

POLST Knowledge Survey of California Providers: *Everybody Failed!*

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Coalition for Compassionate Care of California

Background

- 2008:** Coalition for Compassionate Care of California (CCCC) sponsored legislation to establish POLST (Physician Orders for Life-Sustaining Treatment) program in California.
- 2009–2018:** CCCC implemented POLST across California, fostered 27 local coalitions, and conducted extensive provider training.
- 2021:** CCCC and others sponsored legislation to stand up a statewide electronic POLST Registry, which is in development.
- 2024:** CCCC deployed a survey/knowledge test to assess the current state of understanding of POLST across clinical disciplines and healthcare settings to inform educational efforts prior to the Registry launch.

Methods

- Survey: **4 demographic questions, 19 multiple-choice questions on POLST purpose, form completion, and process**
- Questions addressed **4 POLST competencies**:
 - Clinical Knowledge
 - Documentation
 - Patient-Centered Care
 - Cultural Sensitivity
- Deployment:** August 12 to September 30, 2024, in SurveyMonkey, snow-balled by 42 state agencies, professional associations, and healthcare industry partners.

Fig. 1 Average Percentage Correct Answers – Setting

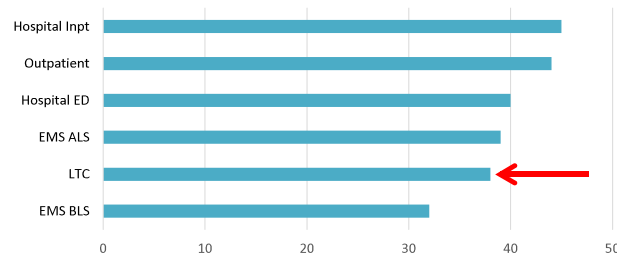
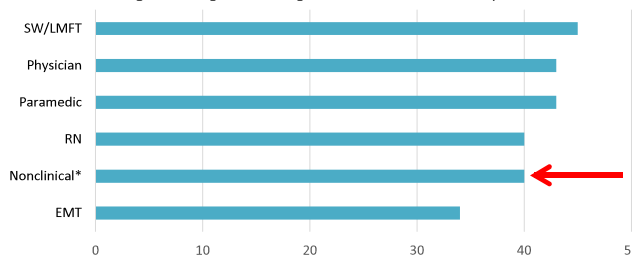


Fig. 2 Average Percentage Correct Answers – Discipline



*Mostly nursing home administrators

Results – Overall

- 3,247 completed surveys; 57 of 58 California counties represented.
- 6 of 14 healthcare settings & 6 of 12 disciplines sufficiently represented for analysis (>100 respondents/category).
- ~50% respondents were physicians; ~25% were EMS/first responders.
- The average percentage of correct answers across all respondents <50% for 11 of 19 questions; 3 scored average correct <5%.**
- Only 1 question had an average percentage of correct answers >75%.**

“If this had been an actual test, graded by discipline or setting, everyone would have failed!”

Table 1. Questions With ≤50% Average Correct Answers from LTC Respondents

Question #	Topic	Avg % Correct LTC	Avg % Correct LTC Phys	Avg % Correct Overall
6	Patient appropriateness for POLST	9%	19%	24%
8	Signature for incapacitated, unrepresented SNF resident	50%	26%	23%
9	Relationship between Sections A and B on the POLST	30%	38%	41%
10	Signatures required to make POLST valid	19%	7%	19%
12	Proper use of translated POLST forms	27%	45%	44%
14	Persons qualifying as “legally recognized decision makers”	1%	0%	2%
15	Circumstances in which a healthcare professional is allowed to NOT follow a POLST form	4%	2%	3%
16	Circumstances in which Section A of POLST is applicable	38%	36%	35%
17	Circumstances in which POLST should be reviewed/updated	43%	57%	41%
22	Operational distinctions btw POLST and prehospital DNR	1%	2%	1%
23	Precedence of POLST or AHCD when instructions conflict	41%	55%	46%

Table 2. Questions With >50% Average Correct Answers from LTC Respondents

Question #	Topic	Avg % Correct LTC	Avg % Correct LTC Phys	Average % Correct Overall
5	General purpose of POLST	54%	74%	63%
7	Voluntariness of POLST completion	52%	64%	73%
13	Circumstances under which POLST must be voided and replaced	86%	93%	79%
18	Expiration of POLST	72%	83%	67%
19	Circumstances under which a physician can recommend revising a POLST	67%	74%	64%
20	Owner of the POLST form	58%	57%	66%
21	Disposition of original POLST	59%	62%	56%

Results – Long-Term Care

- The average percentage of correct answers from LTC respondents was 38% – the second “worst” performance next to EMS BLS (see Figs 1&2).**
- LTC respondents generally tracked overall scores, with these notable deviations:**
 - >10 % pts lower:** Patient appropriateness for POLST; Relationship between Sections A and B on the POLST; Proper use of translated forms; Voluntariness of POLST completion
 - >10 % pts higher:** Signature for incapacitated/unrepresented SNF residents
- LTC PHYSICIANS generally tracked LTC average scores, with these notable deviations:**
 - >10 pts % lower:** Signature for incapacitated/unrepresented SNF residents; Signatures required to make POLST valid
 - >10 pts % higher:** General purpose of POLST; Patient appropriateness for POLST; Voluntariness of POLST completion; Proper use of translated forms; Circumstances in which POLST should be reviewed/updated; Expiration of POLST; Precedence of POLST or AHCD when instructions conflict

Limitations

Convenience sample: Survey completion both **voluntary & nonrandom**.

Survey amounted to an **“open-book exam”**: Respondents could have researched correct answers from easily available internet sources.

Responses could be based on what the respondent knows “should” be done, rather than what they actually do.

Likely that responses included a higher proportion of correct answers than a random selection survey would and may not reflect actual practice.

Discussion/Conclusions

Accurate knowledge of and adherence to POLST process across disciplines and settings are crucial to goal-concordant care.

Misunderstandings and misuses persist across all settings and disciplines, resulting in diminished patient autonomy, overtreatment, unnecessary suffering and cost.

Given the reliance on POLST in the SNF setting, **the generally poor performance of LTC respondents is of special concern.**

There is an **immediate and urgent need for refresher education on the fundamentals of POLST** process provided by a centralized authoritative source.



Rehab Reveal: Prostatitis Masquerading as Recurrent UTI

C. Gross and C. Chen

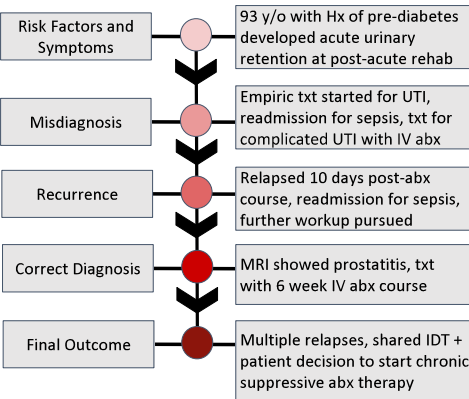
INTRO

- Prostatitis is common with a lifetime prevalence of 25% and a recurrence rate of 25-50%¹.
- Inadequate recognition and treatment leads to antibiotic resistance, functional decline, and progression to chronic pain syndromes².
- Due to its complexity and prolonged treatment, these patients often require management across the continuum of care, particularly in post-acute settings.

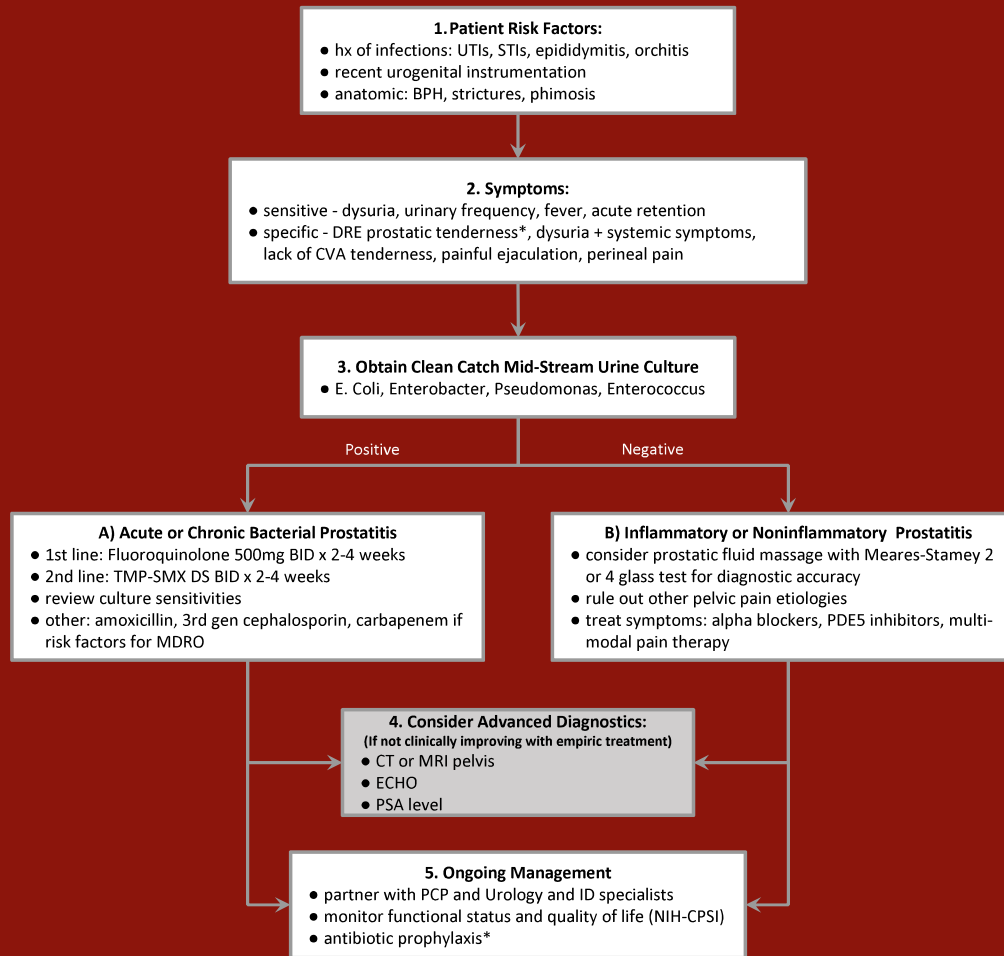
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CASE PRESENTATION



Prostatitis should be a diagnostic consideration in older men with recurrent UTI symptoms.



