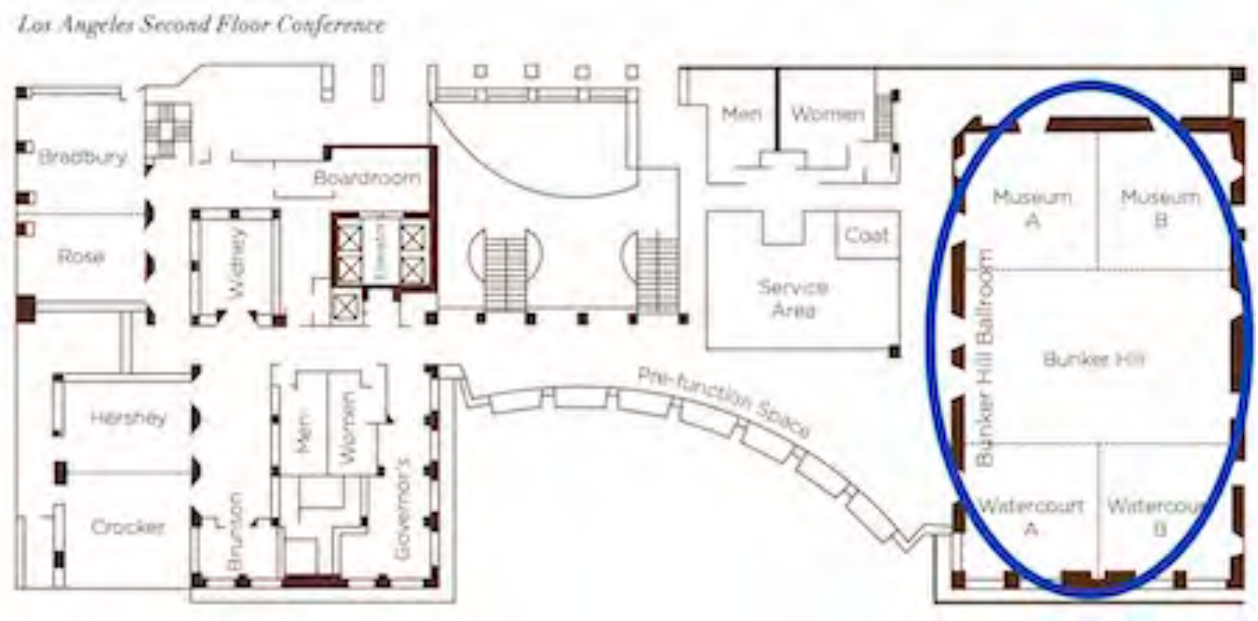
1. Characterize elder abuse and recognize practices to appropriately manage current and future risks;
2. Define methods to improve the collaborative culture of your facility for achieving success for future quality improvement projects;
3. Develop goals and interventions for risk management problems;
4. Identify skills you can improve in your practice;
5. Define best practices to improve resident centered care using current and anticipatory care models.



Conference Location & Information

Omni Los Angeles Hotel at California Plaza
251 South Olive Street, Los Angeles, CA 90012

Omni Hotel – Second Floor



Continuing Education Information

Participants are required to sign in at the registration desk. The post event evaluations will be emailed to participants, evaluations MUST be completed to receive continuing education credit. The submission deadline is July 31, 2019. If you prefer a hardcopy of the evaluation and credit request, please visit the registration desk to request a copy or call (888) 332-3299.

Product Theaters & Exhibits

Please take every opportunity to visit each product theater and exhibitor. Their contributions and participation at our annual meeting is essential to our growth and sustainability. Be sure to pick up your Participant Passport at registration, drop off your completed Passport at the registration desk in order to be eligible for the raffle, deadline is 3pm on Saturday.

Program Accreditation Statement

Continuing Medical Education (CME)

California Association of Long Term Care Medicine is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.

California Association of Long Term Care Medicine designates this Live activity for a maximum of **12.0 *AMA PRA Category 1 Credit(s)™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

This course complies with Assembly Bill 1195 Continuing Education: Cultural and Linguistic Competency.

American Board of Post-Acute and Long-Term Care Medicine (ABPLM)

This live activity has been pre-approved by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) for a total of **8.25 management hours and 3.75 clinical hours** toward certification or recertification as a Certified Medical Director (CMD) in post-acute and long-term care medicine. The CMD program is administered by the ABPLM. Each physician should claim only those hours of credit spent on the activity.

American Board of Internal Medicine MOC Statement

Successful completion of this activity enables the participant to earn **12.0 Practice Assessment points** [and patient safety MOC credit] in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. It is the sponsor's responsibility to submit participant completion information to ABIM for the purpose of granting the MOC points.

Board of Registered Nursing (BRN)

The California Association of Long Term Care Medicine (CALTCM) is a provider approved by the California Board of Registered Nursing (Provider #CEP-16690). This activity has been approved for up to **12.0 contact hours**.

Nursing Home Administrators Program (NHAP)

This activity has been approved by the Nursing Home Administrator Program for up to **12.0 hours of NHAP credit**. Course approval number: 1797012-6921/P.

This course meets multiple requirements of the California Business and professions Codes 2190–2196.5 for physician CME, including cultural competency and geriatric credits.

Program Course Chair and Education Committee

Education Committee Chair

Heather D'Adamo, MD

Education Committee

Debra Bakerjian, PhD, APRN, FAAN, FAANP
Diane Chau, MD
Heather D'Adamo, MD
Rebecca Ferrini, MD, MPH, CMD
Timothy Gieseke, MD, CMD
Janice Hoffman, Pharm.D, CGP, FASCP
Barbara Hulz
Craig Jaffe
Albert Lam, MD
Vanessa Mandal, MD
James Michail, MD
KJ Page, RN-BC, LNHA
Gabriela Sauder, MD
Rajneet Sekhon, MD
Karl Steinberg, MD, CMD, HMDC
Michael Wasserman, MD, CMD

Faculty & Planner Disclosures

It is the policy of California Association of Long Term Care Medicine (CALTCM) to ensure balance, independence, objectivity, and scientific rigor in all of its sponsored educational programs. All faculty participating in any activities which are designated for *AMA PRA Category 1 Credit(s)* ™ are expected to disclose to the audience **any** real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of the CME activity. This pertains to relationships with pharmaceutical companies, biomedical device manufacturers, or other corporations whose products or services are related to the subject matter of the presentation topic. The intent of this policy is not to prevent a speaker with a potential conflict of interest from making a presentation. It is merely intended that any potential conflict should be identified openly so that the listeners may form their own judgments about the presentation with the full disclosure of the facts. It remains for the audience to determine whether the speakers' outside interests may reflect a possible bias in either the exposition or the conclusions presented.

The following faculty and planners have indicated any affiliation with organizations which have interests related to the content of this conference. This is pointed out to you so that you may form your own judgments about the presentations with full disclosure of the facts. All conflicts of interest have been resolved in accordance with the ACCME's Standards for Commercial Support.

Faculty and Planners	Role	Affiliation / Financial Interest	Name of Organization
Margherita Aikman, RN, BSN, PharmD, BCPS, BCACP, CACP, CDE, APh	Faculty	None	
Patricia Bach, PsyD, RN	Faculty/ Planner	None	
Deb Bakerjian, PhD, APRN, FAAN, FAANP	Faculty/ Planner	None	
Alex Bardakh, MPP, PLC	Faculty	None	
Jason Belden	Faculty	None	
David Berman, MD	Planner	None	
Diane Chau, MD	Planner	None	
Heather D'Adamo, MD	Planner	None	
Michelle Eslami, MD, CMD, FACP	Planner	None	
Rebecca Ferrini, MD, MPH, CMD	Faculty/ Planner	None	
Kathy Gamboa, RN	Faculty	None	
Robert Gibson, PhD, J.D.	Faculty	None	
Timothy Gieseke, MD, CMD	Faculty/ Planner	None	

Faculty and Planners	Role	Affiliation / Financial Interest	Name of Organization
Janice Hoffman, PharmD, EdD, APh, BCGP, FASCP	Faculty/ Planner	None	
Ashkan Javaheri, MD	Faculty	None	
Albert Lam, MD	Faculty/ Planner	None	
Patricia Lau, MPA	Planner	None	
Magda Lenartowicz, MD	Planner	None	
Ro Linscheid, NHA	Planner	None	
Jay Luxenberg, MD	Faculty	None	
Vanessa Mandal, MD, MS, CMD	Faculty/ Planner	None	
Patricia Marks	Faculty	None	
James Michail, MD	Planner	None	
Maribeth Nono, RN, MAN	Faculty	None	
Ron Ordona, DNP, FNP-BC	Planner	None	
Dan Osterweil, MD, FACP, CMD	Faculty	None	
KJ Page, RN, NHA, ND	Planner	None	
Peter Patterson, MD, MBA, FCAP, FACMQ	Faculty	None	
Teresa Rogers-Marsh, MSN-ED	Faculty	None	
Gabriela Sauder, MD	Planner	None	
Rajneet Sekhon, MD, CMD, HMDC	Planner	None	
Karl Steinberg, MD, CMD, HMDC	Faculty/ Planner	Non-branded Speakers Bureau, Honoraria	Boehringer Ingelheim Sanofi Astellas
Indira Subramanian, MD	Faculty	Consulting Fee, Consultant	Acadia
Merlyn Trinidad, RN-BSN	Faculty	None	
Michael Wasserman, MD, CMD	Faculty/ Planner	Editorial Board, Honoraria	Merck Manual
Kerry Weiner, MD, MPH	Faculty	None	
Christine Wilson, RN, J.D., MS-HCE	Faculty	None	
Thomas Yoshikawa, MD	Faculty	None	

Faculty Biographies

Margherita Aikman, RN, BSN, Pharm.D., BCACP, BCPS, CACP, CDE, APh
Supervisor, Clinical Pharmacy at Dignity Health - Sacramento
Mar has been in health care over 20 years and currently works as the Supervisor of Clinical Pharmacists for Dignity Health in the greater Sacramento area. There she manages a group of amazing clinicians whom devote their time to improving patients' lives. The Dignity Health Clinical Pharmacists see patients for chronic disease state management, medication management and as a geriatric consult in tandem with a geriatrician. Mar is passionate about her team, good clinical decisions, her family, skiing, and a clean up to date medication profile—not necessarily in that order.

Pat Bach, PsyD, RN
Clinical psychologist in northern California specializing in geriatrics and neuropsychology. Dr. Patricia Bach is a consulting clinical neuropsychologist and integrated care specialist with interests in geriatrics, behavioral medicine and long-term care. She is an assistant professor in the Department of Family and Community Medicine at Eastern Virginia Medical School and past president of Psychologists in Long-Term Care. Pat has been an active member of AMDA since 2007, serves on the boards of CALTCM, the American Board of Post-Acute and Long Term Care Medicine (ABPLM) and the Journal of the American Medical Directors' Association (JAMDA) editorial board. She is a chaplain with the Placer County Law Enforcement Chaplaincy and maintains a private practice in Roseville, CA.

Debra Bakerjian PhD, FNP, FAAN, FAANP, FGSA
Debra Bakerjian is associate clinical professor, at the Betty Irene Moore School of Nursing at UC Davis. She has over 25 years of nursing homes practice experience and has served as a consultant to many nursing homes, providing expert help in quality of care, quality improvement and patient safety. Dr. Bakerjian teaches geriatrics, quality improvement, and patient safety at UC Davis and mentors doctoral students, visiting scholars, masters leadership, nurse practitioner, and physician assistant students. She is also passionate about interprofessional education and collaborative practice and is a frequent invited speaker across the schools of medicine and nursing and the health system on these topics. Bakerjian earned a Doctor of Philosophy in Health Policy and Gerontology in 2006 and a Master in Science of Nursing in 1992, both from UC San Francisco School of Nursing. Her doctoral study, "Utilization of Nurse Practitioners in Nursing Homes: A Comparison with Physicians," received the 2006 Dissertation of the Year Award at UC San Francisco. Bakerjian earned a Family Nurse Practitioner and Physician Assistant certificate from the UC Davis School of Medicine in 1989.

Bakerjian is active in both state and national organizations associated with the care of older adults. She is the Immediate Past-President of the California Association of Long Term Care

Medicine and has been a member of CALTCM and AMDA since 2001, where she serves on the governance, transitions of care, and innovations committees. She was one of first nurses to serve on the steering committee for Advancing Excellence in American Nursing Homes' and is currently on the National Quality Forum's Common Formats standing committee. She is a member of the Health Sciences Executive Committee of the Gerontological Society of America. She is a past president of the Gerontological Advanced Practice Nurses Association and past chair of the GAPNA Foundation. Dr. Bakerjian is a Fellow of both the American Association of Nurse Practitioners, the American Academy in Nursing and the Gerontological Society of America.

Alex Bardakh, MPP, PLC
Alex Bardakh, MPP, PLC, is the Director of Public Policy and Advocacy for AMDA – The Society. Mr. Bardakh works for the Society's extensive Public Policy agenda through Advocacy in Congress and numerous Federal Agencies. A graduate from the University of Maryland Baltimore County (UMBC) in Political Science/Psychology and Master's Degree in Public and Legal Policy, Mr. Bardakh has extensive experience in health policy with a specific focus on areas such as payment models and quality of care initiatives. He has been a recognized national speaker on healthcare policy and has spoken at national conferences throughout the country.

Jason Belden
Jason Belden is the Disaster Preparedness Program Manager with the California Association of Health Facilities (CAHF) in Sacramento, CA. He is also the Fire Life Safety Officer and OSHPD Policy Analyst for the association as well. He has worked in the EMS and Disaster response fields for over 20 years through his work with Cal Fire, Vacaville Fire, and the State of California. He also specializes in Office of Statewide Health Planning and Development Facilities Development Division (OSHPD FDD) policy analysis and regulatory affairs. He is responsible for all internal and external communication with OSHPD FDD and California Department of Public Health - Fire Life Safety Division (CDPH FLS) including seminar content used to educate physical plant maintenance staff. He is Chairman of the Care Delivery Design and Improvement Committee for the State of California and a board member of the Culture Change Coalition of California. He is also the developer of all the physical plant content of CAHFs public and member only website.

Rebecca Ferrini, MD, MPH, CMD
Dr. Rebecca Ferrini MD MPH CMD is a full-time medical director for the County of San Diego 192 bed distinct part skilled nursing facility serving a younger, safety net population for nearly 19 years. She received the 2009 AMDA Medical Director of the Year Award, and speaks and publishes in the areas of quality, leadership, decision-making capacity, behavioral management, Huntington disease and younger adults. She has specialty in Hospice and Palliative medicine and General Preventive Medicine. She has five children

and plays competitive soccer. Her facility is 5 stars (CMS 20/20), has been named a top nursing home in the country for seven years by US News and World Report . Edgemoor received the American Health Care Association / National Center for Assisted Living (AHCA/NCAL) Gold -- Excellence in Quality Award in 2017 and had a Baldrige site visit in fall 2018.

Kathy Gamboa, RN, BSN
Kathy Gamboa graduated with Bachelor of Science in Nursing at the University of the Assumption Philippines on March 1995. She practiced nursing after passing the local board exam for nursing at the Provincial hospital in the medical ward for almost 2 years. While working as a staff nurse then, she found a better opportunity for her family and started working as a medical representative in a pharmaceutical company. She worked at the company until she migrated into the USA. She started working as a certified nurse assistant while trying to pass the NCLEX, a very challenging but enjoyable job. After passing her NCLEX, she was given an opportunity to practice the profession she loves, learning different fields in nursing, and gaining experience working with people with developmental disabilities, mental disabilities and in geriatrics. Currently she is a Supervising Nurse at Edgemoor Hospital and has been there for almost 3 years. She plans on staying with the county until she retires.

Tim Gieseke MD, CMD
Dr. Gieseke graduated AOA from UCI in 1976 and then completed a straight Internal Medicine at UCD, Sacramento Medical Center. As a general internist, he practiced in all settings of care in Santa Rosa until 2005 when he left his office practice to focus on Post-Acute and Long Term Care Medicine and hospice. This move allowed more time for teaching and involvement wth non-profits like CALTCM, AMDA, CCCC, and California Culture Change. In 2010 he became an Associate Clinical Professor for UCSF in the Santa Rosa Family Medicine Residency. He continues to mentor them in his Geriatric Clinic at a CCRC and in the SNF setting. He is a Medical Director for 2 facilities and a consultant for 3 other facilities.

Dr. Gieseke was President of CALTCM (California Association of Long Term Care Medicine) July 2005-2007, and has been the Chair of the Education committee twice finishing that service in April 2015. He continues on the BOD, the Executive committee, and as their Treasurer. He was a member of AMDA Public Policy committee for 6 years ending in 2014. He has been a member of the POLST Physician Leadership Council since 2009 and joined the BOD of the California Coalition for Person Center Care in September 2017. He remains active on the CALTCM EDC and presents at CALTCM, AMDA meetings, and has developed Webinars for AMDA, CCCC, and HSAG. He is part of the editorial panel for the CALTCM WAVE and received the 2018 Contributor of the year award. He received the CALTCM Leadership Award in 2018. Dr. Gieseke has an interest in International Medicine

and has been a part of the teaching faculty for medical projects in Ecuador in1990, Albania 16 times, and Kosovo twice.

Janice Hoffman-Simen, PharmD, EdD, APh, BCGP, FASCP
Janice Hoffman-Simen is currently an Associate Professor of Pharmacy Practice and Administration at Western University of Health Sciences in Pomona California. She is a Board-Certified Geriatric Pharmacist, licensed California, Advanced Practice Pharmacist and a Fellow of the American Society of Consultant Pharmacists. She received her Pharm.D. from the University of Southern California and completed a Residency in Clinical/Administrative Psychiatric Pharmacy Practice with an emphasis in geriatrics from the University of Maryland at Baltimore. Recently, Dr. Hoffman-Simen completed her Ed.D. (Doctorate in Education) in Organizational Leadership from University of La Verne with the goal of University-wide Administration. She has been innovative in creating communication channels with physicians, getting Geriatrics into California Senate Bill 493, implementing interprofessional teams to include a pharmacist in her facilities as well as designing, implementing and achieving an ASHP-accredited PGY-1 residency in a skilled nursing facility.

Professionally, she has received accolades as the Commission for Certification in Geriatric Pharmacy (CCGP), Excellence in Geriatric Practice Award and has served as National President, Phi Lambda Sigma, Pharmacy Leadership Honor Society; Chair, California Pharmacist Association-Academy of Long-Term Care, Board of Directors for California Long-Term Care Medicine and Past President for the California Chapter of the American Society of Consultant Pharmacists.

Ashkan Javaheri, MD
Dr. Javaheri is a geriatrician with Mercy Medical Group- Dignity Health Medical Foundation in Sacramento, CA. He is the head of the geriatric division and assistant clinical professor at UC Davis School of Medicine. His work is primarily at skilled nursing facilities, memory care clinic, supervising housecall providers, and tele medicine.

Albert Lam, MD
Dr. Albert Lam completed his undergraduate studies in Gerontology and Bioethics at the University of Southern California. He received his medical degree at the University of Southern California, trained in internal medicine at Kaiser Permanente Los Angeles/University of California – Los Angeles, and completed fellowship in Geriatrics at the University of California – Los Angeles. He is at the Palo Alto Foundation Medical Group serving as the Chair of the Department of Geriatrics with an appointment at the Palo Alto Medical Foundation Research Institute, caring for older adults in Skilled Nursing Facilities and developing real-world strategies for implementing best practices, such as INTERACT, in care.

Albert has provided physician leadership at the Avoiding Readmissions through Collaboration (ARC) initiative at El Camino Hospital since 2012 and at Dignity Health's Sequoia Hospital since 2013, developed SNF 2.0® providing a team mentor-based approach to INTERACT and Palliative Care Education since 2012, worked on the Board of Directors for the California Association for Long Term Care Medicine since 2013, and was on the Steering Committee for the CMS Bundled Payment Care Initiative at El Camino Hospital in Santa Clara County 2015-2017. A former Westinghouse Science Talent Search Semifinalist, he has more recently won top prizes at innovation challenges such as the Health 2.0 San Francisco Code-A-Thon.

Jay S. Luxenberg, M.D.
Jay Luxenberg is an internist and geriatrician who has practiced in San Francisco since completing training in 1987. He has served as Chief Medical Officer at On Lok since 2011. On Lok is the original PACE program – Program for All-Inclusive Care for the Elderly. It offers comprehensive health care for more than 1450 frail elderly persons in San Francisco, Fremont and San Jose, California, all of whom are eligible to live in a nursing home. Until June 2011 he served as Chief Medical Officer at the Jewish Home, San Francisco, a 430-bed skilled nursing facility with an acute geropsychiatric hospital unit. He is Clinical Professor, School of Medicine, University of California, San Francisco. He teaches at U.C.S.F., U.C. Berkeley and Stanford. He had a private practice of geriatric medicine from 1987-1996.

After completing a fellowship in geriatric medicine, he spent 1984-87 as a Medical Staff Fellow in the Section on Brain Aging and Dementia, Laboratory of Neurosciences, at the National Institute on Aging, National Institutes of Health in Bethesda, MD. He served on the Board of Directors, including a term as Treasurer, of the International Psychogeriatrics Association. He served on the Board of Directors of On Lok prior to employment there. He is currently President of the Board of Directors of Mount Zion Health Fund. He has published many research papers, reviews and book chapters. His most recent book is "Residential Care - Your Role in the Health Care Team". He has published four Cochrane Database Systemic Reviews (Haloperidol for agitation in dementia, Valproate preparations for agitation in dementia, Antipsychotics for delirium, and Benzodiazepines for delirium). He is editor of the California Association of Long Term Care Medicine newsletter “The Wave”. He serves on the Editorial Board of the Journal of the American Medical Directors Association (JAMDA). He is a Fellow of the American Geriatrics Society and the American College of Physicians.

Vanessa J. Mandal M.D. CMD MS
Graduate Hahnemann University School of Medicine, Philadelphia Pennsylvania.
Elected Internal Medicine Residency and Geriatric Fellowship – Montefiore Medical Center, a Pioneer ACO in the Bronx. Focus on addressing the psychosocial determinants of health through house call visits.

Her 17 year career as an Internist and Geriatrician spans academic practice in NY, ambulatory practice Texas, and full time practice in post-acute setting in California. Dr. Mandal completed a Masters in Healthcare Administration and Inter-professional Leadership at UCSF in 2016 and continues in leadership roles in Greater Sacramento:

- Medical Director, HCR Manor Care- initiated QAPI on reducing inappropriate benzodiazepine and high risk medication use. Facility had ZERO medication deficiency in 2017 survey.
- Recipient of California Association of Health Services at Home (CAHSAH), Physician of the Year Award in 2015 for work as Medical Director of Eskaton Home Health Services.
- Dignity Health Physician Leadership Program, Health Services Advisory Group (HSAG) – improving care coordination between Dignity Health Hospitals in Greater Sacramento and post-acute facilities. Spearhead palliative care efforts in skilled nursing facility.
- Education Committee CALTCM

Maribeth Nono, RN, MAN
Maribeth Nono, RN, MAN is currently the Infection Control/Quality Assurance Supervising Nurse at Edgemoor DPSNF. Previously she worked at Edgemoor County Hospital, first as a staff nurse, then an Intermittent Supervising Nurse/MDS Nurse/Infection Control Nurse, and finally as the Supervising Nurse.

Dan Osterweil, MD, FACP, Msc Ed., CMD,
Vice President and Medical Director of SCAN Health Plan, and Professor of Medicine at UCLA, completed a geriatrics fellowship at UCLA. He is the Emeritus-editor in chief of the Journal of the American Medical Directors Association (JAMDA), which he founded. He is a member of the editorial board of Caring for the Ages. Dr. Osterweil co-authored two editions of Medical Care in the Nursing Home, is the co-editor of Comprehensive Geriatric Assessment, and has published over 60 articles in peer-reviewed journals. His areas of expertise include cognitive and functional assessment, management of dementia, continuous quality improvement in the nursing home.

Dr. Osterweil is Director of a training program entitled “Leadership and Management in Geriatrics” (LMG) and is Associate Director of the Multi-Campus Program in Geriatrics and Gerontology at UCLA (MPGMG). Dr. Osterweil served as geriatric consultant to SCAN for

many years prior to joining SCAN full time. Among his many duties at SCAN, Dr. Osterweil leads SCAN's senior-focused HealthCHEC-Comprehensive Health Evaluation Centers operations.

Peter P Patterson, MD, MBA
Dr. Patterson is an experienced physician-executive with extensive background in medical quality improvement, clinical microbiology, and infection prevention/antibiotic stewardship.

He has worked with many post-acute and long-term care facilities developing a results-oriented antibiotic stewardship protocol that has a major positive impact on prescribing practices in skilled nursing facilities. The protocol won a best-practice award in 2016 from the CALTCM, the California chapter of AMDA – the Society for Post-acute and Long-term Care Medicine.

Dr. Patterson is a frequent invited speaker at conferences and provider-network continuing education meetings. His on-the-ground practice experience and creative insights facilitate the transition in antibiotic prescribing mindset now underway in healthcare.

He received his MD from the University of Alberta. In the past, Dr. Patterson worked for a Fortune 500 healthcare manufacturing company, where he was trained in the principles and methods of continuous quality improvement. He brings the perspectives of a practicing physician-manager to his current work as a consultant to post-acute facilities and to an academic-community research partnership with University of Arizona Tucson (Dr. Kate Ellingson).

Teresa A Rogers-Marsh RN, MSN-Ed
Has been a Registered Nurse for 26 years working in long term care, Medical Surgical, ICU, Cardiac ICU, Emergency room and House Supervisor working in Critical Care, Trauma, Burn unit, and Cardiac ICU. In 2013 she earned her Master's in Nursing which emphasizes adult education. In 2014 she came back to Long term care as the Inservice Education Coordinator/ Director of Staff Development for Edgemoor DPSNF in Santee, Ca. She is passionate about nursing education and is pursuing her Ph.D. in Nursing. She Lives in Lemon Grove with spouse and 2 chihuahuas.

Karl Steinberg MD, CMD, HMDC
Dr. Karl Steinberg is an experienced clinician with over 20 years in practice in San Diego County. He is a geriatrician and board-certified family physician with a subspecialty certification in hospice and palliative medicine. Dr. Steinberg got his undergraduate degree in biochemistry and molecular biology from Harvard in 1980, then taught high school in New York City for three years. He attended medical school at The Ohio State University, graduating in 1987, then completed his family medicine residency at UCSD (San Diego) in

1990. Dr. Steinberg is the Editor-in-Chief of Caring for the Ages, serves on AMDA's board of directors and is incoming chair of AMDA's Public Policy Committee, and chair of the Coalition for Compassionate Care of California. Dr. Steinberg has been a hospice and nursing home medical director since 1995 and is probably best known for taking his dogs on rounds with him on most days.

Indira Subramanian, MD
Dr. Indu Subramanian received her medical degree in 1996 from the University of Toronto, Canada. She interned for a year in San Diego Mercy Hospital before joining the UCLA Neurology Residency Program. Dr. Subramanian received her Movement Disorder Fellowship training at UCLA. Upon completing her two year fellowship training, Dr. Subramanian has stayed on and is now a Clinical Professor at UCLA in the Dept of neurology. She established the movement disorder clinic at the West Los Angeles Veterans Administration and has assumed the position of the Director of the South West PADRECC (Parkinson Disease Research, Education and Clinical Care). She has developed an interest in complementary and alternative medicine with a special interest in Yoga and Mindfulness. She underwent a 200 hour yoga teacher training in 2015 with Annie Carpenter and is currently studying to be a mindfulness instructor to teach MBSR under the direction of J.G.Serpa .She is designing a yoga teacher training program for yoga instructors who are interested in working with PD patients. She is also boarded in Integrative Medicine.

Merlyn Trinidad, RN-BSN
Merlyn Trinidad has been working at Edgemoor DPSNF from 1998 to present. She has been in the Long Term Care field of practice for the past 22 years. She is currently the Director of Nursing and has over 25 years of nursing experience and more than 20 years in nursing administration. She was honored in 2018 as both the CAHF Nurse of the Year and the Phillipine Nurses Association of San Diego (PNASD) nurse Administrator of the Year. She has worked as a Supervisory Nurse and Assistant Director of Nursing since 2012. She oversees the Nursing operations and functions of over 200 nurses at Edgemoor.

Kerry Weiner, MD
Kerry has over 20 years' experience as a physician leader and executive at the national level specializing in developing and managing physician multispecialty medical groups. He has particular expertise in care redesign to meet value-based reimbursement strategies. Kerry is currently working with CareconnectMD, a large PAC medical group in California, creating a special needs ACO devoted to long term care special needs patients. He served as CMO of IPC Healthcare from 2011 - 2017, where he led the clinical functions of a national medical group with over 1300 acute hospitalists, 800 post- acute and 200 behavior health providers. He was a leading advocate for participation in the CMS BPCI pilot, an APM based on episodic payments. (IPC was acquired by TEAMhealth in 2015). Previously, Dr. Weiner served as CMO and Sr. VP of Lakeside Community Health Care for 26 years

where he was also cofounder. He grew the organization to a 140 provider medical group with PCP, hospitalists and 14 sub-specialties. The group cared for FFS patients and managed care patients. In addition, Dr. Weiner was responsible for the care in Lakeside IPA with 2200 providers. The combined company managed risk contracts for 250,000 patients.

Dr. Weiner received his medical degree, master's in public health and bachelor's degree from the University of California, Los Angeles. Dr. Weiner is an active member of the SHM (Society for Hospitalist Medicine) Public Policy Committee and the AMDA Post-Acute and Long Term Care Society Public Policy Committee.

Chris Wilson, RN, JD, MS-HCE, Bioethicist
Chris Wilson received her nursing degree from the LA County Medical Center School of Nursing, her JD from Whittier College, School of Law and her MS in Health Care Ethics from Creighton University. As a nurse, she held various positions in both acute and skilled nursing facilities from nursing assistant to Director of Nursing.
As a member of the firm of Tyler & Wilson, she advises post-acute health care providers, as well as other businesses and individuals, concerning a wide variety of legal issues. As a bioethicist, she counsels consumers and health care providers, helping them to address the ethical challenges presented by difficult health care choices and decisions.
Ms. Wilson is a member of several local and national associations, including the American Society for Bioethics and Humanities, the Joint Bioethics Committee of the LA County Bar and LA County Medical Association as well as the Health Law committee, Dispute Resolution and Trusts and Estates sections of the Beverly Hills Bar Association. She also serves on the advisory Board of the Southern California Bioethics Committee Consortium.

Thomas Yoshikawa, MD
Thomas Yoshikawa, MD, is presently the Associate Chief of Staff for Geriatrics and Extended (Long-term) Care for the VA Greater Los Angeles Healthcare System, based at the West Los Angeles VA Medical Center. He is a Distinguished Professor of Medicine, Geriatric Medicine and Infectious Diseases at the David Geffen School of Medicine and Science. He was previously the Editor-in-Chief of the Journal of the American Geriatric Society for 16 years (2000-2016). Dr. Yoshikawa's research interests are in aging, infections, and host response to infections.

2019 CALTCM Summit for Excellence:
Leading the Future of Post-Acute and Long-Term Care
Friday April 5, 2019: Afternoon Session
Practical Risk Management: Tools to Manage your Worst Nightmares

11:00 AM Registration/Exhibits Open
11:45 AM Product Theater (No CME)

5	**1:00 PM**	**Welcome & Introductions**
15	**1:05 PM**	**Pre-Test**
25	1:20 PM	**Introduction:** **When Discharge is Not an Option - Analyzing a Risky Situation** Rebecca Ferrini, MD, MPH, CMD **Learning Objectives:** 1. Analyze an interaction where conflict is occurring and identify the needs of each individual and a path to a successful resolution. 2. Dramatize with a team to find a solution to a tough problem that does not violate resident rights, maximizes safety, and minimizes risk. 3. Develop an interdisciplinary care plan based on a team decision that withstands scrutiny. 4. Compare your thought process and decision on a thorny situation with that of your peers.
20	1:45 PM	**Skill 1: Finding Out the Law** Robert Gibson, PhD, JD **Learning Objectives:** 1. Find federal and state laws relevant to a risk management issue using an internet search. 2. Apply a law to a risk management situation. 3. Use a law to write a policy or care plan. 4. Describe the difference between a regulation and an interpretive guideline.
30	2:05 PM	**Skill 2: Reviewing & Writing a Policy That Doesn't Make it Worse** Rebecca Ferrini, MD, MPH, CMD **Learning Objectives:** 1. Review and update a facility policy to meet regulatory rights for residents and promote staff engagement. 2. Identify three do's and don'ts in reviewing, writing, or revising a policy. 3. Evaluate a policy for risk to the facility. 4. Analyze and synthesize data from multiple sources (regulations, sample policies and current situation). 5. Review sample policies identifying the essential components.
20	2:35 PM	**Skill 3: Assessing Decision Making Capacity: It's Not That Hard** Robert Gibson, PhD, JD **Learning Objectives:** 1. Examine a risky situation and the role of decision making capacity assessment. 2. Identify the key components of assessment of decision making capacity (U-CARE).

		3. Describe four situations when the rights of the resident are appropriately limited and why.
20	2:55 PM	**Skill 4: Documenting in a Way That Shows You Care** Rebecca Ferrini, MD, MPH, CMD & Robert Gibson, PhD, JD **Learning Objectives:** 1. Write a justification for rights violation. 2. Identify three do's and don'ts for risk management notes. 3. List five important aspects of a risk management note.
	3:15 PM	Break/Exhibits
30	3:45 PM	**Skill 5: Care-Planning: Making it Realistic** Program Faculty: *Rebecca Ferrini, MD, MPH, CMD; Kathy Gamboa, RN, BSN; Robert Gibson, PhD, JD; Patricia Marks; Maribeth Nono, RN, MAN; Teresa Rogers-Marsh, MSN-ED; Merlyn Trinidad, RN-BSN* **Learning Objectives:** 1. Develop a goal and interventions for a risk management problem. 2. Identify the key components of a care plan. 3. Apply resident rights regulations to a risk management problem and reflect in care plan.
30	4:15 PM	**Skill 6: Alignment of the IDT: Bringing Different People Together (Interactive Session)** Program Faculty: *Rebecca Ferrini, MD, MPH, CMD; Kathy Gamboa, RN, BSN; Robert Gibson, PhD, JD; Patricia Marks; Maribeth Nono, RN, MAN; Teresa Rogers-Marsh, MSN-ED; Merlyn Trinidad, RN-BSN* **Learning Objectives:** 1. Explicate the value of working with diverse viewpoints. 2. Identify a skill you can improve in your own work teams.
25	4:45 PM	**Skill 7: Teaching Staff to do the Right Thing** Rebecca Ferrini, MD, MPH, CMD and Teresa Rogers-Marsh, RN **Learning Objectives:** 1. Design the curriculum for an educational program for CNA level staff on resident rights. 2. Identify three important components to effective education. 3. Design an instruction page for staff on a risk management topic.
15	5:10 PM	**Post Test and Q & A Session**
5	5:25 PM	**CALTCM Membership Vote**
15	5:30 PM	**Introducing the CALTCM Mentorship Program**
45	5:45 PM	**Networking with the Experts: Meeting CALTCM's Master Mentors**
	6:30 AM	**CALTCM Poster Session**
	7:30 PM	**Product Theater** (No CME)
300	5.0 hours	

2019 CALTCM Summit for Excellence:
Leading the Future of Post-Acute and Long-Term Care
Saturday April 6, 2019: Morning Session
Hot Topics: On the Front Lines, Clinical Updates

7:15 AM **Exhibits Open**
8:00 AM **Welcome**

8:05 AM **Presentation of 2019 CALTCM Leadership Award**

20 8:10 AM **New Approaches to Delirium**
Jay Luxenberg, MD
Learning Objectives:
1. More precisely recognize risk for and presence of delirium.
2. Create environment of care that minimizes its development and severity.
3. Apply the latest evidence on the value of medications in managing delirium.

30 8:30 AM **Managing Parkinson's in the SNF**
Indira Subramanian, MD
Learning Objectives:
1. Updates in Parkinson's medications.
2. Strategies for monitoring and treating side effects of PD drugs.
3. Managing the psychological and cognitive manifestations of PD.
4. The IDT and managing the motor manifestations - Environmental safety, nutrition and physical therapy for PD LTC residents.

25 9:00 AM **Expert Guidance on Common Infections in LTC Environment**
Thomas Yoshikawa, MD
Learning Objectives:
1. Develop a general approach to suspected infections.
2. Identify, diagnose and treat Pneumonia.
3. Recognize UTIs that warrant antibiotics.
4. Apply knowledge to reduce risk of developing *Clostridium Difficile* infections and appropriately manage infection based on severity of illness.

30 9:25 AM **Medically Illicit Drugs Being Used Therapeutically in the Elderly**
Janice Hoffman, PharmD, EdD, APh, BCGP, FASCP
Learning Objectives:
1. Describe the mechanism of action for each illicit agent.
2. Develop an understanding how an illicit agent is therapeutic in specific psychiatric conditions such as depression and PTSD.
3. Identify the risk and benefits for each illicit agent used therapeutically in the elderly.

25 9:55 AM **First, Do No Harm: The New Beers List**

		Vanessa Mandal, MD, MS, CMD & Margherita Aikman, RN, BSN, PharmD, BCPS, BCACP, CACP, CDE **Learning Objectives:** 1. Identify potentially inappropriate medications leading to adverse drug events in frail elderly. 2. Identify harmful drug-drug interactions.
	10:20 AM	**Break / Exhibits**
20	10:50 AM	**Reducing Hypoglycemic Risk in Diabetes Care** Timothy Gieseke, MD, CMD **Learning Objectives:** 1. Recognize the subtle presentations of hypoglycemia in seniors. 2. Create individual targets for glycemic control. 3. Identify and minimize care plans that are high risk for hypoglycemia. 4. Decide when and why to add a trial of GLP 1 receptor agonists to the care plan.
20	11:10 AM	**Hypertension: Comparing JNC 8 & ACC/AHA Guidelines** Vanessa Mandal, MD, MS, CMD & Margherita Aikman, RN, BSN, PharmD, BCPS, BCACP, CACP, CDE **Learning Objectives:** 1. Interpret appropriate medications and Best Practice goals in treating older adults with hypertensive heart disease, stroke and chronic kidney disease. 2. Differentiate appropriate goals for blood pressure in patients with cognitive impairment. T SPRINT trial.
20	11:30 AM	**Chemotherapy in the SNF** Rebecca Ferrini, MD, MPH, CMD **Learning Objectives:** 1. Demonstrate how to review identify a potentially toxic agent. 2. Identify a list of chemotherapeutic meds which might be prescribed and safely used in the SNF setting. 3. Describe precautions to protect staff and peers from body wastes of those receiving potentially toxic agents. 4. Develop staff training programs that support safe use of these agents for their patients, families, and staff.
20	11:50 AM	**Anticoagulation in Seniors** Margherita Aikman, RN, BSN, PharmD, BCPS, BCACP, CACP, CDE **Learning Objectives:** 1. Understand the role of aspirin in healthy elderly - ASPREE trial. 2. Assess risk of major bleeding in older adults with atrial fibrillation weighing CHADS versus HAS_BLED.
	12:10 PM	**Break**
210	3.5 hours	

2019 CALTCM Summit for Excellence:
Leading the Future of Post-Acute and Long-Term Care
Saturday April 6, 2019: Afternoon Session
Navigating Healthcare

12:10 PM **Break/Exhibits**
12:15 PM **Product Theater** (No CME)
1:00 PM **Break**

15 1:10 PM **CALTCM Awards: 2019 Best Practice & Poster Session Awards**

5 1:25 PM **Overview: "In the Trenches" Session**

35 1:30 PM **"In the Trenches" Breakout Session: Round 1**

Round Table Topics and Speakers:

1. Motivational Interviewing; Patricia Bach, PsyD, RN
2. The Joy of Medicine: Avoiding Burnout; Ashkan Javaheri, MD, CMD
3. Medical Apps and Technology; Jay Luxenberg, MD
4. Avoiding Medical Related Citations; Janice Hoffman-Simen, PharmD, EdD, APh, BCGP, FASCP
5. Compassion Fatigue and Moral Dilemmas; Christine Wilson, RN, J.D., MS-HCE
6. Billing & Coding; Alex Bardakh, MPP, PLC
7. POLST and Palliative Care; Karl Steinberg, MD, CMD, HMDC
8. Antibiotic Stewardship; Peter Patterson, MD, MBA, FCAP, FACMQ
9. Staff Retention; Merlyn Trinidad, RN-BSN
10. How to be Competitive with Medicare Advantage; Dan Osterweil, MD, FACP, CMD

30 2:05 PM **"In the Trenches" Breakout Session: Round 2**

Round Table Topics and Speakers:

1. Motivational Interviewing; Patricia Bach, PsyD, RN
2. The Joy of Medicine: Avoiding Burnout; Ashkan Javaheri, MD, CMD
3. Medical Apps and Technology; Jay Luxenberg, MD
4. Avoiding Medical Related Citations; Janice Hoffman-Simen, PharmD, EdD, APh, BCGP, FASCP
5. Compassion Fatigue and Moral Dilemmas; Christine Wilson, RN, J.D., MS-HCE
6. Billing & Coding; Alex Bardakh, MPP, PLC
7. POLST and Palliative Care; Karl Steinberg, MD, CMD, HMDC
8. Antibiotic Stewardship; Peter Patterson, MD, MBA, FCAP, FACMQ
9. Staff Retention; Merlyn Trinidad, RN-BSN
10. How to be Competitive with Medicare Advantage; Dan Osterweil, MD, FACP, CMD

2:35 PM **Break**

30	2:50 PM	**Regulatory Update** Kerry Weiner, MD, MPH **Learning Objectives:** 1. Identify strategies for developing a practice to meet current and future payment structure demands. 2. Discuss the impact of healthcare reform initiatives on PALTC practitioners - exclusion from APMs. 3. Explain the basic structure of the Patient-Derived Payment Model.
30	3:20 PM	**Public Policy Update** Alex Bardakh, MPP, PLC **Learning Objectives:** 1. Discuss latest federal legislative and regulatory developments. 2. Discuss quality reporting strategies that align with clinical practice and facility reporting requirements. 3. Identify current value-based medicine reporting requirements, including MIPS, APMs SNF VBP.
50	3:50 PM	**Preparing for the Next Firestorm** Timothy Gieseke, MD, CMD & Jason Belden **Learning Objectives:** 1. Identify gaps in your facility's emergency plan in the case of a sudden firestorm threat. 2. Define how you can ensure complex care plans will continue to be executed off site in the case of a sudden evacuation. 3. Create a firestorm care plan template you can adapt in your facility.
15	4:40 PM	**Closing Pearls**
	4:55 PM	**CALTCM Passport Winner Announcement**
	5:00 PM	**Adjourn**
210	3.5 hours	

2019 CALTCM Summit for Excellence:
Leading the Future of Post-Acute and Long-Term Care
Saturday April 6, 2019: Afternoon Session

In the Trenches Session Learning Objectives

35	1:30 PM	**"In the Trenches" Breakout Session: Round 1**
		Round Table Topics and Speakers:
		1. Motivational Interviewing; Patricia Bach, PsyD, RN
		Learning Objectives:
		1. Describe motivational interviewing and its potential systemic applications in long term care.
		2. Discuss the rules, tools and importance of cultural competence in using motivational interviewing to optimize patient-centered care.
		3. Identify multi-modal motivational interviewing tools and resources for use by the LTC team.
		2. The Joy of Medicine: Avoiding Burnout; Ashkan Javaheri, MD, CMD
		Learning Objectives:
		1. Identify signs of clinician's burnout.
		2. Define methods to better balance personal and professional life.
		3. Discuss commonly used strategies to reduce some work related pressure.
		3. Medical Apps and Technology; Jay Luxenberg, MD
		Learning Objectives:
		1. Identify and improve your use of the best medical apps for android and IOS phones and tablets.
		2. Review use of phone-based sensors to collect information useful for motivating patients and assisting in management of chronic illnesses.
		3. Create a culture where frequent use of reference material from smartphones and tablets improves the care in the office and in long-term care.
		4. Avoiding Medical Related Citations; Janice Hoffman-Simen, PharmD, EdD, APh, BCGP, FASCP
		Learning Objectives:
		1. Identify the top 3 pharmacy related citations in 2015.
		2. Know the ARMOR method to avoid polypharmacy and/or unnecessary medications.
		3. Discuss the effects of transitions of care on the medication regimen review.
		5. Compassion Fatigue and Moral Dilemmas; Christine Wilson, RN, J.D., MS-HCE
		Learning Objectives:
		1. Recognize symptoms of compassion fatigue.
		2. Develop a strategy for addressing a moral dilemma in the SNF setting presented by case study.
		6. Billing & Coding; Alex Bardakh, MPP, PLC
		Learning Objectives:
		1. Discuss basics PALTC E&M Coding.
		2. Discuss updates on office-based E&M Changes.
		3. Discuss changes to non-face-to-face coding.

7. POLST and Palliative Care; Karl Steinberg, MD, CMD, HMDC

Learning Objectives:

1. Differentiate between advance health care directives and POLST, and describe the appropriate intended population for POLST completion--which is NOT every skilled nursing facility admission.

2. Support availability of competent advance care planning assistance in nursing facilities.

3. Explain what palliative care services are, and how they can enhance the skilled nursing facility admission, long-term residence experience, and reduce unnecessary rehospitalizations.

8. Antibiotic Stewardship; Peter Patterson, MD, MBA, FCAP, FACMQ

Learning Objectives:

1. Review CMS Phase 2 requirements for antibiotic stewardship programs (ASP), effective since November 2016.

2. Develop a model for results-oriented upgrades to existing CMS requirements.

3. Utilize developed upgrades and insights into your facility antibiotic stewardship program.

9. Staff Retention; Merlyn Trinidad, RN-BSN

Learning Objectives:

1. Compare staffing difficulties across California and strategies used to address them.

2. Analyze factors to promote staff retention.

3. Generate two ideas for enhancing staff acquisition and retention.

10. How to be Competitive with Medicare Advantage; Dan Osterweil, MD, FACP, CMD

Learning Objectives:

1. Describe the key issues involving work with Medicare Advantage plans.

2. Cite key metrics Medicare Advantage plans use to gauge quality.

3. Quote key performance data elements characterizing nursing home.

Practical Risk Management: Tools to Manage Your Worst Nightmares

CALTCM

2019

When Discharge is Not an Option

Analyzing a Risky Situation

CALTCM

2019

Disclosure Statement

- Dr. Rebecca Ferrini, MD, MPH, CMD, Dr. Robert Gibson, PhD, JD, Teresa Rogers-Marsh, MSN-ED, Patricia Marks, Kathy Gamboa, RN, BSN, Maribeth Nono, RN, MAN, and Merlyn Trinidad, RN-BSN have no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Analyze an interaction where conflict is occurring and identify the needs of each individual and a path to a successful resolution.
- Dramatize with a team to find a solution to a tough problem that does not violate resident rights, maximizes safety, and minimizes risk.
- Develop an interdisciplinary care plan based on a team decision that withstands scrutiny.
- Compare your thought process and decision on a thorny situation with that of your peers.