PROSTATITIS DIFFERENTIAL

	Prostatitis	Cystitis/UTI	Pyelonephritis
Dysuria	✓	✓	✓ / -
Urgency	✓ / -	✓	✓ / -
Acute retention or weakened stream	✓ / -	✓ / -	✓ / -
Fever or systemic symptoms	✓	✓ / -	✓
CVA Tenderness or Flank Pain			✓
Perineal Pain	✓		
Painful Ejaculation	✓		

PROSTATITIS NIH CLASSIFICATION

CATEGORY I Acute Bacterial Prostatitis	Acute Infection of the Prostate Gland
CATEGORY II Chronic Bacterial Prostatitis	Recurrent Infection of the Prostate Gland
CATEGORY IIIA Inflammatory CPPS	White Blood Cells in Semen/EPS/Voided Bladder Urine 3 (VB3 or Post-Prostatic Drainage)
CATEGORY IIIB Non-inflammatory CPPS	No White Blood Cells in Semen/EPS/VB3
CATEGORY IV Asymptomatic Inflammatory Prostatitis	• Abnormal semen analysis • Elevated PSA Values • Incidental findings in Prostate Biopsy

DISCUSSION

- Both acute and chronic prostatitis remain largely clinical diagnoses.
- Consideration of patient specific risk factors in addition to a combination of sensitive and specific symptoms may help improve recognition of this common diagnosis.
- Accurate diagnosis coupled with urine culture specificities can greatly enhance appropriate antibiotic stewardship.

CONCLUSIONS

- The burden of recognition and management of prostatitis syndromes will likely fall on post acute and primary care providers.
- Prostatitis could be recognized as a geriatric syndrome best managed through an IDT approach.

FINANCIAL DISCLOSURES

- None



Assessing and Improving Nursing Home Staff Cross-Cultural Care Competence

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INTRO

- Cross-Culture Care competence refers to understanding and respecting the diverse cultural backgrounds of patients to enhance the quality of healthcare. It is crucial for tailoring healthcare to meet patients' cultural beliefs, values, and practices, ultimately improving health outcomes, patient satisfaction, and fostering an inclusive healthcare environment. [1]
- This quality improvement project aims to assess the cultural competence of staff in a nursing home setting and implement targeted interventions to enhance culturally sensitive care.
- In the study, the emphasis was on understanding staff beliefs, behaviors, and awareness around cultural competence and identifying areas for improvement.

METHODS

- Validated 25-item self-report instrument with two sub- scales was used to evaluate the competence levels of staff:
 - Cultural Awareness and Sensitivity (CAS) subscale (11 Items)
 - Cultural Competence Behaviors (CCB) subscale (14 Items)
- The instrument used a 7-point Likert-type scale, mean scores ranging from 1 to 7
- Mean scores of 4 indicates moderate cultural competence
- Mean scores of 5 indicates moderately high cultural competence
- Mean scores approaching the range of 6 to 7 indicates a high level of cultural competence
- Scores were utilized to identify strengths and areas of improvement within the current level of cultural competence. [2]

RESULTS

- Of the 38 staff members, 22 participated in the survey. The overall mean CCA score was 5.14, with CAS averaging 5.50 and CCB at 4.83. (Table 1)
- A significant 38.35% scored below 4, which indicates areas for improvement.
- Higher competence was observed in social services and rehabilitation staff, whereas CNAs and LVNs exhibited lower scores.
- Furthermore, a majority of participants expressed interest in additional training, particularly online models (68.18%) and culturally relevant reading materials (45.45%)

✓ Nursing home staff demonstrated a generally positive attitude toward cultural competence, a gap persists between their awareness and actual behaviors.

✓ Staff expressed a desire for additional resources and support.

	CCA score	CAS subscale Score	CCB subscale Score
Mean (Std)	5.14 (0.89)	5.5 (0.6)	4.83 (1.34)
Range	3.54 - 6.58	4.36 - 6.64	2.38 - 7.0

Table 1: Nursing Home Staff Culture Competence Test Results

Position	CCA score	CAS score	CCB score
Administrator (n=1)	4.76	5.76	4.00
Administrative Staff (n=2)	4.94	5.75	4.37
Social Services (n=1)	5.50	6.64	5.54
Registered Nurse (RN) (n=2)	5.14	5.25	5.00
Licensed Vocational Nurse (LVN) (n=6)	4.68	5.48	4.00
Certified Nursing Assistant (CNA) (n=6)	4.86	5.11	4.64
Activity and Enrichment (n=2)	5.88	5.77	5.96
Rehab Staff (n=2)	5.98	6.37	5.75

Table 2: Nursing Home Staff Culture Competence Test Results by Position



INTERVENTIONS

- C.A.R.E. Approach Posters:

Incorporate this approach into daily care routines. (Figure 1)

- LEARN Model: Apply the LEARN model to improve communication and culturally sensitive care. (Figure 2) [3]

- Self-Reflection Checklist: Use the checklist provided to reflect on staff cultural competence. (Figure 3)

- 7 Steps to Become a More Culturally Competent Nurse:

A recommended read for all staff, not just nurses.

- Resources: A book titled "Transcultural Nursing" was made available in the nursing station, offering guidance on care for different ethnic/racial groups.[4]

- QR Codes: Access online resources via QR codes posted around the facility. (Figure 4)

C.A.R.E. for Every Resident

C	A	R	E
Curiosity Cultivate Cultural Curiosity Actively seek to understand resident's unique cultural context. Cultivate Open Dialogue: Encourage sharing of traditions, beliefs, and customs.	Awareness Acknowledge Differences Recognize and respect individual differences without judgment. Assess Needs: Understand and consider how cultural factors influence care preferences.	Respect Recognize Beliefs Show respect for residents' cultural beliefs and values. Honorize Autonomy: Support their right to make decisions regarding their care.	Empathy Engage with Compassion Listen actively and show genuine care for their experiences. Empower: Provide guidance, foster self-efficacy, and ensure residents feel heard and valued.

Every interaction is an opportunity to build trust and provide care that respects each resident's unique cultural identity.
"Great care comes from great understanding."

Figure 1: CARE approach Posters

Cross-Culture Communication Framework

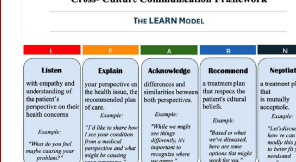


Figure 2: The LEARN Model Cross-Culture Communication Framework

Cultural Competence Self-Reflection Checklist

1. Assess Readiness: Do you feel confident in your cultural background?
2. Take a self-assessment, and then take a survey?
3. Self-Reflection: Do you feel confident in your cultural background?
4. Self-Reflection: Do you feel confident in your cultural background?
2. Assess Readiness: Do you feel confident in your cultural background?
3. Take a self-assessment, and then take a survey?
4. Self-Reflection: Do you feel confident in your cultural background?
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4. Self-Reflection: Do you feel confident in your cultural background?
4. Self-Reflection: Do you feel confident in your cultural background?
5. Self-Reflection: Do you feel confident in your cultural background?

Figure 3: Culture Competence Self-Reflection Checklist

Cultural Competence Online Resources



Figure 4: QR codes for Online Resources

DISCUSSION / FUTURE DIRECTIONS

- Our findings underscore the need for targeted skill-building interventions to enhance staff cultural competence and create a more inclusive care environment. By equipping staff with the tools to provide culturally aligned care, we aim to improve resident satisfaction and health outcomes.

- We will evaluate the effectiveness of these interventions through staff assessments and resident satisfaction surveys. Our goal is to develop a scalable model of culturally competent care that can be expanded to multiple nursing homes.

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Multisystem Approach to Reduce Healthcare Acquired COVID-19 Infections at LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

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BACKGROUND

COVID-19 can significantly contribute to the morbidity and mortality of residents in skilled nursing facilities (SNFs). Several factors make SNF residents particularly vulnerable to the disease. Many residents are over the age of 65, often managing chronic comorbidities and experiencing weakened adaptive immunity. The adaptive immune system, responsible for producing T cells and B cells, declines with age, reducing the body's ability to combat specific pathogens and respond effectively to new infections or vaccines. Additionally, communal dining, shared spaces, and close quarters within SNFs create an environment that facilitates the rapid transmission of respiratory viruses among residents and staff.

PROBLEM STATEMENT

Despite regulatory mandated strategies to prevent the spread of COVID-19 infections throughout congregate living facilities, these facilities such as SNF's continue to struggle managing and preventing respiratory illness outbreaks.

TARGET STATEMENT

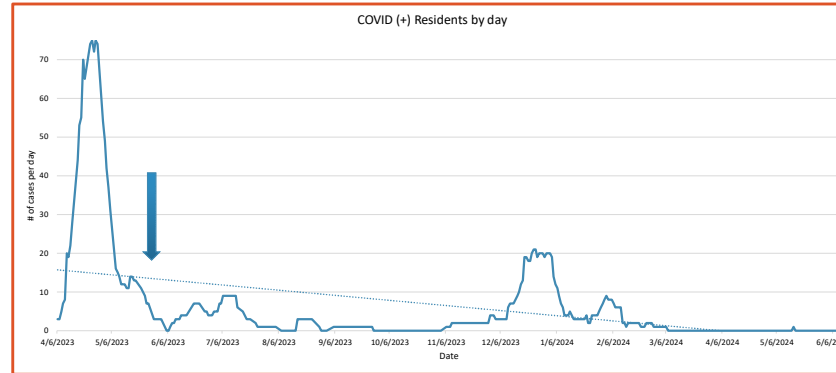
To reduce the number of healthcare acquired COVID-19 infections by 20% by December 2024.

INTERVENTIONS

Interventions were based on transmission levels within the SNF, community, and among staff and residents. Major steps included:

1. Communications
2. Staffing for fit testing, Contact Investigation and resident testing.
3. Staff and resident testing
4. Source Control Masking for staff and visitors.
5. Transition from ASTM level 1 mask to ASTM level III mask.
6. Environmental cleaning of communal areas
7. Staff and visitor screening
8. Limit communal dining for staff and residents.
9. Limit group activities and in-person meetings.
10. Respiratory infection smoking area

RESULTS



METHOD

A retrospective review of medical records from January 2023 to December 2024 examined COVID-19 positive cases among residents in a large skilled nursing facility (SNF). During this time, the facility upgraded its masking protocol from ASTM level I to level III masks as part of broader mitigation efforts. The analysis revealed a 60% reduction in reported COVID-19 cases, highlighting the effectiveness of these strategies. To ensure accuracy, the review excluded residents who tested positive within 30 days of a prior positive result. Additionally, cases were not counted if the resident tested positive within four days of admission and had a prior positive test within the preceding 30 days.

FURTHER ANALYSIS

What do ASTM face mask levels mean?