This Afternoon's Plans

- We will begin with a case presented in a special IDT meeting as the team tries to get their heads around a problem.
- Then we will take apart what you need to know to address the problem(s).
- Grab your pen and paper and get ready!

The Edgemoor Players

PROVIDER: Rebecca Ferrini MD, MPH, CMD,
PSYCHOLOGIST: Robert Gibson, PHD
ACTIVITIES: Teresa Rogers-Marsh, DSD, RN
SOCIAL WORKER: Patricia Marks, Social Worker
NURSING SUPERVISOR: Kathy Gamboa, RN
CNA: Maribeth Nono, RN
ADMINISTRATOR: Merlyn Trinidad, RN

Observe the IDT with Plans to Discuss the Following

- Did you get to know the patient and the main issues?
- Were the right team members at the meeting—who was not needed? Who could have been included?
- What was the tone of the meeting? Did someone dominate the meeting? Was it collaborative?
- Was it efficient?
- Did they define and address the issues?
- What did you feel worked or could have been done better?

WHAT DO WE HAVE TO ADDRESS?

Your New Skill Set

- Skill 1: Finding the law
- Skill 2: Reviewing and writing a policy that doesn't make it worse
- Skill 3: Assessing decision making capacity: it's not that hard
- Skill 4: Documenting in a way that shows you care
- BREAK
- Skill 5 Care planning: Making it realistic
- Skill 6: Alignment of the IDT: Bringing different people together
- Skill 7: Teaching staff to do the right thing
- Post-test!

Skill 1: Finding The Law

Robert M. Gibson, PhD, JD

CALTCM 2019

Disclosure Statement

- Dr. Robert Gibson, PhD, JD has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Find federal and state laws relevant to a risk management issue using an internet search.
- Apply a law to a risk management situation.
- Use a law to write a policy or care plan.
- Describe the difference between a regulation and an interpretive guideline.

Staff Are Concerned…

Possible bad outcomes:

- Accident: falls, hypothermia, hit by car, overdose
- Abuse/exploitation
- Deficiency, citation, bad publicity
- And many others…

Autonomy versus duty to protect:

- Neglect?
- Negligence?

Law, or regulation?

- Laws are the actual statutes passed by congress or state legislatures.
- Regulations are laws created by regulatory agencies, e.g., CMS. These are usually authorized by a statute. The assumption is that agencies have expertise that allow them to better detail how the law will actually operate.
- Generally, regulations will be our main focus in LTC, but particularly on the state level, we need to look at laws too.

Hierarchy of Laws/Regulations

- The U.S Constitution
- Laws (statutes) enacted by Congress (codified in the United States Code or USC)
- Rules promulgated by federal agencies based on USC (codified in the Code of Federal Regulations or CFR)
- The State constitution
- Laws enacted by the State legislature (Welfare and Institutions Code, etc.)
- Rules promulgated by State agencies (California Code or Regulations)
- City/county charters (the "constitution" for the city or county)
- Local laws and ordinances
- Rules promulgated by local agencies
- Your own policies and procedures!

Where Do We Look?

Online resources can provide updated and current laws and regulations.

Journal articles, CDPH All Facilities Letter library, professional association publications, other printed material.

Be careful of written materials as they may be out of date.

California Hospital Association

- Consent Manual
- Record and Data Retention Schedule
- Hospital Compliance Manual
- California Health Information Privacy Manual
- Healthcare Workplace Violence Prevention
- Managing High Profile and Patient Care Conflict Situations

Though focus is hospitals, much applies to LTC. Well researched and organized; many sample documents and policies.

What Do You Look For?

- Resident rights, restriction of rights, dignity, quality of life, exercise of rights as a citizen, reasonable accommodation of resident needs and preferences, activities of interest, decision-making capacity, assessment, competence, notification of family, discharge, transfer, HIPAA, accommodation, resident care, refusal of care, duty to protect…?
- Many of these as search terms may be relevant.

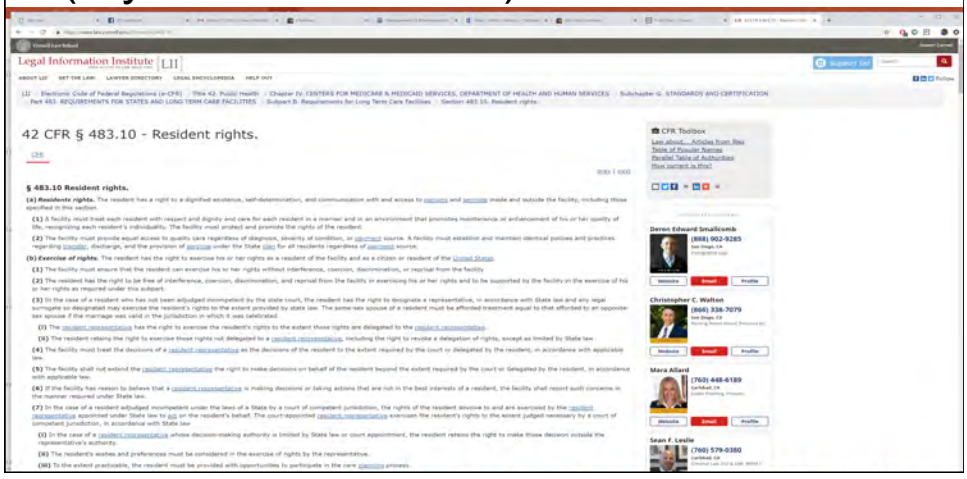
Main Sources of Law/Regulations in LTC

- 42 CFR (Code of federal regulations)
  - Based on laws in United States Code (USC)
  - Contains regulations created by administrative agencies
- 22 CCR (California Code of Regulations)
  - Formerly California Administrative Code
  - Like CFR, contains regulations
- State Law, e.g., Welfare and Institutions Code, Probate Code, Health and Safety Code, etc.

Accessing the Code of Federal Regulations (CFR)

- Google or other browser search, e.g., “Code of federal regulations and resident rights”

Find the Reference That Works for You (Try Law.Cornell.edu)



State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Table of Contents

(Rev. 173, 11-22-17)

Transmittals for Appendix PP

INDEX

State Operations Manual – Resident Rights

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights

Under F tag 600 - Freedom from Abuse, Neglect, and Exploitation (§483.12)

- *"**Neglect**," as defined at §483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."*

And

- ***KEY ELEMENTS OF NONCOMPLIANCE FOR ABUSE AND NEGLECT***
- ***§483.12(a)(1)***
- *To cite deficient practice at F600, the surveyor's investigation will generally show that the facility:*
- *Failed to protect a resident's right to be free from any type of abuse, including corporal punishment, and neglect, that results in, or has the likelihood to result in physical harm, pain, or mental anguish; or*
- *Failed to ensure that a resident was free from neglect when it failed to provide the required structures and processes in order to meet the needs of one or more residents.*

Other Laws or Rights?

- Residents retain all rights under the U.S. Constitution (F tag 550; §483.10(b) Exercise of Rights).
  - *Mrs. Lee wants to put a candidates bumper sticker on her power wheelchair. "It's against facility policy because it might upset other residents."*

U.S. Constitution – First Amendment

- The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
- §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

Mrs. Lee can have her bumper sticker

Why do You Let Them do That?

RATHER WE SHOULD ASK, DO WE HAVE THE AUTHORITY OR JUSTIFICATION TO STOP THEM?

"We Need to Stop Him!" But...

- Restrict him to the facility – Rights as a citizen.
- Discharge him – Rights related to discharge (if he contests, good luck…).
- Send him to treatment – Right to refuse.
- Threaten to discharge him if he doesn't stop – Rights related to discharge?
- Medicate him – Right to be free from chemical restraints.
- Lounge chair so he can't mobilize – Restraint/Rights as a citizen.

Your New Skill Set

- Skill 1: Finding the law
- Skill 2: Reviewing and writing a policy that doesn't make it worse
- Skill 3: Assessing decision making capacity: it's not that hard
- Skill 4: Documenting in a way that shows you care
- BREAK
- Skill 5: Care planning: Making it realistic
- Skill 6: Alignment of the IDT: Bringing different people together
- Skill 7: Teaching staff to do the right thing
- Post-test!

Skill 2: Reviewing & Writing a Policy that Doesn't Make it Worse

Rebecca Ferrini, MD, MPH, CMD

CALTCM 2019

Disclosure Statement

- Dr. Rebecca Ferrini, MD, MPH, CMD has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Evaluate a policy for risk to the facility
- Identify three do's and three don’ts in reviewing, writing or revising a policy
- Review and update a facility policy to meet regulatory rights of residents and promote staff engagement

Anatomy of a Policy and Procedure

- Purpose: why it is written
- Policy: the overriding principles to be followed (WHAT)
- Responsible staff: who is involved
- Procedures: step by step list of who does what when (HOW)
- References: add the law here or other things you used

Read this policy on Substance Abuse – then in your table, identify three things about it that concern you.

Policy and Procedure: CONTRABAND

SUBJECT: CONTRABAND

POLICY NO: 123
PAGE: 1 OF 1
DATE: 12/13/2018

I. POLICY

Facility residents will not have contraband in their rooms that could harm themselves or others.

II. RESPONSIBLE PARTY(IES)

All facility staff

III. PROCEDURES

A. Residents will not have contraband items in their rooms or the facility.

B. The following items are contraband: weapons, guns, drugs, medications not prescribed by facility, glass, Christmas lights, popcorn, tools, food of an unsafe texture personal appliances, living plants, pets.

C. If contraband is suspected, the room or resident will be searched and contraband removed.

D. Visitors are not permitted to bring or carry contraband while in the facility and are subject to search.

IV. BACKGROUND

A. Overview

Developed in 1989

B. Definitions:

Contraband — Weapons or other items by which a resident can harm self or others.

C. Codes and Regulations / Reference / Authority

F-tag 557 CFR §483.10(e)(2)

V. QUESTIONS / INFORMATION

Administrator: (888) 596-1234

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

When Writing a BETTER Policy on Substance Abuse, Where Might You START Looking in the Regulations?

F-740

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.40 Behavioral health services.

Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

Once you identify the important regulations,

THE NEXT STEP IS TO REVIEW THE STATE OPERATIONS MANUAL TO FIND DO'S AND DON'TS FOR WRITING POLICIES.

- A subject index.
- The regulations/F tags.
- Intent of the regulation. What it is trying to accomplish?
- Definitions of relevant terms.
- Guidance – examples and applications to specific populations or situations (a great one for policy writing!).
- Procedures – how the surveyors are instructed to evaluate compliance with the regulation/F tag (another great one for policy writing!).
- Key elements of non-compliance – what the surveyors will use to cite deficient practices. What the failed to do.
- Probes – what he surveyors should ask to assess compliance, e.g., "Through interviews with facility staff and residents and/or their representatives, determine…" (may be combined with Procedures- "Procedures and Probes").
- Potential Tags for additional consideration, e.g., Rights F550 lists F583, Privacy and Confidentiality, F561, Self-determination, Activities of Daily Living (ADLs), and F603, Involuntary Seclusion.

To cite deficient practice at F740*, the surveyor's investigation will generally show that the facility failed to:*

- *Identify, address, and/or obtain necessary services for the behavioral health care needs of residents;*
- *Develop and implement person-centered care plans that include and support the behavioral health care needs, identified in the comprehensive assessment;*
- *Develop individualized interventions related to the resident's diagnosed conditions (e.g., assuring residents have access to community substance use services);*
- *Review and revise behavioral health care plans that have not been effective and/or when the resident has a change in condition;*
- *Learn the resident's history and prior level of functioning in order to identify appropriate goals and interventions;*
- *Identify individual resident responses to stressors and utilize person-centered interventions developed by the IDT to support each resident; or*
- *Achieve expected improvements or maintain the expected stable rate of decline based on the progression of the resident's diagnosed condition.*

This is one of MANY pages with great information that really helps you establish policies that sustain regulatory scrutiny

(Just make sure you are doing it!)

In your handouts, you have copies of better policies on substance abuse and contraband/restricted items to get you started in case you have any residents with these problems….

Don’ts

- Don’t buy your policies--these need to be customized to your setting.
- Don’t try to trap staff with policies.
- Don’t expect policies to change behavior.

Don’t

- Don’t make them stronger than the regulations —setting yourself up for deficiency.
- Don’t state what visitors or patients will do—you cannot control them; say what staff will do.

Do's

- Let everyone in the policy have a chance to review it before it is final
- READ all policies related to your discipline
- Start doing it right, then write a policy to reflect what you are doing
- Make the format and language match the audience. (consider pictures, lower reading level)

Do

- Make it safe for staff to tell you that the policy and procedure is not what's going on.
- Have a primary source to avoid inconsistencies.
- Make it doable—really (can the CNA do all you ask in one shift? Can you really restrict visitors).

Your New Skill Set

- Skill 1: Finding the law
- Skill 2: Reviewing and writing a policy that doesn't make it worse
- Skill 3: Assessing decision making capacity: it's not that hard
- Skill 4: Documenting in a way that shows you care
- BREAK
- Skill 5 Care planning: Making it realistic
- Skill 6: Alignment of the IDT: Bringing different people together
- Skill 7: Teaching staff to do the right thing
- Post-test!

Skill 3: Assessing Decision Making Capacity: It's Not That Hard

Robert Gibson, PhD, JD; Rebecca Ferrini MD, MPH, CMD; Kathy Gamboa, RN; Maribeth Nono, RN, MAN

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Disclosure Statement

- Dr. Robert Gibson, PhD, JD, Dr. Rebecca Ferrini, MD, MPH, CMD, Kathy Gamboa, RN and Maribeth Nono, RN, MAN have no relevant financial relationships with commercial interests to disclose.

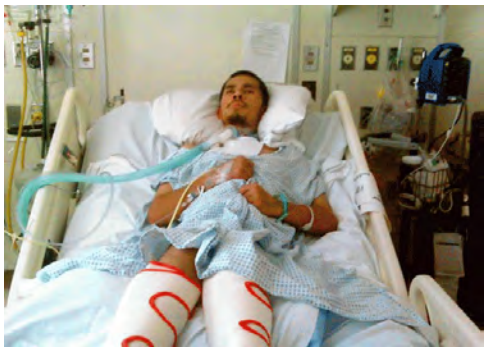
Learning Objectives

- Examine a risky situation and the role of decision making capacity assessment.
- Identify the key components of assessment of decision making capacity (U-CARE).
- Describe four situations when the rights of the resident are appropriately limited and why.

Does a nursing home resident have the right to choose their own clothes?

Does a patient have the right to refuse care?

How About Now?



Residents Have Many Rights Codified in State and Federal Law

Capacity Assessment, Why Do It?

- We have an obligation to support resident rights, but also to protect residents.
- Unless conserved, residents are presumed to have all of their rights.
- Exercise of or restriction of rights is ultimately based on decision-making capacity.
  - If we allow free exercise, but have not adequately assessed, we can be responsible for bad outcomes.
  - If we restrict without adequate assessment, we are violating their rights.

Concerns Related to Decision Making Capacity Assessment?

- Most risk management issues are in relation to the interface between the rights of the residents and the responsibilities of the facility. The key issue is often CAPACITY.
- Many clinicians lack comfort in doing this.
- Many facilities lack consistent processes regarding capacity.

How Do We Do It?

- Cognitive testing?
- Tests of decision-making capacity?
- Clinical opinion?
- Diagnosis?

Ultimately, these may provide some input, but the capacity to make this particular decision is what is relevant and is what must be assessed.

U-CARE Model to Assess Decision Making Capacity

- **Understanding** of relevant information
- **Consistency** of opinions/responses within and between interviews
- **Appreciation** of the significance of the information as it applies to the person's own situation
- Ability to **Reason** with relevant information and to engage in a logical process of weighing options
- Ability to **Express** a choice

Gibson and Ferrini, You Let Them Do What??!! Decision-Making Capacity and The Exercise Of Patient Autonomy In LTC, Volume 18 - Issue 10 - October, 2010 – Annals of Long Term Care

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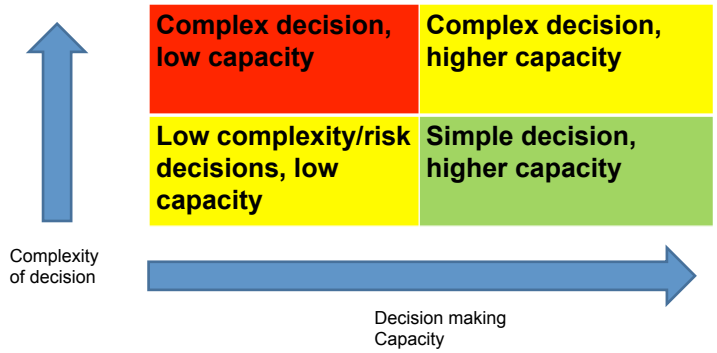
Riskier/More Complex Decisions Require Greater Capacity



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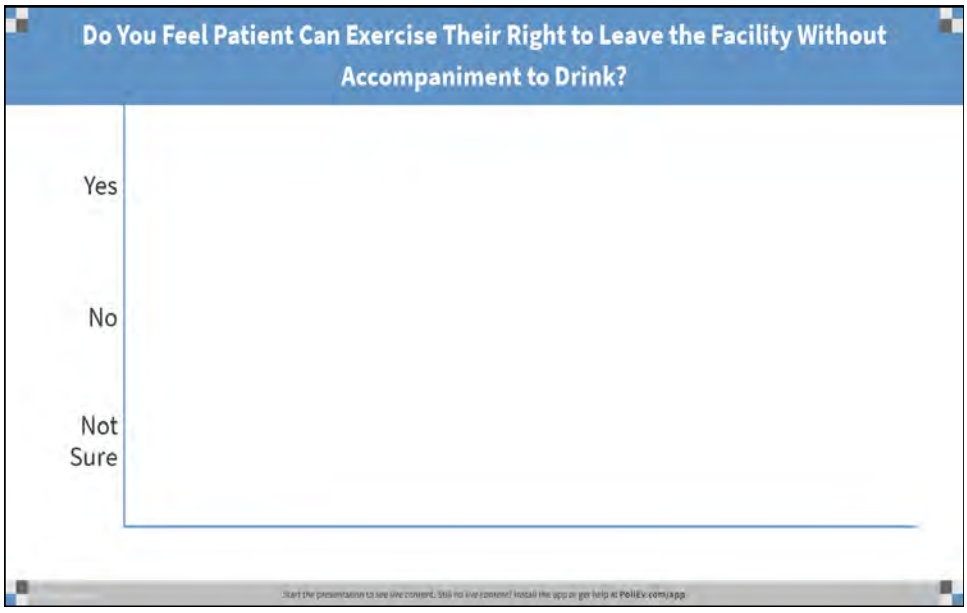
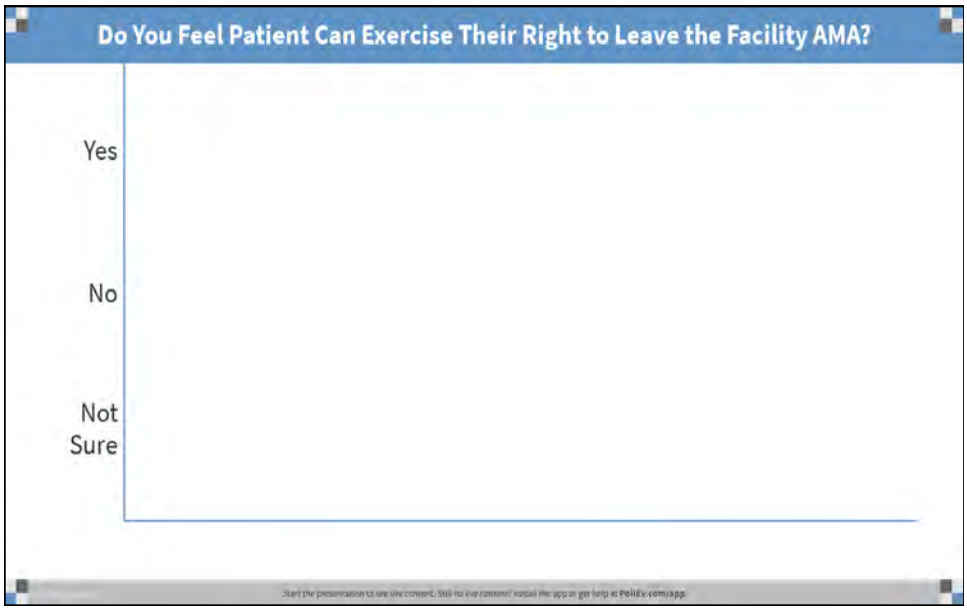
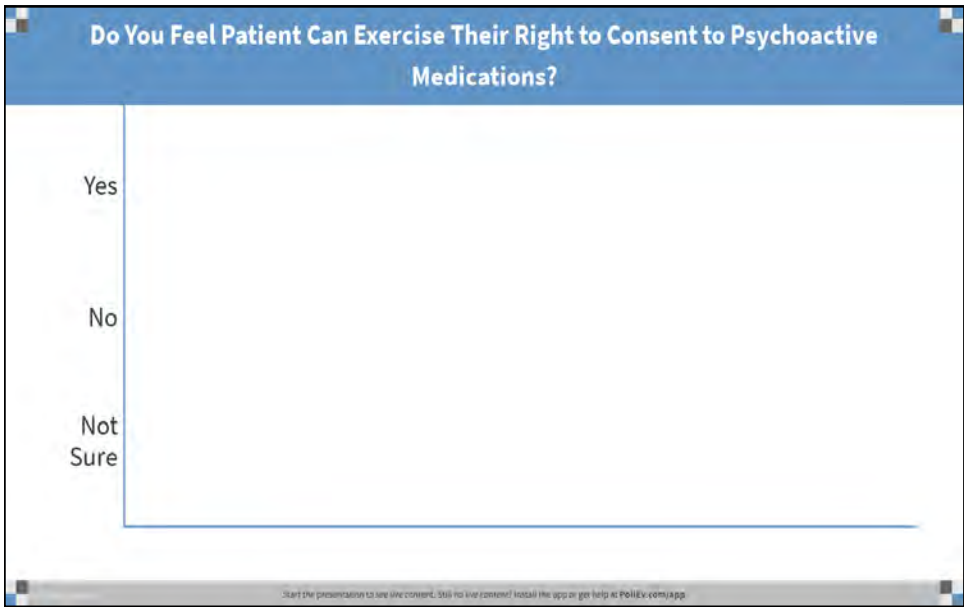
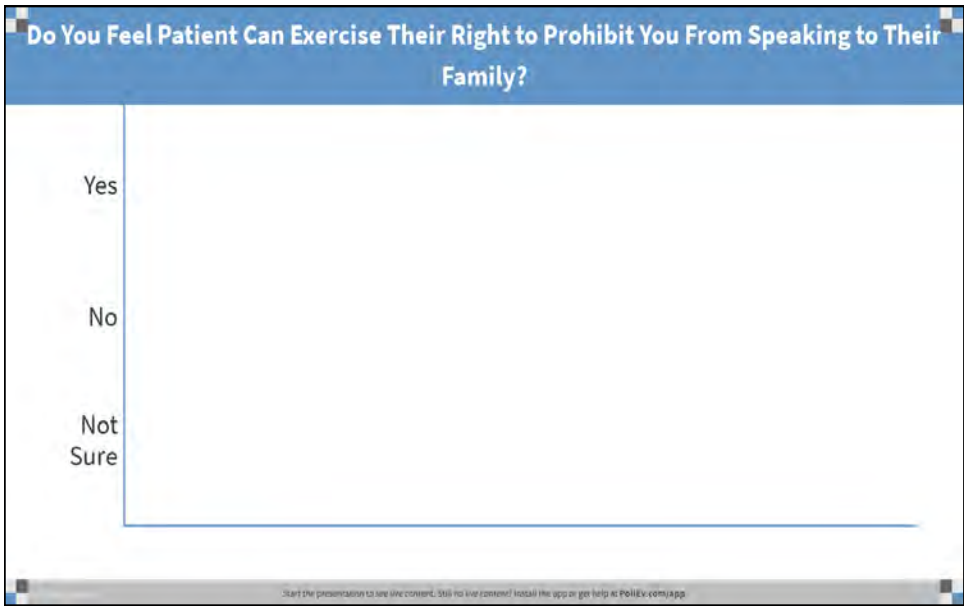
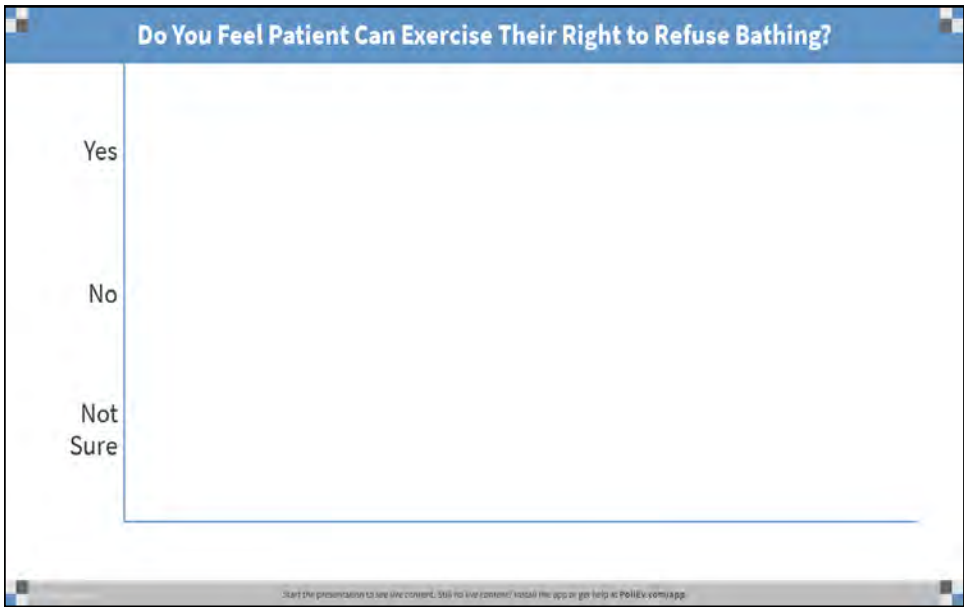
Faculty Role Play of a Patient Discussing a Decision With a Clinician

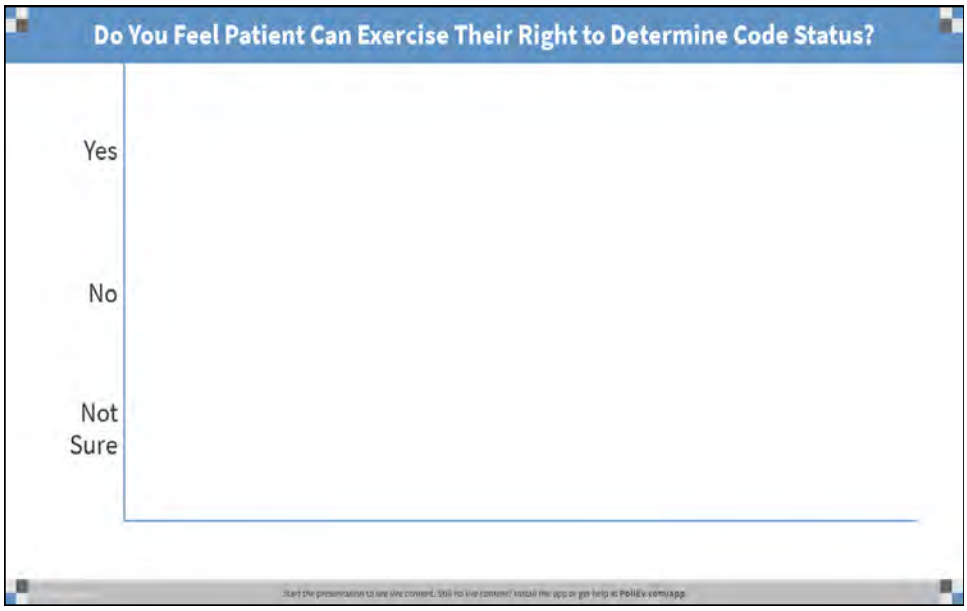



Do You Feel Patient Can Exercise Their Right to Leave the Facility AMA?
Yes
No
Not Sure


Do You Feel Patient Can Exercise Their Right to Consent to Psychoactive Medications?
Yes
No
Not Sure


Do You Feel Patient Can Exercise Their Right to Prohibit You From Speaking to Their Family?
Yes
No
Not Sure


Do You Feel Patient Can Exercise Their Right to Refuse Bathing?
Yes
No
Not Sure



Your New Skill Set

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- Post-test!

Skill 4: Documenting in a Way That Shows You Care

Robert Gibson, PhD, JD;
Rebecca Ferrini MD, MPH, CMD

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Disclosure Statement

- Dr. Robert Gibson, PhD, JD and Dr. Rebecca Ferrini, MD, MPH, CMD have no relevant financial relationships with commercial interests to disclose.

Learning Objectives

Write	Write a justification for rights violation appropriate for a medical record.
Identify	Identify three do's and don'ts for risk management notes.
List	List five important aspects of a risk management note.

5 Important Aspects of a Risk Management Note

- Elucidate the conflict or problem with detail
- Mention legal issues
- Assess decision making capacity
- Explore reasoning in terms of rights (autonomy), safety, ethics and quality of life---framing rights limitations against the rights of other residents
- Have some plan to reduce risk, enhance safety

Risk Management Notes

DO's

- Enter multiple notes.
- Provide explanations of your reasoning in terms of rights, safety, ethics and quality of life of patients.
- Make your caring for the patient and family and deep attempts to understand their needs clear.

DON'T

- Sound negative or judgmental.
- Frame in terms of staff convenience or preference…"we did this to give staff a little rest" versus "we limited her requests in order to honor the rights of others for timely and appropriate care."
- Mention staff names, incident reports or criticize other health care providers.

Your Turn

Write a risk management note from your observations of the IDT meeting and assessment of capacity.

Then share your note with your table. Identify your best sentences and be ready to share them!

5 Important Aspects of a Risk Management Note

- Describe the conflict or problem with detail
- Mention legal issues
- Assess decision making capacity
- Explore reasoning in terms of rights (autonomy), safety, ethics and quality of life---framing rights limitations against the rights of other residents
- Have some plan to reduce risk, enhance safety

Describe the Conflict or Problem with Detail

- *Resident continues to leave facility without accompaniment and return intoxicated posing risk to self and others.*

5 Important Aspects of a Risk Management Note

- Describe the conflict or problem with detail
- Mention legal issues
- Assess decision making capacity
- Explore reasoning in terms of rights (autonomy), safety, ethics and quality of life---framing rights limitations against the rights of other residents
- Have some plan to reduce risk, enhance safety

Mention Legal Issues

- *Our facility has the requirement to honor his right to autonomy and self determination, but must assess his physical and cognitive capacity. Even if determined to be capable of making that decision, must implement plan to promote safety*

5 Important Aspects of a Risk Management Note

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- Have some plan to reduce risk, enhance safety

Assess Decision Making Capacity:

- *Resident exhibits understanding of the problem "I know drinking is harmful" and an understanding of the risks and benefits of leaving unaccompanied, including death, arrest, or being the victim of crime. He offers reasons for his behavior and no desire to change. "I have rights!"*

5 Important Aspects of a Risk Management Note

- Describe the conflict or problem with detail
- Mention legal issues
- Assess decision making capacity
- Explore reasoning in terms of rights (autonomy), safety, ethics and quality of life---framing rights limitations against the rights of other residents
- Have some plan to reduce risk, enhance safety

Explore reasoning in terms of rights (autonomy), safety, ethics and quality of life--framing rights limitations against the rights of other residents

- *Patient has decision making capacity and this must be honored even if we disagree with the decisions he is making. Despite education on risks and counseling, we cannot get him to agree to discontinue drinking. Our plans must focus on reducing risk to others in the facility from potentially aggressive drunkenness and for him from possible consequences of intoxication*

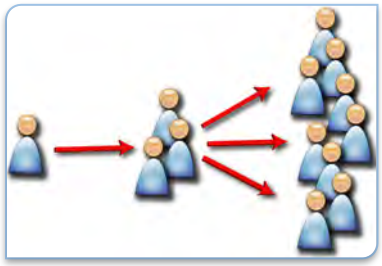
5 Important Aspects of a Risk Management Note

- Describe the conflict or problem with detail
- Mention legal issues
- Assess decision making capacity
- Explore reasoning in terms of rights (autonomy), safety, et[illegible] and quality of life---framing rights limitations against the right[illegible]er residents
- Have some plan to reduce risk, enhance safety

Have Some Plan to Reduce Risk, Enhance Safety

- *To enhance safety, we are trying to identify triggers for drinking, asking family not to provide cash, and looking to purchase an X box which he believes will serve to distract him from urges to drink. We are discontinuing medications which may interact with alcohol. If intoxicated, he is restricted to his room with frequent checks. If belligerent, will call police. If has changes in vital signs, will call 911.*

Good Notes Are Contagious — Find Out Who Can Write Them



Some people have the knack to write good notes.

Maybe that can be you.

Those people can write risk management notes in charts even if they are not their patients.

Others will appreciate them, learn from them as to what to see, say and do and this will build competency and interdisciplinary support.

Your New Skill Set

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Skill 5: Care-Planning: Making it Realistic

Maribeth Nono, RN, MAN;
Kathy Gamboa, RN, BSN

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Disclosure Statement

- Maribeth Nono, RN, MAN and Kathy Gamboa, RN, BSN have no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Identify the Key Components of a Care Plan
- Develop a Goal and Interventions for a Risk Management problem
- Apply resident rights regulations to a risk management problem and reflect in care plan

We Cannot Get More Nurses, But We Can Save Nursing Time!

Care plans are a significant consumer of time and a common factor in deficiencies.

Anatomy of a Care Plan

- Problem: What is the problem (a risk of?) and the diagnosis and observations and contributing factors to the problem
- Goal: A specific goal that melds resident and facility goals that is realistic, time-limited, measurable and achievable (short term can be variable, long term is usually 90 days)
- Interventions: WHAT you will do to meet that goal and WHO will do it?

Facility care plans are often numbered. Libraries are used to find ideas.

Care Plans
LONG TERM CARE PLAN

Number Per MDS CAA	Responsible Department
0 RESIDENT SPECIFIC (Information only)	Nursing
1. DELIRIUM	Nursing
2. COGNITIVE LOSS	Nursing
3. VISION	Nursing
4. COMMUNICATION	Nursing
5. ADL FUNCTIONAL/ Recommended Adaptive Equipment E-58B REHABILITATION POTENTIAL	Nursing
6. URINARY INCONTINENCE / INDWELLING CATHETER	Nursing
7. PSYCHOSOCIAL WELL-BEING	Nursing
8. MOOD STATE	Nursing
9. BEHAVIORAL SYMPTOMS	Nursing
10. ACTIVITIES	Therapeutic Recreation
11. FALLS/INJURY	Nursing
12. NUTRITIONAL STATUS	Dietitian
13. FEEDING TUBE	Dietitian
14. DEHYDRATION/FLUID MAINTENANCE	Dietitian/Nursing
15. ORAL/DENTAL CARE	Nursing
16. PRESSURE ULCER/SKIN ISSUES	Nursing
17. AT RISK FOR ADVERSE EFFECTS OF MEDICATIONS	Nursing
18. PHYSICAL RESTRAINTS	Nursing
19. PAIN	Nursing
20. LONG TERM CARE AT SKILLED LEVEL/ DISCHARGE • Discharge Planning Summary Form E-862 • Leave of Absence (LOA), Therapeutic Pass Order and Careplan 8740	Nursing
#25 CONTRACTURES/ROM	Nursing
# 25-1 RNA program	Initiated by OT/PT then Nursing
#158. ST	ST
#159. OT	OT
#160. PT	PT
DM	Nursing
SEIZURE	Nursing
GI DISTRESS	Nursing
HTN	Nursing
RESPIRATORY DISTRESS	Nursing
HYPOTHYROIDISM	Nursing
CONSTIPATION	Nursing
CHOKING/ASPIRATION	Nursing
Other conditions to be addressed	Nursing

Form 5239 (12/19/2018)

Okay, are you ready to care plan for this resident?

Problem (due to)	Goal	Interventions	Who

Write your best problems, goals and interventions on the white pads!

- Then post it on the wall
- Walk around and see what others have written.
- If you like something, put one of your stickers there
- You only get 10 votes!

WHAT CAN WE LEARN TO IMPROVE CARE PLANNING?

Care Plans Do Not Change the Behavior of Staff or Residents

- We get in trouble for not following the care plan. So don't put anything in there we are not doing.
- Be specific: What does redirect mean? When will we do it? How will we do it? Redirect to what?

Trauma Informed Care

CARE PLAN AS IF YOU DEEPLY UNDERSTAND AND CARE FOR THE RESIDENT

Which Sounds More Caring?

- *Resident noncompliant and belligerent when drinking, accusatory and resistant, refuses counseling.*

VS

- *Unfortunate young man with lack of social connections and skills may choose alcohol as a way to meet needs for connection and escape.*

If Tried and Failed, Document as Part of the Problem

- We have ALREADY educated him and explained the risks and benefits and referred to AA
- Repeating the harms of drinking or benefits of AA Qshift is likely to irritate him and not to help.
- Put in the problem

"*Educated many times, but unable to retain information" or "reminders have been found to annoy resident and not improve behavior."*

Make It Personal, Avoid Repetition

- Add in little details that show you know and care.
- Be careful not to put similar information in different places—might lead to confusion, discrepancies. Pick one place and refer to it.
- If something is true for everyone, don't include it!

Innovation: Primary Source Care Plan

- We presented a Best Practice this morning on increasing efficiency of care planning by referring to primary source documents, rather than copying, and expanding those documents to include important elements.
- If you want more info on this, we can talk…

Homework

- Read a care plan on one of your residents—do the goals and interventions seem realistic and appropriate?
- Look at the care plan library for a risk management issue—does that library seem sufficient?
- Review the sample care plans we are providing on mental illness and substance abuse and share with your team.

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Skill 6: Alignment of the IDT: Bringing Different People Together

Rebecca Ferrini, MD, MPH, CMD; Kathy Gamboa, RN, BSN; Robert Gibson, PhD, JD; Patricia Marks; Maribeth Nono, RN, MAN; Teresa Rogers-Marsh, RN; Merlyn Trinidad, RN-BSN

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Learning Objectives

- Explicate the value of working with diverse viewpoints
- Identify a skill you can improve in your own work in teams

Observe the IDT and Think About:

- What went well? What went poorly?
- Did you feel the team cared about the patient? Was the communication trauma informed?
- What are the patient goals?
- How did they assure the resident did not feel “ganged up on”?
- How did they develop a goal that the patient and staff agreed on?
- Do you believe the patient will change? What might success look like?
- How did the team address the doctors suggestions about violating resident rights?

Your New Skill Set

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Skill 7: Adult Learning: Teaching Staff to do the Right Thing Do They Get It?

Rebecca Ferrini, MD, MPH, CMD; Kathy Gamboa, RN, BSN; Robert Gibson, PhD, JD; Patricia Marks; Maribeth Nono, RN, MAN; Teresa Rogers-Marsh, RN; Merlyn Trinidad, RN-BSN

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Learning Objectives

- Design the curriculum for an educational program for CNA level staff on resident rights.
- Identify three important components to effective education.
- Design an instruction page for staff on a risk management topic.

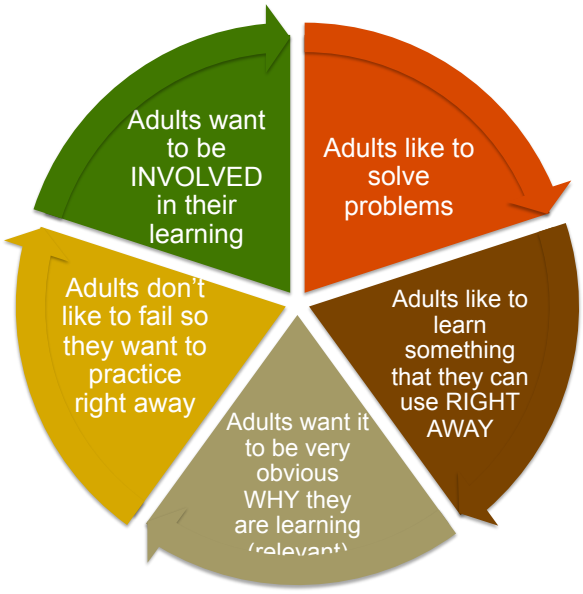
We have learned a whole lot today, but how do we transmit all that we learned to other team members who are not here today?

What Do We Want to Teach?

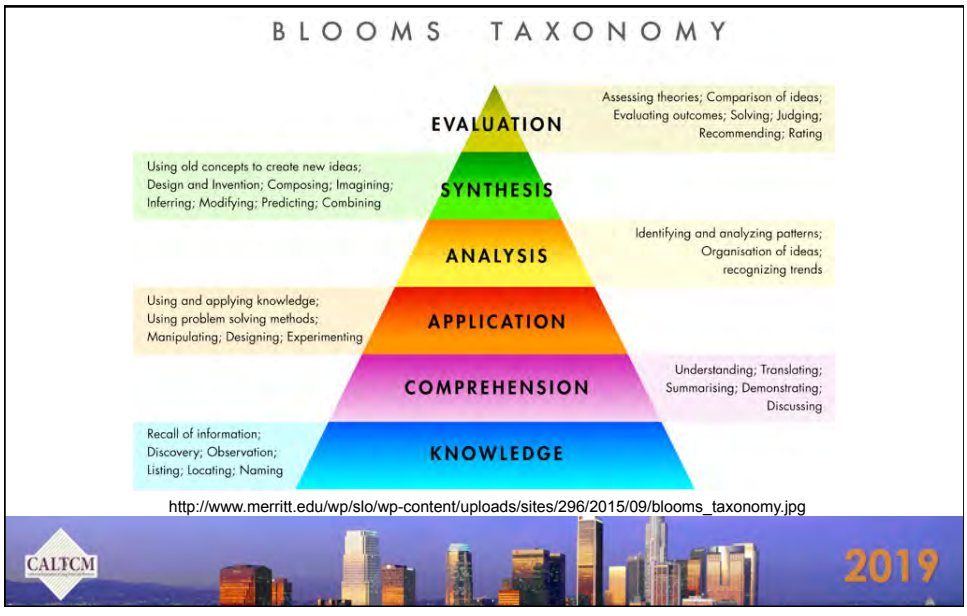
How About Substance Abuse in Long Term Care?

Review the one page handout I developed on substance abuse--- is this the correct content, format for the adult learners in your facility?

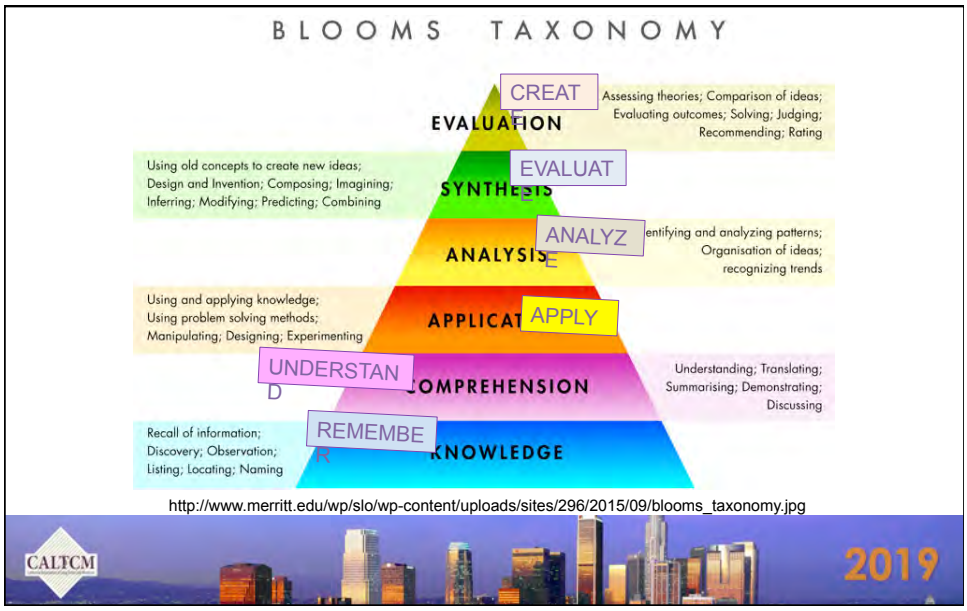
What Do Adults Like?



Blooms Taxonomy tells you to start with where your learners are and what they need.



http://www.merritt.edu/wp/slo/wp-content/uploads/sites/296/2015/09/blooms_taxonomy.jpg



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Knowledge	Comprehension	Application	Analysis	Synthesis	Evaluation
Recalling Information	*Interpreting information in one's own words*	*Applying or generalizing knowledge to new situations*	*Breaking constructs into parts and showing relationships*	*Bringing together parts to form a new whole*	*Making judgments based on given criteria*
Arrange Cite Define Duplicate Label List Match Memorize Name Order Outline Recall Record Relate Repeat Reproduce Select State Tabulate Write	Describe Differentiate Discuss Explain Express Generalize Identify Indicate Locate Paraphrase Recognize Report Restate Select Sort Tell Translate	Apply Calculate Choose Classify Complete Compute Demonstrate Dramatize Employ Illustrate Interpret Modify Operate Practice Prepare Schedule Sketch Solve Use	Analyze Appraise Categorize Compare Contrast Criticize Detect Diagram Differentiate Discriminate Examine Experiment Group Inventory Question Subdivide Summarize Test	Arrange Assemble Collect Combine Compile Compose Construct Create Design Formulate Generate Manage Organize Plan Prepare Propose Rearrange Set up Synthesize Write	Appraise Assess Compare Conclude Critique Defend Estimate Evaluate Grade Judge Justify Measure Predict Prescribe Rank Rate Recommend Score Select Support Validate

These are the kinds of verbs you use for learning objectives based on the level of learning you are trying to achieve.

Let's Practice Using This Taxonomy on Ourselves

What have we learned today?

Here are some examples of KNOWLEDGE (AKA remembering) we may have gained this afternoon

- Define decision making capacity
- List the components of a care plan
- State the statistics about alcoholism in nursing homes or among older people

Here Are Some Ways You Have Demonstrated COMPREHENSION (Understanding)

1. Identify the components of capacity assessment (UCARE)
2. Recognize a risky situation and identify why.
3. Explain the major concerns about a patient drinking in your nursing home
4. Locate a law related to resident rights using an internet source

The Concept of APPLICATION

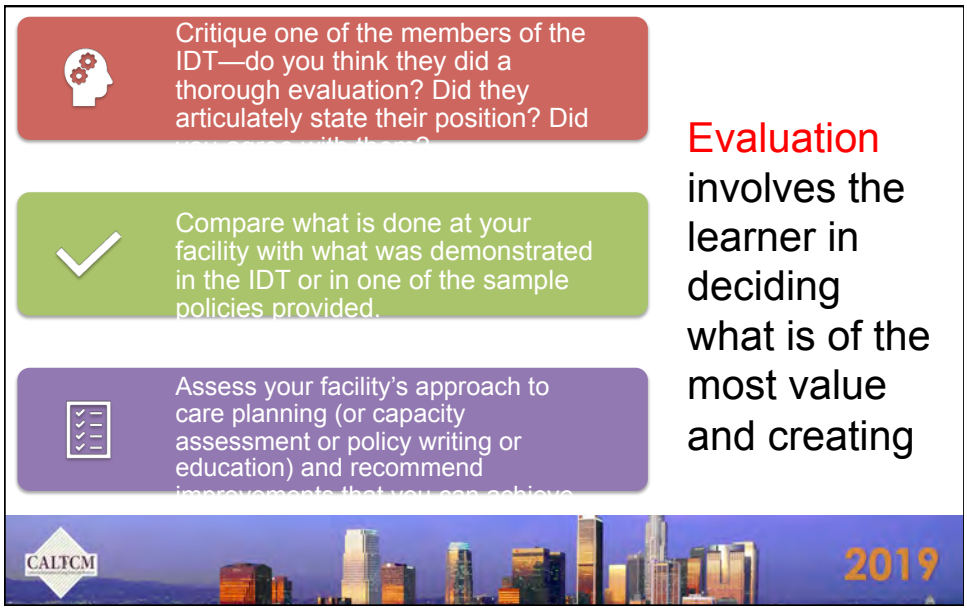
- Using the sample policy and procedures provided on 'restricted items," how would you modify your facility policies?
- Demonstrate how you would assess decision making capacity
- Given this scenario, choose the best response

These Are Ways You May Demonstrate ANALYSIS

- Summarize the main items to include in a care plan if a patient is drinking outside the facility
- Looking at a policy or care plan, detect any potential risk management issues
- Given this case, what do you analyze as the first priority for the provider to address?

Synthesis Is A Higher Level Of Learning

- Develop a care plan for the individual described in the role play
- Write a progress note summarizing the concerns from the perspective of your discipline
- Create a policy on substance abuse for your facility



How Can We Do This All QUICKLY?

- Tell a story that poses a problem for them to solve—maybe a true story about the actual situation!
- Give a chance to ask questions, apply their ideas and practice (for example, practice writing or fill in the form, or role play a conversation)

Make it Applicable

- Check the reading level
- Make it culturally appropriate
- Ask people what they want to know
- Customize to the learner (a separate infection control curriculum for CNA versus LN versus housekeeper)

Let's Practice

Develop a one page handout to teach one concept that you have learned today.

It can be anything!

Capacity, substance abuse, room searches, care planning…

Choose your audience.

Consider how you make it relevant, how they can interact with the material and how they can practice.

We Did Some For You!

- In the online handouts, we made a set of one page handouts with key concepts that we use to educate our staff on topics such as substance abuse, searching a room for contraband, laws and decision making capacity
- You can modify these to your needs

References

Anderson LW and Krathwohl DR. A taxonomy for learning, teaching and assessing: a review of Bloom's taxonomy of educational objectives. New York: Longman.

Bloom, BS 1956 Taxonomy of Educational Objectives: the classification of educational goals. Handbook i: Cognitive domain. New York: Davis McCay.

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Quick Reference on Alcoholism and Long Term Care

- There is evidence that severely ill alcoholics may be placed in nursing homes because it is the only available form of care. It is estimated that up to 49% of patients in nursing homes have an alcohol problem.
- Aging is associated with a number of physiological changes that suggest an increased sensitivity to alcohol. For instance changes in renal and hepatic function. With their diminished cognition, they can experience negative impacts more severely.
- Alcohol use disorders and even moderate to heavy drinking in the elderly are closely related to the presence of different psychiatric symptoms and a worsened constitution (depression, anxiety, hip fractures, etc.)
- You can find out if someone is an alcoholic or has drinking problems with the Alcohol Use Disorder Identification Test—Consumption (AUDIT-C) questions; it consists of the first 3 AUDIT items that ask about the usual frequency of drinking, typical quantity, and frequency of heavy drinking.
- Biomarkers, such as ethyl glucuronide (EtG) in hair (HEtG), offer good information about alcohol consumption patterns. EtG is a minor alcohol metabolite from ethanol that is detectable after consumption of alcohol and has proven to be a sensitive, specific, and accurate biomarker for alcohol consumption. Tox screens can be done.
- An EtG concentration of over 30 pg/mg hair is considered as evidence for excessive and regular alcohol consumption (>60 g of pure alcohol/d), whereas an EtG concentrations of more than 7 pg/mg but below 30 pg/mg is a marker for repeated, but not excessive alcohol use (10 to 60 g of alcohol/d).
- Our facility does not treat alcohol disease or people who are intoxicated.

Dreher-Weber, M., Laireiter, A.-R., Kühberger, A., Kunz, I., Yegles, M., Binz, T., … Wurst, F. M. (2017). Screening for Hazardous Drinking in Nursing Home Residents: Evaluating the Validity of the Current Cutoffs of the Alcohol Use Disorder Identification Test-Consumption Questions by Using Ethyl Glucuronide in Hair. Alcoholism, Clinical And Experimental Research, 41(9), 1593–1601.

Policy and Procedure: SUBSTANCE ABUSE

SUBJECT:	SUBSTANCE ABUSE	POLICY NO:	456
		PAGE:	1 OF 1
		DATE:	12/13/2018

I. POLICY

Facility residents shall not possess or use drugs on facility property.

II. RESPONSIBLE PARTY(IES)

All Facility Staff

III. PROCEDURES

A. Residents are informed of the policy against drugs on admission.

B. Residents who are drug users are not admitted to the facility.

C. If residents identified as using drugs on leave, future leaves will be restricted and plans for discharge are made.

D. Intoxicated residents are sent to the emergency room.

E. If a resident refuses a tox screen, they are assumed to be positive.

F. If substance use is a problem, a referral is made to the social worker.

IV. BACKGROUND

A. Overview

Developed in 2018 after a trip to CALTCM

B. Definitions:

drugs illegal substances

C. Codes and Regulations / Reference / Authority

F-tag F740 §483.40

V. QUESTIONS / INFORMATION

Administrator: (888) 596-1234

Sources of laws and regulations in Long-Term Care.

For LTC, your main sources are:

The Code of Federal Regulations (CFR) contains the regulations put in place by executive agencies affecting LTC. LTC regulations are contained in Title 42 of the CFR. Regulations in the CFR can change every year, so it is important to stay updated with the most recent version. Your best resource is the State Operations Manual that contains the most updated regulations, as well as F Tag references and surveyor guidelines.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

The California Code of Regulations (formerly called the California Administrative Code) provides state regulations, much like the CFR, the CCR contains state regulations. Unlike the CFR, it is not as directly tied to original law, and you still need to examine other areas of law, e.g., the Welfare and Institutions Code, etc.
https://govt.westlaw.com/calregs/Index?transitionType=Default&contextData=%28sc.Default%29

Note: There are also interpretive sources such as CDPH's All Facilities Letters (AFL's) that provide interpretations of laws/regulations that the surveyors will use. The various manuals from the California Hospital Association (e.g., Consent Manual, Privacy Manual) can also be very helpful.

Key points:

- Law further up in the hierarchy takes precedence, e.g., if state and federal law conflict, the federal law must be followed.
- Use the administrative/regulatory versions (CFR, CCR) as they provide detail about how the law will be enforced.
- Check online versions since laws/regulations change.
- Use a search engine like Google to find relevant laws not in the State Operations Manual (CFR) or CCR.

There is a hierarchy of laws, it is:

- The U.S Constitution
- Laws (statutes) enacted by Congress (codified in the United States Code or USC)
- Rules promulgated by federal agencies (codified in the Code of Federal Regulations or CFR)
- The State constitution
- Laws enacted by the State legislature (Welfare and Institutions Code, etc.)
- Rules promulgated by State agencies (California Code or Regulations)
- City/county charters (the "constitution" for the city or county)
- Local laws and ordinances
- Rules promulgated by local agencies.

Policy and Procedure: CONTRABAND

SUBJECT:	CONTRABAND	POLICY NO:	123
		PAGE:	1 OF 1
		DATE:	12/13/2018

I. POLICY

Facility residents will not have contraband in their rooms that could harm themselves or others.

II. RESPONSIBLE PARTY(IES)

All facility staff

III. PROCEDURES

A. Residents will not have contraband items in their rooms or the facility.

B. The following items are contraband: weapons, guns, drugs, medications not prescribed by facility, glass, Christmas lights, popcorn, tools, food of an unsafe texture personal appliances, living plants, pets.

C. If contraband is suspected, the room or resident will be searched and contraband removed.

D. Visitors are not permitted to bring or carry contraband while in the facility and are subject to search.

IV. BACKGROUND

A. Overview

Developed in 1989

B. Definitions:

Contraband	Weapons or other items by which a resident can harm self or others.

C. Codes and Regulations / Reference / Authority

F-tag 557 CFR §483.10(e)(2)

V. QUESTIONS / INFORMATION

Administrator: (888) 596-1234

SUBJECT:	RESTRICTED ITEMS (CONTRABAND) CALTCM EXAMPLE 123A	POLICY NO:	123A
		PAGE:	1 OF 4
		DATE:	

I. POLICY

FACILITY promotes the right of residents to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of other residents.

FACILITY promotes an environment that is safe for residents and free from items that present a danger to residents, staff and the facility.

II. RESPONSIBLE PARTY(IES)

If a resident has a particular need for a restricted item and is able to maintain safe and sanitary possession and use, an exception can be made with IDT approval.

All FACILITY staff is responsible for observing their environment for potentially unsafe items and reporting concerns to the Supervising Nurse.

Administrator, physician, psychologist, nursing leadership or their designee can authorize a search based on reasonable suspicion of the presence of restricted items.

Residents are notified about restricted items by the Supervising Nurse. Administration may become involved if residents continue to violate the policy.

III. PROCEDURES

A. Staff, residents and families are notified in person and through "Things You Need to Know About Edgemoor and Associated Guidelines 2286"

B. For examples of restricted items, see Restricted Items Guideline 315a and Non-Smoking Facility 409

a. For special considerations of restricted items for those on oxygen, see Oxygen Safety/ Oxygen Cylinders 6914.

C. Examples of reasonable suspicion might include:

a. A resident exhibits a sudden change in mental status, with no apparent medical cause, suggestive of intoxication or illegal drug use.

b. Possession of a restricted item is suspected due to observation, smell or report from a credible witness.

D. When restricted items are observed or suspected, the Supervising Nurse assesses the threat posed by the item and guides the next steps, with IDT consultation. Activities that may occur include:

a. Interviewing and informing the resident.
b. Asking for permission to remove the item from resident care areas.
c. Determining if higher level of observation is needed immediately to prevent injury in the time frame when analysis and investigation is taking place (e.g., assigning a staff to observe the resident until the item can be secured).
d. Consulting with other IDT members.
e. Reporting to MD, Administrator on Call and Director of Nursing.
f. Reporting to law enforcement if risk is high.
g. Searching the room or resident for restricted items accompanied by a witness.
h. Filing an incident report.

E. If FACILITY staff reasonably suspect the presence of a restricted item, a search of the resident's room, person, or of suspicious packages is appropriate. If a search is conducted, the following steps are taken to maintain dignity, privacy and safety:

a. The need/rationale for search is reviewed by the Administrator, Physician or Nursing Supervisor.
b. Resident is apprised of the concern and given an opportunity to provide information, or to relinquish an item or to assist in the search.
c. If a search is to be conducted against the preferences of the resident, the resident is invited to be present unless so doing poses a risk to staff.
d. Maintenance is contacted to assist in opening locked drawers if residents refuse to provide the key.
e. Searches are conducted in a dignified manner, items are removed then replaced as they were found, and the search is conducted in private as much as possible.
f. Any search that is not voluntary is accomplished with two staff present, and if possible, one staff member should be an administrator or social worker
g. Staff **may not** open incoming first class mail; however, staff may be present when mail and/or packages are opened by residents.
h. Searches will be documented in the progress notes (including reason for search).
i. Resident response (voluntary/involuntary), what was searched, what was found, what was removed, notification to resident or reason resident was NOT notified, titles of persons conducting search.
j. Involuntary searches or the discovery of dangerous restricted items prompt an incident report.

F. Possession of restricted items by a resident should be addressed by development of a care plan to address the behavior that may include:

a. Regular room searches.

b. Drug/alcohol screening.

c. Education of the resident and staff.

d. Heightened observation of the resident.

e. Consideration of discharge from FACILITY for danger to others.

G. If a resident requests an exception to the policy, the item is removed while an IDT is convened which includes administrative representatives. The team reviews the request, abilities and propensities of the resident and makes and documents decisions about exceptions in the care plan and in the C.NA assignment. These exceptions are reviewed with any change in condition.

IV. BACKGROUND

A. Overview

Not Set.

B. Definitions:

Restricted Items	Restricted items include any item that is prohibited on the FACILITY grounds. Such items include those that are illegal, or that present a safety risk to residents, staff, visitors, or the facility. ***Note***: Due to individual differences in judgment and physical ability, items that pose a safety risk, and as such are contraband, may sometimes vary, based on resident capabilities.

C. Codes and Regulations / Reference / Authority

42 CFR 483.10, 42 CFR 483.12; 22 CCR 72527

V. QUESTIONS / INFORMATION

Edgemoor Medical Director: (XXX) XXX-XXXX

VI. RELATED DOCUMENTS

A. Care Plan Request and Facility Response Form 6858
B. Incident Report Form 312
C. Incident Report and Investigation (including Abuse) 308
D. Resident Rooms-Clutter Storage Belongings 1081
E. Restricted Items Guideline 315a
F. Substance Abuse 1135
G. In-Service # 4384 (2017): Substance Abuse, Dr. Robert Gibson, PHD. Provider approved by the California BRN. Provider # CEP 6709 for 1 (Continuation Education) hour

SUBJECT:	RESTRICTED ITEMS (CONTRABAND) CALTCM EXAMPLE 123A	POLICY NO:	123A
		PAGE:	4 OF 4
		DATE:	

VII. SUPERSEDES

A. Not Set

VIII. APPROVED

This policy and procedure was approved XX/XX by the Quality Council Committee.

Policy and Procedure: SUBSTANCE ABUSE

SUBJECT:	SUBSTANCE ABUSE	POLICY NO:	456
		PAGE:	1 OF 1
		DATE:	12/13/2018

I. POLICY

Facility residents shall not possess or use drugs on facility property.

II. RESPONSIBLE PARTY(IES)

All Facility Staff

III. PROCEDURES

A. Residents are informed of the policy against drugs on admission.

B. Residents who are drug users are not admitted to the facility.

C. If residents identified as using drugs on leave, future leaves will be restricted and plans for discharge are made.

D. Intoxicated residents are sent to the emergency room.

E. If a resident refuses a tox screen, they are assumed to be positive.

F. If substance use is a problem, a referral is made to the social worker.

IV. BACKGROUND

A. Overview

Developed in 2018 after a trip to CALTCM

B. Definitions:

drugs illegal substances

C. Codes and Regulations / Reference / Authority

F-tag F740 §483.40

V. QUESTIONS / INFORMATION

Administrator: (888) 596-1234

SUBJECT:	SUBSTANCE ABUSE CALTCM 456A	POLICY NO:	456A
		PAGE:	1 OF 3
		DATE:	

I. POLICY

FACILITY will take reasonable steps to discourage or prevent residents from self-administering drugs or other medically active/psychoactive substances (e.g., herbal remedies, excessive caffeine, diet/weight loss supplements, "energy" drinks) unless it has been determined to be safe by the interdisciplinary team.

FACILITY will take reasonable steps to insure an environment free from illegal and/or non-prescribed substances with restrictions of resident rights considered only when justified for safety of the individual or others.

II. RESPONSIBLE PARTY(IES)

Physician
Psychologist
Nursing
Social Worker
Administrator

III. PROCEDURES

A. Initial history will ascertain information about substance abuse, treatment and current use.

B. Residents with substance abuse histories, who are amenable to treatment, will be offered treatment available at FACILITY, including counseling and referrals.

C. Clinical staff are alert to possible signs of substance abuse through observation, laboratory studies, and development of consistent relationships. (Plan: Relationship Management 4783)

D. When substance use or abuse is suspected, clinical team members including nursing, social workers, psychologist and physician conduct an assessment and implement harm reduction interventions designed to protect both them, staff and other residents and even the community from adverse impacts as feasible.

E. The Physician and Interdisciplinary Team will take reasonable steps to promote the safety of the resident and facility. Such steps may include:

a. Education and counseling for the resident.
b. Attempt to obtain agreement to limit or discontinue substance use.
c. Room search and other inspections for contraband. (Restricted Items (Contraband) 315; Restricted Items Guideline 315a)
d. Heightened monitoring of the resident.
e. Observation of visitors or contacts with at-risk peers.

f. Review of the resident's medication regimen for possible necessary adjustments to minimize the risk of the resident's use of non-prescribed substances.
g. Notification of payee to reduce available funds to reduce substance use (if appropriated
h. Notification of representative (if resident unable to make their own decisions or provides permission).
i. Reduction of privileges (e.g., operation of power wheelchair (Power Wheelchair Resident Agreement 1762; Wheelchair Mobility Skills Checklist 1449)) or mobility within the facility to protect self and others.
j. Alternations in medications or approach to health and behavioral concerns. (Pain Management Agreement / Chronic Narcotic Opioid Consent Form 385)
k. Room or neighborhood change. (Room Change - Neighborhood Move 203; Room Change Checklist Form 1796; Written Notification of Room Change (Letter) 5347)
l. Notification of law enforcement.
m. Care plan updates.
n. Transfer or discharge. (Discharge Planned 204

IV. BACKGROUND

A. Overview

The resident population at FACILITY includes individuals who are medically fragile, exhibit cognitive impairments, and many of whom have significant histories of substance misuse. Substance abuse in this population poses significant risk of danger to the individual and those around him or her. However, for residents who maintain decision-making capacity, the facility may be limited in what it can offer or enforce.

B. Definitions:

None

C. Codes and Regulations / Reference / Authority

42 CFR: 483.10, 483.12, F-176; 22 CCR: 72527

V. QUESTIONS / INFORMATION

Edgemoor Medical Director: (XXX) XXX-XXXX

VI. RELATED DOCUMENTS

A. In-Service # 4384 (2017): Substance Abuse, Dr. Robert Gibson, PHD. Provider approved by the California BRN. Provider # CEP 6709 for 1 (Continuation Education) hour

B. Private Activities 434

VII. SUPERSEDES

Not Set

VIII. APPROVED

This policy and procedure was approved XX/XX by the Quality Council Committee.

SUBJECT:	DECISION MAKING CAPACITY (CALTCM EXAMPLE)	POLICY NO:	
		PAGE:	1 OF 2
		DATE:	

I. POLICY

1. This facility supports the rights of a resident to make his/her own health care decisions, when possible.

2. It is assumed that residents have the capacity to provide informed consent and for other matters, unless this has legally or clinically been determined otherwise. Decision-Making Capacity (DMC) is re-evaluated in each situation by the Physician or other licensed health care provider.

3. Physicians and the Psychologist generally evaluate capacity. In urgent situations, when the Physician or the Psychologist is not available, licensed nurses or social workers can also evaluate changes in capacity or capacity to make a certain decision.

II. RESPONSIBLE PARTY(IES)

Physician
Psychologist
Licensed Nurses
Social Workers

III. PROCEDURES

A. The Physician shall determine resident's capacity upon admission to the facility and at each time when major healthcare decisions are made (e.g., administration of psychotropic medication, procedure, "code status," Leave without accompaniment, or discharge) and document this assessment in medical record. In this determination, the Physician may consult with resident, his/her family and friends and other healthcare team members.

B. Resident's capacity to make health care decisions is included in the top of the physician orders using the terms full, none or limited. (Decision-Making Capacity and Terms Used: Definitions and Background 5322)

C. Resident's capacity to make health care decisions shall be reviewed with any significant change of condition.

D. The Social Worker reviews the capacity determination and includes this on the C and C form, which is reviewed quarterly. The Social Worker will update the C and C form and place a copy in the chart. (see Contacts and Capacity (C and C / C&C) 113 and Contact and Capacity Form (C and C)- Template 1638)

E. With regard to informed consent for surgery, discharge or psychotropic medications, physicians must make the final determination of capacity. Other trained staff may assess for capacity to make other

individual decisions that are required (e.g., capacity to make the decision to leave the facility unaccompanied, to accept or refuse a certain treatment option, to establish preferred intensity of care) with support of the Physician and Psychologist.

F. In general, residents on Public Guardian/Conservatorship lack the capacity to provide informed consent, although they may be able to express their needs and wishes. Residents on Lanterman Petris Short (LPS) Conservatorship may or may not maintain the right to provide informed consent for medical procedures. (see Conservatorship 114)

G. Residents may refuse a treatment for religious or other personal reasons. Such refusal does not generally show that resident lacks decision-making capacity. If a resident understands proposed treatment or procedure and can communicate his/her decision, such decision will be respected by Interdisciplinary Team (IDT), even if it appears to be unwise. (see Non Adherence; Refusal of Care; Non-Compliant 311)

IV. BACKGROUND

A. Overview

Not Set.

B. Definitions:

Decision-Making Capacity and Terms Used: Definitions and Background 5322

C. Codes and Regulations / Reference / Authority

CA Probate Code Sections 4600-4783; Patient Self-Determination Act; 42 CFR 493.10; 22 CCR72527

V. QUESTIONS / INFORMATION

Adminstrator: (888) 596-1234

Quick reference to determining decision making capacity

Capacity to Decide (U-CARE)

- Understanding of the relevant information
- Consistency- responses are consistent over time, when questions are asked a different way and by different people.
- Appreciation of the significance of information as it applies to the person's situation.
- The ability to Reason with relevant information logically weighing options.
- Ability to Express a choice.

Decision-making capacity should be based on the decision to be made, e.g., if assessing end-of-life treatment options, then discussion of end-of-life treatment options should be the basis for the assessment.

Standardized cognitive tests are insufficient to determine capacity – MMSE of 15 (or low BIMS, SLUMS, MOCA, etc.) is not sufficient to determine incapacity.

Diagnosis alone is not sufficient to determine incapacity.

Competence/incompetence is a court determination; decision-making capacity is a clinical determination.

Conservatorship can define incompetence which overrules capacity assessment for areas where it is effective. Check conservatorship paperwork to see what is addressed. Things outside the court determination of incompetence may then fall under decision-making capacity, e.g., if medical rights unrelated to grave disability are not removed under an LPS conservatorship, then question will be whether the person has capacity to make medical decisions.

Demonstration of capacity assessment
Question : Can resident leave unaccompanied when he is returning intoxicated?

This will be a reassessment of decisionmaking capacity for a particular instance. Wil be done by a nurse, with review and discussion by the psychologist afterwards

Understanding

- Can you tell me about what happened last weekend? (Came in drunk and went to another neighborhood, hit and verbally assaulted another patient while asking for money. Staff had to call law enforcement.)

- Do you remember the sheriff's deputy coming?

- Can you understand what we are worried about? For you and for others?

Consistency

- Observation of resident.
- Multiple conversations.

Appreciation

- What bad things could happen to you?
- What bad things could happen to others?
- What is different now that led to you living in a nursing home? What's different from when you lived at home?
- Do you think alcohol is harmful to you? How? Or if not, why?
- What could you do to make yourself and others safer?
- What could we do to make it safer?

Reasoning

- There are a lot of reasons not to leave by yourself and drink. But you still want to do this. Can you tell me why?
- You say "nothing will happen" even after the sheriff's deputy came and you hit someone. Can you tell me why?

Expression

- Say it back to me...what is your plan?
- What are we asking you to do?
- What will happen if you go out and are drunk?
- What will happen if you are aggressive?
- What are you agreeing to do?

Sample Careplan: Alcohol or Substance Abuse Disorder

ALCOHOL OR OTHER SUBSTANCE ABUSE CARE PLAN LIBRARY

PROBLEM:

- Ongoing substance use disorder defined as:
  - Alcohol/other substance use disorder (requires specialist referral if accepted or possible)
  - Hazardous Drinking/use
  - Harmful Drinking/use
- Insight into condition: None, limited, full
- Motivation to change:
  - Highly motivated to seek and comply with treatment
  - Somewhat motivated to explore ideas related to treatment
  - Wants to quit, but does not feel it is possible
  - Does not want to quit
- Expected/Inevitable occurrence of a fall with or without injury related to substance use.
- Risk of pedestrian accidents, being taken advantage of in the community.
- Long-term substance abuse, cognitive loss, no motivation to change or insight, counseling refused/ineffective.
- Educational explanations, risk conversations not effective in altering behavior, not retained by patient so are no longer attempted.
- Resident denies drinking/use even when visibly intoxicated. Obtains alcohol/drugs outside the facility.
- Impulsivity, poor social skills, life dissatisfaction, poor prognosis, disability, lack of connections are triggers for drinking/use.
- Resident has funds to purchase substances/ alcohol.
- Ineffective Individual coping: impaired adaptive behavior, decrease in ability to handle the stressors of illness or current situation.
- Tendency to maneuver/manipulate people; predatory.
- May have the tendency to deny he needs help by delaying in seeking or refusal of care; may not admit the impact of the condition and projection of blame to others or others responsible for what happened or is happening to him/her.

GOAL:

- Identify when intoxicated to implement closer monitoring to more rapidly identify and possibly prevent falls or other injuries.
- Minimize harm when resident exercises his/her right to leave the facility and obtain substances.
- Prevent substance abuse within the facility.
- Prevent resident from taking advantage of peers in the facility through mobility/ visiting restrictions
- Will wear a reflective vest/ appropriate clothing when out at night.

INTERVENTIONS:

- Identify triggers for this resident through observations or interviews and then work to reduce those triggers (List here any triggers identified_____).
- Talk about medical complications customized to the person.
- Try to calibrate and quantify frequent stages of change, motivation and medical problems potentially impacted by alcohol or substance use disorder.
- Avoid terms like alcoholism, substance abuse (substance use disorder is correct).

- Use correct terms-- http://www.who.int/substance_abuse/terminology/who_lexicon/en/- https://www.nice.org.uk/guidance/ph24/chapter/8-glossary#harmful-drinking
- Focus on reducing income and limit opportunities to purchase alcohol or other substances.
- Place barriers to the activity. Redirect, or encourage other productive activities (OT, PT, ST, TR)
- Establish natural consequences:
    - Reduced freedom to mobilize through the facility due to risk of exploitation and aggression towards peers.
    - Reduced visitors—visit in a central area to reduce contraband and visible to staff; search room/locked drawer after visitation.
    - Pharmacy evaluation of medications, discontinue all medications that are known to interact with alcohol or other substances.
    - Notify referring and consulting practitioners, including on ER transfer, of substance abuse as this may impact their decision-making.
- Educate on hazards of drinking or substance use and on their particular medical problems. Focus on side effects of interest to the resident (impotence, breast enlargement).
- Identify diagnosis specifically and implement appropriate referrals (SEE problem list).
- Identify stage or motivation for change and target interventions to that stage.
- Assess for quantity, frequency, triggers.
- Reinforce for periods of abstinence.
- Document episodes of use on the treatment sheet to evaluate effectiveness of interventions and identify triggers. Monitor with monthly behavioral review.
- Establish relationships/ rapport or structure to discourage.
- Enlist social support system.
- Distraction (e.g. activities).
- Risk mitigation for when drinking happens: Notify residents that if they come to the facility intoxicated, they may be sent to a hospital or be refused of entry to the facility, when they are intoxicated, their medications may be placed on hold, take away the privilege of the use of their power chair/s if drunk or intoxicated. Call 911. Notify all referrers/health care providers of the problem.
- Place flag, light-reflective vest to increase night time visibility. Wear the appropriate clothing when going out of the facility at night. (Ex. Jackets when cold, discourage female residents to wear skimpy clothing, etc.)
- Search and remove all contraband when substance use is suspected, with at least two staff members present. If seen with contraband, initiate search immediately. If the resident refuses, continually observe resident until you can search for suspected items (e.g., resident put to bed or changed).
- When a resident is at risk of alcohol consumption/intoxication (e.g., out of the facility at night, smells like alcohol, appears intoxicated), then implement more frequent checks for safety and try to encourage him/ her to rest in bed.
- Gentle statements of caring and concern related to substance use.
- Link discussions about risks of substance use with something he or she cares about such as body building or walking.
- Psychologist consultation per resident's request or interest in alcohol/ substance use cessation.
- Avoid prescribing any medications interacting with alcohol/ substances.
- If a resident is unable to be aroused or has changed level of consciousness or vital signs, send to the hospital for evaluation and detox.
- Attempt to establish a rep payee.
- Discourage family from providing funds; do not provide items that are not regulatory/ required that could be sold or could be used to barter or could "save" own money. Encourage to leave the money with the Facility's Cashier.

- Make sure there is a diagnosis in the chart, e.g., alcohol abuse, active, and is care planned.
- Make sure there is a pharmacy consult to assure none of his/ her medications (scheduled or prn) or supplements that would interact with unprescribed substances.
- Add a MVI with minerals daily to reduce nutritional risks associated with alcohol consumption
- Limit the ability to purchase items (e.g., do not provide donated clothing –resident must purchase with their own funds which limits funds for substance abuse).
- Use substance use disorder screening tools (AUDIT, ARPS, DAST, etc.)
- Discuss with the resident on the level of his understanding the harmful effect of too much substance use such as loss of consciousness, lack of motor coordination or delayed motor reactions that may lead to balance problems and ataxia; trauma/accident, falls, comatose or death. Especially if he/ she is out of the facility or on the road, impairment of judgement, respiratory depression, slowed heart rate, etc.
- If in withdrawal (seizures, sweating---) refer to acute hospital ER.
- Administer Narcan if unconscious…
- Refer to a specialist to determine if he/ she has an alcohol use disorder (AUD) or SUD (Substance Use Disorder). An AUD is a chronic relapsing brain disease characterized by compulsive alcohol use, loss of control over alcohol intake, and a negative emotional state when not using. As specified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), an AUD is present if an individual meet at least 2 of 11 criteria. These criteria include:
  - drinking large amounts over a long time;
  - having difficulty cutting down;
  - taking up a great deal of time acquiring and drinking alcohol;
  - craving alcohol;
  - not fulfilling responsibilities;
  - having mental, physical and social problems;
  - engaging in risky situations;
  - having withdrawal symptoms when stopping; and
  - needing increased amounts of alcohol to feel its effects.
- Patients may have a mild (w 2-3 criteria), moderate (w 4-5 criteria), or severe (w 6+ criteria) alcohol use disorder.

Sample Care Plan for serious mental illness (e.g., bipolar, schizophrenia, schizoaffective, psychosis NOS)

Problem: List diagnosis and how it was made. Look at DSM/ICD criteria if possible. Indicate if there is a comorbidity of head injury, or dementia. Indicate the duration, age of onset, and life problems related to the diagnosis. Particular risks should also be noted, e.g., "command hallucinations to harm self," "paranoia may cause Pt to become aggressive to 'protect self.'"

Goal:

- To assure that psychosis does not result in any distress to the resident or harm to self or others.
- Avoid acute psychiatric hospitalization for 90 days.
- Avoid metabolic complications of antipsychotics.

Interventions:

- PASRR on admission and with change in diagnosis—review recommendations and document those which can and cannot be accommodated, accepted or refused by the Pt.
- Obtain informed consent for psychotropic medications and notification of dosage changes from the resident/representative and any individual/s they designate (LIST HERE the name of the individual).
- When possible, notify the interested family member/ responsible party of the use or increase of dosage of antipsychotic medication/s per HSC 1418.9 within 48 hours.
- Maintain/establish conservatorship as appropriate.
- Monitor for risks such as: Elopement, psychiatric exacerbation, aggression, non-compliance, medication side effects.
- Document triggers, non-pharmacological interventions and outcomes of use of psychotropic medications.
- Do not challenge delusions or argue with them (like with dementia, validate the feeling behind it) -e.g. "that sounds scary!"
- Monitor signs of psychosis that the individual exhibits (delusions, responding to internal stimuli, irritability, aggression, misperceptions, auditory hallucinations. Report any withdrawal or refusal of care, poor impulse control, low frustration tolerance, unable to think clearly, difficulty communicating needs….
- Assure that medications are swallowed/ingested and not pocketed.
- Provide music or television viewing to drown out auditory hallucinations.
- Provide a structured environment with consistent staff.
- Activities of interest - encourage participation.
- Interdisciplinary psychotropic reviews quarterly and as needed.
- Weight, lipid and glucose values to be measured periodically to evaluate for side effects of antipsychotics.
- Routine measurements of levels of lithium and anticonvulsants used for diagnoses.
- Drug reductions as indicated if patient is stable over a period of time and benefits outweigh risks, but not mandated for those with schizophrenia, Tourette's, HD and schizoaffective disorder.
- Summarize/Document Behaviors observed which are associated with triggered factors such as sudden yelling at peers, uncooperative/ non-compliance was not able to serve meals right away/

(impatient)unable to wait for his turn in the activities etc… Noting the time and events leading to the untoward behaviors.

- Assess daily routine of resident and based from it, develop/create a structured environment/routine with consistent staffing that the resident can easily adapt to himself/ herself without forcing him/ her.

Reference: Care Plan Guideline 3250; Care Plan Resident 1055

DETERMINING DECISION MAKING CAPACITY

Can a resident choose their clothing? Yes, you say! But then I ask, what if they want to wear a bikini in the snow. Then can they decide that? Well—now the decision went from an easy one to a hard one—and that is because there is RISK involved. If someone wants to do something risky in your facility, you have to spend more effort to determine if they can make that decision.

Or how about this one—can a resident refuse care? That is a resident right! But wait, what if a person is kicking and screaming but cannot speak and is very demented, will you let them refuse to be changed? This is the same situation—we have to decide—can we LET them refuse care or violate their right to refuse on the grounds they lack the ability to understand?

There is a problem—residents have rights, but they need to have decision-making capacity to exercise those rights.

We have to find out if they have decision-making capacity. There are so many decisions to make that the courts cannot help us each time determine what to do.

Some people are easy—you or I, we can make all our own decisions without problem—we have FULL decision-making capacity. And a person who is comatose and cannot speak—they have NONE and need a representative. But there is a problem in the middle—people with some or LIMITED capacity.

If a person has limited capacity and they know it and they ask you to use a representative—that is fine.

If a person has limited decision-making capacity and there is no one else to decide for them, then you have to use them as the decision-maker.

But sometimes you have to decide if you can honor the decision of a person with limited decision making and you need help to decide that you cannot always call a doctor or social worker. You have to assess to the best of your ability.

So here is a way to remember the critical parts of making decisions:
UCARE

U= Understanding—do they know what the decision is?
What do you want to do?

C= Consistent—do they say the same thing to you and the supervisor and today and tomorrow?

A= Appreciation—do they APPRECIATE the risks? Can they name what bad things might happen?
Do you know why I think this is a bad idea? Can you name some of the bad things that might happen if you do this?

R= Reasoning—can they balance risks and benefits and give a REASON

Why are you wanting this? What ways does it benefit you? How might it harm you? How did you decide this is what you want? Can you tell me what you will do to make the situation safer?

E= Express—can they TELL you and communicate what they want?

Ask them questions, document their responses. It is best if you can write down the questions you asked them and their responses in their own words.

Asked to assess clinical decision making. Resident wants to leave facility against medical advice. They have been determined to have limited decision making capacity, but have no friends or family to assist. The reason they want to leave is that they found out their benefits are reduced while in long term care and "I want my money." Resident agitated. Repeats statements that they intend to leave. Will not engage in a conversation on the risks. When I try to explain risks, they interrupt and accuse me of profiting by their stay. He says he knows which corner they can go to where he has friends there some have cars, and that he knows where he can get food for homeless people. Tells you they have a coat for the cold weather and "are used to it."

Then, the hard part, you have to decide if they have the ability to make the decision (leaving AMA, refusing care, leaving the facility to go to Walmart, denying their daughter from visiting, deciding code status) or any of the 100s of other decisions made in nursing home. You do this with your judgement and with getting input from others. And then you have to say what you will do to make it safer for them. So maybe you let them exercise their rights, but you are still responsible for safety and efforts to make it safer.

Resident has at least a rudimentary plan for food and shelter and has long history of homelessness, but he is more frail now and the weather is quite cold. Although he states he has a coat, it is not in his belongings. He has a new wound and cannot tell how he will take care of it. Although we do not have the right to forcibly restrain him in the facility we will try to convince him to stay for now and see the social worker in the morning and if he does leave, will give him blankets and call the law enforcement for a welfare check as he is in significant danger of harm if out alone for more than a few hours.

If this is a risky decision, get a second opinion. —maybe they understand the decision and are consistent and can appreciate some risks, but will not show you their resonating—you have to decide what is the best way to balance safety with rights.

Quick reference: adult learning—how to teach and learn as an adult

Remember when you were a kid, listening to the teacher taking notes and then taking a test? Does that relate to what you are doing now in your job? Are you still taking notes and taking tests? Probably not! If you are like most adults in the long term care environment—you are busy working!

You are doing a job every day and you have a lot of experience doing that job. You don't need to learn stuff you already know. You are motivated to learn something where you are having trouble. Sometimes the teacher has to motivate you to learn (new practice, new regulation) by showing you WHY it is important.

To design make education for adults, **first we have to convince them of why they need to learn something new**—why the way they have been doing things is not the best way. We have to use real life example and problems and listen to what they are saying that they need, what they have found works and doesn't work. We cannot just expect them to listen to a whole lot of facts and then start doing what we think is best!

Adults like a chance to apply what they learn to new situations. They want to practice the new knowledge and skills in real life situations. It is best that they have a chance to make mistakes in the classroom with you rather than out there with their patients. Have you ever gone to learn something, found it interesting, but when you went back you just kept doing the same things? That is because you did not have a chance to APPLY what you learned, to see if it works for you and to practice making the change.

Let's say you are teaching an adult a new form to fill out. The best way to learn is to provide a situation and then have them try to practice filling out the form. That would be much better than going over a form already filled out. Or let's say you are teaching them how to assess for drunkenness, you can show them a slide listing things to do, or better yet, you can ask them to role play with each other, asking questions and doing a physical assessment and then writing a note.

The best education for adults should have interactive parts—something they can do. It can be simply asking them questions to think about, but is better to have them do something—role play, review a case and think about what to do, answer a survey, practice a skill, review a case and so on.

Think about the best education you received and the worst? This might help you to develop education that really works.

Plan: Edgemoor's Education 4578

Quick Reference on Alcoholism and Long Term Care

- There is evidence that severely ill alcoholics may be placed in nursing homes because it is the only available form of care. It is estimated that up to 49% of patients in nursing homes have an alcohol problem.
- Aging is associated with a number of physiological changes that suggest an increased sensitivity to alcohol. For instance changes in renal and hepatic function. With their diminished cognition, they can experience negative impacts more severely.
- Alcohol use disorders and even moderate to heavy drinking in the elderly are closely related to the presence of different psychiatric symptoms and a worsened constitution (depression, anxiety, hip fractures, etc.)
- You can find out if someone is an alcoholic or has drinking problems with the Alcohol Use Disorder Identification Test—Consumption (AUDIT-C) questions; it consists of the first 3 AUDIT items that ask about the usual frequency of drinking, typical quantity, and frequency of heavy drinking.
- Biomarkers, such as ethyl glucuronide (EtG) in hair (HEtG), offer good information about alcohol consumption patterns. EtG is a minor alcohol metabolite from ethanol that is detectable after consumption of alcohol and has proven to be a sensitive, specific, and accurate biomarker for alcohol consumption. Tox screens can be done.
- An EtG concentration of over 30 pg/mg hair is considered as evidence for excessive and regular alcohol consumption (>60 g of pure alcohol/d), whereas an EtG concentrations of more than 7 pg/mg but below 30 pg/mg is a marker for repeated, but not excessive alcohol use (10 to 60 g of alcohol/d).
- Our facility does not treat alcohol disease or people who are intoxicated.

Dreher-Weber, M., Laireiter, A.-R., Kühberger, A., Kunz, I., Yegles, M., Binz, T., … Wurst, F. M. (2017). Screening for Hazardous Drinking in Nursing Home Residents: Evaluating the Validity of the Current Cutoffs of the Alcohol Use Disorder Identification Test-Consumption Questions by Using Ethyl Glucuronide in Hair. Alcoholism, Clinical And Experimental Research, 41(9), 1593–1601.

CALTCM Quick Reference: How to communicate with a patient around their substance abuse

- Be honest about what you observe, try not to judge or preach
- Ask questions, seek to understand.
- Talk about how much you care
- Ask them to help you by suggesting what they want (goals) and what they plan
- DO not threaten discharge
- Tell them calmly what YOU will do if they are intoxicated.
- Explain risks—both short term and long term, to themselves and others
- Evaluate their medication profile to see if there are any medications which interact with alcohol
- Evaluate decision making capacity
- Get permission to speak with family
- Consider what interventions you can put in place to make this safer (See suggestions in sample care plan—Educate, encourage reduction in quantity or strength or frequency of intake, encourage more positive relationships, discontinue medications that interact, try to reduce access to funds, if possible, try to meet needs in another way, search and remove contraband from rooms, offer treatment (often off campus—AA or perhaps online…https://www.smartrecovery.org/community/)

Brief Intervention Model: FRAMES*

- **F**eedback of personal risk
- **R**esponsibility (of the patient to change)
- **A**dvice to change (without judging)
- **M**enu of change options (choices)
- **E**mpathy ("it's tough")
- **S**elf-efficacy (optimism -"you can do it")

***Miller & Sanchez, 1993**

World Health Organization manual for Brief Intervention

http://apps.who.int/iris/bitstream/handle/10665/67210/WHO_MSD_MSB_01.6b.pdf;jsessionid=43A6AF05FABF9940991CC06B5B71BB12?sequence=1

Substance Abuse 1135

Sample Careplan: Alcohol or Substance Abuse Disorder

Quick reference how to deal with an intoxicated patient

Dealing with an intoxicated resident is a very risky situation for staff. Here are some pointers;

- First, assess the situation and make sure you know what you are dealing with.
  - Do they appear intoxicated from alcohol or illegal drugs? Signs of intoxication: smell of alcohol, poor coordination, slurred speech, nausea vominting, flished face, seizures.
  - Are substances visible, e.g., can of beer in wheelchair?
  - Could they have a medical condition that makes them look intoxicated?
  - Ask them:
    - Did they use alcohol or drugs?
    - How much.
    - When they last used.

      Note: they may or may not be truthful, but still ask and watch them.
- If the person is intoxicated with alcohol or drugs, get help.
  - Make sure there are always two staff when interacting with the intoxicated resident. Intoxicated people are often unpredictable and may become violent without provocation
- An intoxicated person may not recall accurately, e.g., they fall and “remember” that you pushed them (again, always two staff).
- Try to ensure the patient's safety.
  - Move the person to a safer environment (their room) and remove all harmful objects (anything they can hurt themselves or others with). Reove power chair!
- Continually assess for signs of injury:
  - Head trauma or other injuries. Abrasions, bruises.
  - Low or high blood glucose
- Watch and expect behaviors: confrontational, argumentative, irrational, uncooperative, belligerent, sleepy and emotionaly unstable.
- Monitor for possible
- Alcohol poisoning
  - Full effect of drug or alcohol may take time. It may get worse before better
  - Wake them up atintervals (every 20minutes)
  - Putthem on side with pillow behindthem in case of vomiting
  - **When to call an ambulance (911) : if they are physciall abusive, if they cannot wake up, if they have seizures, if vitals become unstable (low temp, irregular breathing)**
- Have medications reviewed in light of possible interactions before giving them to a potentially intoxicated person (for instance ask pharmacy to review and discontinue all medications that potentially interact with alcohol)

Sample Careplan: Alcohol or Substance Abuse Disorder

CALTCM Quick reference: searching a room in a way that maintains dignity

We always want to preserve the rights of residents when searching a room.

1. Keep your eyes out. Everyone should look for and report contraband.
2. Reward those who tell you about it (instead of blaming them for letting it be there).
3. When you find it one place, see who else is having it too.
4. Make sure rules are being enforced fairly.
5. Only search if there is a reason. (for example: contraband was seen on routine cleaning, a family or friend stated it was there, the resident was seen with it
6. Document why the item is contraband in terms of specific danger to self or others. For example, hairdryer can be a harmful item for the patient given their poor sensation of temperature and coordination and may be accessed by others and cause harm.
7. Go in pairs. Recommend the administration goes as the "rule enforcer"
8. Make sure the resident is notified that a room search will be happening. Do not sneak in when they are perfectly available. *(exception—on bed hold and you think there is something dangerous, then justify why you went in without permission or if the item is very dangerous like a knife or gun and you cannot wait).
9. Ask the resident to be present.
10. Don't make their regular staff be the bad guy because you want to preserve that relationship.
11. Ask first: "can I search your room because…?"
12. Offer choice. "You can give it to me or I will use my master key to open the locked drawer. This will happen either now or in 15 minutes, which do you prefer?" It can be us or you can choose Barbara or Chovy?"
13. Once you notify them you are going to search, you must keep them under observation and away from the area where you think you have contraband until you search. Some residents believe if they are not there, you can't search. Make clear that if they leave, the search will still happen.
14. Don't take photos of the resident, room or items without permission and document consent.
15. If contraband is found make sure the resident knows this is unacceptable. You have to confiscate it. You can offer a chance for family to come get it (limit time) but it must be secured and away from resident who no longer can control it.
16. Be polite and friendly and not angry. Refrain from negative comments during a room search (could be reported as verbal abuse).
17. Have good policies that address both contraband and searches – this will support consistency and dignity.