ASTM rates medical face masks according to three levels, with Level 1 masks providing the lowest level of barrier protection and Level 3 masks providing the highest barrier protection. The intended use for medical face masks is to protect the wearer from splashes or sprays during healthcare procedures, as well as keep large splashes and sprays from the wearer from reaching the environment.¹

Which ASTM face mask level should you use?

- Level 1—For procedures producing low amounts of fluid, spray and/or aerosols
- Level 2—For procedures producing light to moderate amounts of fluid, spray and/or aerosols
- Level 3—For procedures producing moderate to heavy amounts of fluid, spray and/or aerosols²

ANALYSIS (continued)

Surgical Masks Classification and Standards

There are many types of face masks made up of surgical/procedure masks, respirators and powered air-purifying respirators (PAPR). Surgical masks/procedure masks work as a barrier to splashes and droplets and offer less protection against aerosol particles due to lateral dissemination. There are many standards used to classify the level of protection from masks. These include American Society for Testing and Materials (ASTM), F2100 regulated by the Food and Drug Administration (FDA), European Standard EN14683 regulated by ECDC. According to Tang et.al. 2020, to protect against infection surgical/procedure masks must also be fluid resistant (type-IIR or level 3).

Test	EN14683			ASTM F2100		
	Type I	Type II	Type IIR	Level 1	Level 2	Level 3
BFE (%)	≥95	≥98	≥98	≥95	≥98	≥98
PFE (%)	-	-	-	≥95	≥98	≥98
Breathability (mmH ₂ O/cm ²)	<3	<3	<3	<4	<3	<3
FR (mmHg)	-	-	-	80	120	160
Flame resistance	-	-	-	Class 1	Class 1	Class 1
Microbial cleanliness (CFU/g)	≤30	≤30	≤30	-	-	-

Data from [14,15,17]. The ASTM classifies surgical mask's protection into three levels against the following performance requirements: bacterial filtration efficiency (BFE), particulate filtration efficiency (PFE), fluid resistance (FR), breathability, and flame spread. The European Standard EN14683 assesses the face mask based on the BFE, breathability and microbial cleanliness.

CONCLUSION

A multisystem approach is essential to reducing healthcare-acquired COVID-19 infections among residents in large skilled nursing facilities. However, since most infections were traced to staff working while symptomatic, the most impactful intervention was upgrading source control masking from ASTM level I to level III. This change significantly reduced COVID-19 transmission throughout the facility and led to a greater than 60% decrease in healthcare-acquired COVID-19 cases.

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Non-Pharmacological Management of Dementia Related Behaviors: Staff Engagement and Empowerment

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Background

- Dementia is characterized by memory loss, behavioral and personality changes, and disorientation.
- In skilled nursing facilities, where diverse staff interact with residents daily, consistent and effective care strategies are critical.
- North Pointe Care Center is a skilled nursing facility (SNF) located in Sacramento, California, and has a dedicated memory care unit.

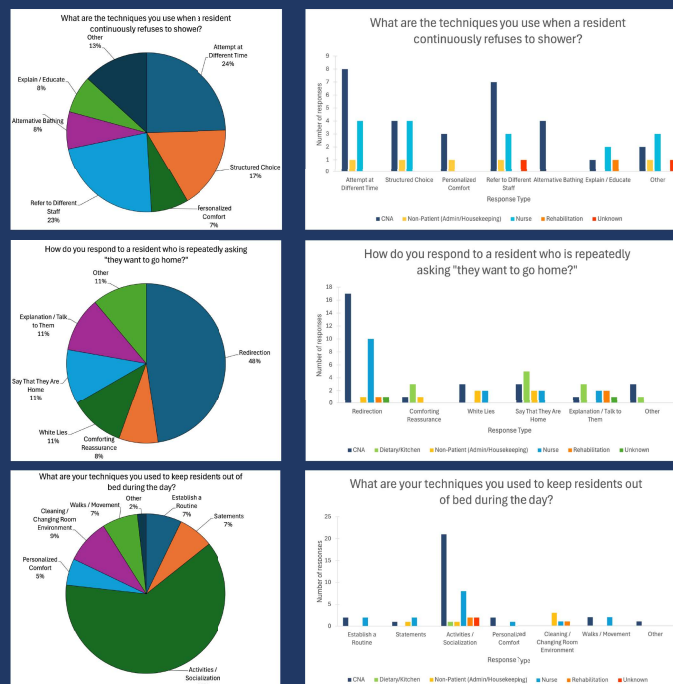
Objective

- Engagement** → Increase staff engagement by encouraging thoughtful deliberation of specific patient interactions through answering survey questions.
- Empowerment** → Use survey responses to inform future staff training to equip them with improved dementia care strategies.
- Integration** → Synthesize survey findings with Artificial Intelligence (AI) results to develop improved strategies in memory care.

Methods

- A survey inquiring about common dementia care challenges was distributed to SNF staff across the following roles: CNAs (n = 29), Dietary/Kitchen (n = 12), Non-Patient-Interacting (Administration and Housekeeping) (n = 6), Nurses (n = 16), Rehabilitation (n = 3), and Unidentified (n = 2) asking the following questions:
 - What are the techniques you use when a resident continuously refuses to shower?
 - How do you respond to a resident who is repeatedly asking “they want to go home?”
 - What are your techniques you used to keep resident out of bed during the day?
 - What are your techniques that help you convince the residents to participate in activities and eat in the dining room?
- Responses to Question 4 were not significantly different from those of Question 3, so these were omitted from analysis, but still included for AI responses.
- Responses were thematically categorized and analyzed to identify common strategies and patterns across staff roles.
- Survey questions were entered into AI platforms—ChatGPT, Gemini, Meta AI, and Perplexity—using a standardized prompt. ChatGPT synthesized and summarized AI responses to identify consistent recommendations for each care challenge.
- Findings from the staff survey and AI-generated responses were presented at a Quality Assurance and Performance Improvement (QAPI) meeting.
- Staff feedback during the meeting formed the final set of recommendations, which were compiled onto laminated cards for staff to wear, and these were formally introduced during full staff meetings.

Results



Most Common Responses & Examples of Staff Answers

Resident refusing showers: Attempt at a different time:

- “Return later when mood improves, offer choices that will involve them in decision making.”

Resident asking to go home: Redirection:

- “Ask them: Where is home? What’s your favorite thing to do when you’re home?”

Keeping resident out of bed: Activities/Socialization:

- “Offer social interactions or group activities early in the day like stretching or helping with simple tasks.”

AI Responses to Survey Questions Summarized

What are the techniques you use when a resident continuously refuses to shower?	1. Offer choices: Time, or caregiver – to foster autonomy. 2. Reframe or soften language: Use terms like “freshen up” instead of “shower.” 3. Ensure comfort and safety: Warm environment, and gentle tone.
How do you respond to a resident who is repeatedly asking “they want to go home?”	1. Validate feelings: Acknowledge the emotion, not the literal request. 2. White lies: Use kind lies (e.g., “we’ll go later”) when appropriate. 3. Redirect gently: Shift focus to calming or meaningful activities. 4. Avoid arguing or correcting (“You are home.”). These usually escalate distress.
What are your techniques you used to keep your resident out of bed during the day?	1. Use environmental cues: Open blinds, natural light, and uplifting sounds. 2. Encourage light physical activity: Short walks, stretching, or dancing. 3. Socialization: Peer interaction or 1-on-1 staff engagement promotes stimulation.
What are your techniques that help you convince the residents to participate in activities and eating in the dining room?	1. Personal invitations: Warm, individualized asks work better than announcements. 2. Use peer influence: “Your friends are already there” can boost interest. 3. Offer structured choices: Between two appealing options, not yes/no.

Major Findings

- Key issues with current staff responses:** Current staff practices involve a heavy reliance on redirection and lack emotion-centered practices and usage of white lies. This presents a gap between practice and recommendations.
- Gaps between staff practices and recommendations:** Staff responses occasionally contrasted with professional clinical opinion and AI recommendations. 18% of responses to “How do you respond to a resident who is repeatedly asking ‘they want to go home?’” was to state that the patient is already home, but this response is not practically advised due to heightened patient distress.
- AI-generated suggestions varied in usefulness:** AI generated several effective recommendations: offering choices, reframing tasks, validating patient emotions rather than logic, “therapeutic fibbing,” and establishing routines. However, other suggestions lacked effectiveness or feasibility: offer meaningful, personalized activities; incorporate comfort items such as favorite towels and soaps.

Recommended Best Practices

Resident refusing showers:

- Offer choices: clothing, type of bath, staff member, etc.
- Warm up the water before providing shower.
- Avoid giving resident the opportunity to say no.

Resident asking to go home:

- White lies: “Your family is stuck in traffic; they will be here later.”

Keeping resident out of bed:

- Open the blinds and turn on lights in the morning
- Tell patients they have an “appointment” to attend.

Increasing resident participation:

- Inviting the resident personally.
- Offer choices: activity room, going outside, etc.

Staff Dementia Care Card:

The QR code leads to the final card developed for North Pointe staff to wear on their lanyards to provide guidance of improved dementia care.





American Heart Association
Certified Care™
Skilled Nursing Facility
Stroke Rehabilitation

Bridging The Gap To Home : Quality Driven Transition Of Heart Failure Patients

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Disclosure:

The facility has no actual or potential conflict of interest in relation to this presentation

Background:

Care transition of heart failure patients from SNF to home is an important aspect in ensuring optimal outcomes. At Tampico, we have taken necessary steps to develop a heart failure program certified by the American Heart Association which has a standard focus and pathway for safe transition back to the community

Purpose:

To determine if the process of the facility following the evidenced based process and standards of the American Heart Association have a huge impact with reduction of rehospitalization

Methods/study design:

To improve outcomes, the following standards were created:

- Program charter was created to solidify the mission and vision of the program following the clinical practice guideline of AHA for heart failure
- Personnel education about heart failure and heart failure program
- Patient and caregiver support and education, looking into their readiness to learn and any barriers for learning and providing education using AHA resources
- Coordination of care from hospital to SNF and back to the community. Sending home health referral, coordinating with Primary physician, reconciliation of medication and post discharge phone call and connecting to resources in the community
- Clinical management of patient that includes checking of weights, monitoring for edema or respiratory changes, monitoring vital signs, physician assessment, following heart failure pathway for changes in condition and discussion of goals of care

Implementation Plan:

Heart failure pathway is created for the facility. This starts prior to a patient being admitted, during stay and discharge back to the community

Results/Analysis:

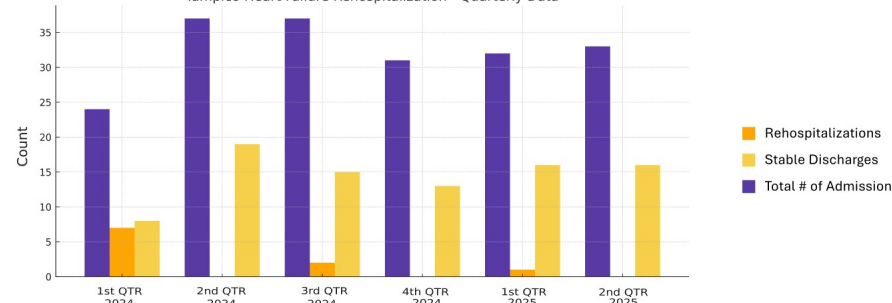
From Q3-Q4 2024 to present, Tampico was able to safely discharge 40-50% of the patient with heart failure back to the community with appropriate support .100% of patients discharged received heart failure education, resources and home health referral.