Restricted Items (Contraband) 315

Hot Topics:
On the Front Lines, Clinical Updates

CALTCM

2019

New Approaches to Delirium

Jay S. Luxenberg, MD

CALTCM

2019

Disclosure Statement

- Dr. Jay Luxenberg, MD has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- More precisely recognize risk for and presence of delirium
- Create environment of care that minimizes its development and severity
- Apply the latest evidence on the value of medications in managing delirium

What Has Changed?

- My last CALTCM talk on delirium was 2015
- Since then I have published **Antipsychotics for treatment of delirium in hospitalised non-ICU patients** *Lisa Burry, Sangeeta Mehta, Marc M Perreault, Jay S Luxenberg, Najma Siddiqi, Brian Hutton, Dean A Fergusson, Chaim Bell, Louise Rose* Cochrane Database of Systematic Reviews 2018

What's New?

- Preventing delirium
- Recognizing/diagnosing delirium
- Treating delirium

Challenge

- Almost all studies are from hospital setting, often post-surgical or ICU
- Extrapolating to SNF, assisted living or home and community settings is a leap of faith

What We Do Know

- Many studies show comprehensive delirium programs improve outcomes
- Example - nursing-driven hospital-wide delirium program targeting improvements in risk identification, prevention, detection, and treatment. Over the course of the program, delirium falls decreased from 0.91 to 0.50 per patient day (*P* = .0002). A decrease in overall falls was also noted (*P* = .0007).

Ferguson A et al. Effectiveness of a Multifaceted Delirium Screening, Prevention, and Treatment Initiative on the Rate of Delirium Falls in the Acute Care Setting. J Nurs Care Qual. 2018 Jul;33(3):213–20.

Screening for Delirium

- Multiple brief screening tools with high sensitivity and specificity, such as the 3-Minute Diagnostic Assessment; 4 A's Test; and proxy-based measures such as the Family Confusion Assessment Method.

Non-pharmacologic Preventions

- Approaches focused on risk factors such as immobility, functional decline, visual or hearing impairment, dehydration, and sleep deprivation are effective for delirium prevention

Non-pharmacologic Preventions

- The Hospital Elder Life Program (HELP), designed in 1999 by S.K. Inouye, is a comprehensive protocol for hospitalized elderly patients and has been implemented successfully in more than 200 hospitals worldwide

Specific At-Risk Populations

- Some interventions target specific at-risk populations, such as new stroke patients:
- Delirium Prevention Guidelines for Elderly Stroke Patients (DPGESP) comprises nine dimensions with 28 interventions, including risk factor assessment, orientation disorder prevention, sleeping pattern maintenance, sensory interventions, constipation, dehydration, hypoxia and infection prevention, pain management, and appropriate nutrition maintenance.

Specific At-Risk Populations

- The Delirium Prevention Guidelines for Elderly Stroke Patients (DPGESP) successfully reduced incidence of post-stroke delirium

Song J, Lee M, Jung D. The Effects of Delirium Prevention Guidelines on Elderly Stroke Patients. Clin Nurs Res. 4 ed. 2018 Nov;27(8):967–83.

Specific At-Risk Populations

- New hip fracture patients:
- Although several multicomponent interventions have demonstrably reduced delirium incidence, the same interventions fail to treat delirium once established

Oberai, T., Laver, K., Crotty, M., Killington, M., & Jaarsma, R. (2018). Effectiveness of multicomponent interventions on incidence of delirium in hospitalized older patients with hip fracture: a systematic review. *International Psychogeriatrics*, *30*(4), 481–492.

Eliminating High-Risk Meds

- High-risk medications, especially those with strong anticholinergic effects, are a potentially modifiable risk factor
- Multicomponent interventions can successfully reduce high-risk medications

Multicomponent Interventions Reduce High-Risk Medications for Delirium in Hospitalized Older Adults

Mobolaji Adeola et al. Journal of the American Geriatrics Society (2018) 66(8), 1638–1645

Sample Formulary Changes

Table 1. Examples of Implemented Order Set Changes for Individuals Aged 70 and Older

Medication	Implemented Changes
Zolpidem	Single-dose maximum 5 mg Ramelteon included as alternative for insomnia Preselection removed from as-needed orders
Diphenhydramine	Indication for insomnia removed Single-dose maximum 25 mg (12.5 mg doses added as alternative) Cetirizine included as alternative for itching Preselection removed from as-needed orders
Methocarbamol	Single-dose maximum 500 mg in neurosurgery order sets Default 24-hour duration in orthopedic postoperative order sets Included warning message: "muscle relaxants should be minimized"
Cyclobenzaprine	Single-dose maximum 5 mg in neurosurgery order sets
Lorazepam	Lower doses to ≤0.5 mg in all order sets
Diazepam	Lower doses to 2.5 mg in neurosurgery order sets
Meperidine	Remove for pain indication from all order sets

Multicomponent Interventions Reduce High-Risk Medications for Delirium in Hospitalized Older Adults
Mobolaji Adeola et al. Journal of the American Geriatrics Society 2018

Compliance

- Unfortunately, even though screening and multicomponent interventions have demonstrated value in reducing delirium, implementation and compliance with best practices is less than ideal

Turchet C, et al. Detecting Delirium in Hospitalized Elderly Patients: A Review of Practice Compliance. Journal of Pharmacy Technology. SAGE Publications Inc; 2018 Feb 26;34(3):91–8.

Sleep and Delirium

- Chicken and egg question about sleep disturbances and delirium
- Having disturbed sleep at baseline is a risk factor for delirium development
  - **A Systematic Review and Meta-Analysis Examining the Impact of Sleep Disturbance on Postoperative Delirium** *Ayótúndé B. Fadayomi et al.* Critical Care Medicine *46*(12), e1204–e1212 (2018)
- There are recent advances in understanding arousal system, sleep

Alpha-2 Agonists

- Evidence that alpha-2 agonists such as dexmedetomidine may prevent delirium compared to use of propofol or benzodiazepines with surgery or in ICU
- Evidence that dexmedetomidine prophylaxes against delirium when used perioperatively

Dexmedetomidine Prophylaxis

- Randomized, placebo-controlled, 2-hospital blinded study of low dose, non-titrated dexmedetomidine in 700 elective surgical patients >65 years old admitted to an intensive care unit in the immediate postoperative period
- Dexmedetomidine 0.1 mcg/kg/hr (a very low dose, well below that used for sedation in most patients) from the time of ICU admission to 8 am on the first postoperative day was associated with a reduction in the incidence of postoperative delirium of >50% (from 23% to 9%, P<0.0001)

Su X, et al. Dexmedetomidine for prevention of delirium in elderly patients after non-cardiac surgery: a randomised, double-blind, placebo-controlled trial. Lancet. 2016 Oct 15;388(10054):1893–902.

Dexmedetomidine Prophylaxis

- Now multiple metanalyses – conclusion is that dexmedetomidine can reduce post-operative delirium incidence for adult cardiac and non-cardiac surgical patients.

Duan X, et al. Efficacy of perioperative dexmedetomidine on postoperative delirium: systematic review and meta-analysis with trial sequential analysis of randomised controlled trials. Br J Anaesth. 2018 Aug;121(2):384–97.

Dexmedetomidine Prophylaxis

- Caveats – some studies are negative

Li X, et al. Impact of dexmedetomidine on the incidence of delirium in elderly patients after cardiac surgery: A randomized controlled trial. Dal Pizzol F, editor. PLoS ONE. 2017;12(2):e0170757.

- Dexmedetomidine use is recommended only in highly monitored settings because of its potential side-effects on the respiratory and circulatory systems e.g. hypotension, bradycardia and sinus arrest

Orexin Antagonists

- Evidence that orexin antagonists such as suvorexant may prevent delirium in ICU
  - **Ability of suvorexant to prevent delirium in patients in the intensive care unit: a randomized controlled trial** *Kazunari Azuma et al.* Acute Medicine & Surgery 2018 Oct;5(4):362–8
- Compared to usual treatment, suvorexant may reduce incidence of delirium
  - **Preventive Effects of Suvorexant on Delirium** *Kotaro Hatta et al.* The Journal of Clinical Psychiatry 2017 78(8):e970–9.

Orexin Antagonists

- It is premature to consider suvorexant appropriate prophylaxis for delirium
- If pharmacologic insomnia treatment indicated then perhaps suvorexant would be better choice than alternatives of benzodiazepines, zolpidem, etc.

Ramelteon or Melatonin

- No real data on melatonin
- One 2014 RCT indicated value of ramelteon as prophylaxis

Hatta K, Kishi Y, Wada K, et al. Preventive Effects of Ramelteon on Delirium: A Randomized Placebo-Controlled Trial. JAMA Psychiatry. 2014;71(4):397–403.

- Current data is inadequate - melatonin receptor agonists for delirium prevention can not be recommended at this time

Walker, C. K., & Gales, M. A. (2017). Melatonin Receptor Agonists for Delirium Prevention. *Annals of Pharmacotherapy*, *51*(1), 72–78.

What Doesn't Work

- Intraoperative ketamine

Intraoperative ketamine administration to prevent delirium or postoperative cognitive dysfunction: A systematic review and meta-analysis *F. Hovaguimian et al.* Acta Anaesthesiologica Scandinavica 2018

- Perioperative gabapentin

Perioperative Gabapentin Does Not Reduce Postoperative Delirium in Older Surgical Patients *Jacqueline M Leung et al* Anesthesiology. 127(4):633–644, 2017

- Antipsychotics

Antipsychotic Medication for Prevention and Treatment of Delirium in Hospitalized Adults: A Systematic Review and Meta-Analysis *Neufeld KJ et al* J Am Geriatr Soc. 2016 Apr;64(4):705-14

Antipsychotics for treatment of delirium in hospitalised non-ICU patients. *Burry L, Mehta S, Perreault MM, Luxenberg JS, Siddiqi N, Hutton B, Fergusson DA, Bell C, Rose L* Cochrane Database Syst Rev. John Wiley & Sons, Ltd; 2018 Jun 18;6(1):CD005594

Effect of Haloperidol on Survival Among Critically Ill Adults With a High Risk of Delirium: The REDUCE Randomized Clinical Trial. *van den Boogaard M, et al.* JAMA. 2018 Feb 20;319(7):680–90.

Summary

- We have effective methods of screening for delirium, and effective multi-modal interventions for decreasing incidence of delirium, at least in hospital setting
- Dexmedetomidine prophylaxis may have value, and preliminary evidence suggests it may have value in treating agitated delirium
- "Traditional" use of antipsychotics for treatment is not supported by data

Managing Parkinson's in the SNF

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PADRECC Director

CALTCM

2019

Disclosure Statement

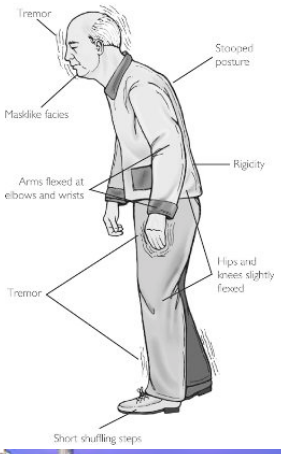
- Dr. Indu Subramanian, MD has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Updates in Parkinson's medications.
- Strategies for monitoring and treating side effects of PD drugs.
- Managing the psychological and cognitive manifestations of PD.
- The IDT and managing the motor manifestations - Environmental safety, nutrition and physical therapy for PD LTC residents.

Parkinsonism

- Parkinsonism is a clinical syndrome characterized by:
  - **T**remor at rest
  - **R**igidity
  - **A**kinesia/bradykinesia
  - **P**ostural instability
- "TRAP"



Geriatric Population

- More likely other systemic disease, malnutrition, polypharmacy, decreased tolerability of drugs
- Also increased comorbidity of other neurological disease: Alzheimer's, Strokes, NPH, subdural hematomas

Diagnosing PD in Elderly

- Clinical diagnosis of 2/3 of bradykinesia, rigidity and tremor
- Impairment of postural reflexes should be used only adjunctively
- Therapeutic response to Levodopa trial also very helpful

PD May Be Over and Under Diagnosed in the Elderly

- Overdiagnosis (due to overlap with normal aging) may lead to unnecessary therapy with resultant side effects/$$
- Underdiagnosis may lead to avoidable disability and poor quality of life
- Surveys indicate that 40-50% of patients in the community and 25% in institutions may be undiagnosed

Pathophysiology of PD

- Loss of Dopaminergic cells within the Substantia Nigra pars compacta (SNpc)
- Lewy bodies - Comprised of α-synuclein protein aggregates
- Pathology also found in other areas of the brain and the peripheral nervous system

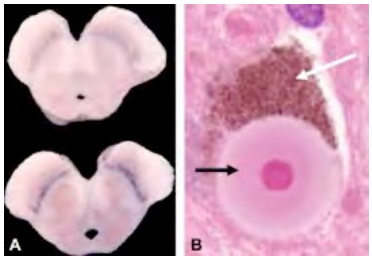
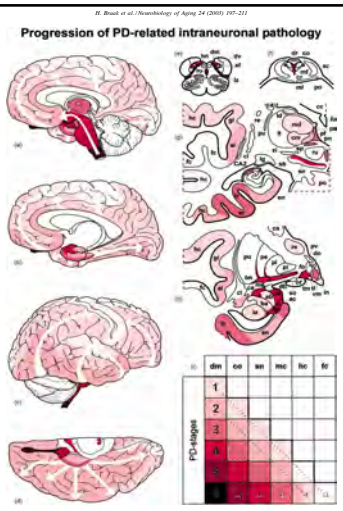


Image courtesy of www.medscape.org



Braak et al. Neurobiol Aging 2003

Non-Motor Symptoms of PD

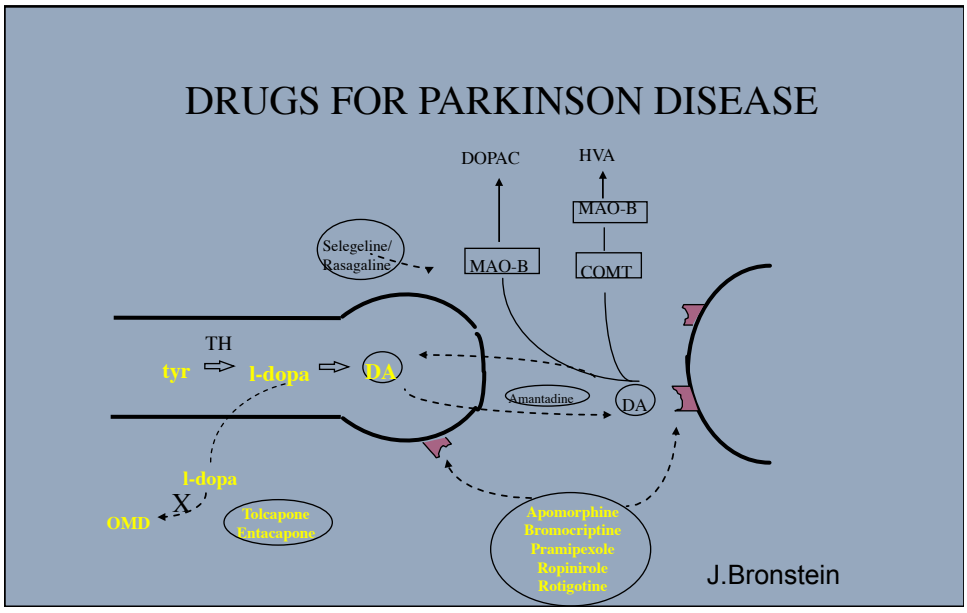
- **Sleep** - REM sleep behavior disorder, fragmented sleep, altered sleep/wake cycle, daytime fatigue
- **Autonomic** - Orthostatic hypotension, bladder problems, constipation, erectile dysfunction, seborrhea, sweating, sialorrhea
- **Psych** - Depression, anxiety, apathy, inability to make decisions
- **Cognitive** - Bradyphrenia, "tip of the tongue" phenomenon, dementia (later)
- **Sensory/Pain** - Shoulder pain, paresthesias

Differential Diagnosis of Parkinsonism

- **Idiopathic Parkinson's Disease**
- Parkinson Plus syndromes/Atypical Parkinsonism
  - Dementia with Lewy Bodies
  - Multiple System Atrophy
  - Progressive Supranuclear Palsy
  - Corticobasal Syndrome
- Secondary causes of parkinsonism
  - Drug-induced
  - Vascular
  - Normal pressure hydrocephalus

Secondary Parkinsonism

- Medication-induced
  - Dopamine blockers: neuroleptics, metoclopramide
- Vascular parkinsonism
  - Characterized by lower>upper extremity involvement
- Normal Pressure Hydrocephalus
  - Triad of gait changes (magnetic gait), incontinence, dementia
- Toxins
  - MPTP, CO, manganese
- Trauma (dementia pugilistica)



Parkinson's Disease Treatment

- Non-pharmacologic treatment
  - Exercise/mind-body approaches like yoga/mindfullnes
  - Nutrition – fiber, hydration
  - Education and Support
- Pharmacologic treatment is symptomatic
- Needs to be individualized. Considerations:
  - Age
  - Symptoms and Severity
  - Comorbidities
  - Cost

Levodopa

- Most effective treatment for PD
- Short half-life - Must be taken at least 3 times/day
- Protein interferes with absorption (amino acid transporter)
- Side effects: nausea, orthostatic hypotension, and hallucinations
- Long-term risk of dyskinesias and motor fluctuations, especially in younger patients
- **First choice for older or more advanced patients**

Sinemet Regular

- Should be given at least TID
- Peripheral side effects include nausea, vomit, orthostatic hypotension
- These can be reduced by increasing amount of carbidopa
- Central side effects include somnolence, later dyskinesias, hallucinations
- Start 25/100 tid and titrate to symptoms, 75-150 of carbidopa total/day
- Be mindful of protein interaction on tube fed patients (run tube feeds at night away from sinemet or will not get absorbed)

Sinemet CR

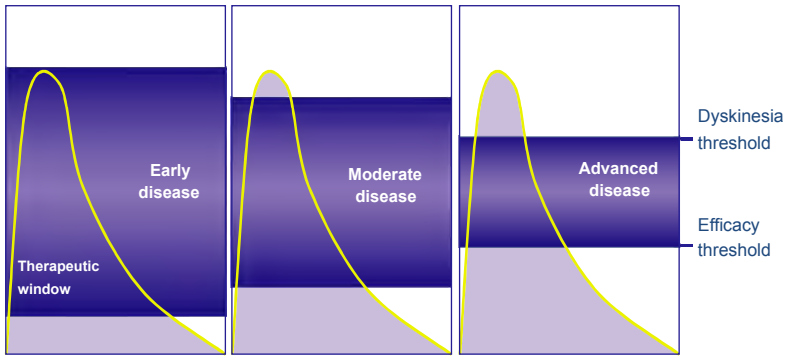
- Usually given at bedtime for wearing off over night
- Has 70-80% bio-availability of Reg sinemet
- Goal is to avoid pulsatile administration
- Lacks the “kick” of Sinemet R (quick onset)
- Can clog up G-tubes so better to switch to IR sinemet

Initial Therapy: The Elderly Patient

- Shorter treatment horizon
- Lower risk of long-term complications
- Higher likelihood of other medical problems

- Levodopa: well tolerated, effective
- Use other medications cautiously due to side effects (cognitive and other)
- Avoid sedating medications

Late PD Changes

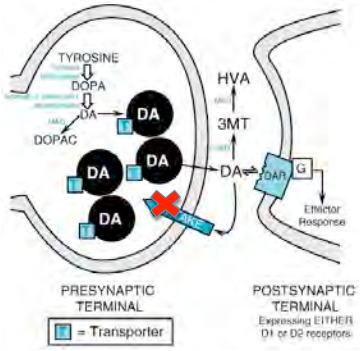


Management of Motor Fluctuations

- Goal is to decrease fluctuations of levodopa levels
- Reduce levodopa dose/increase dose frequency
- Add MAO-B or COMT inhibitor for wearing off
- Add amantadine for dyskinesias (be careful in elderly)
- Newer levodopa formulations
- Surgical: DBS

COMT Inhibitors

- Entacapone, Tolcapone
- Add to levodopa to help with wearing off
- Side effects: diarrhea and nausea. Turns urine orange (not dangerous)
- Tolcapone can rarely cause fulminant hepatic failure



A. Keener 2016

Entacapone (COMTAN)

- COMTAN (200 mg tablet) is given with each administration of carbidopa/levodopa, up to 8 times daily
- Also in combined formulation with C/L called Stalevo (in 50, 75,100, 125,150, 200 strengths)- stalevo now available in generic

Non-Motor PD Symptoms

- **Psychiatric**
  - Dementia
  - Hallucinations
  - Delirium
  - Mood Disturbance
    - Depression
    - Agitation
    - Anxiety and Panic Attacks
- **Autonomic**
  - Orthostatic Hypotension
  - Constipation
  - Urinary problems
  - Sexual problems
  - Sweating and Thermoregulation
- **Sleep Disorders**
  - Insomnia
  - Sleep Fragmentation
  - Parasomnias
  - Restless Legs Syndrome
  - PLMS
  - Excessive daytime sleepiness
  - Sleep attacks
- **Sensory**
  - Pain
  - Paresthesias
  - Altered sensation
  - Restless legs

Hallucinations, Psychosis

- Management: Antipsychotics:
  - Quetiapine- low dose at night largely
  - Clozapine (agranulocytosis:frequent blood monitoring)
  - Avoid typical antipsychotics (haloperidol, risperidone).
  - **New agent Pimavanserin for PD Psychosis – 5 HT2A inverse agonist; Does not block dopamine receptor**

  Cholinesterase Inhibitors:
  - donepezil (po) and rivastigmine (patch) some anecdotal evidence to support; do not worsen PD except tremor
  - PD med down-titration may be necessary

Falls

- Multifactorial:
  - Postural instability
  - Freezing
  - Orthostatic hypotension
- Management:
  - PT eval for fall prevention training
  - Home safety eval
  - **U-step walker** is a great walker for PD patients
  - Has a laser light for freezing, basket and seat

Orthostatic Hypotension

- Nonpharmacologic-management (preferred)
  - Compression stockings or abdominal band
  - Hydration, dietary salt intake
  - Avoidance of rapid postural changes
- Medications (only for those refractory to non-pharmacologic management):
  - Alpha adrenergic agonists (midodrine)
  - Volume expanders (florinef)
  - Norepinephrine prodrug (Droxidopa)
  - **Patients with PD are also prone to supine hypertension, and must be monitored closely if they are being treated with the above medications**
- Adjustments to dopaminergic medication

PD Treatments: Others

- Amantadine: mild symptomatic benefit early in disease, primarily used as adjunct to decrease Levodopa-induced dyskinesias
  - Side effects: anticholinergic, also can cause confusion and hallucinations, livedo reticularis
- Surgical: Deep Brain Stimulation

Novel Agents

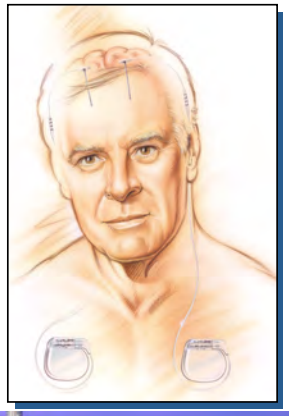
- Impax formulation- Rytary- has microbeads with coating of levodopa formulation that is combination of long and short acting sinemets-improves wearing off in fluctuating patients, decrease dose frequency
- Duopa- liquid sinemet gel formulation that is administered through pump continuously into duodenum; may be good for advanced PD patients with motor fluctuations that have cognitive problems
- Inbrija- new inhaled levodopa (lacks carbidopa) – for reduction of off episodes

DBS for PD

- Targets: STN & GPi – equally effective for motor symptoms
  - STN – able to decrease medication dose
  - GPi – fewer neuropsychiatric side effects
- ViM thalamus – only treats tremor
- Does not alter disease progression
- Risks: stroke/hemorrhage, infection, stimulation-related side effects
- Can exacerbate mood and cognitive issues

The "Ideal" PD Candidate for DBS

- Age: 40-70
- Symptomatic for 5-10 years or more
- Initial Good Response to L-DOPA
- Marked motor fluctuations
  - Severe dyskinesia
  - Minimal "on-time without dyskinesias"
    - Frequent cycles (q3h or less)
  - Substantial disability during "off-periods"
    - Freezing/Gait Disturbance
- Cognitively Intact/Realistic expectations
- Adequate Social support
  - Access to programming of stimulators



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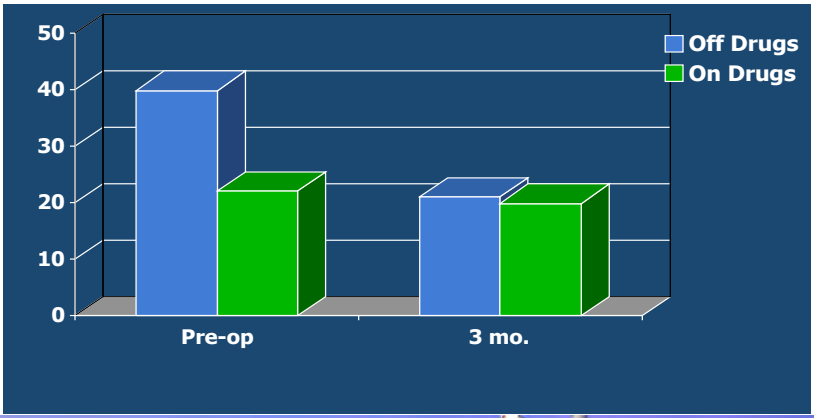
M.Taglaiti 2019

STN DBS Effects on PD Motor Function



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Quality improvement in neurology: Parkinson disease update quality measurement set
Executive summary

Neurology 86 June 14, 2016

Table 1 2015 Parkinson disease measurement set update

Measure title	Measure description
Annual Parkinson's Disease Diagnosis Review[a]	Percentage of all patients with a diagnosis of PD who had their diagnosis reviewed in the past 12 months. (Reviewed is defined as an evaluation of the UK Parkinson's Disease Society Brain Bank Clinical Diagnostic Criteria available at http://www.ncbi.nlm.nih.gov/projects/gap/cgi-bin/GetPdf.cgi?id=phd000042.)
Avoidance of Dopamine-Blocking Medications in Patients with Parkinson's Disease	Percentage of patients with PD provided a contraindicated dopamine-blocking agent (i.e., antipsychotic, antinausea, anti-gastroesophageal reflux disease).
Psychiatric Symptoms Assessment for Patients with Parkinson's Disease[a]	Percentage of all patients with a diagnosis of PD who were assessed for psychiatric symptoms in the past 12 months. (Assessed can be a verbal discussion. Psychiatric symptoms defined as psychosis [i.e., hallucinations and delusions], depression, anxiety disorder, apathy, and impulse control disorder [i.e., gambling, hypersexual activity, binge eating, increased spending].)
Cognitive Impairment or Dysfunction Assessment for Patients with Parkinson's Disease[a]	Percentage of all patients with a diagnosis of PD who were assessed for cognitive impairment or dysfunction in the past 12 months. (Assessed is defined as use of a screening tool [see specifications for recommended tools] or referral to neuropsychologist for testing.)
Querying about Symptoms of Autonomic Dysfunction for Patients with Parkinson's Disease[a]	Percentage of all patients with a diagnosis of PD (or caregivers, as appropriate) who were queried about symptoms of autonomic dysfunction in the past 12 months. (Autonomic dysfunction is defined as orthostatic hypotension or intolerance, constipation, urinary urgency, incontinence, nocturia, fecal incontinence, urinary retention requiring catheterization, delayed gastric emptying, dysphagia, drooling, hyperhidrosis, or sexual dysfunction.)
Querying About Sleep Disturbances for Patients with Parkinson's Disease[a]	Patients with a diagnosis of PD (or caregivers, as appropriate) who were queried about sleep disturbances in the past 12 months. (Sleep disturbances are defined as excessive daytime sleepiness, insomnia/fragmentation [including nocturnal motor features], dream enactment/REM sleep behavior symptoms, restless leg syndrome, or sleep disorder breathing [obstructive sleep apnea].)
Falls Outcome for Patients with Parkinson's Disease	Number of falls that occurred in the preceding 6 months for patients with PD.
Parkinson's Disease Rehabilitative Therapy Options[a]	All patients with a diagnosis of PD (or caregivers, as appropriate) who had rehabilitative therapy options (i.e., physical, occupational, and speech therapy) discussed in the past 12 months.
Counseling Patients with Parkinson's Disease About Regular Exercise Regimen	Percentage of patients with PD counseled on importance of and provided recommendations on regular exercise regimen in the past 12 months. (Regular exercise regimen is defined as at least 150 minutes of moderate-intensity activity each week per the Department of Health and Human Services.)
Querying about Parkinson's Disease Medication-Related Motor Complications[a]	All visits for patients with a diagnosis of PD where patients (or caregivers, as appropriate) were queried about dopaminergic medication-related motor complications (i.e., wearing off, dyskinesia, dystonia, on-off phenomena, and amount of off time).
Advanced Care Planning for Patients with Parkinson's Disease	Patients with advanced PD who have an advance care directive completed or have a designated power of attorney for medical decisions in the last 12 months.

Parkinson's Disease: Prognosis

Major predictors of death within 12 months

- Weight loss
- Dementia
- Worsening dysphagia and hospitalizations for aspiration events
- Increasing postural instability and falls
- Psychosis
- Decrease of dopaminergic medications due to psychotic side effects

End-of-Life Care

- Dopaminergic therapy should be continued as long as the patient is still taking po medications.
  - In fact, dose requirements often increase at the end-of-life due to reduced GI absorption.
- When cessation of dopaminergic medications is deemed necessary, these should be tapered.
  - Abrupt discontinuation can cause NMS or Dopamine Agonist Withdrawal Syndrome.
  - Taper schedules should be made in consultation with a neurologist when possible.
- Certain medications which are commonly used in the hospice setting have anti-dopaminergic properties and should be avoided.
  - Ex: haloperidol, metoclopramide, and prochlorperazine.
  - Reasonable alternatives include quetiapine for agitation and ondansetron for nausea.

Expert Guidance on Common Infections in LTC Environment

Thomas Yoshikawa, MD

CALTCM

2019

Disclosure Statement

- Dr. Thomas Yoshikawa, MD has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Develop a general approach to suspected infections.
- Identify, diagnose and treat Pneumonia.
- Recognize UTIs that warrant antibiotics.
- Apply knowledge to reduce risk of developing Clostridium Difficile infections and appropriately manage infection based on severity of illness.

Infections in Older Adults in LTCFs (2)

General Approach to Suspected Infections/Sepsis:
Clinical Clues & Screen


courtesy of justdial.com

- Rapid change in functional and/or cognitive status
- Unexpected worsening of underlying morbidities:
  - e.g., heart failure, COPD, diabetes, renal function
- Take BP, Pulse, Temperature, Respiratory Status
  - Pulse: >100 beats/min; BP: <100 systolic
  - Temp: >100 (older patients may be hypothermic)
  - Respiration (% O2 Saturation): 100 minus 10 or more
- Procalcitonin: Unclear of usefulness in DX of bacterial infection in this population

Infections in Older Adults in LTCFs (3)

Bacterial Pneumonia

- Leading cause of morbidity and mortality
- Affects 1.5 to 2.5% of LTCF residents
- Major challenge in diagnosis/therapy:
  - ➢ Underlying morbidities confounds clinical presentation
  - ➢ High incidence viral infection
  - ➢ Specific pathogen data unavailable
  - ➢ Multi-drug resistant organisms to consider
  - ➢ Hospitalize or treat in LTCF


courtesy of unicon

Infections in Older Adults in LTCFs (4)

Bacterial Pneumonia

- Most common clinical presentation include (descending order of frequency)
  - Dyspnea/tachypnea; mental status change; fever; chest rales
    - Need <u>at least 2 (two) of the above</u> to Dx LCTF-acquired pneumonia
  - **Aspiration pneumonia:** dysphagia, choking incident, tube feeding, neurological disease and cognitive impairment
- **Diagnostic approach:** Pulse oximetry (low O2 saturation from baseline); chest x-ray (but may be positive in only 20%; negative does not r/o pneumonia.

courtesy of VisualPharm

courtesy of Alamy

Infections in Older Adults in LTCFs (5)

Bacterial Pneumonia

- **Consider hospitalization in residents with:** respiratory compromise; cardiovascular instability; worsening of pre-existing comorbidities; poor oral intake or inadequate nutrition
- **Mild to Moderate symptoms:** amoxicillin-clavulanic acid (especially for <u>aspiration pneumonia</u>), cefpodoxime, doxycycline, or levofloxacin
  - *Treat for 5-7 days for most cases*
- **Severe case or failure to improve with initial therapy:** Ceftriaxone and azithromycin; or ertapenem; or levofloxacin (if not used already)
  - Add vancomycin, linezolid or doxycycline of MRSA
  - Treat for 10 days or more depending on response

Infections in Older Adults in LTCFs (6)

Urinary Tract Infection

- **Most common bacterial infection in this population:** 35-50% are asymptomatic and do NOT require therapy; up to 75% of UTI in LTCF residents do not meet criteria for UTI
- **Indications for treatment without bladder catheters:**
- Positive urinalysis (later positive culture) and:
  - Acute dysuric syndrome or
  - Fever above baseline plus urgency, frequency, suprapubic pain, gross hematuria, costovertebral tenderness, or urinary incontinence

courtesy of CannAmm

- **Residents with long-term urinary catheters** will ALWAYS have a positive culture. Change catheter before obtaining urine for culture to obtain accurate microbiology

Infections in Older Adults in LTCFs (7)

Urinary Tract Infection

- Residents with **long-term catheters** should be treated if they are symptomatic with genitourinary symptoms, fever, or sepsis.
- As with pneumonia patients, **hospitalization for UTI therapy** should be based on similar criteria, i.e.. sepsis syndrome; cardiovascular instability; worsening of pre-existing comorbidities; poor oral intake or inadequate nutrition.
- **Antibiotics for UTI** include nitrofurantoin (for cystitis only), trimethoprim-sulfamethoxazole, ampicillin, or cephalexin. For more severe cases extended-spectrum cephalosporins, fluoroquinolones, or aminoglycosides, and with multi-drug resistant organisms (MDRO), susceptibility studies will be essential to guide therapy. Empirical therapy for MDRO include aminoglycosides, carbapenems

courtesy of Luigi Pelligrini

Infections in Older Adults in LTCFs (8)

Urinary Tract Infection

- **Prevention:**
  - Cranberry juice or tablets are not effective
  - Reduce usage of indwelling bladder catheters
  - Evaluate for structural / anatomic abnormalities of urinary tract

courtesy of Expatica

courtesy of Alamy

Infections in Older Adults in LTCFs (9)

Clostridium Difficile Infection (CDI)

- **Risk Factors for CDI (The 4 "A's")**
  - Age (over 75% CDI occur in persons 65 and older)
  - Admission to health institution (2-5% normal but 20-40% hospital patients colonized with *C. difficile*; most severe disease in LTCF residents)
  - Antibodies to toxin being low (older persons with low antibodies)
  - Antibiotics (changes microflora dynamics and allow *C. difficile* to multiply)
- **Antibiotics with greatest risk for CDI:** Clindamycin, cephalosporins, ampicillin/amoxicillin, fluoroquinolones (high-risk for drug-resistant CDI).
- **CDI caused by 2 exotoxins (A&B).** Ingestion of spores leads to vegetative form (live bacteria) in colon and release of toxin.

Infections in Older Adults in LTCFs (10)

Clostridium Difficile Infection (CDI)

- **Diagnostic Criteria:**
  - Antibiotic therapy within 90 days
  - 3 or more unformed stools within 24 hr with a positive test for toxigenic C. difficile or demonstration pseudomembranous colitis
- **Severity:** 3 loose stools plus:
  - Mild: no to mild abdominal pain
  - Moderate: moderate abdominal pain or tenderness; nausea; volume depletion; mild to moderate leukocytosis
  - Severe: severe abdominal pain; vomiting; ileus; severe volume depletion; leukocytosis; low albumin
  - Severe complicated: hypotensive; respiratory distress; toxic megacolon; Ileus; peritonitis

courtesy of Boston Magazine

Infections in Older Adults in LTCFs (11)

Clostridium Difficile Infection (CDI)

- **Treatment:**
  - Mild disease: Vancomycin 125 mg orally 4 times/day for 10-14 days (Metronidazole 500 mg orally 3 times/day for 10-14 days is being less recommended).
  - Moderate disease: Hospitalize. Replenish with fluids; check renal status; Vancomycin as in mild disease plus/ minus metronidazole
  - Severe disease: Hospitalize. IV fluids; insert nasogastric tube for vancomycin 500 mg 4 times/day (or use rectal enema) plus/minus IV metronidazole.
  - Severe complicated disease: Add antibiotics for intraabdominal sepsis; may require subtotal colectomy.

courtesy of Canary Medical Key

Infections in Older Adults in LTCFs (12)

Clostridium Difficile Infection (CDI)

Recurrent disease:

- No time for detailed discussion.
- There are several different antibiotic regimens proposed as well as prescribing of probiotics. Use of fecal microbiota transplantation has been shown to be extremely effective in prevention (in some studies up to 90%).

courtesy of Blogs@Baruch

Medically Illicit Drugs Being Used Therapeutically in the Elderly

Janice Hoffman-Simen, Pharm.D., Ed.D., APh, BCGP, FASCP

CALTCM

2019

Disclosure Statement

- Dr. Janice Hoffman-Simen, Pharm.D., Ed.D., Aph, BCGP, FASCP has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Describe the mechanism of action for each illicit agent
- Develop an understanding how an illicit agent is therapeutic in a specific psychiatric conditions such as depression, anxiety and PTSD
- Identify the risk and benefits for each illicit agent used therapeutically in the elderly

Medically Illicit Drugs

- Ketamine(Special K) – NMDA receptor antagonist
- Methylenedioxymethamphetamine(MDMA)
- Lysergic Acid Diethylamide(LSD) – serotonin full/partial agonist
- Psilocybin(Shrooms)-serotonin full/partial agonist

Why Medically Illicit?

- The Controlled Substance Act of 1970 categorized as Schedule I (highly abused without medical benefit)
- During 1960's these agents were abused by the youth
- Believed > 30 million people have used ("experimented") LSD, psilocybin, or mescaline (Krebs & Johansen, 2013).
- LSD was first discovered by Hoffmann in the 1940 -
  - tryptamine moiety within LSD was also quickly seen to be the scaffold for the chemical structure of serotonin (Nichols, 2016)

Nichols, D.E., 2016. Psychedelics. Pharmacol. Rev. 68 (2), 264–355. Tittarelli, R., Mannocchi, G., Pantano, F., Romolo, F.S., 2015. Recreational use, analysis and toxicity of tryptamines. Curr. Neuropharmacol. 13 (1), 26–46.

Background Psychedelics

- Classic “serotonergic hallucinogens” =Psychedelic
  - Does NOT include Ketamine or MDMA
- “Psychedelics”
  - Name coined by Humphrey Osmond in 1957,
  - Mind-manifesting capability, beneficial properties of the mind (Osmond,1957).
  - Exert effects as an agonist (or partial agonist) on brain serotonin 5-hydroxytryptamine (5-HT_{2A}) receptors

Nichols, D.E., 2016. Psychedelics. Pharmacol. Rev. 68 (2), 264–355. Tittarelli, R., Mannocchi, G., Pantano, F., Romolo, F.S., 2015. Recreational use, analysis and toxicity of tryptamines. Curr. Neuropharmacol. 13 (1), 26–46.

General ADRs - High-Dose (Psychedelics)

- Vascular problems related to 5-HT_{2A} receptor-
  - vascular smooth muscle contraction
  - Platelet aggregation
  - thrombus formation
  - coronary artery spasms (Nagatomo et al., 2004)
  - Constrict portal venous system, including esophageal collaterals in cirrhosis (Nichols, 2016)
  - Spinal 5-HT_{2A} receptors contribute to sympathetically induced cutaneous vasoconstriction regulated by raphe & parapyramidal neurons in brainstem (Ootsuka et al., 2004).

General ADRs - High-Dose (Psychedelics)

- Acute vasoconstriction caused by serotonin is shared by activation of 5-HT_{1B} & 5-HT_{2A} receptors
  - in intracranial arteries, only the 5-HT_{1B} receptor mediates constriction (Kaumann & Levy, 2006).
  - Both 5-HT_{1B} & 5-HT_{2A} receptors → coronary artery spasm (Nichols, 2016).
  - 5-HT_{1B} mediates contraction of vascular smooth muscle [1]
  - 5-HT_{2A}mediate contractions of normal arteries to serotonin[2]

[1]De Vries P,Villalon CM,Saxena PR Pharmacological aspects of experimental headache models in relation to acute antimigraine therapy. *Eur J Pharmacol*.1999;375:61-74.
[2]Nelson, P. M., Harrod, J. S., and Lamping, K. G. (2012). 5HT(2A) and 5HT(2B) receptors contribute to serotonin-induced vascular dysfunction in diabetes. Exp. Diabetes Res. 2012:398406. doi: 10.1155/2012/398406

Visual ADR Explained with LSD

- 5-HT2A receptor activation by LSD induces
  - dreamlike imagery, imagery which is related to primary process thinking, emotion activation, and alterations in the sense of self and body
  - correlating with LSD-induced loss of self-boundaries
  - Loss of cognitive control.
- Neurophysiological overlap between psychedelic states/dreaming (Kraehenmann, 2017)
- Primary process thinking is the prevalent cognitive mode in dreams (Rapaport, 1950; Holt, 1956; Auld et al., 1968; Shevrin, 1996; Sloman and Steinberg, 1996; Brakel et al., 2000),
- (Maquet et al., 1996; Braun, 1997; Solms, 2000; Lebedev et al., 2015) found both psychedelics and rapid-eye movement dreams
  - Activate temporal lobe regions, leading to visual imagery and changes in the sense of self and body.

Kraehenmann R, Pokorny D, Aicher H, Preller KH, Pokorny T, Bosch OG, Seifritz E, Vollenweider FX.
LSD Increases Primary Process Thinking via Serotonin 2A Receptor Activation.Front Pharmacol. 2017 Nov 8;8:814. doi: 10.3389/fphar.2017.00814. eCollection 2017. PMID: 29167644

News Report CNBC

- https://www.cnbc.com/2017/09/14/how-a-party-drug-could-become-the-next-big-antidepression-treatment.html

Ketamine

Ketamine

(Street names : Bump, cat killer, cat valium, fort dodge, green, honey oil, jet, K, ket, kit kat, psychedelic heroin, purple, special "K", special la coke, super acid, super C and vitamin K)

- First developed in 1962 as a rapid acting general anesthesia (used in Vietnam War for sedation for bullet wound repair)
- PK: Ketamine is a lipid-soluble drug
  - rapidly crosses the blood-brain barrier, exerting it effects on the CNS within 5 minutes after injection.
  - Ketamine has a relatively short half-life of 1-3h, so its subjective effects cease quickly after administration stops (Clements et al., 1982)

Ketamine

- MOA: Ketamine binds to NMDA-receptors, blocking their reuptake of the excitatory neurotransmitter glutamate.
- Ketamine blocks nicotinic acetylcholine ion channels (Lydic and Baghdoyan, 2002; Scheller et al., 1996),
  - increases dopaminergic and noradrenergic neuromodulation
  - acts as a weak agonist of delta & mu opioid receptors (Cai et al., 1997; Kubota et al., 1999; Wang et al., 2012).
- First placebo-controlled study investigating ketamine as antidepressant (Berman et al. 2000).
- Treating major depressive disorder (MDD) & bipolar disorders → rapid action; taking < 48 hours to have beneficial effects similar to seen after 2 weeks using current antidepressant medications (Berman et al. 2000; Murrough et al. 2012; Price et al. 2009; aan het Rot et al. 2009)

Ketamine (con't)

- Another study included 37 admitted to hospital with diagnosis of MDD and/or PTSD , follow-up = 3 years; used a dose 0.5mg/kg SL titrated up by 20-50% per treatment – treatments done at facility twice weekly
- MOA: Glutamate burst activates a set of glutamate receptors (AMPA), which are thought to strengthen synapses in the limbic system and frontal cortex-areas involved in motivation, memory, and mood and which, in depressed people, are underactive.
- Results
  - Age range 21 to 84 years; a median age of 46 (28 female: 9 male)
  - Following treatment, inpatient hospital days were reduced by 70%, and hospital admissions were reduced by 65%.
  - The dose of ketamine patients required was stable over time with no evidence of tolerance building.
  - There were no serious adverse events ;no long-term negative effects (Hartberg, Garrett-Walcott, & De Gioannis, 2018)

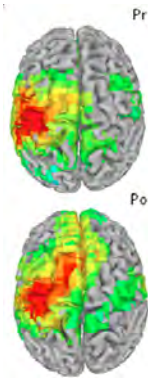
Ketamine (con't)

- A prospective study of patients given ketamine for sedation who had failed previous sedation attempts.
  - Patients with **severe acute behavioral disturbance** requiring parenteral sedation
- Results:
  - 49 patients from 2 hospitals were administered rescue ketamine during 27 month - period;
  - median age was 37years **(range 20-82 years);** 28 were men. Police were involved with 20 patients.
  - Previous sedation included droperidol (10mg; 1), droperidol (10+10 mg; 33), droperidol (10+10+5 mg; 1), droperidol (10+10+10 mg; 11), and combinations of droperidol and benzodiazepines (2) and midazolam alone (1).
  - The median dose of ketamine was 300 mg (range 50 to 500mg). Five patients (10%; 95% confidence interval 4% to 23%) were not sedated within 120 minutes or required additional sedation within 1 hour. Four of 5 patients received 200 mg or less.
  - **Median time to sedation post ketamine was 20 minutes (interquartile range 10 to 30 minutes; 2 to 500 minutes).**
  - Three patients (6%) had adverse effects, 2 had vomiting, and a third had a transient oxygen desaturation to 90% after ketamine that responded to oxygen. (Isbister, Calver, Downes, & Page, 2016)

Neuro-Imaging

Pre Ketamine

Post Ketamine



- Increased dorsal anterior cingulate cortex activity
  - Reward processing and decision making
- Decreased anhedonia behavior
  - Anhedonia: Loss of pleasure from enjoyable activities

Ketamine for Depression Elderly

https://www.youtube.com/watch?v=bCxGwMdZJf8

Esketamine (Spravato) CIII for Treatment Resistant Depression

- Administered via Nasal Spray in adults only
- **Available only through restricted REMs program; given at a certified center – monitor for at least 2 hours after dose; no driving or activity**
- BBW – abuse/misuse, dissociation, increased BP and suicidal ideations
- MOA- S-isomer →NMDA receptor noncompetitive antagonist → increased glutamate
- Adjunctive therapy with oral antidepressant
- 5 Phase III trials with > 1,700 adult patients → superior improvement at 4 weeks with long-term 51% less relapse
  - 12% over 65 years of age 2% over 75 years no overall differences observed on the MADRS
  - Higher C max and AUC in geriatrics
- ADRs- dissociation, cognitive impairment, spinning sensation, reduced sense of touch, feeling drunk, increased BP, anxiety, sedation, N/V

(drugbank.ca; Spravatohcp.com pakage insert)

MDMA- Methylenedioxymethamphetamine

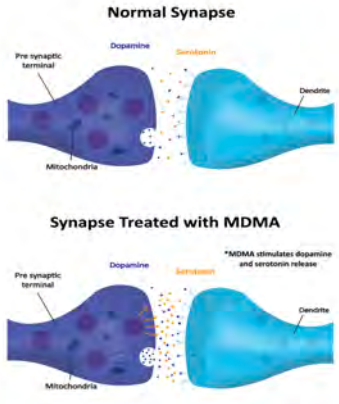
MDMA-Methylenedioxymethamphetamine

(Street Names: Adam, bean, blue kisses, clarity, club drug, disco biscuits, E, ecstasy, hug drug, love drug, lover's speed, Mercedes, Molly, New Yorkers, peace, roll, white dove, X and XTC)

- Background
  - Recreationally used in nightclubs and Raves
  - Synthesized in 1912 (not naturally occurring) for the purpose of stopping internal bleeding by Merck in Germany (MDMA, 2018)
  - In 1985 the FDA scheduled MDMA as Schedule 1

MDMA-Methylenedioxymethamphetamine (Ecstasy)

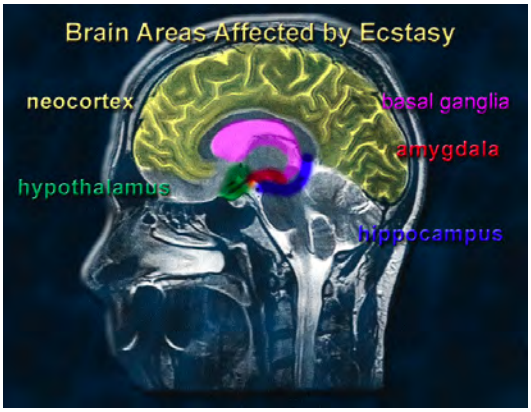
- MOA- promotes release of serotonin, (nor)epinephrine, & dopamine by reversing membrane-bound transporter proteins and inhibiting reuptake in mesolimbocortical circuitry (Feduccia and Duvauchelle, 2008; Nash and Brodkin, 1991)



MDMA-Ecstasy

- Secondary MOA-
  - Stimulates neurohormonal signaling of oxytocin, cortisol, prolactin, and vasopressin (de la Torre et al., 2000; Dumont et al., 2009;Emanuele et al., 2006; Nash Jr et al., 1988).
- PK (Lamers et al., 2003; Tancer and Johanson, 2001; Vollenweider, 1998).
- Onset of action is within 30–45 min of intake
- Peak effects in 90 to 120 min post oral administration
- Near or at pre-drug levels 3 to 6 h later

Ecstasy Effects on the Brain

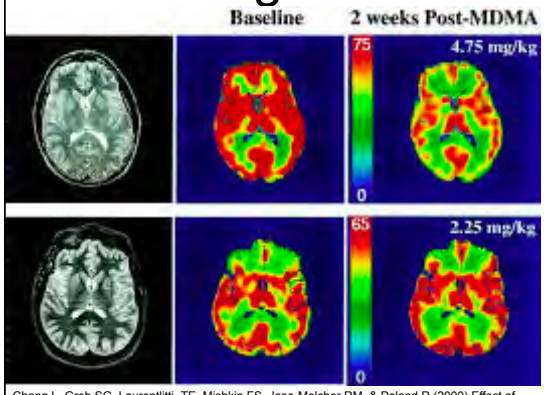


Increase 5HT + NE + DA → Changes in sleep, mood and appetite

Increases love, trust and sexual arousal

At doses of at least 1 mg/kg (or approximately 70 mg) and higher, active doses of MDMA alter mood and cognition and produce slight alterations in perception (Dumont & Verkes, 2006; Liechti et al., 2001).

Brain Images on MDMA - Ecstasy



Chang L, Grob SG, Laurentiitti, TE, Mishkin FS, Jose-Melchor RM, & Poland R (2000) Effect of ecstasy [3,4-methylenedioxymethamphetamine (MDMA)] on cerebral blood flow: a co-registered SPECT and MRI study Psychiatry Research: Neuroimaging Vol98 :1, 28 February; 15-28

The subacute decrease in rCBF after MDMA administration may be due to the direct effect of MDMA on the serotonergic system or the indirect effects of its metabolites on the dopaminergic system these effects may be transient.

Low-dose recreational MDMA use does not cause detectable persistent rCBF changes in humans. The lack of long-term rCBF changes may be due to a non-significant effect of serotonergic deficits on rCBF, or regeneration of serotonergic nerve terminals.

MDMA - Potential ADR

- Hyperthermia- (Henry and Rella, 2001; Liechti et al., 2005).
- Hypothermia -consumed too much water without ingesting required amounts of electrolytes, leading to water intoxication (Milroy, 2011).

MDMA - Potential Uses

- Early studies showed MDMA's capacity to help people talk openly about themselves, their relationships, without defensive conditioning intervening → adjunct to psychotherapy (Greer & Tolbert, 1986; Stolaroff, 2004).
- MDMA has been studied and useful in treating a wide range of conditions, including:
  - Post-traumatic stress & phobias
  - Psychosomatic disorders
  - Depression with/without suicidality
  - Drug addiction
  - Relationship difficulties → Autism
  - Psychological distress of terminal illness

  (Adamson & Metzner, 1988; Downing, 1986; Greer & Tolbert,1986; Grinspoon & Bakalar, 1986; Riedlinger & Riedlinger, 1994, Danforth et al., 2016).

Autism and MDMA

- MDMA has been administered to over 1133 individuals for research purposes without the occurrence of unexpected drug-related SAEs that require expedited reporting per FDA regulations.
- Support autistic adults in increasing social adaptability among the typically developing population
- Functional brain imaging studies with anxiogenic stimuli in autistic individuals suggest that the amygdala may be differentially activated, with greater activation in the anterior cingulate gryus and superior temporal cortex, and less activation in the left amygdala and left orbito-frontal cortex (Ashwin et al., 2007)
- Amygdala may signal in an atypical manner to the fusiform gyrus, a key brain region involved in facial recognition, resulting in differences in social perception between autistic and typically developing (TD) individuals (Hall et al.,2010).
- MDMA catalyzes shifts toward openness and introspection that do not require ongoing administration to achieve lasting benefits

Danforth AL et al. (2016) MDMA-assisted therapy: A new treatment model for social anxiety in autistic adults. Progress in Neuro-Psychopharmacology & Biological Psychiatry 64 237–249

MDMA for PTSD

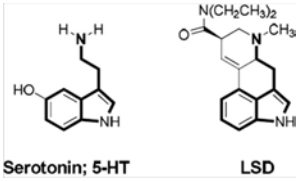
- PTSD patients are prone to extremes of emotional numbing or overwhelming anxiety, and often have a narrow window between thresholds of under and over-arousal (Ogden and Pain, 2006).
- MDMA allows patients to stay emotionally engaged without being overwhelmed by anxiety while revisiting traumatic experiences, it may thereby catalyze effective exposure therapy (Mithoefer 2011).
- Phase II studies looked at MDMA assisted psychotherapy and RCT on post combat veterans from the Iraq and Afghanistan wars
- Other Phase II trials are occurring in Canada, Israel and Australia to replicate (Mithoefer 2011)
- Phase III studies are planned across multiple international sites (UK)
- Another UK study 2016, using MDMA-Assisted Psychotherapy as a treatment for post-detox alcoholics; (addictions often present high levels of pre-morbid trauma),
- Estimated date for FDA approval for MDMA assisted psychotherapy → 2021

LSD (Lysergic acid diethylamide)

LSD (Lysergic acid diethylamide)

Street Names: A, Acid, black star, blotter, boomers, cubes, Elvis, golden dragon, L, microdot, paper acid, pink robots, superman, twenty-five, yellow sunshine and ying yang.

- Background: The presence of the tryptamine moiety within LSD was also quickly seen to be the scaffold for the chemical structure of serotonin (Nichols, 2016)
- MOA: common mechanism of action is primarily at the 5-HT2A receptor (Geyer & Vollenweider, 2008), which appears to be crucial for the specific psycho-vegetative effects, probably by activating a complex signal cascade (Halberstadt, 2015; Vollenweider and Kometer, 2010).



LSD (Lysergic acid diethylamide) For Cluster Headaches

- Any discussion of treatments in cluster headache includes primarily off-label use of approved drugs or unapproved therapies of other types as only sumatriptan is the only FDA approved agent.
- Findings (Schindler et al, 2015) are consistent with earlier evidence that indoleamine hallucinogens are effective agents for the treatment of cluster headache (Matharu et al. 2005 ; Sewell, Halpern, & Pope 2006).
- LSD provided over 70% of those who tried them with at least moderate protection from cluster headache attacks (Schindler et al, 2015) .

LSD for Pain

- in 1964, Kast conducted a comparative efficacy trial of LSD (100 mcg orally) compared to two oral opioids (Dilaudid 2mg or Demerol 100 mg)
  - sample of 50 severely medically ill patients, mostly with terminal cancer, but also those with other medical illnesses (i.e. infectious illnesses, severe burns) (Kast & Collins, 1964).
  - The LSD group had statistically significant reductions in pain compared to the two opioid groups, lasting from 3 h post-dosing to up at 19 h post-dose administration.
  - theorized that LSD's analgesic effects related to its ability to alter pain attention and perception(Kast, 1967).
  - patients in the LSD group appeared to display a decreased fear of death.

Psilocybin/Psilocin

Psilocybin/Psilocin

(Street Names: Boomers, god's flesh, little smoke, magic mushroom, Mexican mushrooms, mushrooms, musk, sherm, shrooms, silly putty and simple simon)

- Background
  - A monoamine/indole alkaloid naturally occurring in psilocybe genus of mushrooms (Mithoefer et al., 2016).
  - Psychedelic prodrug compound produced by more than 200 species of mushrooms (Griffiths et al., 2016)
  - Serotonergic hallucinogens are the oldest recreational drugs dating back to the prehistoric era.
    - The Aztecs used 'god's flesh' (psilocybe mushrooms) in various religious healing ceremonies (Nichols, 2016).

Psilocybin/Psilocin

- MOA - psilocybin-induced effects in humans was found to be 5-HT2A receptor activation.
- Psilocybin increased goal-directed behavior toward positive compared with negative cues, facilitated positive but inhibited negative sequential emotional effects
- Psilocybin shifts the emotional bias across various psychologic domains through activation of 5-HT2A receptors →mood regulation & emotional face recognition

Nichols, D.E., 2016. Psychedelics. Pharmacol. Rev. 68 (2), 264–355. Tittarelli, R., Mannocchi, G., Pantano, F., Romolo, F.S., 2015. Recreational use, analysis and toxicity of tryptamines. Curr. Neuropharmacol. 13 (1), 26–46.

Psilocybin/Psilocin “Shrooms” for Treating Anxiety/Depression in Terminally ill

- Treating anxiety and depression in terminally ill patients → physician Valentina Wasson after participation in a ceremony involving ‘magic mushrooms’ containing psilocybin in 1957 →years later by writer Aldous Huxley (Halifax and Grof, 1977; Reichea et al, 2018).
- Recent study conducted on 29 patients, with life-threatening cancer
  - 60-80% of the patients showed a continuing decline in anxiety and depression 6.5 months after the initial use of psilocybin.

Ross, S. Therapeutic use of classic psychedelics to treat cancer-related psychiatric distress. *International Review of Psychiatry* 2018, 30 (4) 317–330 https://doi.org/10.1080/09540261.2018.1482261

Psilocybin/Psilocin “Shrooms” for Treating Anxiety/Depression in Terminally ill

- RCTs trials were published 2011 to 2016 (n.92), with psilocybin treatment
  - demonstrated that psychedelic-assisted treatment can produce rapid, robust, and sustained improvements in cancer-related psychological and existential distress (i.e. Death anxiety)
  - University of California Los Angeles (UCLA)
    - a small cross-over (at 2-weeks) trial that recruited 12 participants with advanced-stage cancer & DSM-IV diagnosis of adjustment disorder with anxiety, generalized anxiety disorder, acute stress disorder or anxiety disorder due to cancer (Grob et al., 2011).
    - The trial demonstrated feasibility – recruitment & safety → no psilocybin-related serious psychiatric or medical adverse events.
    - No statistical significance but acute trends for reductions in anxiety and depression in the psilocybin-1st group over the niacin-1st group prior to the crossover.

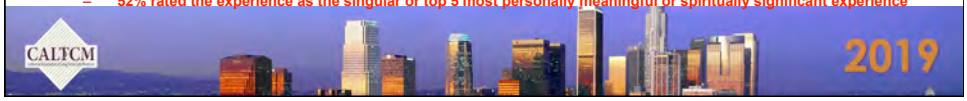
Ross, S. Therapeutic use of classic psychedelics to treat cancer-related psychiatric distress. *International Review of Psychiatry* 2018, 30 (4) 317–330 http ://doi.org/10.1080/09540261.2018.1482261

Psilocybin/Psilocin "Shrooms" for Treating Anxiety/Depression in Terminally ill

- Johns Hopkins University (JHU) (Griffiths et al., 2016)
  - compared single high-dose of psilocybin (0.31 mg/ kg) vs an active control (single low-dose of psilocybin [1 or 3 mg/70 kg]) to treat a combination of cancer-related depression & anxiety.
  - A cross-over design (at 5-weeks post session- 1) with final outcome assessment at 6 months.
  - Fifty-one participants with life-threatening cancers were treated
  - Primary therapeutic outcome variables measuring cancer-related depression & anxiety were clinician-rated GRID-HAM-D-17 and HAM-A respectively
  - Findings
    - There were no significant ADE attributable to psilocybin.
    - High dose psilocybin produced large & sustained (5-weeks post-single dosing) improvements in depression & anxiety symptoms

Psilocybin/Psilocin "Shrooms" for Treating Anxiety/Depression in Terminally ill

- New York University (NYU) Langone Medical Center (Ross et al., 2016)
- compared a single dose of psilocybin (0.3 mg/kg) vs single dose niacin (250 mg), administered in conjunction with psychotherapy.
- A cross-over design (at 7-weeks post dose-1) with final outcome assessment at 6.5 months post dose-2 (i.e. after the cross-over).
- Recruited 29 individuals with life-threatening cancers + Adjustment disorder with anxiety (n.18, 62%); Adjustment disorder with anxiety and depression (n.8, 28%); Generalized Anxiety Disorder (n.3, 10%).
- outcome variables measuring cancer-related anxiety and depression self-rated measures: STAI, HADS, BDI.
- Findings
  - there were no SAEs, either psychiatric or medical, that were attributable to psilocybin, further demonstrating the safety of administering psilocybin
  - 58% of participants in the psilocybin-1st group met criteria for an anxiolytic response (i.e. 50% decrease relative to baseline) using the HADS Anxiety sub-scale (compared to 14%in the niacin first group)
  - 83% of subjects in the psilocybin-1st group (compared to 14% in the niacin- 1st group) met criteria for anti-depressant response
  - Psilocybin produced statistically significant improvements in:
    - cancer-related hopelessness and demoralization
    - quality-of-life
    - spiritual well-being.
  - At the final 6.5 month follow-up, in addition to above - there was an improvement in a measure of attitudes towards death and dying (although there were no acute or longer-term improvements in a death anxiety measure).
  - **70% of participants rated the psilocybin experience as being one of the most significant events of their lives**
  - **52% rated the experience as the singular or top 5 most personally meaningful or spiritually significant experience**



Conclusion

- With the war on drugs during the 1980's research on these drugs was halted for 30 years.
- Recent research (although small numbers) is showing some positive results- giving promise for therapeutic uses of these medically illicit drugs in the treatment of
  - Refractory Depression
  - PTSD
  - Anxiety particularly existential distress
  - Autism

  ***REGARDLESS of AGE – even in the elderly
- The profound effects of these drugs is just beginning to be understood
- Hope for the utilize of these drugs for the **positive** impact of people's lives and quality of life is a potential outcome as more research is completed

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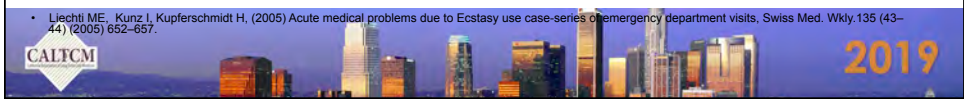

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First Do No Harm, The New Beers List

Vanessa J. Mandal MD, MS, CMD

CALTCM

2019

Disclosure Statement

- Dr. Vanessa Mandal, MD, MS, CMD has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Identify potentially inappropriate medications leading to adverse drug events in frail elderly
- Identify harmful drug-drug interactions

Beers Criteria

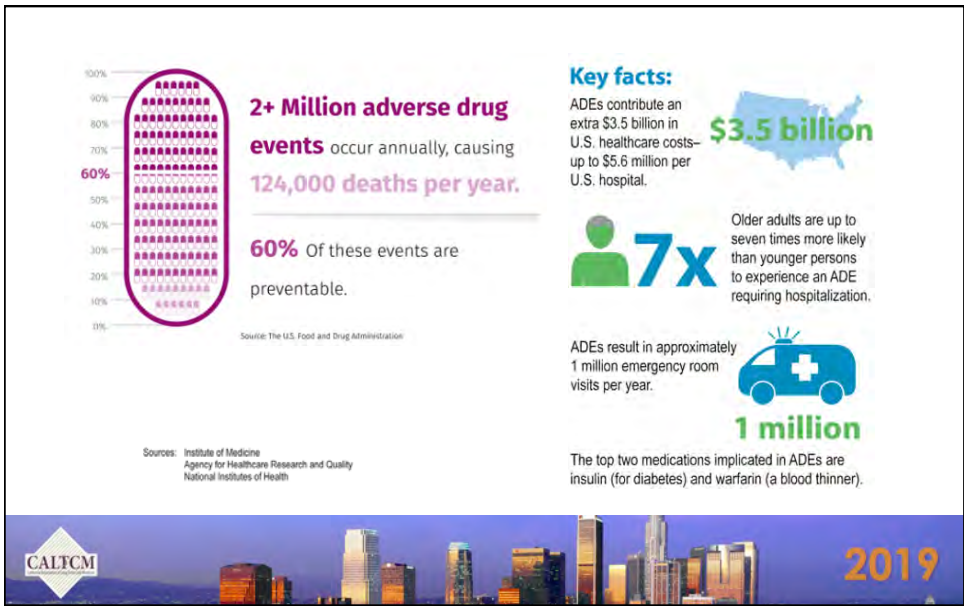
"Explicit list of potentially inappropriate medications (PIMs) best avoided by older adults in most circumstances or under specific situations, diseases or conditions."

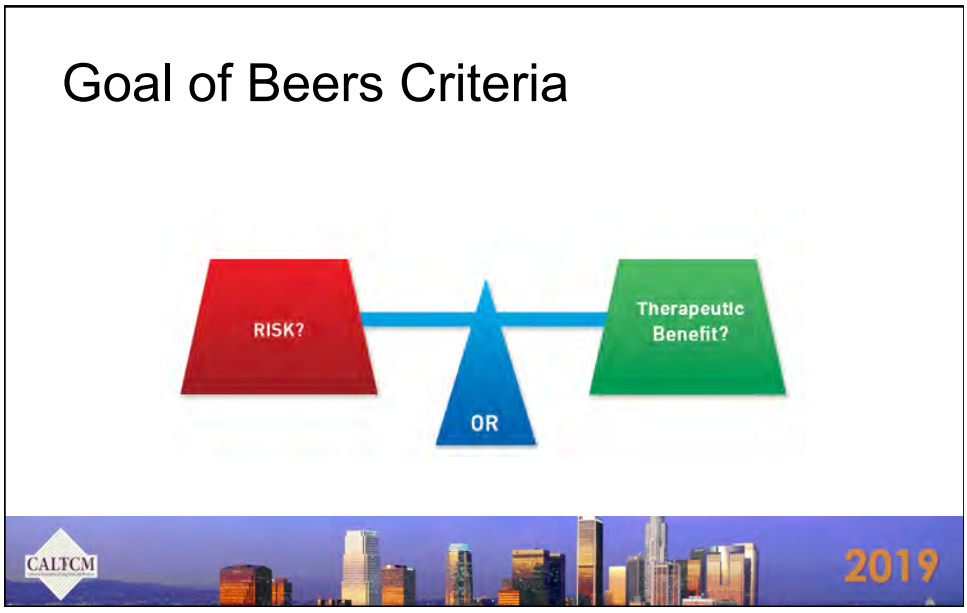
American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults
https://doi.org/10.1111/jgs.15767

Beers Criteria

Educational Tool: Medication Appropriateness

Quality Measure: Adverse Events


100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2+ Million adverse drug events occur annually, causing 124,000 deaths per year.
60% Of these events are preventable.
Source: The U.S. Food and Drug Administration
Sources: Institute of Medicine
Agency for Healthcare Research and Quality
National Institutes of Health
Key facts:
ADEs contribute an extra $3.5 billion in U.S. healthcare costs– up to $5.6 million per U.S. hospital.
$3.5 billion
7x
Older adults are up to seven times more likely than younger persons to experience an ADE requiring hospitalization.
ADEs result in approximately 1 million emergency room visits per year.
1 million
The top two medications implicated in ADEs are insulin (for diabetes) and warfarin (a blood thinner).
CALTCM
2019

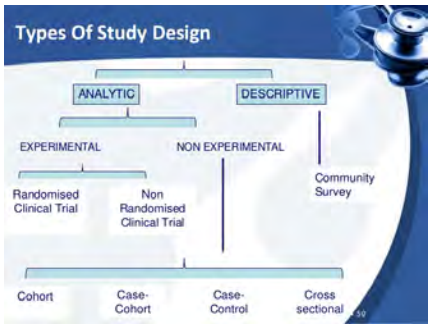

Goal of Beers Criteria
RISK?
OR
Therapeutic Benefit?
CALTCM
2019

Beers Criteria

- Expert panel of 13 clinicians - physicians, nurses and pharmacists.
- 1442 references from which 377 articles abstracted into evidence tables.
- Rationale for each recommendation, quality of supporting evidence and graded strength noted.

Table 1: Quality of Evidence

- High – more than 1 well designed RCT.
- Moderate – RCTs with limitations, well controlled trials without randomization.
- Low- observational studies, risk for bias



Type of Criteria

1. Drugs that are potentially inappropriate in most older adults.
2. Drugs that should typically be avoided in older adults with certain conditions.
3. Drug to be used with caution.
4. Drug-drug interactions.
5. Drug dose adjustment based on renal function.

2019 Beers Criteria

25 medications dropped because

- No longer available in the United States.
- Not limited to older population alone.

Criteria modified or dropped based on changes in quality of evidence.

2019 Beers Criteria

Table 2: 30 individual criteria or medication classes to avoid in older adults.

Tables 3 and 4: 16 criteria specific to more than 40 medications or medication classes that should be used with caution.

Tables 8-10: Clarification in language and rationale.

PIMs in Older Adults

Delirium

- Anticholinergics
- Antipsychotics
- Benzodiazepines
- Z-drugs
- H2-Receptor Antagonists

www.geriatricscareonline.org

10 Tips to Reduce Delirium in Elderly

1. Avoid physical restraints
2. Avoid unnecessary lines (IV, Foley, monitors)
3. Avoid BZDs and anticholinergics
4. Avoid daytime napping
5. Avoid NPO
6. Treat pain adequately
7. Treat AUR and stool impaction
8. Maintain patient's mobility and self-care
9. Provide eyeglasses and hearing aids
10. Involve family to reorient patient

Anticholinergics

- Pyrilamine added
- Diphenhydramine (oral)
- Hydroxyzine
- Meclizine
- Promethazine
- Brompheniramine
- Chlorpheniramine
- Cyprohepatine
- Doxylamine

Adverse side effects

- Associated with the first generation H_1-antihistamines and due to their lack of selectivity for the H_1 receptor and anti-cholinergic activity. Side effects are due to CNS depression:
  - Sedation
  - Dizziness
  - Tinnitus (ringing in the ear)
  - Blurred vision
  - Euphoria
  - Uncoordination
  - Anxiety
  - Insomnia
  - Tremor
  - Nausea/vomiting
  - Dry mouth/dry cough
- Newer second generation H1-antihistamines are more selective for the peripheral histamine receptors and have far less side effects (drowsiness, fatigue, headache, nausea and dry mouth)

Anticholinergics

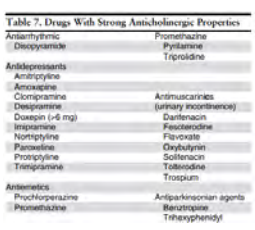
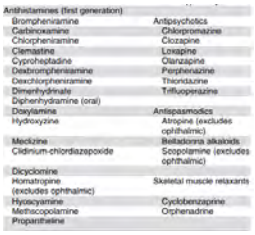


Table 7. Drugs With Strong Anticholinergic Properties

Antiarrhythmic	Promethazine
Disopyramide	Pyrilamine
	Triprolidine
Antidepressants	
Amitriptyline	
Amoxapine	
Clomipramine	Antimuscarinics (urinary incontinence)
Desipramine	Darifenacin
Doxepin (>6 mg)	Fesoterodine
Imipramine	Flavoxate
Nortriptyline	Oxybutynin
Paroxetine	Solifenacin
Protriptyline	Tolterodine
Trimipramine	Trospium
Antiemetics	
Prochlorperazine	Antiparkinsonian agents
Promethazine	Benztropine
	Trihexyphenidyl



Antihistamines (first generation)

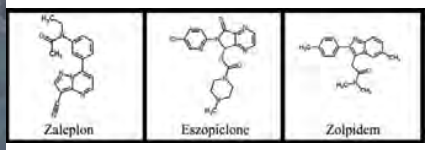
Brompheniramine	Antipsychotics
Carbinoxamine	Chlorpromazine
Chlorpheniramine	Clozapine
Clemastine	Loxapine
Cyproheptadine	Olanzapine
Dexbrompheniramine	Perphenazine
Dexchlorpheniramine	Thioridazine
Dimenhydrinate	Trifluoperazine
Diphenhydramine (oral)	
Doxylamine	Antispasmodics
Hydroxyzine	Atropine (excludes ophthalmic)
Meclizine	Belladonna alkaloids
Clidinium-chlordiazepoxide	Scopolamine (excludes ophthalmic)
Dicyclomine	
Homatropine (excludes ophthalmic)	Skeletal muscle relaxants
Hyoscyamine	Cyclobenzaprine
Methscopolamine	Orphenadrine
Propantheline	

Benzodiazepines

Short Acting
- Alprazolam
- Lorazepam
- Temazepam
- Triazolam

Long Acting
- Clonazepam
- Diazepam
- Chlordiazepoxide

Z Drugs



Benzodiazepines and Z Drugs

Benzodiazepines: Adverse Effects

CNS

- Drowsiness, dizziness, sedation (common, dose related)
- Impaired motor skills (can be insidious because underestimated)
- Impaired concentration and judgment
- Paradoxical effects, i.e. symptoms of CNS stimulation (2-5%)
- Confusional states, anterograde amnesia (with high doses)
- Lethargy, medullary depression (with very high doses)
- Rebound effects (insomnia, restlessness, etc.) after abrupt discontinuation of 2-3 weeks of treatment.
- Increased risk of falls and fractures in the elderly (mainly with long half-life drugs)

(All the above mentioned effects are more common in the elderly)

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5282809

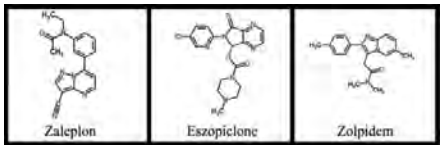
Antipsychotics

- Avoid for behavioral problems of dementia or delirium.

- Non pharmacological approaches:
- www.nursinghometoolkit.com
- www.hospitalelderlifeprogram.org
- https://teepasnow.com/

Dementia, Cognitive Impairment

1. Anticholinergics
2. Antipsychotics
3. Benzodiazepines
4. Z-drugs



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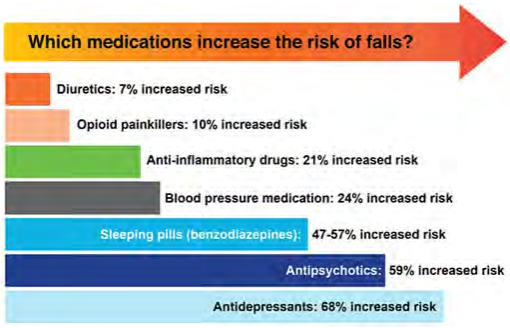
FALLS



Antidepressants

- Amitripyline
- Nortriptyline
- Desipramine
- Doxepin
- Imipramine
- Paroxetine

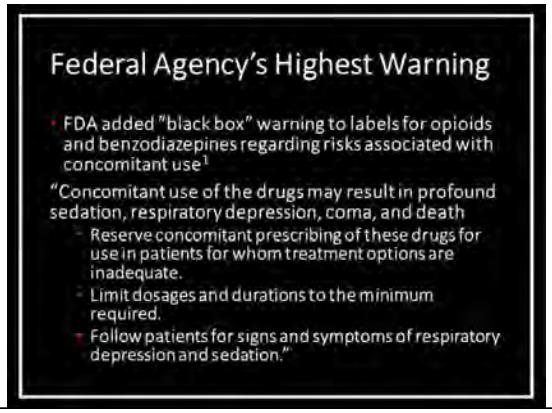
Common side effects associated with tricyclic antidepressants

	Sedation	Anti-cholinergic effects	Hypo-tension	Cardiac effects	Seizures	Weight gain
Amitriptyline	+++	+++	+++	+++	++	++
Clomipramine	++	+++	++	+++	+++	+
Desipramine	0/+	+	+	++	+	+
Nortriptyline	+	+	+	++	+	+

0/+=minimal; +=mild; ++=moderate; +++=moderately severe.
From Goodman and Gilman's, *The Pharmacological Basis of Therapeutics*, 9th edition.

Opioids

- Avoid use of opioids concurrently with benzodiazepines and gabapentinoids



Cardiovascular: Alpha Blockers

Peripheral alpha blockers

Avoid use for HTN

- Doxazosin
- Prazosin
- Terazosin

Alpha- adrenergic antagonists:
Adverse effects:

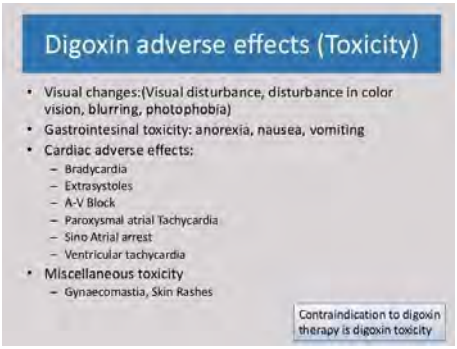
- orthostatic hypotension:
  - blockade of alpha receptors on veins→ reduced venous tone→blood accumulate in veins when patient assumes erect position →reduced return of blood to the heart →reduced cardiac output → decrease BP
  - reduce blood flow to brain →lightheadedness, dizziness

Heart Failure

- Nondihihydropyridines- if reduced EF
- NSAIDs, cyclooxygenase-2 inhibitors
- Thiazolidinedione
- Dronedarone
- Cilostazol- avoid with heart failure of any type.

Cardiac: Digoxin

- Avoid as first line agent in atrial fibrillation
- Avoid as first line for heart failure
- Avoid doses > 0.125mg daily



Cardiac: Digoxin

Table 1

Potential Interactions with Digoxin

Increase Serum Levels

Amiodarone	Propafenone
Benzodiazepines	Propantheline
Bepridil	Quinidine
Cyclosporine	Quinine
Diphenoxylate	Spironolactone
Indomethacin	Tetracyclines
Itraconazole	Verapamil
Macrolides	

Decrease Serum Levels

Oral aminoglycosides	Metoclopramide
Al^{+++}/Mg^{++}-containing antacids	Neomycin
Antineoplastics	Penicillamine
Activated charcoal	Rifampin
Cholestyramine	St. John's wort
Colestipol	Sulfasalazine
Kaolin/pectin	

Enhance Pharmacodynamic Effects

Beta-blockers	Succinylcholine
Calcium	Sympathomimetics
Verapamil	Diuretics
Diltiazem	

Antagonize Pharmacodynamic Effects

Thyroid hormones

Renal Impairment

- Bactrim- worsening renal function, hyperkalemia
- Ciprofloxacin- CNS effects, tendon rupture
- Dofelitide- QTc prolongation, torsade
- Edoxaban- avoid if creatinine clearance less than 15

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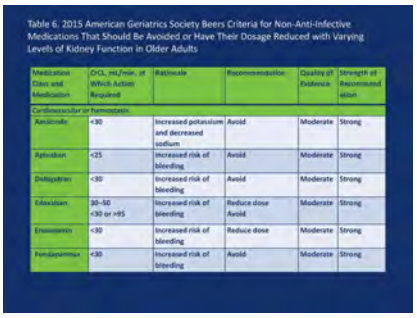
Table 6. 2015 American Geriatrics Society Beers Criteria for Non-Anti-Infective Medications That Should Be Avoided or Have Their Dosage Reduced with Varying Levels of Kidney Function in Older Adults

Medication Class and Medication	CrCl, mL/min, at Which Action Required	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation
Cardiovascular or hemostasis					
Amiodarone	<30	Increased potassium and decreased sodium	Avoid	Moderate	Strong
Apixaban	<25	Increased risk of bleeding	Avoid	Moderate	Strong
Dabigatran	<30	Increased risk of bleeding	Avoid	Moderate	Strong
Edoxaban	30–50 <30 or >95	Increased risk of bleeding	Reduce dose Avoid	Moderate	Strong
Enoxaparin	<30	Increased risk of bleeding	Reduce dose	Moderate	Strong
Fondaparinux	<30	Increased risk of bleeding	Avoid	Moderate	Strong

Hypoglycemia

- Sliding scale insulin alone
- Long acting sulfonylureas
- Glimepiride added


"I'm the Blood Sugar Fairy.
If you can see me, yours is too low."

Hyponatremia

- Diuretics
- Antidepressants-SSRIs, SNRIs, TCAs
- TRAMADOL
- Antipsychotics
- Carbamazepine
- Oxcarbazepine

Bleeding

- Caution ASA for primary prevention of cardiovascular disease and colorectal cancer.
- Dabigatran and Rivaroxaban caution in adults over 75
- Warfarin, increased risk of bleed with Cipro, macrolides, Bactrim, Amiodarone, NSAIDs, ASA

PPIs

TABLE: DRUG–DRUG INTERACTIONS FOR PROTON PUMP INHIBITORS AND ANTACIDS

Medications	Interactions	Mechanism	Solution
Omeprezole Esomeprazole	Clopidogrel	CYP2C19 is inhibited by omeprazole and esomeprazole, which normally convert clopidogrel to its active form, thereby decreasing its blood levels.	Switch to pantoprazole, which does not inhibit CYP2C19.
Omeprezole Esomeprazole	Diazepam Warfarin Citalopram Phenytoin	Omeprazole inhibits elimination, potentially increasing drug levels.	Switch to pantoprazole.
All PPIs	Nelfinavir Rilpivirine	PPIs increase stomach pH, leading to decreased absorption of these medications.	Switch to an H_2 blocker.
All PPIs	Harvoni	PPIs decrease gastric acid, which is needed for Harvoni drug absorption.	Decrease to omeprazole 20 mg daily or equivalent, or switch to an H_2 blocker.
All PPIs	Methotrexate	PPIs inhibit active secretion of medication in renal tubules.	Switch to an H_2 blocker, or monitor for signs and symptoms of methotrexate toxicity.
All PPIs	Digoxin	PPIs can increase blood levels by changing gastric pH, favoring increased absorption of digoxin.	Switch to an H_2 blocker.
Antacids	Fluoroquinolones Tetracyclines	Ions in antacids bind and form insoluble chelate complexes, inhibiting absorption of these medications.	Separate medications and antacids by 4 hours.

Drugs Cautioned With **STRONG** Recommendation

Drug class (example)	Recommendation	Rationale	Quality of evidence	Strength of recommendation
First-generation antihistamines (diphenhydramine)	Avoid	Highly anticholinergic	Moderate	Strong
Antiparkinsonian agents (benztropine)	Avoid	Not recommended for prevention of extrapyramidal symptoms with antipsychotics; more effective agents available for treatment of Parkinson disease	Moderate	Strong
Antispasmodics (hyoscyamine)	Avoid	Highly anticholinergic	Moderate	Strong
Antidepressants (amitriptyline)	Avoid	Highly anticholinergic	High	Strong
Antipsychotics (conventional or atypical)	Avoid except for schizophrenia, bipolar disorder, or short-term use as antiemetic during chemotherapy	Increased risk of stroke and death in persons with dementia	Moderate	Strong
Skeletal muscle relaxants (methocarbamol)	Avoid	Most muscle relaxants are poorly tolerated by older adults	Moderate	Strong
Benzodiazepine (lorazepam)	Avoid	All benzodiazepines increase risk of cognitive impairment, delirium, falls, fractures, and motor vehicle crashes in older adults	Moderate	Strong
Nonbenzodiazepine and benzodiazepine hypnotics (zolpidem)	Avoid	Adverse events similar to those of benzodiazepines in older adults	Moderate	Strong
Proton pump inhibitors	Avoid using for > 8 weeks unless for high-risk patients	Risk of *Clostridium difficile* infection, bone loss, and fractures	High	Strong

Goal of Beers Criteria

Beers Criteria: A Useful Clinical Tool in PDPM World

- Educational tool in clinical rounds, huddles
- Educational tool in medication appropriateness
- Public Health tool to improve medication safety in older adults.
- Increase awareness of polypharmacy and potentially inappropriate medications.

Reducing Hypoglycemic Risk in Diabetes Care

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CCRC, SNF Medical Director and SNF Consultant

2019

Disclosure Statement

- Dr. Timothy Gieseke, MD, CMD has no relevant financial relationship with commercial interests to disclose.

Learning Objectives

- Recognize the subtle presentations of hypoglycemia in seniors
- Set individualized targets for glycemic control
- Minimize care plans that are high risk for hypoglycemia
- Know why and when to add a trial of GLP 1 receptor agonists to the care plan

Diabetes in NHs

- Independent predictor of placement
- In a 2012 study:
  - Prevalence ~32%
  - Cost of care 19.6 billion
- ~ 90% are Type II diabetics (elevated C-peptide), but we do see Type 1s
- Prediabetes confers 2x > risk of CVDz
- Complications of DM ~ triple cost of care

Why Focus on Diabetes?

- Readmission Penalties (adjusted payments) as of January 1, 2019
- The CMS "SNF Readmission Measure (SNF-RM)" has been tracked and reported since Oct 2016 (2% withhold began then)
- SNF-RM is for all-cause SNF Readmissions the first 30 days after discharge from the Acute Hospital.
- Payments are adjusted based on SNF-RM relative to other SNFs.
- Hypo- & Hyperglycemia are major causes for readmissions.

Readmission Rate > in Diabetes

- CMS (data April 2016–March 2017) found persons on diabetic medications had readmission rate:
  - 22.75% vs. 18.8% for all persons.
- Serious hypoglycemia was a common cause for these readmissions

Case of Duncan Mills

- 86 y/o long stay resident with old right CVA, Stage 3B CKD, HBP, MCI, and Type II IDDM. His FS BG is ~ 140 before breakfast & ~ 180 before dinner. He receives: Metformin LA 1500 mg daily & NPH 70/30 a.c. bid. Lately, he has been mentally slow in the morning though his FS BG has increased to 160. His CNA notices at 2:00 am that he is moaning and restless.
- If you were his nurse, what would you be thinking?

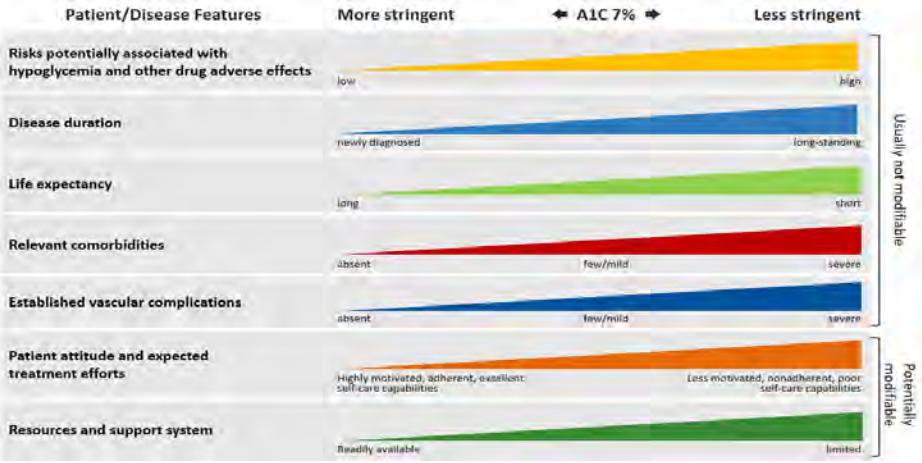
Check FBG = 50 mg/dl

- ***Somogyi effect***—when nocturnal hypoglycemia occurs and isn't recognized, Norepinephrine and Glucagon are released raising glucose levels so hours later, the FBG is 160
- NPH at dinner has peak effect at 2-3 a.m.
- NPH should only be given a.c breakfast or HS(peak effect at bkft)
- NPH has higher-risk for hypoglycemia then other basal insulins

Hypoglycemia in the Elderly is Often Subtle

- May not have robust ***alarm symptoms*** (tremors, anxiety, sweating, hunger, lightheadedness or rapid palpitations)
- **CNS Dysfunction** common
  - Confusion, agitation, fatigue, or reduced LOC
  - Weakness & falls
  - If severe: Seizures, MI, CVA, Brain Injury, or Death
- ***Definition:***
  - Mild if < 70 mg/dl or ***higher*** (if typical symptoms)
  - Severe if:
    - < 55
    - Hypoglycemia requiring bystander resuscitation

Approach to Setting A1C Goal



American Diabetes Association. Standards of Medical Care in Diabetes- 2017. Glycemic Targets. Diabetes Care. 40(S1):S53, 2017.

ADA Glycemic Targets for Older Adults

Patient Characteristics/ Health Status	Rationale	Reasonable A1C Goal	Fasting or Preprandial Glucose	Bedtime Glucose
Healthy (few coexisting chronic illnesses, intact cognitive and functional status)	Longer remaining life expectancy.	<7.5%	90–130 mg/dl	90–150 mg/dl
Complex/ Intermediate (multiple coexisting illnesses or 2+ instrumental ADL[1] impairments or mild-to-moderate cognitive impairment)	Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk.	<8.0%	90–150 mg/dl	100–180 mg/dl
Very complex/ Poor health (LTC[2] or end-stage chronic illnesses or moderate-to-severe cognitive impairment or 2+ ADL dependencies) 1. Activities of daily living (ADL) 2. Long term care (LTC)	Limited remaining life expectancy makes benefit uncertain. *Avoid hyperglycemia to prevent dehydration, electrolyte abnormalities, urinary incontinence, dizziness, falls, hyperglycemic crisis.	<8.5%	100–180 mg/dl	110–200 mg/dl

Standards of Medical Care in Diabetes- 2017. Older Adults. American Diabetes Association. Diabetes Care 40(S1): S101, 2017. *Munshi et al, Diabetes Care. 39:308-18, 2016.

Monitoring Glycemic Control

- ***FBG***
  - Frequency depends on desired control, risk of hypoglycemia, and patient preference
  - Before meals and bedtime until stable
  - 2 or 3 a.m. if identify risk for nocturnal hypoglycemia
  - Values > 400 mg% may not be accurate & could be considerably higher
- ***A1C***
  - Assumes RBC half life of 3 months
  - Falsely low if < 3 mo. RBC half life as in CKD, HCT < 30
  - When A1C does not correlate with FBG measurements, ***rely on FBGs***

1. Post acute/long term care (PA/LTC)
2. Red blood cell count (RBC)
3. Hematocrit (Hct)

Block FBG Testing for Stable DM

- Test 1 time a day (a.c tid + h.s) over the course of a week, to assess control over the whole day. Eg.
  - Monday (Bkft), Tuesday (Lunch), Weds(Dinner), Thurs(h.s.), Friday (Bkft), Sat (Lunch), Sunday (Dinner)
  - May only do this for 1-2 weeks prior to next visit and not test at other times unless becomes unstable.
- FBG testing is expensive and wearing on the fingers and patient

Rule of 15 for Rx Hypoglycemia

- When fasting (FS) glucose is <70 mg/dl, give 15 grams carbohydrate
- Carbohydrate sources (15–20 g) for treating hypoglycemia
  - ½ cup fruit juice or non-diet soda or 3-4 lifesavers
  - 1 cup milk (no fat or low fat works faster)
  - If unable to take PO,[1] give glucose gel or glucagon and call MD
- Wait 15 minutes and recheck FS BG
  - If glucose is still <70 mg/dl, repeat 15 grams carb p.o
  - Wait additional 15 minutes and recheck.
  - If still low, repeat treatment and call MD
- Once FBG returns to normal, the individual should consume a meal or snack to prevent recurrence of hypoglycemia
- Inform physician or NP, so that regimen can be assessed and future low can be prevented

1. PO=by mouth

A Core Curriculum for Diabetes Educators, 3rd Ed, AADE, Chicago, Illinois, 1998
American Diabetes Association. Standards of Medical Care in Diabetes- 2017. Glycemic Targets. Diabetes Care. 40(S1):S53-4, 2017.