Tampico Heart Failure Rehospitalization

Quarter/Year	Total # of admission with HF	Rehospitalization rit HF	Stable Discharge to Community
1st QTR 2024	24	7	8 (33%)
2nd QTR 2024	37	0	19 (51%)
3rd QTR 2024	37	2	15 (40%)
4th QTR 2024	31	0	13 (42%)
1st QTR 2025	32	1	16 (50%)
2nd QTR 2025	33	0	16 (49%)



Tampico Heart Failure Rehospitalization - Quarterly Data



Conclusion/ interpretation:

Developing a standard disease specific program following AHA standards is vitally important in improving the outcome of the heart failure patient population

References:

- American Heart Association Skilled Nursing facility Heart Failure Certification
- Point click care

Acknowledgements:

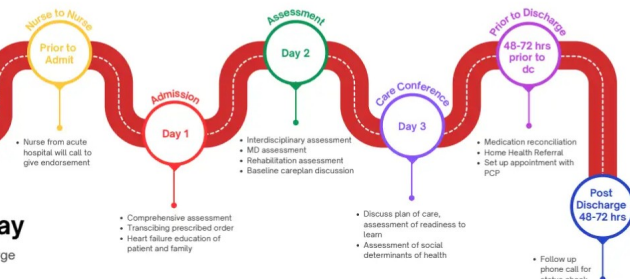
- Tampico Health Care Center and team
- Pacificare Health Management
- American Heart Association, Health Care Certification

Further Study:

It is important for this study to continue to further assess patient outcome annually

Tampico Heart Failure Pathway

Helping patients down the right path towards a safe discharge



Reducing Inappropriate Use of Alpha-blockers in Geriatric Patients

Hen Popilski¹, Shiri Guy-Alfandary¹
¹Seegnal eHealth, Kiryat Ono, Israel

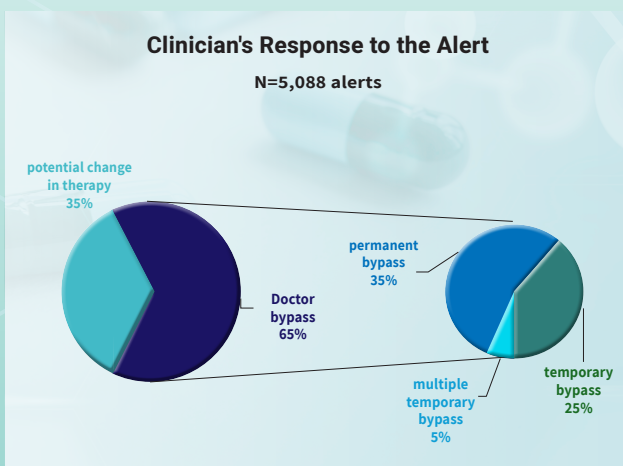
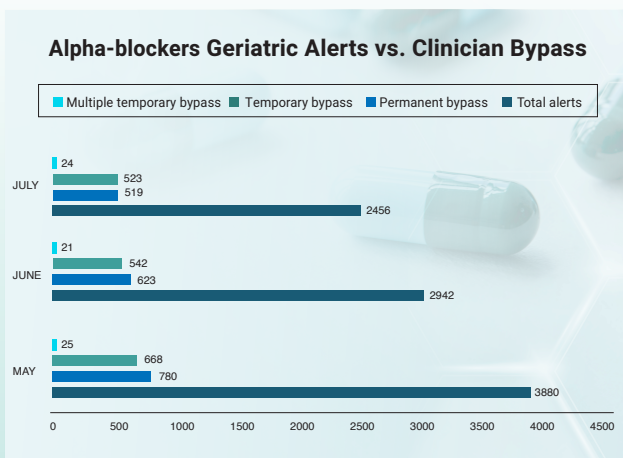


Background

The use of α 1-blockers for hypertension is not recommended in older adults due to the risk of orthostatic hypotension and falls, and their use is typically reserved for resistant hypertension after standard options have failed. Despite this, non-specific α 1-blockers remain common for BPH and are still prescribed for HTN due to historical prescribing patterns. They may also worsen urinary incontinence in women, making them especially unsuitable for elderly females. This study aimed to assess the prevalence, prescribing patterns, and physicians' responses to a newly introduced geriatric alert regarding α 1-blocker use in elderly female patients.

Design

In April 2025, a new mandatory alert regarding the use of α 1-blockers in older adults was activated in a clinical decision support system within an HMO serving 2.7 million patients. The alert was specifically targeted at women >70 years old. As part of the physician's workflow, to proceed with prescribing, they must take an action, either by modifying the treatment or overriding it. During the following 3 months, we recorded alerts, overrides, and override type (temporary/ permanent) to evaluate physicians' actions, and indirectly, also to assess the extent of this potentially inappropriate usage in clinical practice.



Results

During the study period, 314,390 patients aged 65 and older visited a clinician, of whom 55,425 (18%) triggered a geriatric precaution alert. The study population included 124,461 female patients aged 70 or older, and 5,088 (4.1%) of them were prescribed an α 1-blocker, primarily doxazosin (99.94%), which accounted for 9% of all geriatric alerts. Among these patients, the alert was not overridden in 1,795 cases (35%), suggesting a potential change in therapy, as this alert type is considered mandatory and requires clinician action (either an override or treatment modification) to proceed with prescribing. In the remaining 3,293 cases, the alert was overridden, 46% as a temporary override and 54% as a permanent one. In 237 (7%) of the patients, there were multiple temporary overrides.

Conclusions

The rate of α 1-blocker prescriptions in older women is not negligible and may carry serious risks. Therefore, the estimated treatment modification rate of 35% may significantly reduce the potential risk of falls, along with the associated health consequences and healthcare costs. However, the high rate of overrides, particularly temporary overrides, which may reflect hesitancy, highlights the need to raise this clinical issue within the organization to increase awareness of the risks and the rational use of these agents in this vulnerable population.

Implementation of Telemedicine in Nursing Facility and Clinics During the COVID-19 Pandemic: An Observational Study

Kyle O’Ryan
California Emerging Technology Fund (CETF)

ABSTRACT

Telemedicine utilization grew exponentially during the COVID-19 pandemic. Long-term care facilities (LTCFs) were the most vulnerable, hardest hit, and least resourced to combat the pandemic. This study summarized the implementation of Telemedicine in LTCFs and community clinics during the COVID-19 pandemic. Characteristics of Telemedicine visits, and patient and provider satisfaction were described. The study also discussed barriers and challenges to Telemedicine adoption and provided recommendations for future program adoption and for policymakers and regulators.

The findings emphasize the need for leadership to support staff buy-in and change management, the need for quality and consistent training, and the need for technical assessments of WiFi capacity, cybersecurity, and compatibility with software and networks.

INTRODUCTION

In 2020, at the peak of the COVID-19 pandemic, the California Emerging Technology Fund (CETF), launched an implementation project to improve the adoption of Telemedicine. The LTCF setting was selected because older adults in congregate settings were disproportionately affected by the pandemic. Nearly 30% of the deaths in the United States occurred in LTCFs. LTCF operations were completely disrupted with a shortfall of staff and increased morbidity and mortality in the facilities creating a barrier for clinicians to conduct in-person visits with their patients. Further, in March 2020, the Center for Medicare and Medicaid Services (CMS) enacted Telemedicine waivers for LTCFs that encouraged Telemedicine use and they were reimbursed as the originating site for hosting video visits. This study identifies the barriers to Telemedicine adoption and provided policy recommendations for Telemedicine adoption.

METHODOLOGY

This is an observational study spanning two phases. The study received approval from University of Southern California Institutional Review Board approval (UP-21-000986). In Phase 1 (Oct 2020-June 2022), 5 LTCFs participated in Telemedicine implementation. In Phase 2 (Aug 2021 – June 2023), 5 LTCFs, 2 community-based health clinics, and a critical access hospital actively participated in the project.

In Phase 1, the participants were offered the AMD-1740 Tablet Cart by AMD Global. In Phase 2, in addition to the AMD cart, the Amwell C500 Telemedicine cart was offered as an option.

A critical first step for participants was to conduct an assessment to ensure buildings had WiFi capacity to transmit broadband Internet to support Telemedicine equipment. The participating clinical programs (or networks) were required to establish a leadership team consisting of high-level administrators, nursing directors/managers, and IT and data managers. Program leadership participated in a monthly 60-minute learning community video meeting during the study period.

Descriptive statistics were used to describe the key findings on facility characteristics, demographics, visit modality, physician specialty, patient and clinician satisfaction. We used a qualitative thematic analysis to summarize the barriers and challenges of implementing Telemedicine, and recommendations on facilitating telemedicine implementation for the future.