ADA & EASD Consensus Report on Rx Type 2 DM

- Diabetes Care October 4, 2018
  - http://care.diabetesjournals.org/content/early/2018/09/27/dci18-0033
- For patients with CVDz or high risk of CVDz, SGL2s or Incretin RAs are next drugs of choice if Metformin inadequate, not tolerated, or contraindicated.
- Incretin RAs are generally recommended as the first injectable medicine
- Updates: Lifestyle, Diabetes Self-management, Medications,Obesity, & Surgical interventions

Glucose Management for Patients With Type 2 Diabetes

HbA1c								
5.7%	PREDIABETES	1	Diabetes education on self-management, lifestyle interventions 3%–5% weight loss 150 min/wk exercise					
6.5%	DIABETES	2	Add metformin					
		3	Add a second antihyperglycemic drug					
			Pio	DPP4	GLP1RA[a]	SGLT2[a]	SU	Basal Insulin[a]
		HbA1c	↓	↓	↓↓	↓	↓	↓↓
		Weight	↑	*No effect*	↓↓	↓	↑	↑
		Hypoglycemia	*No effect*	*No effect*	*No effect*	*No effect*	↑	↑↑
		MACE[1]	*No effect*	*No effect*	↓	↓		
		HF	↑	*No effect to* ↑	*No effect*	↓		
>9.0%		4	Add basal insulin[a] ± prandial insulin[a] or SGLT2[a] or GLP1RA[a]					

a. Indicates a higher-cost drug. 1. Major adverse cardiac event (MACE)

JEB Reusch and JE Manson. Management of Type 2 Diabetes in 2017: Getting to Goal. JAMA. Published online 3/1/17. doi:10.1001/jame.2017.0241

Metformin is First Line Rx

- First line drug therapy as long as renal function is adequate (***ok to use EGFR***)
  - EGFR 30-45 ml/min can use sub-max. dose (500 BID), but avoid new start in this range.
  - **Metformin ER** 1500 mg daily may be safer
  - Don't use if EGFR < 30 ml/min (Lactic Acidosis).
- **B12** deficiency possible with long term use

ADA. Standards of Medical Care in Diabetes- 2019. Pharmacologic Approaches. Diabetes Care. 40(1):S64-74, 2017. Kancherla et al. JAGS. 2017.

SGLT2 Inhibitors (Empaglifolzin, Cana-, Dapa-)

- Block sodium glucose cotransporter in the proximal renal tubule, enhancing excretion of glucose and sodium.
- Must have adequate renal function (eGFR **> 45** ml/min).
- Expect: Weight loss & lower Systolic/diastolic BP
- **Empagliflozin reduced mortality** 32% within 3.1 yrs (CV Mortality 38%, Heart Failure 35% in NEJM Nov 2015).
  - **FDA indication** for reducing **MACE**
- May reduce progression CKD
- **Concerns**: Genital mycotic infections, UTI's, High Cost, Euglycemic DKA, ***PVD Amputations (Canagliflozin)***

Injectable Therapies – Start with GLP-1 RAs

- GLP-1 Receptor Agonists (Liraglutide, Dulaglutide, Bydureon)
  - Act like supra-physiologic levels of ***incretins***:
    - Enhance glucose stimulated insulin secretion and **glucagon suppression**
    - Post-prandial hyperglycemia improved
    - Slows gastric emptying & promotes early satiety @ CNS[1] level

  - ***Potent***, low risk of hypoglycemia, promote weight loss, modest decrease in BP
  - **Liraglutide**: decreased mortality and reduced MACE w/in 3.8 years, but not heart failure (NEJM July 2016)
    - **FDA indication** for reducing MACE
  - Concerns: risk of pancreatitis?, ***GI*** side effects (nausea, vomiting, diarrhea), C-cell hyperplasia and MTC[2] in rodents, ***Cost high***

1. Central nervous system (CNS)
2. Medullary thyroid carcinoma (MTC)

Marso et al. New Engl J Med. . 375:311-22, 2016

Basal Insulin (NPH, Glargine, Levemir, Degludec)

- Activate insulin receptor to enhance postprandial glucose disposal and suppress hepatic glucose production
- Universally effective
- Degludec has lower risk hypoglycemia
- ***Concerns*** (for all insulins): serious hypoglycemia, weight gain, training requirement,
- **High Cost**: Only 3 companies produce insulin analogs
  - Tripled price 2003-2013.
  - Doubled price 2012-2016

Rapid Acting Insulins

- **Highest risk** for inducing serious hypoglycemia
- Regular insulin greater risk then analogs
- Give immediately a.c meals (even regular insulin)
- May give analogs immediately p.c. if eating not predictable
- Minimize bedtime use to reduce risk nocturnal hypoglycemia (eg. SSI a.c. tid – not h.s.)

Why Not Just Use Sliding Scale Insulin?

- Dose is not individualized
- Insulin is reactive, rather than proactive to what will happen
  - Giving insulin to cover when the BG is already high, rather than preventing the hyperglycemia

- Leads to wide fluctuations in glucose levels
  - "**brittle diabetes**" is commonly iatrogenic
- Does not provide basal insulinization (needed by insulin deficient diabetics) nor consider nutritional coverage
- If used w/o basal insulin, Calif. facilities have received ***IJ citation***[1]

1. Immediate jeopardy (IJ)

Leahy J. Endocr Pract 12:86-90, 2006; Queale WS et al. Arch Intern Med 157:545-552, 1997
Clement S et al. Diabetes Care 27:553-91, 2004; American Diabetes Association. Diabetes Care 40(1):Supp, 2017

Some of the Variability of FBG May be Due to Injection Errors

- Diabetes Care in the UK, "FIT UK Forum for Injection Technique UK"
- Free
- http://www.fit4diabetes.com/files/4514/7946/3482/FIT_UK_Recommendations_4th_Edition.pdf
- Only 1 pen/patient
- Wrong angle of injection
- Wrong size needle
- Injection time errors
- Failure to rotate injection sites in predictable pattern to minimize tissue injury
- Wrong injection site
- Injecting into site of lipodystrophy or hypertrophy

Case of Laura C.

- 80-year-old with HBP,[1] chronic atrial fibrillation, diastolic heart failure, overweight, and prediabetes.
- She is hospitalized with acute abdomen due to perforated diverticulitis with SIRS.[2]
- She requires emergency laparotomy, colostomy, ICU[3] level care, antibiotics, SSI insulin in the ICU on the ward.
- She had complicating *C. diff* for which she is now on oral Vancomycin.
- She is starting to eat, but still has FBG in 200–330 range.
- She is transferred to you on SSI Novalog AC TID[4] + HS.
- How would you manage her diabetes?

1. High blood pressure (HBP)
2. Systemic inflammatory response syndrome (SIRS)
3. Intensive care unit (ICU)
4. TID=3x/day

Adjust Orders to Reduce Hypoglycemic Risk

- Medically complex and sick
  - A1C target 8.0–8.5% while so sick
  - FBG 100–180 on AC TID + HS
  - Check 2–3 a.m. FBG 2x/ wk
- Add basal insulin in the **morning** with goal of morning FBG 100–140 range
- Cancel SSI at bedtime
- Add 3 units of RA analog insulin with or after each meal with hold if doesn't eat
- Continue corrective SSI RA analog added to scheduled meal insulin
- Reassess in 2–3 days

Case of Shirley M.

- 50+ year-old women with Type II IDDM with class 3 obesity, severe OSA (BiPAP[1]-dependent HS), and persistent flaccid left hemiparesis after a large CVA.
- Her glycemic control remains poor with FBG in 150–350 range before meals and bedtime despite Lantus 80 units a.m./40 units HS and Novalog 30 units AC TID.
- She attempts to restrict calories, but is commonly hungry.
- What might you do to improve her glycemic control and health?

1. Bilevel positive airway pressure (BIPAP)

Options

- Reduce basal insulin if TDD[1] of insulin > 1 unit/kg/day
  - Reduce Glargine and see if hunger, xs PO intake, and FBG improve
- Add a GLP-1 RA
  - Liraglutide .6 mg SQ x 1 wk, then 1.2 mg SQ x 1 wk, then 1.8 mg SQ thereafter
  - She tolerated this well, lost ~5 kg, took less insulin, and had FBG most of the time in the low 100 range and no documented lows

1. Total daily dose (TDD)

Case of Phil M.

- 60+ year-old with developmental delay, long standing schizophrenia, over-weight, and Type 2 NIDDM for about 10 year managed with Metformin
- Hospitalized for poorly controlled DM with dehydration, glucose 650, and A1C 10.9
- He received IV fluids and insulin, but is transferred to SNF for rehab only on Metformin because DPOA[1] is concerned that he will lose his independent living, if his care is too complex
- What do you do?

1. Durable power of attorney (DPOA)

Many Concerns

- Was he taking his Metformin?
- Was his supervision adequate?—delayed crisis recognition
- **Glucotoxicity**
  - High glucose levels worsen insulin resistance
  - Using insulin to control hyperglycemia, resistance improves reducing need for supplemental insulin
- Lantus 15 units daily initially
- Decided to try Liraglutide because it is once a day with much lower risk of hypoglycemia
- Able to stop Lantus and achieve near normal FBG w/o lows
- TAR[1] for Dulaglutide (SQ weekly)

1. Treatment authorization request (TAR)

Evidence Based Consensus Guidelines for Managing Type 2 DM

- Consensus statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the comprehensive type 2 diabetes management algorithm – 2019 executive summary
- https://journals.aace.com/doi/full/10.4158/CS-2018-0535

Resources for Clinicians

1. ADA 2019 Standards of Care—Abridged Version for PCPs
   http://clinical.diabetesjournals.org/content/diaclin/early/2018/12/16/cd18-0105.full.pdf
2. ADA 2019 Standards of Care—Abridged Version for PCPs
   http://clinical.diabetesjournals.org/content/diaclin/early/2018/12/16/cd18-0105.full.pdf
3. American Association of Clinical Endocrinologists (AACE) 2018 Comprehensive Type 2 Diabetes Management Alorithm—free
   a. https://www.aace.com/publications/algorithm
   b. Evidence based, but more expert opinion
   c. Free slide presentation
4. AMDA, The Society of Post Acute and Long Term Care Medicine
   a. https://paltc.org/. (Resources, Clinical Products, Product type, Clinical Practice Guidelines (CPGs), Diabetes CPG)
   b. Clinical Practice guideline for Diabetes Care in PA/LTC updated 2016
   c. Hard copy and electronic version ($39 for members)

Resources for Clinicians

- HSAG Readmission California Tools and Worksheets
  - https://www.hsag.com/care-coord-ca-tools
- HSAG Readmission California Tools and Worksheets
  - https://www.hsag.com/care-coord-ca-tools
- Yale Monograph Newsletter list serve—Free
  - https://visitor.r20.constantcontact.com/manage/optin?v=001TYH5ba1NOYXtML0xfSflmrUFWVBwFA7-5fPWBSG8c91yDf2baDSH-MYoJ1v1QYH1urG7SAwC3bvNqQUr24vFLE9fCVfr6CyM0dJ7iO-y2bLDauNFwTzPVRZv8R9VpW-xhFVX1d0sS7msbfFnu7UpuRpsPVKebg6s
  - Concise daily 5–6 page review of ADA (June), and European Association for the Study of Diabetes (EASD) (September), annual meetings
  - Quick way to keep up on current clinical developments in diabetes care
- Epocrates Online—commercial for PC, tablets, and smart phones
  - https://online.epocrates.com/
  - Quick and practical resource I use multiple times daily

Hypertension: Comparing JNC 8 and ACC/AHA Guidelines

Vanessa Mandal, MD, MS, CMD
Margherita Aikman, RN, BSN, PharmD, BCPS, BCACP, CACP, CDE

CALTCM

2019

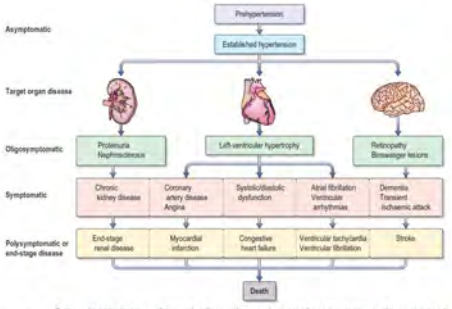
Disclosure Statement

- Dr. Vanessa Mandal, MD, MS, CMD and Dr. Margherita Aikman, RN, BSN, PharmD, BCPS, BCACP, CACP, CDE have no relevant financial relationships with commercial interests to disclose.

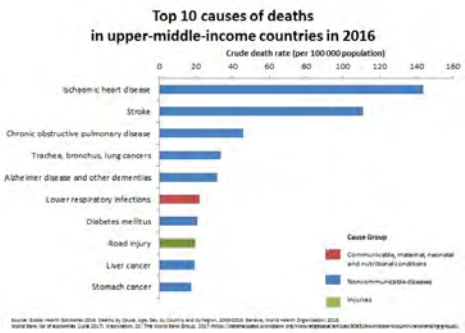
Learning Objectives

- Interpret appropriate medications and Best Practice goals in treating older adults with hypertensive heart disease, stroke and chronic kidney disease.
- Differentiate appropriate goals for blood pressure in patients with cognitive impairment. T SPRINT trial.

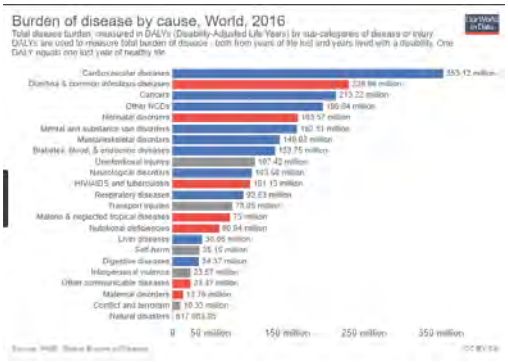
Why Treat: Prevent Target Organ Damage



Range of hypertensive cardiovascular disease from prehypertension to target-organ damage and end-stage disease. From Messerli FH, Williams B, Ritz E. Essential hypertension. *Lancet* 2007; 370: 591–603, with permission from Elsevier.



Cardiac Disease Burden



HTN Causing Cardiac Disease

- Franklin D. Roosevelt (FDR) was referred to Dr. Howard Bruenn, a cardiologist at Bethesda Naval Hospital who, on March 27, 1944 found him cyanotic, breathless, with an enlarged left ventricle and a blood pressure of 186/108. Bruenn diagnosed hypertensive heart disease and wanted to give digitalis, but was prohibited by Dr. Ross McIntire, the president's personal physician and then surgeon-general of the U.S. Navy.

Hypertension

Exponential growth and changes to rival iphone up-grades!

Joe

78 year old male
No significant cardiovascular family history
Forgets to take medications
Medications: Multivitamin daily, Aspirin 81mg daily
Tamsulosin 4mg daily for BPH

Recent Labs:
- LDL 100
- CrL 45 mL/min

Blood Pressure today in office: 138/88

What should we do?

How is Hypertension Diagnosed?

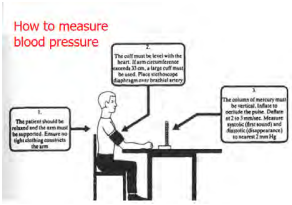
ACC/AHA

Use average of 2 or 3 measurements taken on 2 or 3 separate visits.

Evaluate white coat HTN in adults with untreated SBP >130 mmHg but <160 mmHg or DBP >80 mmHg but <100 mmHg.

JNC 8 Panel

The HOW of taking a blood pressure is not addressed.



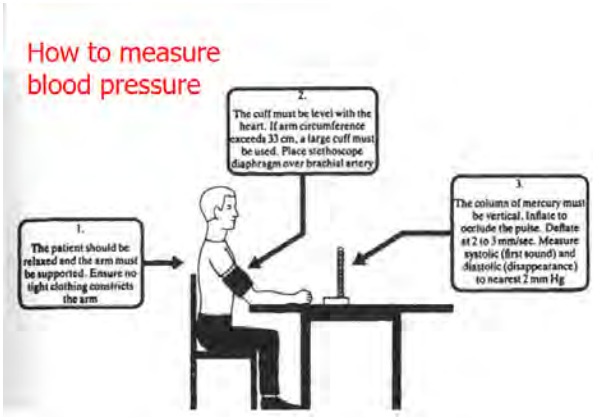
International Society of Hypertension

Blood pressure should be measured after the patient has emptied their bladder and has been seated for five minutes with back supported and legs resting uncrossed on the ground

Arm used for measurement should rest on a table, at heart-level.

Use a sphygmomanometer/stethoscope or automated electronic device (preferred) with the correct size arm cuff.

Are we doing proper blood pressure every time for every patient?



Treating HTN in the Elderly

Recommended BP goals according to JNC 7, JNC 8, and 2017 ACC/AHA guidelines[1,2,6]

Patient group	JNC 7	JNC 8	2017 ACC/AHA
General	<140/90 mm Hg	<140/90 mm Hg	<130/80 mm Hg*
Older patients	<140/90 mm Hg	<150/90 mm Hg[†]	<130 mm Hg[‡]
Diabetes	<130/80 mm Hg	<140/90 mm Hg	<130/80 mm Hg
Chronic kidney disease	<130/80 mm Hg	<140/90 mm Hg	<130/80 mm Hg

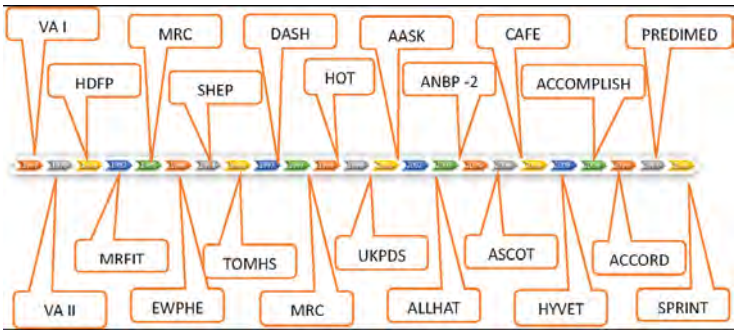
ACC, American College of Cardiology; AHA, American Heart Association; BP, blood pressure; JNC 7, Seventh Report of the Joint National Committee; JNC 8, Eighth Joint National Committee.

*Includes patients with atherosclerotic cardiovascular disease (ASCVD) or an estimated 10-year risk ≥10%, as well as patients needing primary prevention or those with 10-year ASCVD risk <10%.

[†]General population ≥60 years of age. Treatment does not need to be adjusted in patients ≥60 years who may have lower systolic BP (eg, <140 mm Hg) and are not experiencing adverse effects.

[‡]Ambulatory, community-dwelling, noninstitutionalized patients ≥65 years of age. Clinical judgment, patient preference, and a team-based approach to assess benefits and risks are reasonable for patients with a high burden of comorbidity and limited life expectancy.

To See Where We Are We Need to Understand Our Past & Our Path



Joe

78 year old male
No significant cardiovascular family history
Forgets to take medications
Medications: Multivitamin daily, Aspirin 81mg daily
Tamsulosin 4mg daily for BPH

Recent Labs:
- TC 200
- HDL 30
- LDL 100
- CrL 45 mL/min
- A1C 5.8%

Are we doing proper blood pressure every time for every patient?

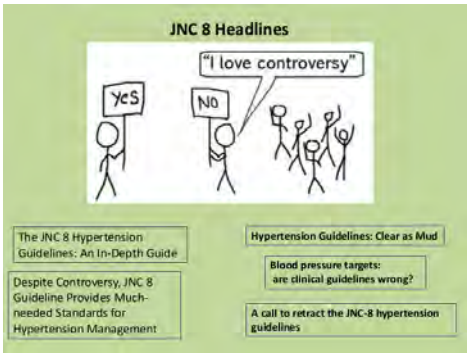
Blood Pressure today in office: 138/89
Proper technique ensured and the second BP and 139/84

What should we do?

Where Are We Now?
Older Adults Benefit Against Potential Harms

Depends on WHO you Ask!
Controversy on WHEN to treat
Good News: more agreement than disagreement

JNC-8 Versus AHA/ACC



American Heart Association

AMERICAN COLLEGE of CARDIOLOGY

JNC-8 Versus ACC/AHA

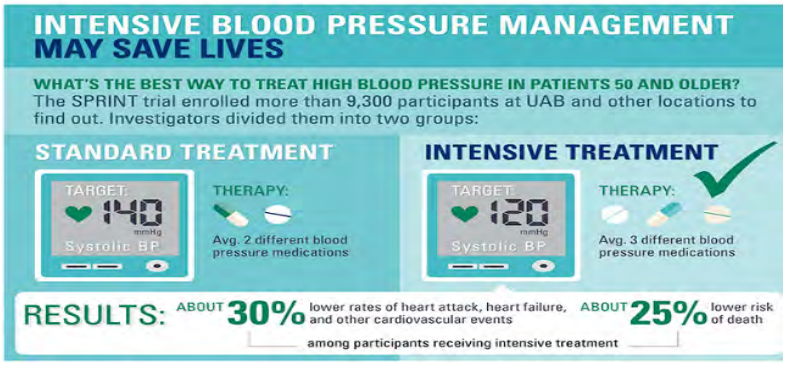
(2014) BP:140/90 or 150/90

Initial systematic review of RCTs from 1996 to 2013, with subsequent review of RCT evidence and recommendations based on standardized protocols

(2017): BP 130/80

Disproportionate weight to the SPRINT trial, an RCT assessing standard vs. strict blood pressure treatment

SPRINT Trial



SPRINT Trial

9361 patients enrolled

Stopped at 3.6 mean follow-up of planned 6 years

Major **Exclusion** Criteria

- Stroke
- Diabetes
- CHF (symptoms or EF <35%)
- Proteinuria more than 1g/day
- CKD with eGFR < 20ml/min
- Risk of non-adherence

SPRINT Trial

Benefit

- 25% lower RR in primary outcome (composite CVD events)
- 38% lower RR for HF
- 43% lower RR for death from CV cause
- 27% lower RR from death from any cause

Harm

- Improper blood pressure measurement
- Symptomatic hypotension
- Syncope
- Greater medication burden
- Potential overtreatment

SPRINT TRIAL: Impact on Brain

Primary Outcomes

7.2%	adjudicated probable dementia (cases per 1000 person-years) HR 0.83; 95% CI, 0.67-1.04, P=0.10	8.6%

Secondary Outcomes

14.6%	Mild cognitive impairment HR 0.81; 95% CI, 0.69-0.95, P=0.007	18.3%
20.2%	Composite of dementia and MCI HR 0.85; 95% CI, 0.74-0.97, P=0.01	24.1%

In ambulatory adults with hypertension, intensive BP control (SBP < 120 mmHg) did not reduce risk of probable dementia but significantly reduced mild cognitive impairment.

Joe

Three months later
Adopted lifestyle modifications
78 year old male
No significant cardiovascular family history
Forgets to take medications
Medications: Multivitamin daily, Aspirin 81mg daily
Tamsulosin 4mg daily for BPH

Recent Labs:
- TC 200
- HDL 30
- LDL 100
- CrL 45 mL/min
- A1C 5.9 % (showing impaired glucose tolerance)

Proper Blood Pressure today in office: 137/88?

What should we do?

Lifestyle Interventions

LIFESTYLE INTERVENTION	AVERAGE EFFECT ON SBP (MM HG)	AVERAGE EFFECT ON DBP (MM HG)
Regular aerobic exercise	–5	–4
DASH diet	–11	–5.5
Weight loss of 3% to 9% of body weight in overweight patients	–3	–3
Reduced salt diet	–5	–3
Alcohol moderation	–4	–2.5

Should We SPRINT to a Lower Blood Pressure Goal for Joe?

Let's dive deeper!

Blood Pressure (mmHg)	ACC/AHA Guideline Treatment Recommendations
Normal: < 120/80	Maintain healthy lifestyle habits
Elevated: 120 - 129/< 80	Encourage lifestyle changes Check for medications that increase BP (NSAIDs, SNRIs, estrogen, etc)
Stage 1 hypertension: 130 - 139/80 - 89	Implement lifestyle changes alone if ACC/AHA 10-year CV risk < 10% Use BP meds for patients with CV disease, diabetes, chronic kidney disease, or 10-year CV risk ≥ 10%
Stage 2 hypertension: ≥ 140/90	Reinforce lifestyle changes and use BP meds

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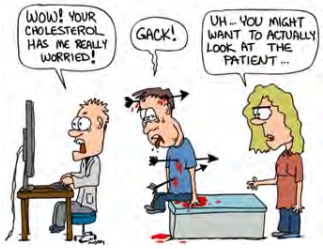
ASCVD Calculator

http://www.cvriskcalculator.com



Joe's Risk

37.2%

10-year risk of heart disease or stroke

On the basis of your age alone, the USPSTF guidelines suggest there is **insufficient evidence you will benefit from starting aspirin** for heart disease and stroke risk reduction.

Despite your high calculated risk for heart disease or stroke over 7.5%, on the basis of your age >75 and greater risk of statin side effects, the ACC/AHA guidelines suggest only that you **consider being on a moderate intensity statin**.

Based on your age, your blood pressure is **well-controlled**.

Demography	Cholesterol	Blood pressure	Risk factors
Age: 78	Total: 200	Systolic: 139	Diabetes: no
Gender: male	HDL: 30	Diastolic: 89	Smoking: no
Race: not African-American		On medication: no	

What is Best for Your Patient

Medication Selection

- Guidelines in agreement
- Consider compelling indications
- Consider Black versus Non-Black since studies have shown Black population less likely to respond to ACEI/ARB as 1st line
- Consider Side Effect Profile

Treating HTN in the Elderly: Assess Harm

Drug Class	Common suffix	Common Examples	Important Side Effects
ACE Inhibitors	-pril	Lisinopril, benazepril, fosinopril, enalapril	Dry cough, renal dysfunction
Thiazide diuretics	None	Hydrochlorothiazide (HCTZ), chlorthiazide, chlorthalidone	Hypokalemia, hyponatremia, renal dysfunction, ↑ insulin resistance
Loop diuretics	None	Furosemide, bumetanide, torsemide	Hypokalemia, hyponatremia, renal dysfunction
Dihydropyridine calcium channel blockers	-dipine	Amlodipine, felodipine, nicardipine, nifedipine	Constipation, lower extremity edema
Non-dihydropyridine calcium channel blockers	None	Diltiazem, verapamil	↓ myocardial contractility, bradycardia
ARBs	-sartan	Losartan, valsartan, irbesartan	Renal dysfunction
Beta blockers	-olol	Metoprolol, carvedilol, labetalol, propranolol, esmolol	↓ myocardial contractility (acutely), bradycardia, fatigue, sexual dysfunction, depression
Alpha blockers	-osin	Terazosin, prazosin, doxazosin	Orthostatic hypotension

Medication Selection

First Line: ACEI/ARB/CCB/TZD

Diabetic → ACEI/ARB

Fall Risk → Consider CCB

Medication Pearls

- ✓ Combining ACEI/ARB + TZD or ACEI/ARB +CCB at low doses is better than maxing out one—better BP control with less electrolyte issues
- ✓ ACEI as effective as ARB: cheaper and avoid the rolling ARB recalls and shortages
- ✓ Chlorthalidone may be more efficacious than hydrochlorothiazide—but also affects electrolytes more

Medication Pearls

- ✓ Check electrolytes two weeks after starting or adjusting an ACEI/ ARB or diuretic
- ✓ Use Beta Blocker only if compelling indications (AF,CAD,CHF) or if needed as a 3rd or 4th line.

Med Specific Pearls

- ✓ Get people off Clonidine if possible—or at least use a patch to prevent rebound
- ✓ Use your pharmacist to double check for drug interactions—ex: statins and CCB

Joe

Medications: Multivitamin daily, Aspirin 81mg daily
Tamsulosin 4mg daily for BPH

Proper Blood Pressure today in office: 138/89?

What should we do?

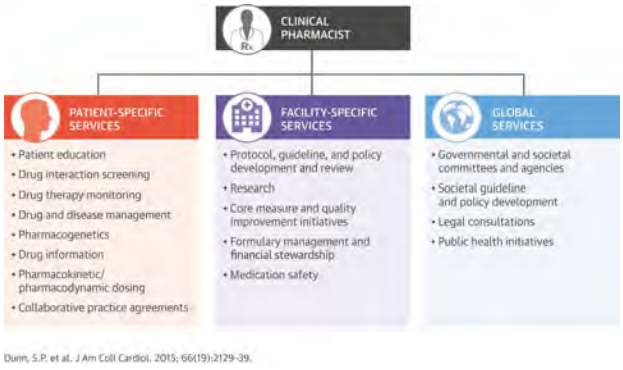
Plan:

- d/c Aspirin
- Start Lisinopril 2.5mg daily
- Continue Tamsulosin 4mg daily
- Continue Multivitamin daily
- BMP in two weeks
- F/u appointment with clinical pharmacist for BP & Lisinopril start and for education with family on medication adherence—pill box or other options

Key Points in Frail Elderly

- Guidelines helpful to a point
- Assess risk versus benefit
- Drug disease interaction
- Drug-drug interaction
- Affordability
- Compliance
- Preference

Team Intelligence: Utilize Clinical Pharmacists



Dunn, S.P. et al. J Am Coll Cardiol. 2015; 66(19):2129-39.

Chemotherapy in the SNF

Rebecca Ferrini, MD, MPH, CMD

CALTCM

2019

Disclosure Statement

- Dr. Rebecca Ferrini, MD, MPH, CMD has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Demonstrate how to review identify a potentially toxic agent.
- Identify a list of chemotherapeutic meds which might be prescribed and safely used in the SNF setting.
- Describe precautions to protect staff and peers from body wastes of those receiving potentially toxic agents.
- Develop staff training programs that support safe use of these agents for their patients, families, and staff.

Do You Do CHEMOTHERAPY at Your Nursing Home?

Just Add to Applejuice and Drink!

- 67 year old patient with cancer diagnosis and dysphagia was prescribed Gleevec by her oncologist.
- She could not swallow the pill so the recommendation was to put in apple juice.
- MD writes order……..
- Nurse is concerned—isn't that chemo?
- We called the oncologist---they didn't know…..

Investigation...

- Looked up literature, consulted pharmacist—pharmacist suggested that if Pharmacist put in apple juice, they would need a chemo hood! But Ok for nurse to do it….????
- Repeated calls to oncologist did not come up with a solution
- We had to present them with data on harms and our refusal to administer
- Outcome—she went daily to oncologist who gave medication there after preparation by hospital pharmacy in liquid form.

So We Began to Wonder, Are There Other Chemo Drugs We Are Using and do Not Know About?

And We Found These.....

- Megestrol (Megace) Temodar (temozolomide)
- Methotrexate Anastrozole (Arimidex)
- Restasis (Eye drops)
- Cyclosporin
- Lupron Injectable/Medroxyprogesterone (Depo -Provera injectable)
- Depo-Testosterone (Testosterone Cypionate Injection) Zidovudine
- Ribavirin
- Interferon (Intron A, Rebif)

You may think of chemotherapy as active, ongoing cancer treatment, often accomplished in hospital or infusion center.

- But when implementing RCRA we identified that many common medications used for many conditions beside cancer, were being used in our facility and may need special handling.

SNF is a Black Hole

- There are guidelines on chemotherapy administration for hospitals which imply short term therapy and handling of wastes.
- There are guidelines for families of chemo patients abut what to do at home
- But we could not find anything for the SNF environment.

We Asked Pharmacist…

- Many chemo drugs fall on either U or P lists (hazardous) in RCRA lists, but not all. (40 CFR C261.30 thru 261.33)
- EPA does not have a complete list of chemo drugs

Pharmacist Confirmed Black Hole

In literature, I did not find any drug list which states disposing them into a Yellow Container. The list may be an institutional decision. Using Google and looking at medications used in our facility, we identified the following chemo without U or P codes…

Chemotherapy drugs: Such as Temodar, methotrexate, anastrozole, Imatinib (Gleevec), fluorouracil, exemestane (Aromasin);

- **Antineoplastic drugs:** Megestrol (Megace), Lupron Injectable, Depo-Provera injectable, Depo-testosterone
- **Carcinogenic drugs**: Zidovudine,
- **Antineoplastic teratogenic agent**: Ribavirin (aminothiadiazole)
- **Antineoplastic Interferons**: Interferon (Intron A, Betaseron)

Important Medication Handling Information

Do not crush	Do not crush, cut, score, manipulate the medication in any way.
Do not touch	Do not touch the medication when dispensing.
PPE	Wear Chemo gloves while dispensing the medication (Goggles, mask, gown.....)
Close	Keep medicine bottle tightly closed. Put in baggie and try not to touch the outside of the baggie with anything that touched the medication.
Wash	Wash hands thoroughly after administering medication or if it touches the skin.
Discard	Un-used/expired/spit out medications can go in black bin. Put in baggie and seal and label with drug name.
Yellow Bag	Set-up yellow bag specially Marked HAZARD for PPE and waste that may be contaminated. When you put contaminated things in there, tie off the bag. Notify housekeeping to take the bag away daily.

What is Voluntary Will be Required

- Starting in December 2019, there are new regulations for pharmaceutical safety (USP-800)
- Pharmacists and Nurses must wear PPE (gown, mask and chemo gloves) when administering or dispensing Chemo drugs.
- The bubble packs, bottles, baggies, soufflé cups and so on all go into YELLOW BAGS...
- https://www.pharmacytimes.com/resource-centers/usp-800/preparing-for-new-rules-on-hazardous-drug-management

Do body fluids need special handling too?

Chemotherapy Drugs Are Excreted in Body Fluids

(whether they got the drug in or outside your facility)

How long do we need precautions?

Many Have Chemo in the Urine or Feces or Other Body Fluids For 48-72 Hrs. After Dose and Need Special Handling.
Longer if Daily Use….

Flushing Precaution

- Can you close the lid ?
  - *We could not our toilets did not have lids!*
- We decided to use something we already had—the paper toilet covers!
- How many times do you flush?
  - *Flush once with the seat cover on, second flush brings seat cover into toilet.*
- Should I wear protection when I flush?
  - *Yes to prevent exposure.. Gown, chemo gloves, mask and face shield!*

Summary of Precautions

- Medication dispensing: Wear PPE
- Handling wastes:
  - Wear PPE (chemo gloves, gown)
  - Flush toilets twice
  - Cohort patients and staff
  - Use yellow bags for disposal

CHEMO PRECAUTION CART CONTENTS

- **SUPPLIES**
- Chemo gloves
- PPE gowns
- PPE mask
- PPE mask with face shield
- Spill cleanup kit
- Yellow bags
- Orange Bleach Wipes
- Disposable toilet seat covers
- **NOTE:** Contact Central Supply/Environmental Services if anything on the list is running low so that they can replace it.

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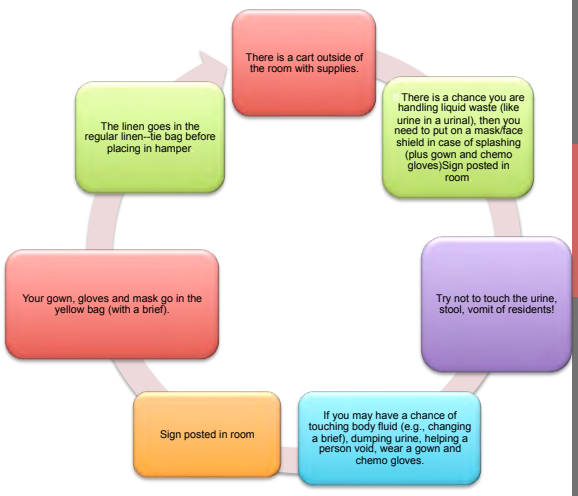


IMPORTANT TOILETING/ LINEN/ CLOTHING ISSUES (CNA, LVN, RN)

If you are pregnant or concerned about reproductive harm, ask your supervisor to accommodate your concerns.

01

Costs involved development of the policy and procedure, training, training time for staff and monitoring of implementation by staff.

02

There are costs associated chemotherapy waste disposal and supplies

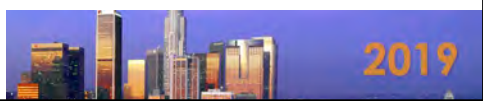
How much did this all cost???

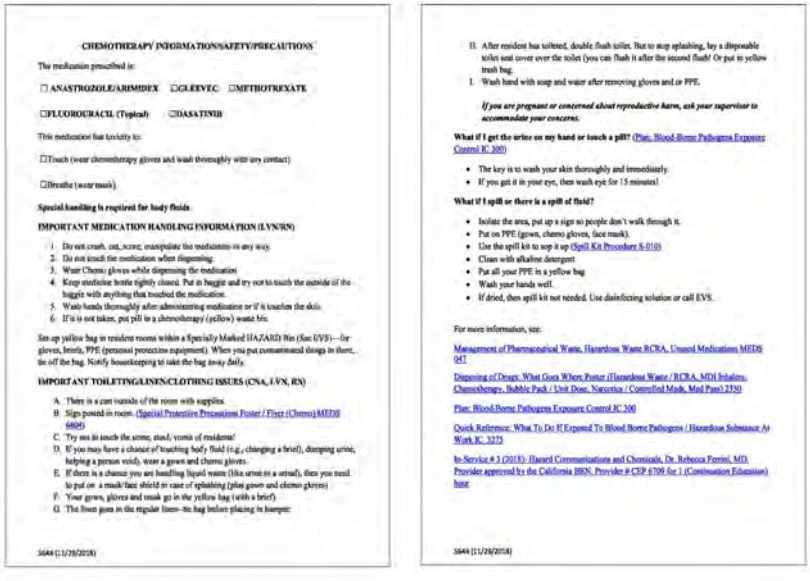
Supplies Are More Costly....

- Chemo waste disposal is average of 35 pounds per resident per week at $0.35/lb is $1.75/day
- Chemo gloves cost $0.09 a glove and we estimate 6 sets per shift is $3.24/daily (regular gloves are 3-4 cents each)
- Chemo gowns cost $0.73/gown and if we use three a shift, this is $6.57/day.
- Chemo face shields are about $0.97 each and this is $8.73/ day
- This brings daily resident total (incontinent) to around $20.29/day (not counting seat protectors..)

What Are the Benefits?

- Compliance with regulations and best practice
- Avoidance of lawsuits or worker's compensation claims.
- Protects the health of staff and residents
- Increases the capability of long term care providers to provide treatment with these agents on-site and in a safe manner
- Immeasurable benefits of preventing reproductive harm or cancer in staff.





CHEMOTHERAPY INFORMATION/SAFETY/PRECAUTIONS

The medication prescribed is:

☐ ANASTROZOLE/ARIMIDEX ☐GLEEVEC ☐METHOTREXATE

☐FLUOROURACIL (Topical) ☐DASATINIB

This medication has toxicity to:

☐Touch (wear chemotherapy gloves and wash thoroughly with any contact)

☐Breathe (wear mask)

Special handling is required for body fluids

IMPORTANT MEDICATION HANDLING INFORMATION (LVN/RN)

1. Do not crush, cut, score, manipulate the medication in any way.
2. Do not touch the medication when dispensing.
3. Wear Chemo gloves while dispensing the medication
4. Keep medicine bottle tightly closed. Put in baggie and try not to touch the outside of the baggie with anything that touched the medication.
5. Wash hands thoroughly after administering medication or if it touches the skin.
6. If it is not taken, put pill in a chemotherapy (yellow) waste bin.

Set-up yellow bag in resident rooms within a Specially Marked HAZARD Bin (Soc EVS)—for gloves, briefs, PPE (personal protective equipment). When you put contaminated things in there, tie off the bag. Notify housekeeping to take the bag away daily.

IMPORTANT TOILETING/LINEN/CLOTHING ISSUES (CNA, LVN, RN)

A. There is a cart outside of the room with supplies.
B. Sign posted in room. (Special Protective Precautions Poster / Flyer (Chemo) MEDS 6604)
C. Try not to touch the urine, stool, vomit of residents!
D. If you may have a chance of touching body fluid (e.g., changing a brief), disposing urine, helping a person void), wear a gown and chemo gloves.
E. If there is a chance you are handling liquid waste (like urine or a urinal), then you need to put on a mask/face shield in case of splashing (plus gown and chemo gloves)
F. Your gown, gloves and mask go in the yellow bag (with a brief).
G. The linen goes in the regular linen--no bag before placing in hamper.

5644 (11/29/2018)

H. After resident has toileted, double flush toilet. But to stop splashing, lay a disposable toilet seat cover over the toilet (you can flush it after the second flush! Or put in yellow trash bag.
I. Wash hand with soap and water after removing gloves and or PPE.

If you are pregnant or concerned about reproductive harm, ask your supervisor to accommodate your concerns.

What if I get the urine on my hand or touch a pill? (Plan: Blood-Borne Pathogens Exposure Control IC 300)

- The key is to wash your skin thoroughly and immediately.
- If you get it in your eye, then wash eye for 15 minutes!

What if I spill or there is a spill of fluid?

- Isolate the area, put up a sign so people don't walk through it.
- Put on PPE (gown, chemo gloves, face mask).
- Use the spill kit to sop it up (Spill Kit Procedure S-010)
- Clean with alkaline detergent
- Put all your PPE in a yellow bag
- Wash your hands well.
- If dried, then spill kit not needed. Use disinfecting solution or call EVS.

For more information, see:

Management of Pharmaceutical Waste, Hazardous Waste RCRA, Unused Medications MEDS 047

Dispensing of Drugs: What Goes Where Poster (Hazardous Waste / RCRA, MDI Inhalers, Chemotherapy, Bubble Pack / Unit Dose, Narcotics / Controlled Meds, Med Pass) 2550

Plan: Blood-Borne Pathogens Exposure Control IC 300

Quick Reference: What To Do If Exposed To Blood Borne Pathogens / Hazardous Substance At Work IC 3275

In-Service # 3 (2018): Hazard Communications and Chemicals, Dr. Rebecca Ferrini, MD. Provider approved by the California BRN. Provider # CEP 6709 for 1 (Continuation Education) hour

5644 (11/29/2018)

CHEMO PRECAUTION CART CONTENTS

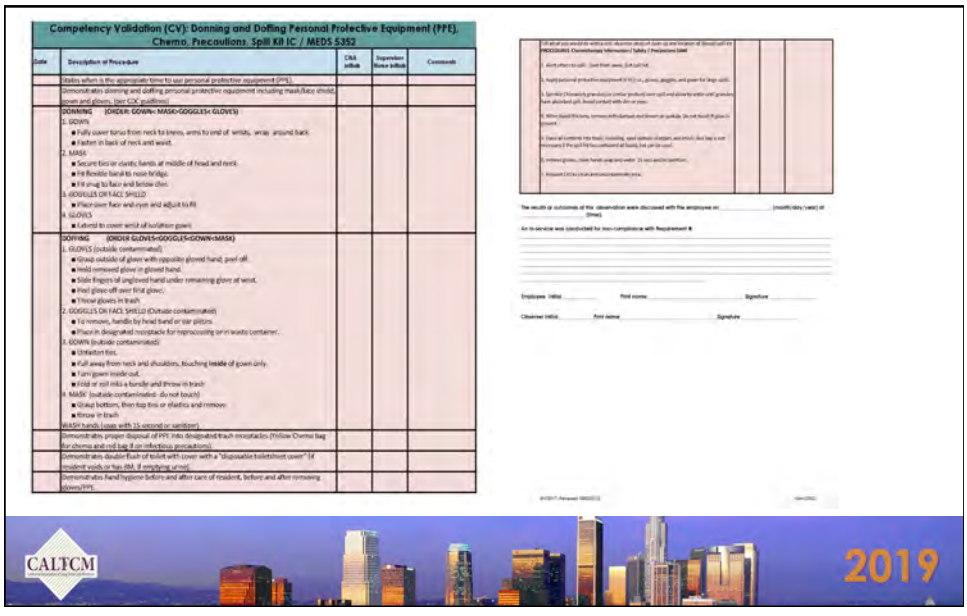
NOTE: Please contact Central Supply/EVS if anything on this list is running low so that they can replace it.

- Special Protective Precautions Poster / Flyer (Chemo) MEDS 6404
- Chemotherapy Information / Safety / Precautions 5644
- CDC Sequence for Putting on or Taking off Personal Protective Equipment (PPE) Fact Sheet IC 3461
- Disposing of Drugs: What Goes Where Poster (Hazardous Waste / RCRA, MDI Inhalers, Chemotherapy, Bubble Pack / Unit Dose, Narcotics / Controlled Meds, Med Pass) 2350

SUPPLIES

- Chemo gloves
- PPE gowns
- PPE mask
- PPE mask with face shield
- Spill cleanup kit
- Yellow bags
- Orange Bleach Wipes
- Disposable toilet seat covers

Form 6481 (11/05/2018)



Competency Validation (CV): Donning and Doffing Personal Protective Equipment (PPE), Chemo. Precautions, Spill Kit IC / MEDS 5352

Date	Description of Procedure	CNA initials	Supervisor Name initials	Comments
	Alerts when is the appropriate time to use personal protective equipment (PPE).			
	Demonstrates donning and doffing personal protective equipment including mask/face shield, gown and gloves. (per CDC guidlines)			
	DONNING (ORDER: GOWN< MASK<GOGGLES< GLOVES) 1. GOWN ■ Fully cover torso from neck to knees, arms to end of wrists, wrap around back ■ Fasten in back of neck and waist. 2. MASK ■ Secure ties or elastic bands at middle of head and neck. ■ Fit flexible band to nose bridge. ■ Fit snug to face and below chin 3. GOGGLES OR FACE SHIELD ■ Place over face and eyes and adjust to fit 4. GLOVES ■ Extend to cover wrist of isolation gown			
	DOFFING (ORDER GLOVES<GOGGLES<GOWN<MASK) 1. GLOVES (outside contaminated) ■ Grasp outside of glove with opposite gloved hand; peel off. ■ Hold removed glove in gloved hand. ■ Slide fingers of ungloved hand under remaining glove at wrist. ■ Peel glove off over first glove. ■ Throw gloves in trash 2. GOGGLES OR FACE SHIELD (Outside contaminated) ■ To remove, handle by head band or ear pieces. ■ Place in designated receptacle for reprocessing or in waste container. 3. GOWN (outside contaminated) ■ Untie/cut ties. ■ Pull away from neck and shoulders, touching inside of gown only. ■ Turn gown inside out. ■ Fold or roll into a bundle and throw in trash 4. MASK (outside contaminated- do not touch) ■ Grasp bottom, then top ties or elastics and remove. ■ Throw in trash WASH hands (soap with 15 second or sanitizer)			
	Demonstrates proper disposal of PPE into designated trash receptacles (Yellow Chemo bag for chemo and red bag if on infectious precautions).			
	Demonstrates double flush of toilet with cover with a "disposable toilet/short cover" (if resident voids or has BM. If emptying of vial).			
	Demonstrates hand hygiene before and after care of resident, before and after removing gloves/PPE.			

The results or outcomes of this intervention were discussed with the employee on _____ (month/day/year) at _____ (time).

An in-service was conducted for non-compliance with Requirement #.

Employee Initial _____ Print name _____ Signature _____

Observer Initial _____ Print name _____ Signature _____

Anticoagulation in Seniors

Margherita "Mar" Aikman
RN, BSN, Pharm.D, BCACP, BCPS, CACP, CDE, Aph

CALTCM

2019

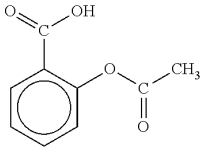
Disclosure Statement

- Dr. Margherita Aikman, RN, BSN, Pharm.D, BCACP, BCPS, CACP, CDE, Aph has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Understand the role of aspirin in healthy elderly – ASPREE Trial
- Assess risk of major bleeding in older adults with atrial fibrillation weighing CHADS & CHADSVAC versus HAS_BLED

Aspirin



- Used since antiquity
- One of the most studied compounds/medications
- Still finding clarity: Who should use it when & who should not

MECHANISM OF ACTION

Aspirin's COX activity, effect and respective mechanisms vary with dose:

Low doses (typically 75 to 81 mg/day) irreversibly acetylate serine 530 of cyclooxygenase **(COX)-1** inhibiting platelet generation of thromboxane A2, resulting in an **antithrombotic effect.**

Intermediate doses (650 mg to 4 g/day) inhibit COX-1 and COX-2, blocking prostaglandin (PG) production, creating analgesic and antipyretic effects.

High doses (between 4 and 8 g/day) are effective as anti-inflammatory agents in rheumatic disorders. However, the usefulness of aspirin at these high doses is limited by toxicity, including tinnitus, hearing loss, and gastric intolerance.

The purpose of using LOW dose aspirin is to limit the activity to COX-1 effect.

For Secondary Prevention:

- Many trials have shown that low-dose aspirin reduces the risk of subsequent myocardial infarction, stroke and vascular death for those patients who have survived an occlusive cardiovascular event

For Primary Prevention:

- Does taking a low-dose aspirin daily help healthy older people live longer and healthier lives by delaying the onset of illness?

Aspirin has known adverse effects such as bleeding and reduced blood clotting, does this offset any benefit?

Where do we find the balance?

ASPREE

What is the ASPREE Trial?

ASPREE (**ASP**irin in **R**educing **E**vents in the **E**lderly)

- International randomized double-blind, placebo-controlled trial
- 19,114 older people with 16,703 people in Australia and 2,411 people in the United States
- Approximately 9,500 people in both the aspirin and placebo groups
- Enrolled participants mostly **70 years and older**
- The study started in 2010 and finished in 2017

ASPREE

https://www.aspree.org/

Study Goal

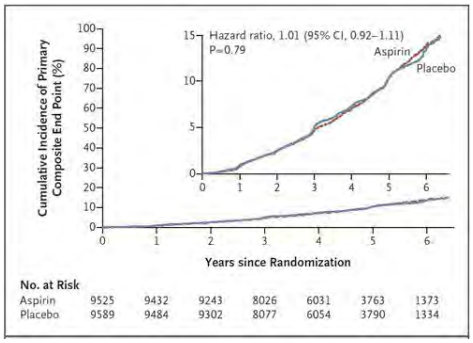
The main goal of the ASPREE study was to determine the value of daily low-dose aspirin in **healthy older people**.

Focus was to determine if aspirin would increase survival free of persistent physical disability or dementia in healthy older people

The ASPREE study did not evaluate the use of low-dose aspirin for people who have a had a heart attack or stroke and who take aspirin to prevent reoccurrence

The NEW ENGLAND JOURNAL of MEDICINE
OCTOBER 18, 2018

Effect of Aspirin on Disability-free Survival in the Healthy Elderly



CONCLUSIONS

Aspirin use in healthy elderly persons did not prolong disability-free survival over a period of 5 years but led to a higher rate of major hemorrhage than placebo. (Funded by the National Institute on Aging and others; ASPREE ClinicalTrials.gov number, NCT01038583.)

October 18, 2018
N Engl J Med 2018; 379:1499-1508
DOI: 10.1056/NEJMoa1800722

Outcomes

No significant difference between the aspirin and the placebo groups on the primary outcome of survival free of persistent physical disability or dementia

During the four and a half years of taking low-dose aspirin, cross the population studied, the daily low-dose aspirin had no measured benefit in preventing heart disease, physical disability, dementia or stroke

ASPREE results showed that those taking the low-dose aspirin increased the risk of bleeding

From the results of the ASPREE trial, low-dose aspirin dose not extend healthy life span in those persons age **70** years or older who are considered healthy and do not require aspirin based on current preventative guidelines

Age & Aspirin

U.S. Preventive Services TASK FORCE

Population	Recommendation	Grade (What's This?)
Adults aged 50 to 59 years with a ≥10% 10-year CVD risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B
Adults aged 60 to 69 years with a ≥10% 10-year CVD risk	The decision to initiate low-dose aspirin use for the primary prevention of CVD and CRC in adults aged 60 to 69 years who have a 10% or greater 10-year CVD risk should be an individual one. Persons who are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years are more likely to benefit. Persons who place a higher value on the potential benefits than the potential harms may choose to initiate low-dose aspirin.	C
Adults younger than 50 years	The current evidence is insufficient to assess the balance of benefits and harms of initiating aspirin use for the primary prevention of CVD and CRC in adults younger than 50 years.	I
Adults aged 70 years or older	The current evidence is insufficient to assess the balance of benefits and harms of initiating aspirin use for the primary prevention of CVD and CRC in adults aged 70 years or older.	I

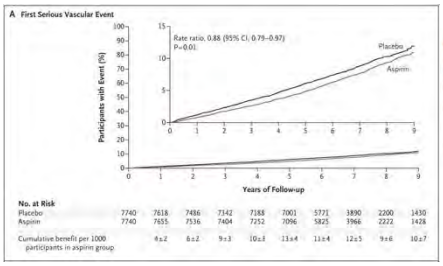
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Effects of Aspirin for Primary Prevention in Persons with Diabetes Mellitus

The ASCEND Study Collaborative Group*

ASCEND STUDY
TINY EFFECT, NOT WORTH THE RISK



CONCLUSIONS
Aspirin use prevented serious vascular events in persons who had diabetes and no evident cardiovascular disease at trial entry, but it also caused major bleeding events. The absolute benefits were largely counterbalanced by the bleeding hazard. (Funded by the British Heart Foundation and others; ASCEND Current Controlled Trials number, ISRCTN60635500; ClinicalTrials.gov number, NCT00135226.)

October 18, 2018
N Engl J Med 2018; 379:1529-1539
DOI: 10.1056/NEJMoa1804988

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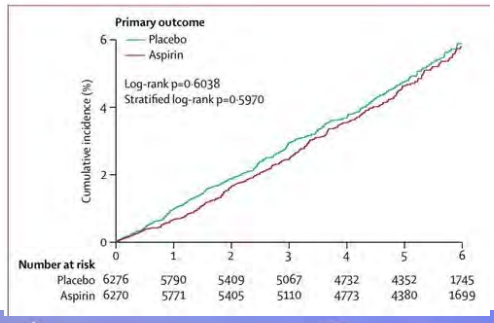
THE LANCET

ARTICLES | VOLUME 392, ISSUE 10152, P1036-1046, SEPTEMBER 22, 2018

Use of aspirin to reduce risk of initial vascular events in patients at moderate risk of cardiovascular disease (ARRIVE): a randomised, double-blind, placebo-controlled trial

Prof J Michael Gaziano, MD · Carlos Brotons, MD · Rosa Coppolecchia, DO · Prof Claudio Cricelli, PhD · Prof Harald Darius, MD · Prof Philip B Gorelick, MD · et al. Show all authors



ARRIVE Trial
Failed to show that aspirin was superior to placebo at preventing adverse cardiovascular events among moderate-risk patients.

August 26, 2018
DOI:https://doi.org/10.1016/S0140-6736(18)31924-X

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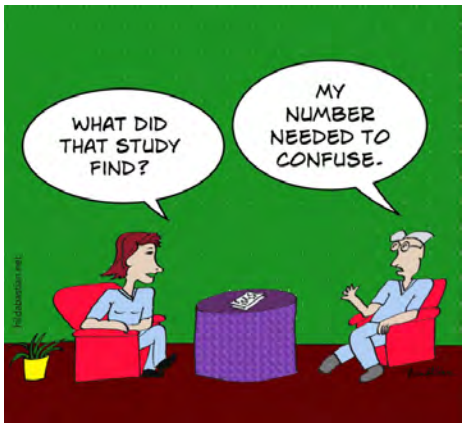
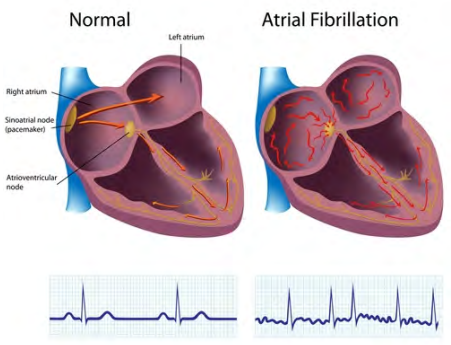
Conclusion

Modern medicine is getting good at managing cardiovascular risk thus making aspirin potentially more dangerous than useful **in healthy older persons for primary prevention**.



Clot Versus Bleed: The Atrial Fibrillation Dilemma

Atrial Fibrillation (A Fib)



AFib increases a person's risk for stroke by four to five times compared with stroke risk for people who do not have AFib.

https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_atrial_fibrillation.htm

To Anticoagulate or Not; That is the Question

Goal is to prevent system embolization & stroke

Need to understand & balance risk versus benefit

A-Fib Clot Risk Scores

$CHADS_2$ -> CHA_2DS_2VASc

CHADS2 Risk	Score
CHF	1
Hypertension	1
Age > 75	1
Diabetes	1
Stroke or TIA	2

CHA2DS2-VASc Risk	Score
CHF or LVEF ≤ 40%	1
Hypertension	1
Age ≥ 75	2
Diabetes	1
Stroke/TIA/ Thromboembolism	2
Vascular Disease	1
Age 65 - 74	1
Female	1

CHADS2

CHA2DS2-VASc

Gage BF, Waterman AD, Shannon W, et al. Validation of clinical classification schemes for predicting stroke: results from the National Registry of Atrial Fibrillation. JAMA 2001;285: 2864–70.

CHADS2 (2001)

The CHADS2 risk score is the simplest score and assigns points to the presence of:

- Congestive heart failure
- Hypertension
- Age >75
- Diabetes
- and previous stroke (2 points)

Gage BF, Waterman AD, Shannon W, et al. Validation of clinical classification schemes for predicting stroke: results from the National Registry of Atrial Fibrillation. JAMA 2001;285: 2864–70.

CHA2DS2-VASc (2010)

- **To better identify patients that are truly at low risk**, the CHA2DS2-VASc risk score was developed that also included vascular disease, age between 65 and 74 years, and gender
- Scoring systems all come with limitations including age, but that doesn't mean we can't use them to help create our clinical decision making

Lip GYH, Nieuwlaat R, Pisters R, et al. Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the Euro HeartSurvey on Atrial Fibrillation. Chest 2010;137: 263–72.

A-Fib Bleeding Risk Scores

HAS-BLED

– Hypertension, Abnormal renal and liver function, Stroke, Bleeding, Labile INR, Elderly, Drugs or alcohol

ATRIA

– Anticoagulation and Risk Factors in Atrial Fibrillation

ORBIT

– Outcomes Registry for Better Informed Treatment of Atrial Fibrillation

On The Spot Patient Assessment

https://chadsvasc.org/

More Risk = More Risk

CHA2DS2-VASc

- Congestive heart failure, Hypertension, Age, Diabetes Mellitus, Prior Stroke, Vascular disease, Sex category

HAS-BLED

- Hypertension, Abnormal renal and liver function, Stroke, Bleeding, Labile INR, Elderly, Drugs or alcohol

What is the Utility of Bleed Risk Scores?

…"bleeding risks scores serve only to allow physicians to justify excluding a high-risk patient from potentially life-threatening therapy."

"current guidelines from AHA/ACC/HRS and European Society of Cardiology do not support their use in the decision making for antithrombotic therapy in patients with AF."

"Further studies are needed to determine whether these scores hold up in the setting of lower-risk Direct Oral Anticoagulants (DOAC) treatment."

Bleeding Risk Scores in Atrial Fibrillation: Helpful or Harmful?
Marissa K. EdmistonMD, and William R. Lewis
13 Sep 2018https://doi.org/10.1161/JAHA.118.010582Journal of the American Heart Association. 2018;

Conclusions

Use tools available to help calculate risk versus benefit but use these resources to support what you see and the patient in front of you

Always balance risk when considering preventative care

There is no ONE best answer. This is educated decision making— *The ART of medicine*

Thank You!

Any Questions?

Navigating Healthcare

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"In The Trenches"

1. Motivational Interviewing; Patricia Bach, PsyD, RN
2. The Joy of Medicine: Avoiding Burnout; Ashkan Javaheri, MD, CMD
3. Medical Apps & Technology; Jay Luxenberg, MD
4. Avoiding Medical Related Citations; Janice Hoffman-Simen, PharmD, EdD, Aph, BCGP, FASCP
5. Compassion Fatigue and Moral Dilemmas; Chris Wilson, RN, JD, MS-HCE
6. Billing & Coding; Alex Bardakh, MPP, PLC
7. POLST & Palliative Care; Karl Steinberg, MD, CMD, HMDC
8. Antibiotic Stewardship; Peter Patterson, MD, MBA, FCAP, FACMQ
9. Staff Retention; Merlyn Trinidad, RN-BSN
10. How to be Competitive with Medicare Advantage; Dan Osterweil, MD, FACP, CMD

Regulatory Update: PDPM

Kerry Weiner, MD

CALTCM 2019

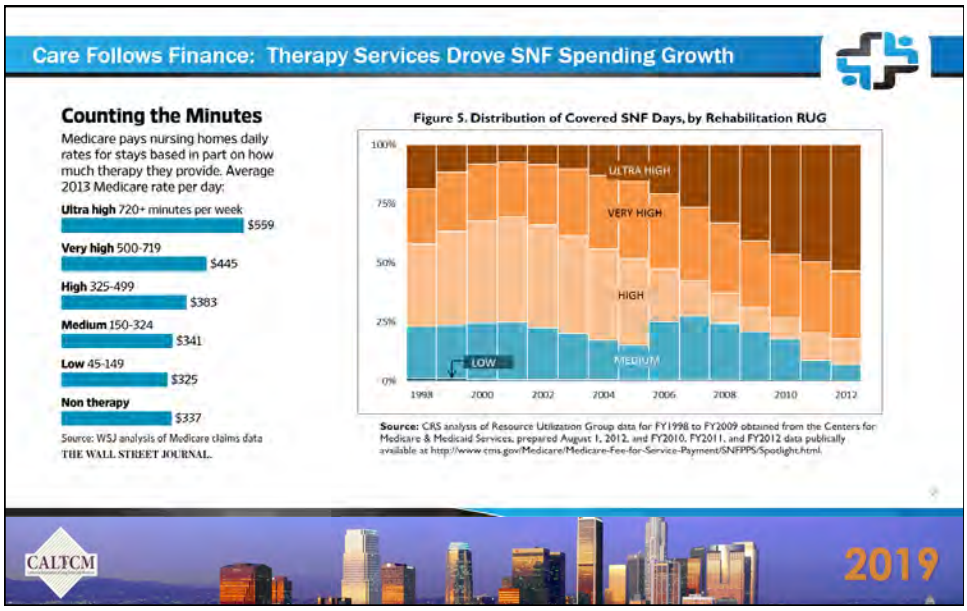
Disclosure Statement

- Dr. Kerry Weiner, MD has no relevant financial relationships with commercial interests to disclose.
- Additional slides contributed by Aaron Hagopian, MBA; *Patient-Driven Payment Model: How Physicians Can Add Greater Value Under the New SNF Reimbursement System*

Learning Objectives

- Identify strategies for developing a practice to meet current and future payment structure demands.
- Discuss the impact of healthcare reform initiatives on PALTC practitioners - exclusion from APMs.
- Explain the basic structure of the Patient-Derived Payment Model.

Patient-Driven Payment Model (PDPM)
A Revolution in PALTC



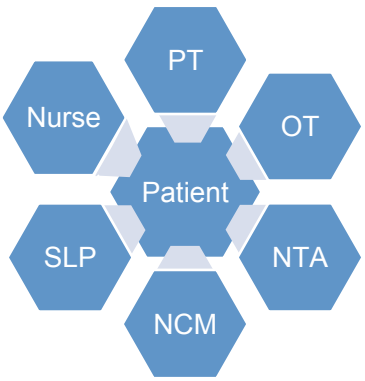
Game Changing Differences

- RUG IV
  - 80% dependent on Level/ hours of therapy
  - 10% dependent on ADLs
  - 10% dependent on geographic location
  - Total MDS items: 20
- PDPM:
  - Driven by primary clinical diagnosis + co-morbidities based on ICD-10 codes
  - Modified by cognitive, functional status assessments
  - Modified by LOS
  - Total MDS items: 161

Drivers of Patient Outcomes?

- Chicken and egg?
- Minutes of therapy?
- Nursing needs?
- Actuary's dream?
- SNF's nightmare?

PDPM Care Compensation Factors



Clinician's Impact in PDPM

- Payment linked to patient condition(s) on admission
- New category, NTA (non-therapy ancillary), depends on patient co-morbidities and therapy
- Modify payment of 3 categories during stay if acuity changes
  - Reimbursement decreases over time unless there are documented changes in condition.

PDPM Payment

Nursing	Nursing Base Rate	X	Nursing CMI	X		=	Total	
							+	
PT	PT Base Rate	X	PT CMI	X	PT adjustment factor	=	Total	
							+	
OT	OT Base Rate	X	OT CMI	X	OT adjustment factor	=	Total	
							+	
SLP	SLP Base Rate	X	SLP CMI	X		=	Total	
							+	
NTA	NTA Base Rate	X	NTA CMI	X	NTA adjustment factor	=	Total	
							+	
Non-case mix	Base Rate					=	Total	

Daily rate

Variable Per Diem Adjustment Factor

- OT, PT
  - 1-20 days = 1.0 x $
  - 21-27 days = 0.98 x $ and drops by .02 every week thereafter (91 days = 0.78)
- NTA
  - 1-3 days = 3.0 x $
  - 4-100 days = 1.0 x $
- IPA (Interim Payment Assessment) for significant change

Admission Note Documentation is Essential

- Establish primary diagnosis
- Primary admitting diagnosis may be different than inpatient diagnosis
- Important to note any surgery done during proceeding inpatient stay
- Specific codes (not general codes) justify SNF
- Completed within first 5 days

PDPM Primary Diagnosis Clinical Categories Based on Physician Documented ICD-10 Codes

Surgical Categories

- MJR or Spinal
- Other Ortho Surgical
- Non- Ortho Surgical
- Non- Surgical Ortho

Medical Categories

- Medical Management
- Acute Infections
- Cancer
- Pulmonary
- CV and Coagulations
- Acute Neurologic

NTA: Non Therapy Ancillary Cost Calculation

- Primary Diagnosis
- Weighted Co-morbidities & Extensive services (50)
- First 3 days LOS impact: 3 X $

Non-Therapy Ancillary Conditions/Services

Condition/Extensive Service	Points
HIV/AIDS	8
Parenteral IV Feeding: Level High	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	5
Special Treatments/Programs: Ventilator Post-admit Code	4
Parenteral IV feeding: Level Low	3
Lung Transplant Status	3
Special Treatments/Programs: Transfusion Post-admit Code	2
Major Organ Transplant Status, Except Lung	2
Active Diagnoses: Multiple Sclerosis Code	2
Opportunistic Infections	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	2
Chronic Myeloid Leukemia	2
Wound Infection Code	2
Active Diagnoses: Diabetes Mellitus (DM) Code	2
Endocarditis	1
Immune Disorders	1
End-Stage Liver Disease	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	1
Narcolepsy and Cataplexy	1
Cystic Fibrosis	1
Special Treatments/Programs: Tracheostomy Post-admit Code	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	1
Special Treatments/Programs: Isolation Post-admit Code	1
Specified Hereditary Metabolic/Immune Disorders	1

Non-Therapy Ancillary Conditions/Services

Condition/Extensive Service	Points
Morbid Obesity	1
Special Treatments/Programs: Radiation Post-admit Code	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	1
Psoriatic Arthropathy and Systemic Sclerosis	1
Chronic Pancreatitis	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	1
Complications of Specified Implanted Device or Graft	1
Bladder and Bowel Appliances: Intermittent catheterization	1
Inflammatory Bowel Disease	1
Aseptic Necrosis of Bone	1
Special Treatments/Programs: Suctioning Post-admit Code	1
Cardio-Respiratory Failure and Shock	1
Myelodysplastic Syndromes and Myelofibrosis	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	1
Diabetic Retinopathy - Except : Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1
Nutritional Approaches While a Resident: Feeding Tube	1
Severe Skin Burn or Condition	1
Intractable Epilepsy	1
Active Diagnoses: Malnutrition Code	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	1
Cirrhosis of Liver	1
Bladder and Bowel Appliances: Ostomy	1
Respiratory Arrest	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	1

SLP: Clinical Category+ …

SLP Payment Factors

- Primary Diagnosis
- Acute Neurologic Condition
- SLP Co-morbidities
- Cognitive impairment
- Swallowing disorder
- Mechanically Altered Diet

SLP Co-morbidities

- CVA, TIA
- Aphasia
- Hemiplegia/ Hemiparesis
- Traumatic Brain Injury
- ALS
- Oral Ca
- Laryngeal CA
- Apraxia
- Dysphagia
- Speech & language Deficits
- Tracheostomy care
- Ventilator

Swallowing Dysfunction & Mechanically Altered Diet

- Swallowing dysfunction matters
- Appropriate therapy
- Dietary modifications
- Unintended consequences

PT & OT Clinical Categories

- Based on data showing similar costs among certain clinical categories, the PT & OT components use four collapsed clinical categories for patient classification:

PDPM Clinical Categories	PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic	Non-Orthopedic Surgery & Acute Neurologic
Non-Orthopedic Surgery	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic - Surgical Extremities Not Major Joint	
Medical Management	Medical Management
Cancer	
Pulmonary	
Cardiovascular & Coagulations	
Acute Infections	

PT & OT Functional Score: GG Items

Section GG items included in the PT & OT Functional Score:

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130B1 – Self-care: Oral Hygiene	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	
GG0170J1 – Mobility: Walk 50 feet with 2 turns	0 – 4 (average of 2 items)
GG0170K1 – Mobility: Walk 150 feet	

Nursing Component

- RUG-IV classifies patients into a therapy RUG, based on how much therapy the patient receives, and a non-therapy RUG, based on certain patient characteristics:
  - Only one of these RUGs is used for payment purposes
  - Therapy RUGs are used to bill for over 90% of Part A days
- Therapy RUGs use a consistent nursing case-mix adjustment, which obscures clinically meaningful differences in nursing characteristics between patients in the same therapy RUG

PDPM Nursing Payment Modifications

- PDPM utilizes the same basic nursing classification structure as RUG-IV, with certain modifications:
  - Function score based on Section GG of the MDS 3.0
  - Collapsed functional groups, reducing the number of nursing groups from 43 to 25

Case Presentation

81 yo F with COPD admitted to Hospital for SOB and fever. HPI: 10 days at home with cold symptoms, sputum production and fever, weakness, poor appetite, SOB.
PMH: COPD, HTN, Diverticulosis, Mild Dementia

Hospital course: Found to be in respiratory distress, BP 90/60, acidotic and admitted to ICU. Placed on BICAP and treated with IV antibiotics. Improved over 7 days. DC to SNF because of generalized weakness.

Med list: includes Albuterol, Atrovent inhaler and steroid taper, Metformin, Metamucil, Rouvastatin, Benazepril, Bactrim

PE: vitals stable, Oriented x 2, wt. 240, Ht. 5'4"
Lungs: Few wheezes
Hrt: RRR
Ext: Lft ankle ulcer 3cm, tender, red, with mild exudate
Culture: MRSA recovered
Pre –Albumin 9

Primary Diagnosis COPD: Pulmonary - Medical Management
NTA Co-morbidities: Less Obvious Opportunities

1Pt. Cardio-respiratory shock
1Pt. Morbid Obesity
2 pt. Active DM
1 Pt. Multi-drug resistant organism
1 Pt. Diabetic foot ulcer
2 Pt. Wound infection
1 Pt. Malnutrition

9 Pt. Total; increased NTA CMI 0.72 to 2.53 ($77.30/d vs. $199.80/d) = difference of $1715.00 for 14 day stay; about $250.00 more than PPS

Patient Example:
79 Year Old Man with Femur Fracture

- Patient is a 79 year old male with acute diagnosis of **femoral fracture**. He is also recovering from pneumonia. The patient has no cognitive impairment but is **depressed**. The patient needs considerable assistance with activities of daily living.

Category & CMI Placement

- The patient's primary diagnosis of femur fracture qualifies him for placement into the Other Orthopedic category for him stay at the skilled nursing facility. The categories and resultant CMI's that the patient qualifies for are as follows for each of the case-mix adjusted components:

Component	Case-mix group (CMG)	Case-mix index (CMI)
Nursing	CBC2	1.54
PT	TG	1.67
OT	TG	1.64
ST	SD	0.68
NTA	NF	0.72

Daily Payment for Each Component Over 30 Day Stay

Component	Case-mix group	Case-mix index	Base Rate	Per diem
Nursing	CBC2	1.54	$103.46	$159.33
PT	TG	1.67	$ 59.33	$ 99.08
OT	TG	1.64	$ 55.23	$ 90.58
ST	SA	0.68	$ 22.15	$ 15.06
NTA	NF	0.72	$ 78.05	$56.20
Non case-mix			$ 92.63	$ 92.63
			PDPM Base per diem	$512.87
			PPS Per Diem – RUG	$631.22

	# of Days	PDPM Per Diem	PDPM Total	PPS Per Diem	PPS Total
Days 1-3	3	$ 625.27	$1,875.80	$631.22	$1,893.66
Days 4-20	17	$ 512.87	$8,718.87	$631.22	$10,730.74
Days 21-27	7	$ 510.89	$3,576.25	$631.22	$4,418.54
Days 28-30	3	$ 507.01	$1,521.03	$631.22	$1,893.66
Total	30	$ 523.06	$15,691.95	$631.22	$18,936.60

Worse Isn't Better; Better Isn't Worse

- Relationship between functional status and payment is not linear
- Moderate functional decline a/w higher reimbursement
- Focus on most appropriate care!

Impact of PDPM

- Proper ICD-10 coding is critical for payment
- Proper evaluation and MDS coding required
- Maximizing payment is ONLY the initial step!
- Delivering EFFECTIVE care will determine the ultimate results
- Focus MUST be on proper clinical approach
- The Geriatrics approach to care is NECESSARY!

Important Concepts & Diagnosis

- ICD 10 coding
  - Major factor in base rate calculation
  - Identify primary dx
  - Co- morbidities in NTA; SLP
- LOS: first three days
  - 5 days to document
  - NTA: 1-3 days 3X wt.
  - Other categories:+20 d taper

Items not to miss:

- Major changes of condition
- Acute neuro conditions
- Preceding surgeries in ACH
- HIV and AIDS
- Diabetes and complications
- COPD/asthma/ fibrosis
- Infections: Ortho, resistant, opportune
- Immune def/ CTD, IBD
- Morbid obesity / malnutrition
- Psoriatic arthritis
- CML/ myloplastic disease
- ESLD/ cirrhosis
- Chronic pancreatitis

amda The Society For Post-Acute And Long-Term Care Medicine™

Public Policy Update

CALTCM April 6, 2019

Alex Bardakh, MPP, Director Public Policy and Advocacy

@AlexBardakh_LTC

Speaker Disclosures

- Alex Bardakh has no relevant financial relationships with commercial interests to disclose.

Learning Objectives

By the end of the session, participants will be able to:

- Describe healthcare political landscape and its impact on PALTC
- Describe value-based medicine impact on PALTC clinicians

Legislative Priorities

Democratic House/Republican Senate

- **Drug Pricing**
- **Surprise Billing**
- **Medicare Expansion?**
- **Nursing Home Quality**

Emmer Consulting, Inc. – 2/11/18

Regulatory Priorities

- Admin Burden Reduction
- Drug Pricing
- Evaluation and Management Coding
- My HealthEData Initiative
- Interoperability

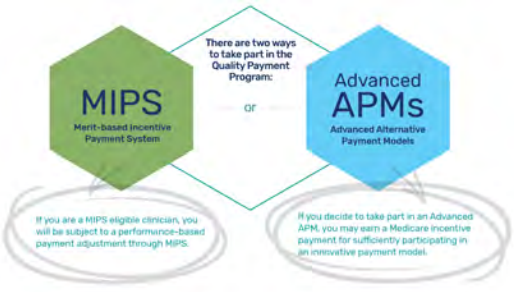
Society on the Hill

- Geriatric Workforce Enhancement Program (GWEP)
- PA/LTC Role in Value-Based Medicine
- Advance Care Planning
- Telehealth

MACRA Quality Payment Program

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program:



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MIPS Year 3 (2019) Final

Performance Category Weights

Year 2 (2018) Final

Performance Category	Performance Category Weight
Quality	50%
Cost	10%
Improvement Activities	15%
Promoting Interoperability	25%

Year 3 (2019) Final

Performance Category	Performance Category Weight
Quality	45%
Cost	15%
Improvement Activities	15%
Promoting Interoperability	25%

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MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

Final Score 2018	Payment Adjustment 2020
≥70 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
15.01-69.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
15 points	• Neutral payment adjustment
3.76-14.99	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	• Negative payment adjustment of -5%

Year 3 (2019) Final

Final Score 2019	Payment Adjustment 2021
≥75 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
30.01-74.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

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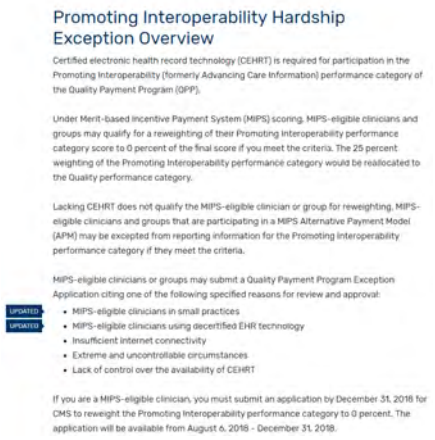
Hardship Exemptions For PI Category

- Must fill out separate application each year!
- PALTC clinicians eligible under Lack of Control over the availability of CEHRT
- Information available at [redacted]



Promoting Interoperability Hardship Exception Overview

Certified electronic health record technology (CEHRT) is required for participation in the Promoting Interoperability (formerly Advancing Care Information) performance category of the Quality Payment Program (QPP).

Under Merit-based Incentive Payment System (MIPS) scoring, MIPS-eligible clinicians and groups may qualify for a reweighting of their Promoting Interoperability performance category score to 0 percent of the final score if you meet the criteria. The 25 percent weighting of the Promoting Interoperability performance category would be reallocated to the Quality performance category.

Lacking CEHRT does not qualify the MIPS-eligible clinician or group for reweighting. MIPS-eligible clinicians and groups that are participating in a MIPS Alternative Payment Model (APM) may be excepted from reporting information for the Promoting Interoperability performance category if they meet the criteria.

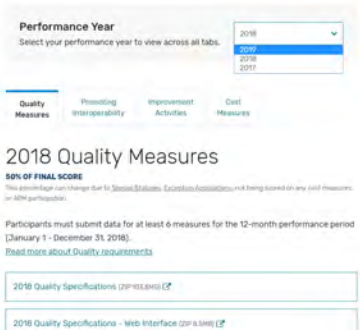
MIPS-eligible clinicians or groups may submit a Quality Payment Program Exception Application citing one of the following specified reasons for review and approval:

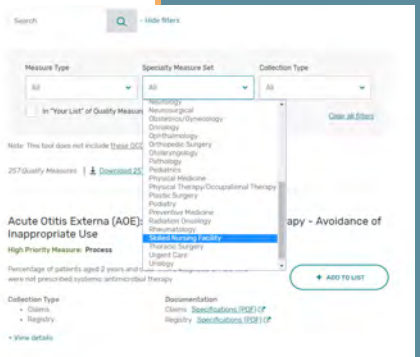
- UPDATED MIPS-eligible clinicians in small practices
- UPDATED MIPS-eligible clinicians using decertified EHR technology
- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT

If you are a MIPS-eligible clinician, you must submit an application by December 31, 2018 for CMS to reweight the Promoting Interoperability performance category to 0 percent. The application will be available from August 6, 2018 - December 31, 2018.

New For 2019 – SNF Specialty Set Identified

Specialty Measure Sets
Clinicians and groups can choose to submit a specialty or subspecialty measure set. In doing so, they must submit data on at least 6 measures within that set. If the set contains fewer than 6 measures, the clinician or group should submit each measure in the set.





Advanced APMs

Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

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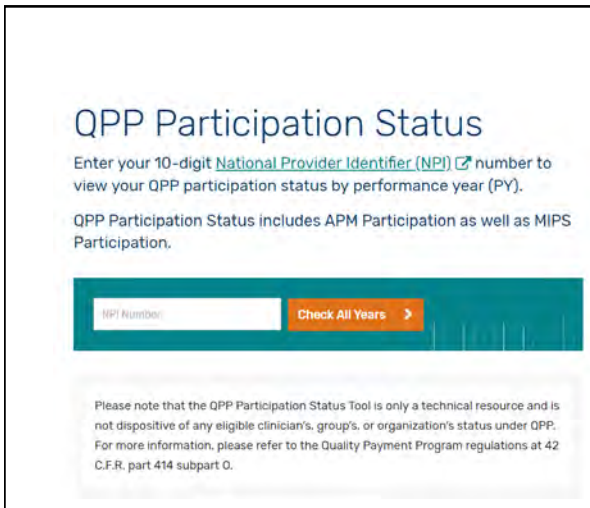
APMs

- No dedicated model for PALTC practitioners
- Society supports CMMI models on end-of-life
- Society working with AAHPM on end-of-life MACRA funded quality measures
- Double sided risk ACOs growing

QPP: What to Expect in 2019

- Majority still in MIPS
- Must “meaningfully” participate to avoid penalty
- SNF specific list of measures available
- Post-acute facility based option in the works but not available yet
- Check with your practice where you stand
- Society webinar with CMS staff

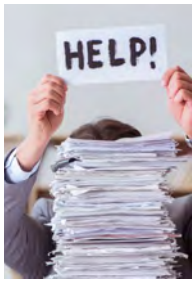


Check Your Status!

https://qpp.cms.gov/participation-lookup

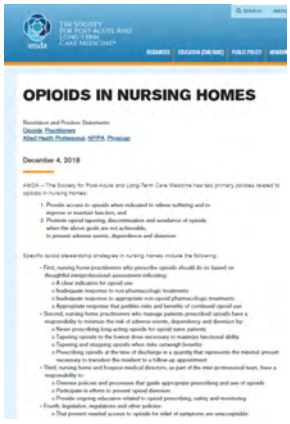
Evaluation and Management Coding

CMS Rework of Evaluation and Management Coding



- 2018 Physician Fee Schedule proposed rule proposed significant changes to **Office-Based** E&M Coding Documentation and Billing Requirements
- 2018 Physician Fee Schedule Final Rule delayed majority of the proposal until 2021. Several proposals on documenting History of Present Illness Finalized
- AMA CPT/RUC Workgroup developing alternative proposals
- **No current proposals for institutional primary care codes including SNF E&M but possible in the future**

Opioid Crisis



Opioids

- CDC Guidelines on Opioid Use do not address PALTC
- Society Released Position Statements on Dec 4, 2018
  - Provide access to opioids when indicated to relieve suffering and to improve or maintain function, and
  - Promote opioid tapering, discontinuation and avoidance of opioids when the above goals are not achievable,to prevent adverse events, dependence and diversion.

Antipsychotics

Congressional leader fears false diagnosing, wants more scrutiny of nursing homes' antipsychotic use

Antipsychotics

- Continued focus on Improving Dementia Care in Nursing Homes
- Troubling reports of false schizophrenia diagnosis to improve 5-Star Ratings
- Society developed a workgroup to address concerns

Health IT

CMS/ONC Rule on Data Sharing

- Published Feb 11, 2019
- Implements 21st Century Cures Legislation
- Data exchange as Hospital CoP
- Rules on data blocking
- Two Requests for Information (RFIs) to obtain feedback on interoperability and health information technology adoption in PAC

Newsroom Press Kit Blog Data Contact

Fact sheet

CMS Advances Interoperability & Patient Access to Health Data through New Proposals

Feb 08, 2019 | Leadership Legislation

Share

CMS Advances Interoperability & Patient Access to Health Data through New Proposals

Today, February 11, 2019, the Centers for Medicare & Medicaid Services (CMS) proposed policy changes supporting its MyHealthEData initiative to improve patient access and advance electronic data exchange and care coordination throughout the healthcare system. The Interoperability and Patient Access Proposed Rule outlines opportunities to make patient data more useful and transferable through open, secure, standardized, and machine-readable formats while reducing restrictive burdens on healthcare providers.

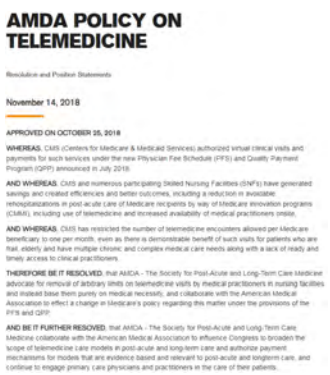
In addition to the policy proposals, CMS is releasing two Requests for Information (RFIs) to obtain feedback on interoperability and health information technology (health IT) adoption in Post-Acute Care (PAC) settings, and the role of patient matching in interoperability and improved patient care.

Telehealth

Telehealth

- Legislative effort to provide reimbursement for telehealth services in PALTC
- Remove once a month restriction on using SNF subsequent care codes via telehealth
  - Passed BoD resolution
  - Adopted by AMA House of Delegates
- Use of newly established G codes for telehealth – viable in SNF?

New Society Resources



AMDA POLICY ON TELEMEDICINE

Resolution and Position Statements

November 14, 2018

APPROVED ON OCTOBER 25, 2018

WHEREAS, CMS (Centers for Medicare & Medicaid Services) authorized virtual clinical visits and payments for such services under the new Physician Fee Schedule (PFS) and Quality Payment Program (QPP) announced in July 2018.

AND WHEREAS, CMS and numerous participating Skilled Nursing Facilities (SNFs) have generated savings and created efficiencies and better outcomes, including a reduction in avoidable rehospitalizations in post-acute care of Medicare recipients by way of Medicare innovation programs (CMMI), including use of telemedicine and increased availability of medical practitioners onsite.

AND WHEREAS, CMS has restricted the number of telemedicine encounters allowed per Medicare beneficiary to one per month, even as there is demonstrable benefit of such visits for patients who are frail, elderly and have multiple chronic and complex medical care needs along with a lack of ready and timely access to clinical practitioners.

THEREFORE BE IT RESOLVED, that AMDA - The Society for Post-Acute and Long-Term Care Medicine advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on medical necessity, and collaborate with the American Medical Association to effect a change in Medicare's policy regarding this matter under the provisions of the PFS and QPP.

AND BE IT FURTHER RESOVED, that AMDA - The Society for Post-Acute and Long-Term Care Medicine collaborate with the American Medical Association to influence Congress to broaden the scope of telemedicine care models in post-acute and long-term care and authorize payment mechanisms for models that are evidence based and relevant to post-acute and longterm care, and continue to engage primary care physicians and practitioners in the care of their patients.

JAMDA

The Journal of Post-Acute and Long-Term Care Medicine

Caring for the Ages

February 2019 Volume 20, Issue 2, Pages 115–122

Standards for the Use of Telemedicine for Evaluation and Management of Resident Change of Condition in the Nursing Home

Abstract

Objectives

Settings and participants

Article Tools

ATLANTA GEORGIA 2019

Requirements of Participation

Phase 3 RoPs, effective 11/28/19

1. Quality Assurance and Performance Improvement

- Develop, implement, and maintain effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life.
- Mandatory training within QAPI on infection prevention and control program (IPCP), educating staff on written standards, policies, and procedures for each program.

2. Person-Centered Care Planning, Baseline Care Plan

- Develop baseline care plan within 48 hours of admission
- IDT: Include CNA, dietary, social worker. AND Resident/resident rep.
- DC planning, follow-up care documentation

Phase 3 RoPs, effective 11/28/19

3. Trauma-Informed Care

- Appropriate staffing, competencies, necessary behavioral health care services/resources
- Based on facility assessment

4. Infection Control

- Formal IPCP, including Infection Preventionist, who must be on QA&A Committee

5. Compliance & Ethics Program

- Facility must have established written compliance and ethics standards to reduce violations, abuse, neglect.

6. Physical Environment

- No more than 2 residents to a room (new rooms), call light at bedside, bathrooms with sink, shower and toilet, smoking policies

Phase 3 RoPs, effective 11/28/19

7. Training Requirements

- Communication, abuse/neglect/exploitation, resident rights, QAPI, Compliance & Ethics, ICPC, CNAs get 12 hours on dementia annually
- Behavioral health, and specific target areas based on facility assessment

8. Dietary

- Required certification/education levels, competencies
- Accommodation of preferred mealtimes, …and much more

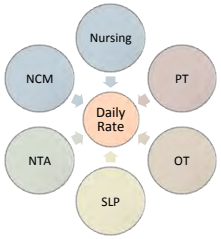
SNF Payment - Introducing PDPM

What is the Patient Driven Payment Model (PDPM)?

Begins October 1st, 2019

Represents a marked improvement over the RUG-IV model for the following reasons:

- Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided.
  - Improves targeting of resources to patients with varying therapy needs based on discipline (PT, OT, SLP)
  - Nursing Case-Mix now separated into a Nursing component and a Non-Therapy Ancillary (NTA) component
- Significantly reduces administrative burden on providers.
  - MDS data from the 5-day assessment is used to calculate five Case-Mix Index (CMI) clinically adjusted components
- Improves SNF payments to currently underserved beneficiaries without increasing total Medicare payments.
  - More accurately compensate for levels of care
  - Likely to see higher reimbursement for higher acuity patients



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SNF Value-Based Purchasing Program (VBP) and Quality Reporting Program (QRP)

SNF VBP

- Skilled Nursing Facility 30-Day All-Cause Readmission Measure
- The Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is used in the SNF VBP Program. The SNFRM estimates the risk-standardized rate of unplanned readmissions within 30 days for:
- People with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals.
- Any cause of condition
- SNFs will earn a SNF VBP Performance score (0 to 100) and ranking which is calculated based on that SNF's performance on the measure. The SNF VBP performance score is equal to the higher of the achievement score and improvement score.
- SNFs will be awarded points for achievement on a 0-100-point scale and improvement on a 0-90-point scale, based on how their performance compares to national benchmarks and thresholds.

SNF QRP Assessment-Based Quality Measures

NQF Measure ID	Measure Title	Data Collection Timeframe	Data Submission Deadline
NQF #0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	01/01/17-12/31/17	May 15, 2018
NQF #0678	Percent of Patients or Residents with Pressure Ulcers that are New or Worsened	01/01/17-12/31/17	May 15, 2018
NQF #2631	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	01/01/17-12/31/17	May 15, 2018

SNF QRP claims-based measures

Measure	Data Source
Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Medicare FFS claims
Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Medicare FFS claims
Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure	Medicare FFS claims

Other Issues

What else are we working on?

- Medical marijuana in nursing homes
- Observation Status
- Dysphagia in nursing homes
- Nursing home staffing ratios
- Clinician burnout

Questions?

Preparing for the Next Firestorm

Timothy Gieseke MD, CMD, Medical Director
Jason Belden, CAHF Disaster Coordinator

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Disclosure Statement

- Dr. Timothy Gieseke, MD, CMD and Jason Belden have no relevant financial relationships with commercial interests to disclose.

Learning Objectives

- Identify gaps in your facility's emergency plan in the case of a sudden firestorm threat
- Define how you can ensure complex care plans will continue to be executed off site in the case of a sudden evacuation
- Create a firestorm care plan template you can adapt in your facility

Session Outline

- Nature of Firestorms
- Paradise Camp Fire
- Santa Rosa Tubbs Fire
- Debriefing from Tubbs and Nuns fires
- CAHF Perspective on Fire Storms
- Potential Disaster Management Projects

Nature of Firestorms in California

- **Drought** of 2011-16 allowed beetles to infest and kill vast forests.
- **Rain** 2016-17 allowed growth of flammable underground vegetation
- **Extended Dry Season** (2017 & 2018) extended rainless period 78 days longer the average.
- **Santa Ana's** (So CA) & **El Diablo** (No Cal) powerful off shore winds commonly develop in October and November
- **Hot Fire** (> 2,500 degrees) expected d/t wind and plentiful fuel
- **Wind storms** w/in these fires (created by this heat) are explosive and unpredictable. Fire Embers commonly blown 0.5 miles beyond fire.
- **Spread rapidly**
  - Tubbs fire (10/8/17, Santa Rosa) moved 12 miles through northern Santa Rosa in 4 hr
  - Butte County Camp Fire (11/8/18) jumped 1 of 2 exit roads from Paradise w/in 2 hrs. and destroyed Paradise w/in 4 hrs.

Butte County Camp Fire (11/8/18)

- Deadliest & most destructive wildfire in California history
- Within first 4 hours, most of Paradise, Ca was destroyed including Feather River Hospital and 3 SNFs
- 86 deaths & 18,804 structures destroyed
- Amazingly, the 3 SNFs were evacuated w/o a resident left behind.