RESULTS

SNF Pilot Project Evaluation Facilities (Phase 1)

Facility	Patient Population	Facility Type	Total # of Forms Submitted
LA Jewish Health	Geriatric	SNF	n= 25 67.57%
Eskaton	Geriatric	ALF	n= 7 18.92%

FCC Project Evaluation Facilities (Phase 2)

Facility	Patient Population	Facility Type	Total # of Forms Submitted
LA Jewish Health	Geriatric	Residential Living, SNF	n=51 0.58%
Brethren Hillcrest Homes	Geriatric	SNF	n= 2 0.02%
Chaparral House	Geriatric	SNF	n=2 0.02%
Chapa-De Indian Health	Native and Community	Community Clinic	n= 912 10.42%
The Fountains	Geriatric	SNF	n= 4 0.04%
SNAHC	Native and Community	Community Clinic	n= 7,564 86.39%
SIHO	Rural Community	Rural Health Clinic, SNF	n= 61 0.70%
TVHC	Community	Community Clinic	n= 160 1.83%

Patient Demographics and Visit Details

	Phase 1	Phase 2
Age	88.5 ± 8.1	n= 8,756
0-1		0.19%
1-12		2.36%
12-17		2.14%
18-30		15.66%
31-45		30.38%
45-64		37.99%
65+		10.64%
Not Specified		0.64%
Gender	n= 37	n= 8,756
Female	78.38%	8.46%
Male	21.32%	4.97%
Not Specified		86.57%
Race	n= 37	n= 8,756
Asian Pacific Islander		7.17%
Black/ African American		15.79%
White	94.60%	38.59%
Latino/ Hispanic	2.70%	7.47%
Native American		13.52%
Other		6.88%
Not Specified	2.70%	10.58%
Clinician Specialty	n= 37	n= 8,756
Primary Care	72.97%	77.34%
Psychiatry	2.70%	17.18%
Pediatrics		3.79%
Rheumatology		0.37%
Pain Management		0.67%
Endocrinology		0.17%
Not Specified	24.33%	0.48%

Patient and Clinician Telemedicine Satisfaction

	Phase 1	Phase 2
Prevention of Transfer	n= 37	n= 59
Yes	18.92%	52.54%
No, Due to Routine Visit	51.35%	47.46%
No Answer	29.73%	
Patient Comfort	n= 37	n= 1,147
Very Comfortable	13.52%	69.2%
Comfortable	81.08%	30.1%
Not Comfortable	2.70%	0.7%
No Answer	2.70%	
Resident/Patient Recommendation	n= 37	
Yes	43.25%	
Not Sure	54.05%	
No Answer	2.70%	
Patient Preference for Future Visit		n= 1,130
Video Visit		15.49%
In Person		8.05%
Telephone		17.88%
Video Visit or Telephone		4.69%
Video Visit or In Person		3.45%
In Person or Telephone		0.71%
Any of these Listed		49.73%
Patient Recommendation		n= 1,127
Video Visit		15.08%
In Person		9.05%
Telephone		14.82%
Video Visit or Telephone		3.19%
Video Visit or In Person		2.93%
In Person or Telephone		0.54%
Any of these Listed		54.39%
Clinician Comfort	n= 37	n= 1,158
Comfortable	86.49%	99.6%
Not Comfortable	2.70%	0.4%
No Answer	10.81%	
Operator Perception of Improving Care Delivery	n= 37	n= 1,063
Yes	89.19%	99.34%
No	2.70%	0.47%
Not Sure	5.41%	0.19%
No Answer	32.70%	

BARRIERS AND CHALLENGES

Barriers and Challenges Identified in Phase 1 and 2

- The provision of Telemedicine equipment alone is not sufficient.
- The advantages of Telemedicine may have been under-appreciated because patients are not aware of Telemedicine.
- The use of a Telemedicine cart requires a number of upfront costs, including increased cybersecurity and changes in workflow.
- The misconception that Telemedicine takes less time than an in-person visit and ignores the opportunity that Telemedicine creates by enabling virtual participation by family, nurses, treating physicians in visits.
- The investment in faster internet and devices may cause concern for a facility to implement Telemedicine.
- The coordination of different platforms in the healthcare system may cause problems for staff at a facility.
- The uncertainty about payment parity once the public health emergency ends may cause a facility to not implement Telemedicine.
- The turnover of staff may cause a facility to not implement Telemedicine.
- The concern for quality of Telemedicine may cause staff, patients, and clinicians to be resistant to change.
- The delivery of quality training, including all technical issues and daily practice changes, was disruptive and time consuming.
- Each facility has their own unique challenges.
- The need for a champion at a facility is required to minimize barriers to implementation.

RECOMMENDATIONS

Recommendations	
Facilities and Programs	Policymakers
• Identify a high-level champions for the provider and within each facility who will provide leadership. • Prepare and pave the way for staff buy-in with sufficient orientation and training. • Recognize sources of resistance to change and engage those who have concerns. • Understand and address contextual issues as related to unique aspects and needs of each facility. • Realize the importance of initial investment of time and resources to derive the benefits and optimize return on investments. • Ensure coordination and support between information technology (IT) and clinical staff to ensure that both technical and clinic considerations are integrated into implementation. • Recognize that technical assessments should be made in advance of launching a Telemedicine program.	• Create easier funding paths from both Government and Private Sources that are Less Labor Intensive for Staff. • Recognize health technology is a tool that requires integration into IT systems and is essential to achieving Digital Equity. • Understand that Telemedicine equipment alone is not sufficient to implement access to this modality. • Prioritize optimization of Telemedicine to enhance health and medical care for all patients. • Address both Digital Access and Telemedicine with urgency, as the implications for the medically underserved and digitally disadvantaged are at grave risk.

CONCLUSION

- Telemedicine shows a high level of patient and provider satisfaction in Telemedicine as a modality for care (including family satisfaction for LTCF patients).
- Telemedicine can decrease emergency transfer of patients to the hospital, particularly from SNFs, which reduces impacts on patients and reduces costs to the system.
- Telemedicine can increase access to medical expertise and specialty care to improve patient outcomes, in specialties such as pain medicine, endocrinology, neurology, among others.
- Telemedicine can decrease the number of vehicle trips to healthcare facilities without impairing patient outcomes, thereby reducing impacts on the environment.
- Telemedicine costs are costs associated with set-up, training, and maintenance; therefore, administrative oversight and dedicated support staff are needed to fine-tune and upgrade Telemedicine services as technologies emerge.
- Successful implementation of Telemedicine requires organizational leadership and focus.

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“Patient Declines Peri-Care” – A Case of Fournier’s Gangrene in a Patient Taking an SGLT-2 Inhibitor

Soraya Azari, MD, Laguna Honda Hospital & Rehabilitation Center, San Francisco Department of Public Health

Introduction

SGLT-2 (Sodium-glucose cotransporter-2) **Inhibitors** are a class of medication widely recommended for common conditions, including diabetes, chronic kidney disease and heart failure.

Residents of long-term care facilities may have challenges with performing routine hygiene tasks.

Patient Presentation

MG is a 61yo male with a history of **diabetes (Hb A1c 7.4)**, obesity, chronic pain, opioid use disorder, and non-healing leg ulcers was prescribed empagliflozin (Jardiance™) for his DM. Three weeks prior, he suffered a **non-displaced intertrochanteric fracture of the femur** during a routine lift transfer. Due to fear and pain, he had chronic difficulty with ADLs (turning, cleaning, incontinence care), leading to moisture-associated skin damage (MASD) in the groin. He **declined repeated offers of ADL care**, often sitting in stool for several days. He developed **altered mental status** and was transferred to the ER.

Clinical Course

ED Course:

ED Triage Vitals: **HR 152**, BP 126/88, temp 36.9 C and Resp 17.

STAT labs notable for: **WBC 22,000** (left-shift), Hb 11.9, Platelets 334,000, Creatinine 0.45 mg/dL, Sodium 134 mmol/L, **anion gap 15**, carbon dioxide 20mmol/L, albumin 2.1g/dL 15, total bilirubin 0.4mg/dL, AST 12 U/L, ALT 10 U/L, alkaline phosphatase 131 U/L

CT Abdomen/Pelvis with Contrast: Findings suspicious for Fournier's gangrene including large **9.7 cm perineal abscess with subcutaneous gas** involving the scrotum and infiltrating into the soft tissue at the base of the penis. Known right femoral neck fracture, bilateral severe degenerative changes of the hips, and lateral subluxation/dislocation of the left femoral head

Hospital Course

Patient was stabilized in the ER and given vancomycin, piperacillin-tazobactam, and clindamycin. Patient was admitted to the hospital and Urology took the patient emergently to the operating room for debridement of the scrotal abscess and placement of a drain. He was found to have a large abscess with no extension to the urethra and bladder. **Intra-operative cultures grew *Candida glabrata***. He was treated with piperacillin-tazobactam and micafungin, and then transitioned to fluconazole. The patient required **four trips to the operating room** for debridement and irrigation of the wound site, and then final wound closure. He was **hospitalized for 18 days** and then returned back to the skilled nursing facility for ongoing long-term care. The empagliflozin was discontinued.

Take-Aways

SGLT-2 inhibitors inhibit the reabsorption of glucose in the renal tubules, causing glucosuria. They have a known risk of urinary tract infections, yeast infection, lower limb amputations and necrotizing fasciitis. The FDA released an alert about the risk of Fournier’s gangrene from SGLT-2i in August 2018. Of note, trials of SGLT-2 inhibitors did not include long-term care residents. A single observational study suggest an increase in the hazard of death among nursing home residents prescribed SGLT2i compared to GLP1 agonists (Riester et al. Diab, Obesity and Metabolism.2024;26(8): 3403)

Providers should exercise caution with use of these medications among patients that have recurrent UTIs or yeast infections, symptom unawareness with GU infections, or hygiene challenges, as was relevant in this case.

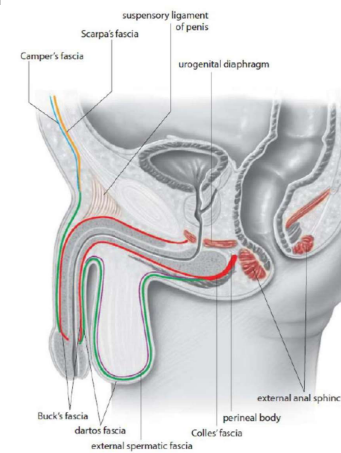


Figure 1. Anatomy of the fascial planes of the lower abdomen and pelvis.²⁴

Image from www.emdocs.net

Bridging Generations: Enhancing Intergenerational Connection in Skilled Nursing Through Resident-Preferred Game Play

Jeron Leonard
The Science Academy STEM Magnet

INTRODUCTION

- **Loneliness and isolation** are common in skilled nursing facilities (SNFs), linked to depression, cognitive decline, and reduced quality of life.
- **Student-led QI project** explored games as a bridge between residents and youth.
- **Initial hypothesis:** technology-based games would engage residents.
- **Pre-surveys findings:** residents preferred traditional, low-tech activities → project strategy shifted to resident-preferred games.

OBJECTIVES

- **Evaluate** whether game-based activities can enhance intergenerational connections in a SNF.
- **Compare** resident preferences for digital vs. traditional activities.
- **Reduce loneliness and increase engagement** by centering activities on resident-selected games.
- **Foster volunteer growth** by providing opportunities to build empathy, communication, and understanding of aging.



QR code for surveys

nostalgia
storytelling
curiosity
understanding
connection
empathy
joy
patience

METHODS

Framework: Plan-Do-Study-Act (PDSA) quality improvement model.

Resident Preference and Surveys

Social Connection (UCLA Loneliness Scale)

- How often do you feel that you lack companionship?
- How often do you feel left out?
- How often do you feel isolated from others?

Pre-survey (before program):

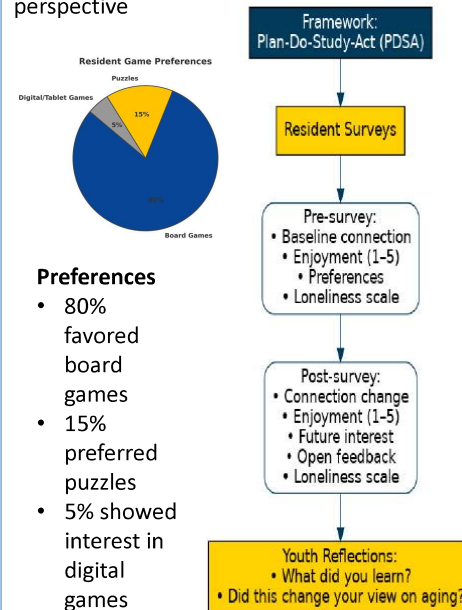
- Assessed baseline *connection* and *enjoyment of activities* (1-5 scale).

Post-survey (after each session):

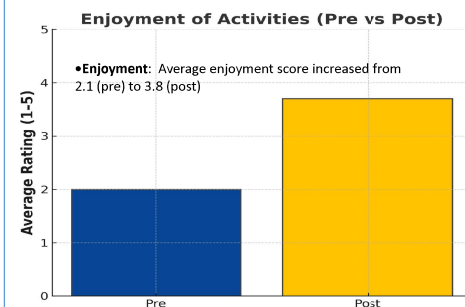
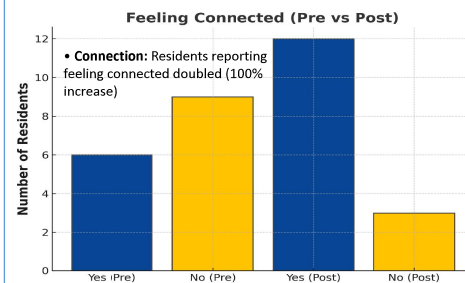
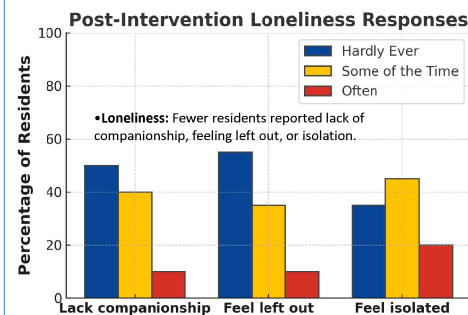
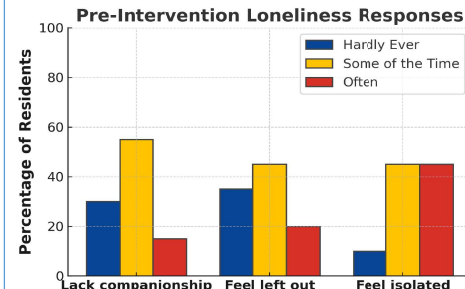
- Assessed change in *connection* and rated *enjoyment of the day's activity* (1-5 scale).

Youth Reflections

- Open-ended prompts on empathy + perspective



RESULTS



CONCLUSIONS

- **Simple, low-tech activities** proved more effective than digital games.
- **Intergenerational programs** reduced loneliness and enhanced connection.
- **Anticipated youth benefits:** growth in empathy, patience, and communication skills.

Next Steps / Future Directions

- Continue **PDSA** cycles to evaluate long-term effectiveness
- **Expand** to additional SNFs and school partnerships.
- **Increase volunteer participation** to broaden intergenerational impact.

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A DESCRIPTIVE STUDY OF IMMEDIATE JEOPARDY CITATIONS -

SNF FAILURES TO HONOR CPR-RELATED RESIDENT PREFERENCES



Background

Research/practice suggest: Need to re-evaluate Cardiopulmonary Resuscitation (CPR) procedures in nursing homes (staffing challenges, inconsistent advance directive informed consent process, and large variations in CPR/AED standards/regulations)

Prior legislation, regulation, guidelines:

- Long-standing history of No CPR guidelines in nursing homes
- 1990 Patient Self-Determination Act (mandated informed resident right to decision-making)
- 1994 American Heart Association initiated public access to defibrillation (discourse on early CPR)
- 2012 Centers for Medicare & Medicaid Services issued F-tag 155 on resident right to advance directives
- 2015 Centers for Medicare & Medicaid Services issued F-tag 678 on resident right to CPR
- 2024 States vary in requiring presence of defibrillators in nursing home

Levine et al. (2007), Lurie et al. (2008), Shah et al. (2008), Hovav et al. (2010), Mawardi et al. (2010), Spector et al. (2014), Lindenberg et al. (2015)

Mary Ellen Dellefield, PhD, RN, FAAN
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Nurse Scientist, VA Boston Healthcare System

FINDINGS

FINDINGS: STRUCTURAL VARIABLES

SNF Characteristics	n (%)	mean (SD), range
State		
Minnesota	41 (46.2%)	
Ohio	21 (23.7%)	
Michigan	17 (18.7%)	
Wisconsin	10 (11.0%)	
Sample Size		
N	89 (86.2%)	
Mean Rating (1-5)	3.11 (1.49)	
Health Inspection Rating (1-5)	2.19 (1.30)	
Staffing Rating (1-5)	3.96 (1.41)	
Quality Rating (1-5)	3.70 (1.47)	
Bed Size	69.42 (47.73)	26-300
Affiliation with Larger Entity		
Yes	52 (58.9%)	
No	41 (44.7%)	
Profit Status		
For-profit, corporation	41 (44.7%)	
Non-profit, corporation	22 (23.7%)	
For-profit, individual	8 (8.6%)	
For-profit, limited liability company	5 (5.4%)	
Non-profit, church	4 (4.2%)	
For-profit, partnership	2 (2.2%)	
Government, state	1 (1.1%)	
Government, city	1 (1.1%)	
Co-location		
Located Within a Hospital, No part of CHCC	90 (96.8%)	

NARRATIVE FINDINGS: Structure Category and Code Counts

Structure Category & Code	n (%)
Staff Role	
LPN	45 (100%)
CNA	45 (100%)
RN	22 (50%)
DKN	22 (50%)
Physician	12 (27%)
Nurse Practitioner	14 (31%)
Nurse Manager	12 (27%)
Agent	9 (20%)
ADON	8 (18%)
Charge RN	3 (7%)
Social worker	3 (7%)
Medication aide	2 (5%)
Nurse assistant	1 (2%)
Shift	
Night	34 (40%)
Day	32 (37%)
Evening	19 (22%)
Staffing Characteristics	
Working self-autonomous with facility operations	21 (25%)
No RN on duty	21 (25%)
Documentation of staff emotional state	18 (21%)
Incomplete CPR certification	12 (14%)
Report of high workload or burnout	3 (4%)
Misc. staff-related problems	3 (4%)

PROCESS CATEGORIES AND CODES	n (%)
Early Detection	
Assess assessment	14 (15%)
Logistics (person, resources, documentation, equipment)	28 (31%)
Delay in calling EMS	28 (31%)
Delay in identifying code status	20 (24%)
Delay in the nursing staff starting CPR	20 (24%)
Equipment not used AED	1 (1%)
Equipment not used - ambu bag	1 (1%)
Equipment not used - handboard	4 (5%)
Equipment not used - code card	3 (4%)
Failure to start CPR (nursing staff)	41 (46%)
Failure in communication (family)	10 (12%)
Failure in communication (staff)	59 (70%)
Failure in coordinating CPR until resident declared dead	3 (4%)
Failure in policy/procedure (not following or not present)	1 (1%)
Failure in staff coordination of CPR intervention	59 (70%)
Failure in teamwork	2 (2%)
Failure to follow code preference of resident	46 (52%)
Failure to follow CPR policy	79 (90%)
Incomplete documentation of CPR event	13 (15%)
Lack of clarity about code status (in documentation)	39 (44%)
No existing policy for CPR intervention	5 (6%)
No documentation of CPR incident that occurred	16 (18%)
No documentation of CPR preference in care plan	10 (12%)
No advanced directives or incomplete advanced directives	13 (15%)

Outcome Category & Code	n (%)
Wrong Intervention	
No CPR when full code	41 (46%)
CPR provided when DNR	4 (5%)
Temporal Delay	
0 hour or less	13 (15%)
1 hour	4 (5%)
1-4 hours	1 (1%)

NARRATIVE THEMES

CPR EVENT REQUIRES PROMPT RESPONSE - DIFFERENT TYPE OF WORK, IMPORTANT:

- STANDARDIZED ARMBAND
- INSTRUCTIONS IN EACH ROOM
- RN STAFFING
- CPR CERTIFICATION
- POLST/DOCUMENTATION
- LOGISTICAL EXCELLENCE
- AUDITS
- PRACTICING CPR EVENT
- FUNCTIONING AED
- VALUING ADVANCED CARE PLANNING

Practice-Based Recommendations

1. CPR certify ALL nursing staff
2. Have STANDARDIZED armband identifying CPR residents
3. Routinely audit POLST, MD orders, care plan, armband for accuracy
4. Post AHA one-page handout in EVERY room
5. Update crash cart with essential pre-EMS equipment
6. At least QUARTERLY CPR drills timed for responsiveness
7. Get RN/BSN POLST certified
8. Identify staff roles for EACH shift in event of a cardiac arrest
9. Acknowledge challenges inherent in responding to this emergency event

Study Purposes

- Identify patterns of practice failures related to CPR in nursing home setting
- Describe use of content analysis to analyze statements of deficiency

Methods—Design and Sample

- Descriptive study using demographics & content analysis
- 2019-2022 Statement of Deficiencies for SNFs on Nursing Home Compare (now CMS Care Compare)
 - <http://www.cms.gov>
- From CMS form 2567 and CMS Care Compare
- Purposive sampling IJ citation: F-678
- Used Region V
 - Includes: Michigan, Minnesota, Ohio, Wisconsin
 - n=93 SODs

Methods—Codebook

- **Codebook development**
 - **Original development:** Prior research exploring nursing surveillance in VA nursing home immediate jeopardy citations
 - **Modified:** AHA CPR guidelines and AHA certification training content
 - Developed broad categories of practice failures
 - Linked categories and subcategories with Donabedian's framework
 - Structure
 - Process
 - Outcome

Disclosure

Drs. Madrigal (current) and Dellefield (former) are employees of the U.S. Department of Veterans Affairs (VA). The views expressed in this presentation do not reflect the position or policy of the VA or U.S. Government.