Recap –

Fire starts @ approximately 6:30 AM
CAHF receives first call @ 7:30 Am
CAHF contacts facilities to advise them
CAHF notifies public health EPO
CAHF loses communication @9:30
CAHF activates mutual aid plan through SAS-MAP (Sacramento Area Skilled Nursing Mutual Aid Plan)


CYPRESS MEADOWS


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See Account of Heroic Effort Below

- "As Camp fire flames closed in, Paradise nursing home staff leaps to action – saving 91 lives"
  - Nov 19, 2018 article in Santa Rosa Press Democrat
- Cypress Meadows evacuation
- https://www.pressdemocrat.com/news/8976221-181/as-flames-closed-in-paradise

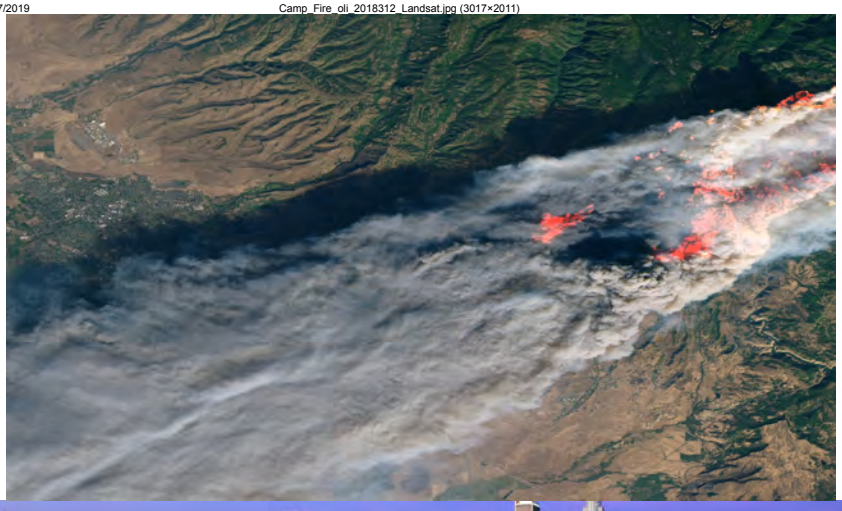
Ruins of Cypress Meadows Post-Acute

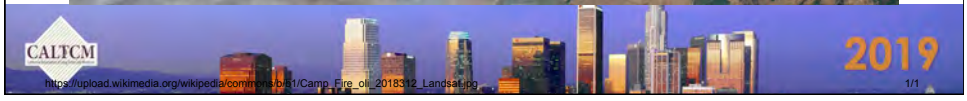
What Went Right?

- Activated early “Situational Awareness”
- Prioritized Life Safety (adapted to changing risk)
- Engaged response agencies to assist evacuation
- Arranged for job fairs for displaced staff
- Arranged for continued payroll despite loss

Areas for Improvement

- Construction types & lack of brush clearing
- Go Bag's
- Backup communication systems when power & cell towers fail
- County/City discordant emergency messaging
- Staging areas not identified before hand
- Business continuity plans don't address loss of building
- Unclear understanding of insurance coverage





Toxic Smoke Spread

- Over much of coastal Northern CA and hung there for 2 weeks.
- Air quality was an issue for multiple facilities as well as frail seniors in the community
- I provided terminal care for a senior from a coastal community who didn't protect her airways

Santa Rosa Tubbs Fire

(Late Sunday evening 10/8/2017)

- Blew across a 6 lane freeway taking out another 1200 homes and multiple businesses
- Blew between 2 acute hospitals (Sutter & Kaiser) forcing both to evacuate
- Destroyed 5,100 structures (2,800 homes)
- 24 deaths w/most > 70 y/o with disabilities
- 5 of 7 SNFs evacuated including 500 resident CCRC

Apocalyptic Consequences

- ~ 40 RCFEs burned with most residents escaping only with clothes they wore and no meds or med history
- Villa Capri & Varenna (high end independent living & RCFE) partially burned. Management charged w/patient abandonment.
- Over 200 physicians lost their homes (~1200 physicians in SR)
- Electrical power & cell towers (internet service) went down early in fire limiting communication & access to medical records
- Simultaneously, **Nuns Fire**, threatened East Santa Rosa
- All schools & multiple roads closed
- 35,000 residents evacuated
- Most community medical offices closed for 1 week or greater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My Monday Experience

One A.M. Call from Neighbor, threat seemed low, went back to sleep

Three A.M. Widespread electrical power & cell tower failure

no internet, cell phone, or home phone

Five A.M knock on my front door, threat now high

- Neighbor turned off gas to my house
- Transistor Radio for KSRO radio fire updates

– N95 masks for poor air quality

7:30 A.M. Wife left for our daughter's home in Novato

Evacuations in process at my CCRC & 2 other SNFs

Checked 4th SNF in downtown Santa Rosa which remained open

8:30 A.M. SMS Text to admit displaced RCFE residents to Apple Valley Post-acute in Sebastopol

CCRC Evacuation Process

- 3:25 A.M. Alarm sounded – independent living residents left, many w/o meds or change of clothes & dispersed to friends, families, or other facilities.
- 8:30 A.M. SNF and Assisted Living began evacuating with facility staff to the SR Vets Memorial Facility receiving area where Red Cross, Salvation Army, & volunteers provided emergency support
- Next 24 hrs. SNF & RCFE residents transferred with facility caregivers to sister or contract facilities (per disaster plan) in nearby counties
- ICC (Incident Command Center) moved to safe location to continue care coordination & tracking of residents

Receiving CCRC Facility Physicians Overwhelmed

- SNF & Assisted Living (ALU) transferred to Oakland and San Francisco CCRC's, but these are medically complex frail patients
- Our Associate Medical Director relocated to Oakland to provide on site care at both facilities over the next 2 weeks. Most of our staff left Santa Rosa to care for our displaced residents.
- Rx filled for displaced residents w/o med lists (CCRC Clinic paper records arrived at a later time).
- GehriMed EHR begun September 2017, but most medical records still paper based on October 8
- Pharmacist authorized to fill Rx w/o physician order in a declared emergency (California law)

Creekside SNF Sheltered in Place

- Transferred the most difficult and easiest patients to a nearby sister facility
- Hepa Filters, Duck taped air intake ducts, & N95 masks
- Only 45% of usual staffing d/t schools & roads closed, and mandatory evacuations
- Food and sleeping rooms set-up for displaced employees
- Readied for possible emergency evacuation if order came

Apple Valley Post-Acute in Sebastopol Staffed Up to Receive Victims

- RCFE residents - No meds, medical records, or contact info.
- Social Activities & dining room converted to hospital ward w/multiple gurneys (rental equipment)
- New residents cognitively impaired, sleep deprived, & traumatized.
- Spouses/friends unavailable d/t their evacuation & absence
- of internet and cell signals
- VA clinic records accessed through SF VA system.
- Kaiser records accessed through Marin County Kaiser system
- By Wednesday some local medical offices, cell and internet operating again
  - Cloud based EHRs available allowing better medication orders

By Friday, Fire Threat Improved

- Commuted from Novato to work at CKSD & Apple
- Sunday moved home
- Monday Oct 16, some SNFs initiated reopening process & licensing approval. Then readmissions began.
- Displaced SNF residents return in stages.
- Some SNFs required new admission orders and H&Ps
- Most obtained waiver from DHS to readmit w/o the added work since patients were never officially discharged.

Post Fire Resident Complications

- Frail and medically complex had worst outcomes
- Most SNFs had 1-3 deaths attributed to displacement stress and poor air quality
- Acute hospital admissions had higher mortality
- Common Complications:
  - PTSD,
  - 3-6 lb, wt. loss & loss of ADLs (Fall Risk)
  - Rapid revision of care plans.
  - Prolonged Asthma (lasting 3-4 months)

What Went Well?

- County notification system for evacuation @ 2:30 a.m 10/9 worked with residents sent quickly to safe evacuation sites for later dispersal to families, or sister / contracted facilities.
- Incident command centers @ facilities executed evacuation plans well for dispersing and tracking residents with face sheets and monthly order sheets as well as 24/7 staffing at evacuation sites
- Creekside Post-Acute sheltered in place obtaining many HEPA filters within hours, blocking air ducts, lowering patient census ~50% to accommodate smaller remaining staff
- Staff were amazing, even people who had lost their homes worked at open facilities or where residents had been sent

Debriefing: "Shelter In Place"

- Immediately transferred **residents** who would be **hard to evacuate** rapidly and those easy to evacuate, in anticipation of less staffing for shelter in place.
- A resident who was **BIPAP** dependent arrived at outside facility w/o unit. Another unit was sent the next day, but she had TIA the first night at the receiving facility.
- Communication the first few days was difficult.
- Facility based Social Media Thread (**Facebook**) could have improved bidirectional communication with staff and families.
- **Staffing** facility for remaining residents was difficult with so many staff newly homeless, school cancellations, and road closures
- Supply of **N95** Masks adequate – air quality outside facility poor x ~2 weeks
- See AHCA/NCAL Guidebook for Shelter in Place (pg24): https://www.ahcancal.org/facility_operations/disaster_planning/Documents/SIP_Guidebook_Final.pdf

Debriefing: CCRC

- Initial PA Announcement x 3 (independent living residents - ILR) was difficult to understand or not heard.
- Many ILR gathered not knowing they were being emergently evacuated
- Initial alarm was auditory. Needed better more efficient way to alert the hearing impaired.
- Need to place "Core apartment Elevators" on Generator system to evacuate mobility challenged residents living on 2nd story of units
- Needed a complete list of cell and email addresses of ILRs to facilitate communication after evacuation.
- Universal "Go Bag": All meds, Cell phones/Tablets/Chargers, Hearing aids, Eyeglasses, Dentures, Rings, CPAP, ABTs, Flash light, Sturdy pair of shoes, + 3 days cloths.
- Facility had an **emergency call in message line** worked well, but not all residents had # or could navigate the web page for updates.

Debriefing: CCRC

- Vacated red door tags on apartments saved staff time verifying all buildings clear.
- Daily facility Facebook postings helpful
- Incident command center
  - daily reached out to residents and employees by phone
  - coordinated off campus staff presence for SNF and Assisted living residents.
  - daily tracked status of displaced residents using cloud based spread sheets.
- Prearranged car pools to evacuate ILR residents w/o cars
- In future,
  - Photos will be taken of SNF and ALU residents wrist bands as they depart jotting down destination and taking a photo of ambulance number.
  - More walkie-talkies for staff communication when phones not working.
- Facility subsequently converted to cloud based electronic health records

Advances in Technology

- **Image Trend** – a web based app which simultaneously notifies facility management of an emergency
- MOHAWK – Sonoma Co Command Center
- Evacuation orders come from Police
- County Dept. of Health provides health advice

Rapid Evacuation Decisions

- Transportation by contract & repurposed
- Facility Lap tops and Med Carts
- Off site safe relocation centers
- Tracking systems for staff & residents
- Tie into regional system for potential receiving facilities

Disaster Management Projects

- Fully implement an EHR that contains physician notes, POLST, & Lab results
- Develop and keep a cloud based active list of staff and family cell # and email addresses, to facilitate communication
- Develop a social media members only account on your web page for communication amongst staff and families through a disaster
- Provide electronic tools & training for Incident Command personnel to coordinate & co-manage off site staffing and patient care
- Plan for communicating effectively when the power and cell towers are out. Consider: Walkie-Talkies, Satellite Radio, LED lights, Transistor Radios
- Prepare for poor air quality: Hepa Filters, Reducing unfiltered outside air intake, N95 masks, & education of Staff, Families, and residents

Disaster Management Projects

- Revisit effectiveness of emergency alarm systems. Traditional auditory systems have gaps for HOH and sedated patients.
- Encourage staff to have an app or text message alert on their smart phones like **Nixle link** (888777 – enter your Zip Code) for real time threat alerts
- **"Go Bag"** for each resident that include: Med List (monthly orders), Face Sheet, Eyeglasses, Hearing aids, Dentures, CPAP/BIPAP, Prosthesis, Cane/Walker, Gait Belt
- "Button Bags" for attaching Orders/face sheet & small items to Patient clothing so stays with patient during transfer
- **"Go Bags"** for staff that include: Change of Cloths, Meds for at least 3 days, Chargers, Key accounts and passwords, etc.

Disaster Management Projects

- Update patient wrist bands to include: Name, DOB, Facility, Contact information
- Track evacuees by photo of wrist band when boarding vehicle & matching those on board to a photo of vehicle license
- If time permits, plan for evacuation of high tech like lap tops and med carts.
- Prepare for common problems displaced residents may have on return to facility like: Asthma, Reduced ADLs w/ higher fall risk, Wt. loss, & PTSD
  - May need more CNAs, MSW, Clinical Psychologists, Chaplains, & Rehab staff

Thank you!

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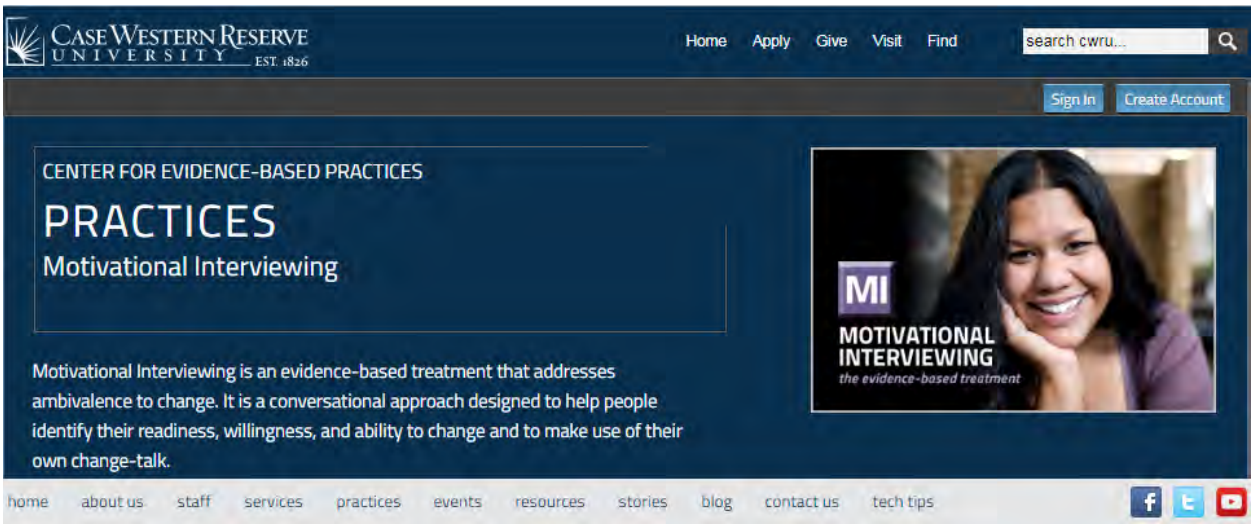
Handouts

In the Trenches Session

(Attached in alphabetical order.)



https://www.centerforebp.case.edu/practices/mi

Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based treatment that addresses ambivalence to change. MI is a conversational approach designed to help people with the following:

- Discover their own interest in considering and/or making a change in their life (e.g., diet, exercise, managing symptoms of physical or mental illness, reducing and eliminating the use of alcohol, tobacco, and other drugs)
- Express in their own words their desire for change (i.e., "change-talk")
- Examine their ambivalence about the change
- Plan for and begin the process of change
- Elicit and strengthen change-talk
- Enhance their confidence in taking action and noticing that even small, incremental changes are important
- Strengthen their commitment to change

CORE PRINCIPLES

There are four core principles of MI:

- Express empathy
- Roll with resistance
- Develop discrepancy
- Support self-efficacy

MAKING THE CASE

Ambivalence is a natural state of uncertainty that each of us experiences throughout most change processes (e.g., dieting; exercising; maintaining health; restructuring an organization). Ambivalence occurs because of conflicting feelings about the process and outcomes of change.

Although ambivalence is natural, many of us are not aware of it. In addition, many service providers have not been trained to respond to people who are ambivalent about change, and most service programs are not designed to accept and work with people who are ambivalent. Yet, there is a solution. Change your service approach and the culture of your organization with Motivational Interviewing:

Increase

- Positive treatment outcomes
- Consumer quality-of-life
- Consumer engagement and retention
- Staff recruitment, satisfaction, and retention

Decrease

- Staff burn-out and attrition
- Confrontations with consumers
- Consumer no-show and drop-out

Tools from Our Center

Recommended MI resources produced by our Center:

- A List of MI Resources (you are here)
- Motivational Interviewing (MI) | Making the Case (mini-poster)
- MI Reminder Card: Am I Doing This Right?
- Readiness Ruler (pocket card)
- The Spirit of MI | Motivational Interviewing (audio cd)

CORE PRINCIPLES

There are four core principles of MI:

- Express empathy
- Roll with resistance
- Develop discrepancy
- Support self-efficacy

Contact us for MI technical assistance (consulting & training). Click here.

MAKING THE CASE

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- Confrontations with consumers
- Consumer no-show and drop-out

New CPT Codes Since 2016

- Advance Care Planning codes 99497/99498 - reimbursed since January 1, 2016 (billable in SNF/NF)
- Chronic Care Management Codes 99490 – reimbursed since January 1, 2016 (billable in SNF/NF)
- Chronic Care Management 99491 (physician only) – reimbursed since January 1, 2019 (billable in SNF/NF)
- Complex Chronic Care Management Codes 99487/99489 – reimbursed since January 1, 2017 (billable in SNF/NF)
- Transitional Care Management – 99495/99496 – reimbursed since January 1, 2015 – (NOT billable in SNF/NF)
- Non-Face-to-Face Prolonged Service 99358/99359 – reimbursed since January 1, 2017 (billable in SNF/NF)
- Cognitive Assessment 99483 – reimbursed since January 1, 2018 (facility non-facility payment available)
- Behavioral Health Integration 99484/99492/99493/99494 – reimbursed since January 1, 2017 (billable in SNF/NF)

Resources:

AMDA:

Guide to PALTC Coding: https://paltc.org/product-store/guide-post-acute-and-long-term-care-coding-reimbursement-and-documentation

Advance Care Planning Series: https://paltc.org/product-store/guide-post-acute-and-long-term-care-coding-reimbursement-and-documentation

CMS:

CCM
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf

Advance Care Planning
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

TCM
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

FAQ CCM
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf

Prolonged Services F2F
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3678CP.pdf
CMS fact sheet
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html

In the Trenches: Avoiding Medication-Related Citations: J. Hoffman, PharmD, EdD, APh, BCGP, FASCP

Objectives:

1) Identify the top 3 pharmacy related citations in 2015
2) Know the ARMOR method to avoid polypharmacy and/or unnecessary medications
3) Discuss the effects of transitions of care on the medication regimen review

- According to The Henry J. Kaiser Family Foundation the average number of Deficiencies per SNF in the State of California in 2016 = 14.5
- As of December 2018, according to U.S. Centers for Medicare and Medicaid Services (increase to 36.9/home):

State	# Homes	Total Deficiencies	Total Serious Deficiencies	Deficiencies/Home	Sum of Fines	# of Fines	Average Fine	# Payment Suspension
CA	1200	44,379	215	0.18	$8,783,945	336	$26,142	151

Top Citations from 2015 (reference: Feldkamp, J (2017). Top Regulatory Citations for Nursing Facilities *Caring for the Ages*, January 2017.)

Survey process for SNF occurs as frequently as every 9 months or as seldom as 15 months.

Out of the top 10 cited deficiencies involved 3 pharmacy related (Federal fiscal year 2015):

1. F-Tag 441 - Infection Control Program (improper handling of clean linens, improper handwashing, improper handling of medications and unnecessary antibiotics)
   Resolution: Create antibiotic stewardship with all disciplines involved; education to all staff – monthly if indicated
2. F-Tag 431- Pharmacy Services (administration records, medication labeling)
   Resolution: QAPI program with the pharmacy to avoid potential medication errors and harm to the resident
3. F-Tag 329- Unnecessary drugs (excessive dose and/or duration, inadequate monitoring or diagnosis to support use or use with the presence of adverse effects such as sedation)
   Resolution: Consultant Pharmacist, physicians and facility need to be vigilant in monitoring for unnecessary medications particularly psychoactives –
   a. Create a Behavior Management team to monitor the psychoactive medications to reduce unnecessary use –
   b. Chart Audits with dates of
      i. Attempted or completed gradual dose reduction attempts
      ii. Psychiatrist and Attending DOCUMENTATION as to why the psychoactive medication is necessary (ie. WHY reduction is clinically contraindicated)
   c. Data in the MDS MUST be consistent with the medication list and diagnoses in resident chart

- ***ARMOR*** - A tool used to emphasize quality of life as a key factor for making decisions on changing or discontinuing medication (Marcu, Oana. The Bagful of Pills: Polypharmacy in the Elderly. Swedish Family medicine. 2006.)

  Assess Review Minimize Optimize Reassess

Transitions of Care

- DRR MUST be completed upon admission to SNF and physician notified within 24 hours to recommend any changes especially if potential issues are noted
- Acute hospital medications match the admission orders BUT do not match the previous admission to the facility or at home medications -NEED CLARIFICATION
- Pharmacist can assist however, the burden of DRR rests on the facility to document
- Clarify with Physician any omitted or extra medications as discrepancies are quite frequent

Joy of Medicine: Balance between professional and personal life
Clinician "Burnout"

54% of surveyed physicians showed at least one sing of burnout.

Symptoms are:

Emotional (and physical) exhaustion
Depersonalization/cynicism (resentment toward patients)
Diminished sense of personal accomplishment/see work negatively!

Causes are:

Increased productivity expectations
Increasing requirements/certification! Diminished autonomy
Declining sense of fulfillment derived from work! Inefficient use of time
Challenges with work-life balance
Shift from private practice to being employees! Electronic medical records
Bureaucracy/paperwork

Results of burnout:

Decreased quality of care
Less satisfaction of medical care
Higher rates of medical errors/complications
Higher physician and staff turnover
Decreased continuity of care
Lower patient compliance

Physician Wellness/ solution resources:

http://wellmd.stanford.edu
https://www.thehappymd.com
https://www.aafp.org– Physician Health First www.acgme.org/what-we-do/initiatives/physician-well-being

In The Trenches – Medical Apps

- Caveats – this is based primarily on my own experience, and I use an iPhone not Android, so my Android info is limited
- Medical apps seem to disappear from the app store with remarkable frequency, so please check availability
- Apps vary from proprietary apps that integrate with your EHR of choice, to general apps that are useful irrespective of your EHR
- Utility of many of these apps will depend on your personal workflow. E.g., I use the free Osirix Lite application on my Macintosh computer to read Dicom images. I do not see spending $49.99 plus in-app purchases to use the IOS version – so far life have gone well in spite of not being able to read Dicom images emailed to my phone. For that matter, there are free iPhone Dicom viewers to play with if you have access to a Dicom server
- If you are like me, you download special function apps and then realize you simply never use them.
- Some web sites formatted for mobile use can be used as apps by putting them on your home screen – e.g. Nursing Home Compare www.medicare.gov/nursinghomecompare/search.html? Also Frax tool www.sheffield.ac.uk/FRAX I use some of these more than actual apps, and of course they take almost no storage. Downside is you need internet access.
- If you take care of patients that can use their own smart phones, there are a cornucopia of blood sugar tracking apps, compliance aids, pharmacy apps, communication with PCP apps, etc. As I deal with a nursing home eligible population, these aren't useful to my practice.
- General apps are often very useful for medical reasons – Evernote for notes and clipped web pages, calculators, and the ever popular Google.
- I use Cheatsheet app on my phone and watch to keep track of those pesky codes needed to enter and exit various sites without triggering alarms.
- Check out the ResearchKit Apps available
- Here are the true medical apps I use most often

App	Review
UpToDate	My go to general reference app, it requires annual subscription and offers CME. Alternatives include DynaMed Plus
Medscape	General reference, can search drug prices by location. Free.
Doximity	Useful for finding colleagues and sending and receiving faxes. Free.
Epocrates	Drug and interaction reference
IBM Micromedex	Drug and interaction reference, may be available free through your university ties.
Merck Pro	The Merck manual for professionals – general reference, free.
Mediquations	There are many medical calculator apps. This is my go-to app and it is updated periodically
Med Board CA	Great resource to periodically check to see if your license has been taken away
ACP Guidelines	All of the ACP's current and past guidelines
The Compendium	WHO guidelines for diagnosing and treating TB, updated June 2018
Genworth Cost of Care	Fabulous resource of up-to-date cost information for localities on cost of nursing home, assisted living, home and adult day care.
Visible Body Human Anatomy Atlas	Useful both to review anatomy and illustrate for patients. $24.99 but sometimes on sale. Oh, I wish this was available when I took anatomy in medical school
TreatHF	American College of Cardiology (ACC) guidelines for heart failure
Readcube Papers	This is the reference app that I use to access pdfs and Medline searches, synching with my computers. They bought the app I previously used, called Papers, and replaced it with a subscription model – so far I am impressed.
AnticoagEvaluator	American College of Cardiology (ACC) app that calculates Cha_2DS_2-Vasc scores, reviews therapy options. Last updated May 2017. For non-valvular a-fib.
Antidote App	American College of Emergency Physicians – excellent reference for poisonings. Oh, this would have been useful for the enemies of the Medici in the 1400s.
ADA Standards of Care	2018 revisions of American Diabetes Association standards for diagnosing and treating diabetes, includes interactive algorithms and assessment tools. Free, and with iPad and Android versions as well.
Pocket Casts	Gazillions of podcast apps, but this is one of my favorite to listen to podcasts such as ReachMD's Focus on Geriatric Medicine and Aging. I also have favorite podcasts that are so boring that they are the most effective non-pharmacologic sleeping aid I have seen.
MMWR Express	Free app to read the CDC's full reports and summaries from the Morbidity and Mortality Weekly Report

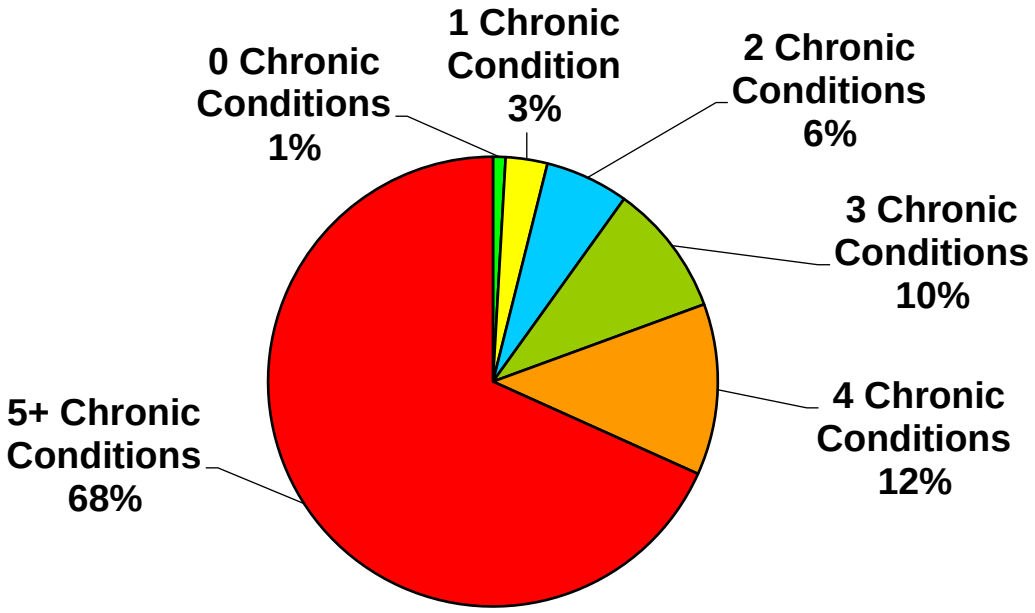
For questions, my email is jay@luxenberg.net

In The Trenches - How to be Competitive with Medicare Advantage

Dan Osterweil MD, CMD, FACP

Background Facts:

- In 2018 one in three (34%) of MDCR beneficiaries (20.4M) is enrolled in a MA plan
- This grows at 8% per year
- California is a delegated care Managed care model
    - Health plans do not provide care
    - Health plans contract with Provider groups
    - Health plans and Medical groups share risk for managing beneficiaries



What do MA plans and delegated Medical Groups expect?

- Bed availability to accommodate admissions 24/7
- Moderate rates based on value added
- Collaborate w/ plans in utilization management
- Physician /NP availability
- Rehab services 6-7 day/week
- Teams versed in care transition
- ED to SNF w/o pre-authorization
- Subacute services
- Bed side dialysis

What should you do to be ready?

- Have teams ready and capable to care for patients with various degree of complexity
    - Team trained in INTERACT /SNF2.0
- Have protocols and staff trained to solicit patient preferences
- Changing the practice work flow
    - Team care-shared responsibilities with non-physicians
    - Share information (e.g., EHR)
    - Coordinate care
    - Utilize evidence and or consensus-based approaches

What would make you <u>more</u> saleable?

- Have performance and quality data to share
- Established QI program with transparency
- Establish working relationship with referring Hospitals.
- Develop and maintain on going communication with hospitals and physicians
- Maintain a GNP on your staff
- ***Communicate, communicate, communicate***

More questions:
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SNF/NF Capabilities List

INTERACT® Version 4.0 Tool

This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs, who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility _____

Address _____

Tel (_____) _____ **Key Contact** _____

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing Onsite		
Basic Metabolic Panel (*BUN, Ca, Cl-, CRE, eGFR, GLU, K+, Na+, tCO_2)*	Y	N
Bladder Ultrasound	Y	N
Cardiac Echo	Y	N
Complete Blood Count (CBC)	Y	N
EKG	Y	N
INR	Y	N
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
Venous Doppler	Y	N
Consultations		
Cardiology	Y	N
Orthopedics	Y	N
Psychiatry	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N
Therapies On Site		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

Capabilities	Yes	No
Nursing Services		
24 Hour RN Converage	Y	N
O2 saturation	Y	N
Incentive spirometry	Y	N
Nebulizer treatments	Y	N
Interventions		
Advanced CPR *(ACLS capability)*	Y	N
Analgesic Pumps	Y	N
Automatic Defibrillator	Y	N
Blood Administration	Y	N
Hemodialysis	Y	N
Isolation *(for MRSA, VRE, etc…)*	Y	N
IV Antibiotics	Y	N
IV Fluids *(initiation and maintenance)*	Y	N
IV Meds – Other (*e.g. furosemide)*	Y	N
Peritoneal Dialysis	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Tracheostomy Management	Y	N
Surgical Drain Management	Y	N
Ventilator Care	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N
Other Specialized Services *(specify)*		

Updated June 2018

Medication Reconciliation Worksheet for Post-Hospital Care

INTERACT®
Version 4.0 Tool

Part 1: Hospital Recommended Medications Needing Clarification

Medications Recommended by Hospital at Discharge for which Clarification is Needed	**Clarification Needed***	**Resolution for Final Medication Orders** *(Continue, Stop, Change)*

**Examples: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication*

Part 2: Medications Prior to Hospitalization Needing Clarification

Medications Taken Before Hospitalization Not Currently on Hospital-Recommended List	**Comments** *(e.g. reason for the medication before hospitalization, and reason it was stopped in the hospital, if known)*	**Resolution for Final Medication Orders** *(Continue, Stop, Change)*

Residents Name _____ **Date** _____/_____/_____

<Facilty letterhead>

Asymptomatic Bacteriuria – Breaking the Cycle

Urinary tract infection (UTI) is the most common indication for antibiotic use in post-acute facilities and a significant proportion of this use is inappropriate and unnecessary. Asymptomatic bacteriuria (ASB) is prevalent in residents of post-acute facilities and is frequently misidentified as a "UTI". The Antibiotic Stewardship Program at <facility name> has developed this guidance to facilitate the evaluation and appropriate management of ASB.

Definition:

ASB refers to bacteria in the urine at levels often regarded as clinically significant (100,000 colonies/ml) but with no symptoms or localizing signs suggestive of UTI. Pyuria (>10 WBC/hpf) accompanying ASB is not an indication for antibiotic treatment; nor is a culture result showing a low colony count (25,000 or 50,000 colonies/ml).

Ordering of UA/C&S:

The 'Choosing Wisely' guideline from the American Medical Directors Association (AMDA) recommends against obtaining urine studies unless there are clear signs and symptoms that localize to the urinary tract. Multiple studies have also shown that confusion or altered mental status is not a reliable indication for urine studies. Such studies often lead to unnecessary antibiotic treatment.

Urine studies are **not** recommended for:

- Change in urine color, odor or turbidity – these are typically due to resident hydration and not indicators of infection.
- Catheterized residents while the catheter remains in situ. This includes both Foley and suprapubic catheters.
- After a patient fall.
- To document cure after treatment of UTI.

Common ways ASB masquerades as an infection requiring antibiotic Rx:

Masquerade scenario	Best practice response
A positive UA/C&S result (an organism name and susceptibilities; any colony count) is a "positive test"	A positive culture often masquerades as a "positive test", requiring treatment – up-to-date decision criteria require **both** a positive culture **and** specific clinical features
A positive UA/C&S result predicts "risk of later invasive infection" even when there are no symptoms/signs	Multiple studies show antibiotic Rx of ASB confers no benefit and does not prevent invasive disease
"Confused this morning ... start Cipro and get a UA/C&S"	Hold antibiotic; put patient on 48-hr observation pathway and push fluids; confusion often resolves w/o antibiotic
C&S result = 50,000 colonies E. coli **ESBL+** "This is a superbug ... should be treated"	Multi-drug resistant organism (MDRO) w/o symptoms is not an indication for antibiotic Rx or contact isolation
C&S result = 100,000 colonies ... no symptoms or signs "This is a positive test ... can't ignore it"	This is ASB, not a "UTI"; standardized definition of UTI requires a positive clinical (McGeer criteria) as well

<Facility letterhead>

Are You Sure Your Loved One Has A UTI?

How Taking Antibiotics When They Are Not Needed Can Cause More Harm Than Good

At <Facility Name>, our goal is to provide the best care possible. We believe in working together with our Residents and families so you feel we are meeting the needs of your loved one. In this spirit we are writing to share new findings about antibiotic resistance and urinary tract infection (UTI).

Today there is national and world-wide attention focused on antibiotic resistance and its root cause – unnecessary use of antibiotics. One of the most frequent reasons seniors are given antibiotics is UTI. Yet studies are showing that many of these UTI's are misdiagnosed – a result of confusion between normal resident bacteria and those causing infection.

It turns out there are many bacteria living in and on our bodies that cause no harm. In fact these bacteria – which outnumber our human cells 10-to-1 – are needed for us to live, digest our food and have our immune systems function properly. Some of these bacteria live naturally in the bladder without causing any pain or symptoms. This is called *asymptomatic bacteriuria*, which can be present in half or more of seniors living in long-term care settings.

In the past when a urine specimen tested positive for bacteria – even when no symptoms were present – doctors were taught to treat this bacteriuria with antibiotics – just in case they might eliminate the cause of any future problems. We now know this is unnecessary and often harmful. Multiple studies have shown that giving antibiotics in this situation does not help. It does not prevent UTIs or urinary sepsis. It does not improve bladder control. It does not help memory problems or balance. In fact the main result of treating asymptomatic patients with antibiotics is complications. Antibiotics here can kill "friendly" bacteria leading to vaginal yeast overgrowth or severe diarrhea from overgrowth of toxic bacteria in the bowel. Yet the most sinister unseen complication is the emergence of resistant bacteria. Their resistance is the result of repeated cycles of antibiotic treatment. These resistant bacteria have come to predominate in our world – now a global public health emergency more important than AIDS or Ebola virus.

As a family member you are an important care partner for your loved one. By understanding the risks of using antibiotics when not needed you help us to provide good, safe care. Antibiotics should be used only when the doctor or nurse practitioner is sure that there is an infection. We no longer use antibiotics just-in-case. When antibiotics are prescribed or not prescribed, we want you to feel comfortable asking questions.

The safest care happens when the entire team understands and follows the most current recommendations. If you would like more information please ask one of our nurses for the <Facility Name> packet on Antibiotics and UTI.

Update on POLST and Advance Care Planning (ACP) in Post-Acute and Long-Term Care (PALTC)

POLST Issues

- **Never** required (by law and by intended use), yet some nursing homes essentially use it as a code status document on every new admission
    - Some facilities "require" a new POLST even when the patient has a valid POLST form—even one that was just completed at the hospital a day or two before *(inappropriate!)*
- POLST is intended for patients who are seriously ill, generally with a life expectancy of one year or less (not a strict rule, but in general) https://polst.org/wp-content/uploads/2018/04/2018.04.27-Appropriate-Use-of-POLST-Paradigm.pdf
    - This does not apply to many nursing home admissions.
    - If a patient wants full-code status (i.e., CPR in the event of an arrest), they really don't need a POLST form completed, since this is the default treatment—but for those people who **do** want the most aggressive treatment, it's advisable to complete one stating that
    - For less ill patients, it's more important that they have an advance health care directive (AHCD) and designate a surrogate/proxy/decisionmaker—even though this is more inconvenient in a nursing home since ombudsman witness required
- POLST is more than just a form; it needs to reflect diligent discussion(s) between the health care professional and the patient/family – yet there are those who sign POLST orders without even confirming that their content is accurate (*inappropriate!*)
- Some nursing homes will have a family member sign a resident's POLST instead of the patient, even when the patient has decision-making capacity (*inappropriate!*)
- Ideally, both patient and family should be aware of what is being ordered on a POLST
- Remember: Section A of POLST only applies when the person has no pulse and is not breathing: "DN[A]R/No CPR" does not mean "do nothing" or "just let me die," important discussion point
    - Also, CPR success rate very low in the nursing home population
- If you choose "CPR" in section A, you **must** choose "full care" in section B.
- But: You can choose "No CPR" and still choose "full care" (e.g., ok to put on a ventilator)
- Consider "Do Not Transfer" option for nursing home residents on section B
    - Remember: "Trial Period of Full Treatment"
- Original POLST goes with the patient, but copies should be made (valid) and shared with other health care providers, including community PCP and local hospital (e-Registry pilots underway)
    - Facilities sometimes don't send POLST home with patient or share with PCP
- CCCC's decision aids (CPR, tube feeding, hydration, ventilation) were recently updated and are excellent resources https://coalitionccc.org/tools-resources/decision-guides/
- Three choices on tube feeding (section C): None, trial period, long-term. Note that tube feeding is contraindicated in advanced dementia. Also, note that Oregon has removed the section about tube-feeding on their POLST form (a whole separate discussion), but never an emergency decision and it's not required to fill this section out

Advance Care Planning

- Made "in advance" of deterioration in physical/cognitive condition to make wishes known [Not "Advance**d**" as in complicated or the opposite of basic. Because sometimes it's very simple.]
- Made with patient, health care professionals, preferably family, and sometimes with legal assistance – but lawyers should not be the ones doing the medical conversations
- Can be billed using codes 99497 and 99498 by docs/NP/PAs

In The Trenches' Presentation, Creating an Appealing Workplace: Staff Retention Strategies

Low retention impact to facility: costly to retrain staff and hire people, loss of valuable knowledge can delay projects, low morale, unhappy employee, stress, and burnout, less productive especially replacing productive and contributing employee, injuries and workers comp, increase rate of call in sick.

Learning Objectives:

Compare nursing staffing difficulties across California and strategies used to address.

- Compensation is lower in skilled nursing home than in Acute care. Average starting salary in Acute Care is $*** , Average starting salary for Long Term Care is $***
  - Strategies used to address: Better recognition program, appreciation, performance review
- Difficult to hire
  - Strategies: better recruitment advertise, relationship with school, assess hiring process
- Interest in working with frail or elderly than acute care
  - Strategies: Hiring process, screening candidates well, skill and interest, job fit and interest.
- Team nursing approach is used in Long Term Care (higher nurse to patient ratio: higher workload) compared to Primary Nursing which is used in Acute Care. Residents in Long Term Care also have more complex needs as they have complex mental, physical and psychological care needs.
  - Strategies: Involve staff on decision making, do interdisciplinary meeting with CNA's, voice of the customer is heard, increased management support
- More requirements in CA for foreign graduates compare to other states
  - Strategies: Working with available resources such as HR to implement programs to hire New Graduate Nurses or Nurses without Long Term Care experience, educational support.
- Increase and changing Regulations to comply / audits/documentation that remove them from patient care
  - Strategies to address: In-Service education and support of staff
- Lack of supervision because of shortage of License Nurse
  - Strategies: Balance the need to Registered Nurse who needs to supervise C.N.A. and LVN.
- Registry dependence are costly and inconsistent
  - Strategies: increase the regular staff who are committed and consistent, 12 hour shift

Analyzes factors promoting staff retention.

- Better recruitment and selection / better hiring process, Skills and interest
- Compensation competitive to others , allow Overtime
- Workload is realistic with patient ratio / acuity adjusted staffing
- Managerial support / leadership style – staff participation, teamwork, commitment, feel empowered, embrace collaborative relationship with physician, coaching,
- Retirement / benefits / copayment/deductions/premiums
- Education / career path / training / opportunities for advancement
- Recognition, appreciation, birthday appreciation, nurse of the month/ year
- Flexible scheduling, allow Registry / partime / per diem / travel nurse
- Fairness
- Do you have friends at work?

Generates two ideas for enhancing staff acquisition and retention.

- Communication – make rounds to check how they are doing, expectation, appreciate, say thank you, show them that you care, ask questions, job fit, Mission/Vision and values, skills and interest, exit interview
- SWOT analysis / survey / Performance review / diversity

Compassion Fatigue

Ten Factors Unique to Long Term Care

1. Public and community perception of the “Nursing Home Physician/Nurse/other care professional”

2. Fewer collegial resources [particularly if you are a sole physician practice or night shift RN]

3. Regulatory pressure on everyone from Medical Director to CNA

4. Multiple patients who are unable to make their own health care decisions so consultation with family members who may be dealing with their own stress as well is necessary.

5. By the time you see a patient you are often two steps removed from their regular PCP; the hospitalist, often in conjunction with specialists, handles the acute hospital admission then turns care over to you.

6. Family members sometimes insist on “doing everything” often due to their own issues [though this can also occur in the acute, it is seen more often in LTC].

7. Patients and family members are used to seeing at least one physician every day at the acute and do not understand how the nurses and physicians work together in long term care to provide appropriate medical care.

8. Family feelings of guilt for “putting mom in a home”

9. Unrepresented / homeless patients who lack capacity [hospitals have them also, but they discharge them to US]

10. Specific [and often different] documentation requirements

Case Study: Moral Dilemma

Mary is 83 years old and lives at Shady Acres skilled nursing facility. You have been her attending physician for two years and always enjoy seeing her. She is gracious and expresses appreciation every time you visit. She also has a son and daughter, each of whom visit once or twice a month.

Mary is an avid reader and, in her day, was a college professor. One day she asks you if you have heard anything about VSED [voluntarily stopping eating and drinking in order to hasten death]. You are somewhat surprised by this and in this brief conversation she tells you “I’m not ready for that just yet, but I think that it could be a good thing if you are tired and ready to go.”

Over the next few months, her congestive heart failure and mobility limitations due to arthritis are getting worse. She has trouble catching her breath and can no longer walk all the way around the facility and back to her room using her walker. She is starting to be incontinent at times as she can’t make it to the bathroom quickly enough. Her daughter and son are both raising children; her son’s child has special needs and her daughter’s child is a pre-teen who is starting to get into a little bit of trouble.

You see her for a routine visit and out of the blue she says “I think I am ready to stop eating and drinking.” Of course, you discuss this in greater detail, but she is very firm in her convictions. She begins to refuse food and the facility staff become concerned.

When her level of consciousness starts to slip, her children get wind of the situation and call you “Doctor, you must do something!”

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

QUICK-GUIDE SUGGESTIONS PREVENTION/INTERVENTION WITH THE NEGATIVE EFFECTS OF CAREGIVING

B. Hudnall Stamm, Ph.D.

Individual Level

1. **Self Assessment**
   a. History of traumatic events
      i) If you have a history, welcome to the 50% who do ☺
      ii) What are your triggers?
      iii) Can you reduce their potency by therapy or other positive means?
   b. Stressor load outside of work environment
      i) Do you do things that refresh you?
      ii) What tasks do you have to do that use your energy?
         (1) Is there a way to share the load with friends or family?
         (2) What can you "not do" e.g. should you alter your expectations of what is "necessary"
2. **Health behaviors**
   a. Sleep—most people are sleep deprived which makes you more physically and psychologically vulnerable
   b. Exercise: even 20 minutes 3 times a week makes a difference.
      i) Consider exercising with people who help "refresh" you, multi-tasking!
   c. Diet
      i) Do you eat at regular intervals, skip meals?
      ii) Do you eat enough fresh foods?
      iii) How about your caffeine, nicotine intake?
   d. Interpersonal Relationships
      i) Do you have unfinished business with others that uses energy?
      ii) Can you tell your friends and colleagues about how your work affects you (not your client's details) and ask for their support?
      iii) Can you tell your friends and family not to expect you to solve their problems since you are "so good at it"?
3. **Other Assessment**
   a. What would your friends and family tell you about your work?
   b. Can you use them to help monitor your exposure, let you know when you start to seem stressed?
   c. What do you lean from your supervision?
      i) Is your supervision "safe," or do you monitor what you tell your supervisor? If it is not safe, can you change supervisors? Should you add an "outside of work" supervisor?

Work-Group Level

1. **Caseload**
   a. Can you vary your caseload?
   b. If you cannot see a variety of different patients/clients, can you:
      i) Intersperse patients/clients with administrative tasks
      ii) Distribute the level of distress of cases, mix people who are doing well and nearer completion of their therapy, or more stable cases for case management with those who are more volatile and struggling.
   c. Try to end the day (if at all possible) with a positive activity so that you don't head home with fresh feelings of distress that you have not had time to dissipate in the work-setting where they belong. Otherwise, it is all too easy to imagine that they belong in your home/personal sphere.
2. **Collegial and Professional-Peer Support**
   a. Can you count on your colleagues to help
      i) Listen if you are struggling
      ii) Tell you when you are struggling more than a conversation by the coffee-pot can contain; when you need to seek supervision or professional support to deal with your feelings about work?
   b. If you cannot count on your work-colleagues
      i) Find a collegial group you can trust
         (1) This may be in person, for example, a professional "lunch" group that meets for support
         (2) Alternatively, it can utilize technology, e.g. telehealth, and be virtual community
      ii) Set basic ground rules for confidentiality
         (1) Client confidentiality—you don't have to tell their story; you really need to deal with how working with them made you feel! This is about you, not them.
         (2) Provider (e.g. your) confidentiality—what you share should be considered confidential unless the group agrees to share particular information. It is a necessary part of feeling safe to share.
3. **Professional Hope**
   a. Burnout eats your ability to envision a better life.
   b. Professionals who have hope are far better at offering it to others!