A Holistic and Proactive Approach to Management of Behavioral Challenges in LTC Residents

Sabine Gysens PhD, Shannon Bevett RN, Lin Lin Soe RN, Laguna Honda Hospital and Rehabilitation Center

Background

Behavioral challenges, common among residents in LTC facilities like LHH, often led to urgent use of Psychiatry Staff resources that did not result in systemic changes. The Therapeutic Care Team was created to implement a proactive rather than crisis-driven approach to these challenges: early intervention, collaboration with frontline caregivers, increased mastery. TCT was meant to be a bridge between Psychiatry and frontline staff, instrumental in empowering staff through education, guidance on implementation of recommendations, and ultimately increase holistic understanding of residents' presentation.

Acknowledgments

Many thanks to Julian Philipp, MFT and Laurie Lenrow, LCSW, members of the Psychiatry Dept who were instrumental in operationalization and implementation of the program. Thank you to all the members of the TCT team who participated in this project with enthusiasm and dedication and took the learning to the units.

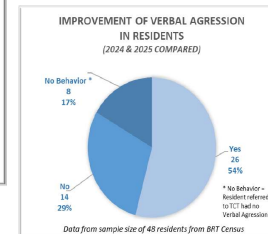
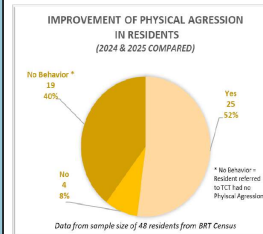
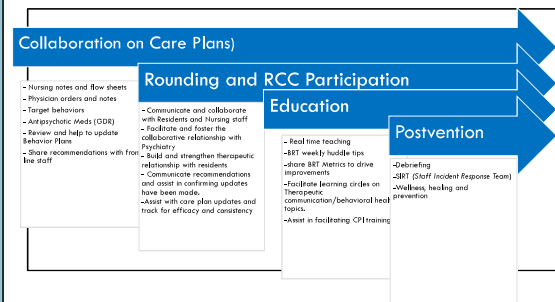
Methodology

TCT members participated in weekly training sessions with members of the Psychiatry Dept to learn and integrate holistic formulation approaches through case reviews, and apply this understanding to interventions on the units.

They became instrumental in improving frontline staff understanding of resident triggers and improving their sense of self-efficacy in managing difficult behaviors. Ongoing evaluation and feedback loops were created to assess efficacy of behavioral interventions and reinforce positive outcomes.

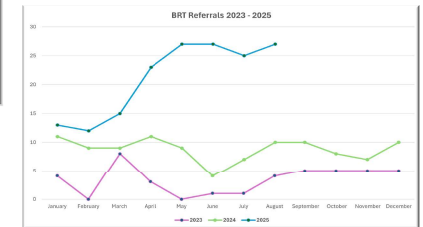
1	Resident Name	Room #
2	Resident Unit (to know the resident)	
3	Resident name, gender, language, other:	
4	Referrals:	
5	Strengths:	
6	Values:	
7	What approaches is it most receptive to?	
8	What verbal/nonverbal cues are important to be aware of?	
9	What behavioral interventions of agency, observation without evidence:	
10	What may have contributed to this participating factor/triggers?	
11	What is it's perspective of what they need/what should happen? (it's goals)	
12	How or how supported behavior?	
13	Has anything helped?	
14	Has anything made it worse?	
15	Thinking about self assessment/evaluation:	
16	Feedback from training/docs, useful for our discussion:	
17	What is working?	
18	What are areas for improvement?	
19	Support level of agencies/therapists?	
20	Continue to work, modify, or stop this approach/intervention?	
21	Recommendations for agency/therapist/other (implementation to help approach/other)	

Results and Conclusions



A Holistic, Individualized, Systems-Based approach to managing residents' behavioral challenges in LTC can lead to improved staff satisfaction and improved behavioral health outcomes for resident populations.

Initially, frontline staff perceived the TCT nurses as surveillance figures, but eventually understanding grew around the team's supportive, non-punitive role in enhancing quality of care. The number of calls to TCT requesting their guidance with implementation and problem-solving increased, resulting in improved staff satisfaction and a decrease in physical and verbal aggression in residents.



Quotes from Unit Staff: "BRT shows up without complaint and ready to support." "We value your help and willingness to get things settled down for both the resident and staff." "We can depend on you to provide value to the team with how you address things professionally and always friendly."

Rebuilding Medical Education in a SNF Setting

Laurence Peiperl MD, Laguna Honda Hospital and Rehabilitation Center, San Francisco Dept. of Public Health

Introduction

The COVID-19 pandemic led to suspension of the Medical Staff education and residency training programs at Laguna Honda, a large, publicly operated SNF in San Francisco. As restrictions eased, we clarified goals for our educational series:

- Advance understanding of evidence-based knowledge related to prevention, diagnosis and treatment of disease
- Enhance interprofessional collaboration
- Support clinical decisions consistent with individual goals of care
- We excluded updates on administrative policies

Format: lunch-hour, weekly, in-person and/or videoconference

We also resumed service as a training site for the UCSF Family/Community Medicine residency program.

Methods

Talks: education, not training

- 1) LHH physicians and interprofessional collaborators
- 2) SNF specialty consultants
- 3) Experts from outside institutions
- 4) Case Discussions
- 5) Journal Clubs

FCM Residents: Integrate 1-2 trainees per session into ongoing patient care activities, with case-based teaching

Results and Conclusions

Med Staff Education Series
June 2024 – May 2025:

- 25 educational talks
- 9 case discussion sessions
- 2 journal clubs
- 1 Jeopardy game holiday party to review key points of talks

Attendance: 12-25 physicians per session

Not provided:

- Free lunch
- CME credits
- Honoraria for speakers

Survey Evaluation Sept 2025

12 responses from 25 eligible physicians

The Med Staff Educational Conference series:

Improves knowledge in topics relevant to my patients: 11/12

Builds sense of professional community among med staff: 10/12

Provides forum for discussion of challenging cases: 10/12

"Helps me get to know specialists"

FCM Residency Precepting
October 2024 – June 2025:

6 preceptors over 5 half-days/wk

30 individual FCM residents over 55 half-day sessions

FCM resident feedback: "Now I can tell my patients that they're going to a really good place"

Acknowledgments

We thank the members of the LHH Medical Staff Education Committee for their support; Rebecca Ferrini, MD for helpful advice on program evaluation; and Colin Purrington for poster templates

The views expressed herein do not necessarily reflect the official policies of the City and County of San Francisco; nor does mention of the San Francisco Department of Public Health imply its endorsement

Application of Root Cause Analysis for Fall Prevention: A Quality Improvement Initiative for Older Adults in a Skilled Nursing and Long-Term Care Facility



ESKATON

Terrence Ranjo, DNP, RN, GERO-BC
Eskaton Senior Living

Wei-Chen Tung, Ph.D., RN, FAAN
The Valley Foundation School of Nursing, San José State University

Background



Falls are the leading cause of injuries among people aged 65 and older.

- One in four older adults reported falls in 2021
- The death rate from falls increased to 41% from 2012 to 2021 (CDC, 2023).

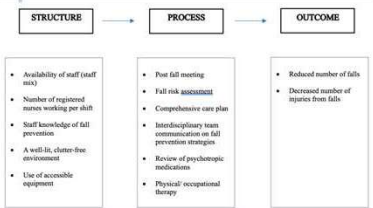
Impact of Falls in Post-Acute and Long-Term Care

- Advanced age and multiple medical diagnoses put those in SNF and LTC facilities at the highest risk of falls and fall-related injuries (Soncrant et al., 2020).
- Falls lead to hip fractures, head trauma, prolonged hospitalization, and increased risk of death (AHRQ, 2023).
- Increased staffing and workload, poor survey performance, financial losses from higher insurance premiums, and lawsuits (AHRQ, 2023).

Related Literature

- Half of residents in nursing facilities fall annually, and one in every ten falls will lead to a severe injury (AHRQ, 2023).
- Federal regulations like CMS require LTC facilities to incorporate quality assurance performance improvement initiatives to address identified quality concerns in LTC (Rose et al., 2021).
- Root cause analysis (RCA) can help clinicians identify several root causes of falls and guide them in developing personalized approaches to preventing falls (Soncrant et al., 2020).

Application of the Donabedian Model in Fall Prevention



Purpose of the Project

- Implement the RCA process as an intervention to reduce fall rates, with a focus on the impact of individualized care planning.
- Explore the relationship between age, length of stay, previous history of falls, and the incidence of falls among residents of skilled nursing and long-term care facilities.

Methods

Project Design

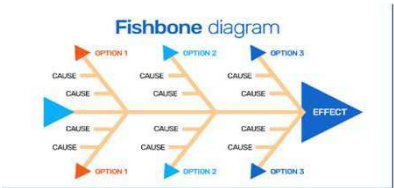
- ❖ Quasi-experimental
- ❖ Monthly fall rates were collected three months before and after the implementation.

Participants

- ❖ SNF and LTC residents aged 65 and older.
- ❖ Exclusion criteria were (a) those younger than 65 and (b) bedbound. Participants are either receiving skilled nursing services or long-term care.

Intervention

- ❖ RCA of 17 falls was completed during the three-month implementation phase.
- ❖ An individualized care plan was implemented to address root causes.

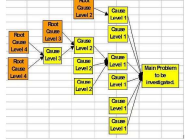


Setting

- ❖ The Reutlinger Community- a continuing care retirement community in Danville, California.
- ❖ The most common diagnoses include cardiovascular diseases, endocrine and metabolic disorders, neurological disorders, post-orthopedic surgery status, and psychiatric illnesses such as dementia.

Data Collection

- ❖ Monthly fall rate data
- ❖ Chart review
- ❖ Staff interview



Tools for Root Cause Analysis by Ben Linders

Data Analysis

- ❖ A two-proportion z-test computed the significant difference in fall rates before and after the intervention.
- ❖ A binary logistic regression assessed whether variables such as length of stay, history of falls, and diagnosis of dementia significantly influenced the odds of residents experiencing a fall while in the skilled nursing and LTC facility.
- ❖ Statistical significance at $p < 0.05$.

Results

- ❖ The facility recorded a fall rate of 7.37 per 1,000 bed days. After the project commenced in August 2024, the facility documented a reduced fall rate of 4.23 per 1,000 bed days ($n=17$).



- ❖ Table 3 reflects a 3.14 falls per 1,000 bed days reduction when comparing the three months before and after the project's implementation.

- ❖ Table 3 shows that the result was marginally significant, with a computed p -value of 0.063, slightly above the set threshold of 0.05 for significance. This indicates a higher proportion of falls during the pre-intervention period (approximately 0.7%, $n = 4343$) than the post-intervention period (approximately 0.4% of falls, $n = 4019$).

Table 3

Two Proportions z-Test for the Difference between Pre- and Post-Fall Rates

Samples	Responses	n	Proportion
Pre-intervention	32	4343	.007
Post-intervention	17	4019	.004

- ❖ Table 4 shows the results of the RCA conducted, where over two-thirds, or 70% ($n = 12$), of residents fell while attempting to transfer independently without seeking assistance from the nursing staff.

- ❖ Among these residents, 50% ($n = 6$) fell while attempting to walk to the bathroom.

- ❖ No residents suffered significant injuries or fractures after the implementation of RCA, although one resident had fallen with a fracture three months before its implementation.

Table 4

Identified Causes of Falls from Root Cause Analysis

Causes of Falls	n	%
Transferring independently without seeking assistance (i.e., walking around the room or going to the bathroom)	12	70%
Equipment issues (i.e., wheelchair, low air loss mattress)	2	12%
Adjustment to a new environment (i.e., rolling out of bed during sleep)	2	12%
Assisted fall during therapy session	1	6%
Total	17	100%

- ❖ Table 6 reveals that a history of falls is a significant predictor of future falls ($p = 0.016$). Residents with a history of falls are approximately five times more likely to experience another fall than those without such a history ($OR = 5.90$, 95% CI 1.38, 25.19).

Table 6

Logistic Regression Results with Length of Stay, History of Fall, and Diagnosis for Predicting Fall

Variable	p	OR	95.00% CI
(Intercept)	<.001	-	-
Length of Stay: Long Stay	.137	0.29	[0.06, 1.48]
History of Fall: Yes	.016	5.90	[1.38, 25.19]
Diagnosis: Dementia	.180	2.27	[0.69, 7.49]



Conclusion

- ✓ Utilizing the RCA process reduces the number of falls among older adults. It aids clinicians in identifying intrinsic, extrinsic, and environmental root causes of falls.
- ✓ The RCA outcomes revealed three primary causes of falls: limited mobility (intrinsic), independent transfers without requesting assistance (extrinsic), and adjustments to a new environment and device (environmental).
- ✓ To address these root causes, the following processes and structural interventions were implemented:

- Prompt and comprehensive fall risk assessment on admission;
- Interdisciplinary and individualized care planning;
- Regular purposeful staff rounding to anticipate residents' needs, such as toileting;
- Re-evaluating resident equipment, like wheelchairs;
- Adjusting the environment, including bed and personal item placement.



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Neuropsychological Rehabilitation Case Report: Integration of Neuropsychology to facilitate SNF discharge for a patient with communication challenges

Michelle Murphy, Psy.D., Laguna Honda Hospital and Rehab Center, SF Dept of Public Health

Introduction

This is a Case Report demonstrating the benefits of the integration of Neuropsychology in the care of an individual in a Skilled Nursing Facility. This individual was a child of immigrant parents, had unrecognized Mild Intellectual Disability Disorder with unrecognized difficulties in receptive language, Type 2 diabetes, a recent above the knee amputation (AKA), and other medical conditions. These cognitive difficulties and especially his difficulties with receptive language impacted his ability to meaningfully engage with his physicians, benefit from physical therapy, understand his Type 2 diabetes diagnosis, and accept a new discharge plan.

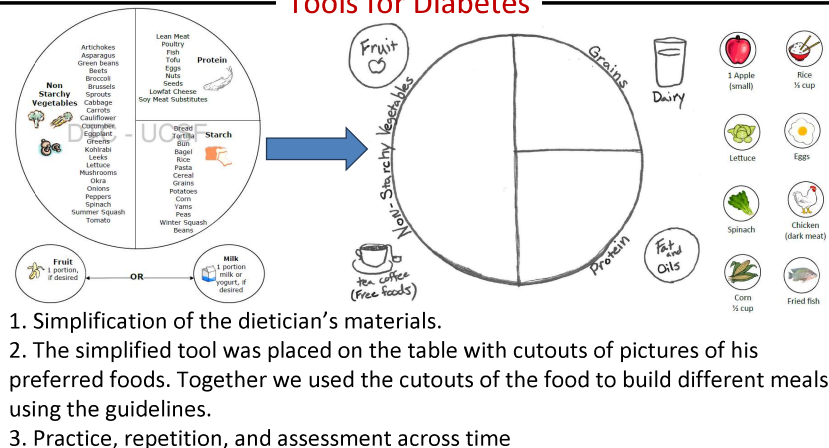
Methods

Intradisciplinary collaboration targeting multiple Goals of care.

Goals of care

1. Understand the whole individual
 - a) Comprehensive Neuropsychological Assessment
2. Obtain and learn to use a prosthesis
 - a) Joint sessions / Co-treatments
 - b) Use visual tools with PT for pain ratings
 - c) Simplify and write down instructions
 - d) Add visual aids to instructions
3. Increase support in the community
 - a) LHH Neuropsychological Assessment paved the way for a community assessment at the Regional Center
4. Improve self-management of Diabetes
 - a) Plate tool with cut-outs of food
 - b) Simplification of description
 - c) Repetition
5. Safe Longterm Discharge
 - a) Value Identification
 - b) Illustrated graph of different levels of care
 - c) Brief targeted family therapy (discharge plan changed from home to a Residential Care Facility)

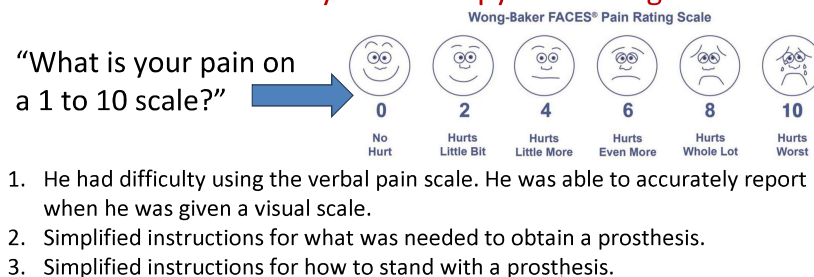
Tools for Diabetes



Results

1. Improved his understanding of his diabetes and how to manage his sugar through better eating habits. As a result, his diabetes was better managed.
2. He was able to obtain a prosthesis.
3. He was able to exercise with his prosthesis.
4. Get connected to the Regional Center
5. Safely discharged to a lower level of care.
6. Improve communication with sibling.

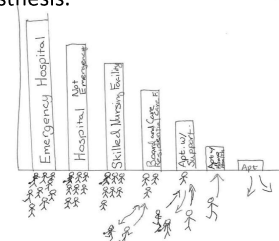
Tools for Physical Therapy & Discharge



Value Identification

1. Do things. Be active. Talk to people. Watch TV.
2. Be close to family.
3. Smoke cigarettes outside.
4. Prefers a private room but will share if a private room costs too much.

Levels of Care



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- UCSF (2023) *The Plate Method: for meal planning* [https://ucsf.app.box.com/s/g2okch4h2i27riqt48s9hi65o655gi0w](#)
- Informed and inspired by Barbara Wilson, OBE, Ph.D, CPsychol, ScD, FBPsS, FMedSci, ACSS; Jill Winegardner, Ph.D.; Saugatuck Institute for Neuropsychological Rehabilitation (SINR) Conferences

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Ng, Ricky, MSW (Medical Social Worker)
Sanchez, Alexander, RDN (Dietician)
Laguna Honda Hospital and Rehabilitation Center

Age-Friendly Pain Management for Elderly Trauma Patients

V. Teppone, M. Magallanes, W. Labib,
M. Dam, K. Earley, K. Danji

INTRO

- Older adults face higher mortality, morbidity, and complications due to frailty and age-related physiological changes
- Development of an age-friendly pain management guideline emphasizing multimodal, opioid sparing strategies for geriatric care.

METHODS

- Multi-disciplinary collaboration including clinicians, pharmacists, and geriatric specialists to develop tailored guidelines and order sets supported through systematic reviews and expert input

RESULTS

- Key components in developing pain management guideline included frailty assessments:
 - Modified 5-item Frailty Index (mFI-5)
 - Trauma-Specific Frailty Index (TSFI)
- Non-pharmacological and pharmacological approach with an emphasis on non-opioid analgesics and multimodal pain control

DISCUSSION

- The pain management guideline provides a standardized, evidence-based approach to improving outcomes for elderly patients
- Integrating frailty assessments and targeted interventions address a significant care gap.
- This model is critical for advancing geriatric trauma care, improving quality, and enhancing patient outcomes

FINANCIAL DISCLOSURE

- No financial disclosures

Development of an age-friendly pain management guideline provides a standardized and evidence-based approach for implementing opioid-sparing, multimodal pain strategies for geriatric trauma patients.

LOMA LINDA
UNIVERSITY
HEALTH



Implementing Acute Pain Management

- Development of Age-Friendly Pain Management Guideline
- Acute Pain Management in Elderly Trauma Order Set in LLUMC EMR

Order Sets, Panels, & Pathways	
ID	Name
304...	Acute Pain Management in Elderly Trauma

▼ Non-Pharmacological Pain Management
▶ Non-Pharmacological Pain Management
▼ Pharmacological Pain Management
▼ AGE 60-79 YO, NON-FRAIL (mFI-5 < 2 and/or TSFI < 0.25)
☐ NON-OPIOID Pain Medications for MILD PAIN
☐ OPIOID Pain Medications for MODERATE TO SEVERE PAIN and RESCUE
▼ AGE > 80 YO, FRAIL (mFI-5 > 2 or TSFI > 0.25)
☐ NON-OPIOID Pain Medications for MILD PAIN
☐ OPIOID Pain Medications for MODERATE TO SEVERE PAIN and RESCUE
▶ NPO STATE
▶ Supportive Care
▼ Consults
▶ Consults
▼ Additional SmartSet Orders

Potential Future Projects

- Evaluating if utilization of the pain management order set is associated with improved patient outcomes such as decreased incidence of hospital-acquired delirium, decreased opioid use, or decreased length of hospital stay.

Simplifying Medication Administration: Reducing Complexity to Enhance Patient Care

Dr. Albert Lam MD, Eugenio Ocampo PharmD, Rowena Patel RN, Brooke Kazama MPH
Laguna Honda Hospital and Rehabilitation Center, San Francisco Department of Public Health

Introduction

- Laguna Honda Hospital and Rehabilitation Center (LHH) is a 780-bed hospital with 769 SNF beds.
- LHH cares for a large complex patient/resident population.
- Medication simplification efforts would greatly decrease the amount of nursing time spent passing meds and reduce risk of errors and interactions
- An interdisciplinary team of Medicine, Pharmacy, and Nursing leaders was formed to drive this med simplification journey

Background

Nurses are spending around **190 minutes** passing medications (day shift of eight hours)

Why?

Baseline

Average number of medications per Resident:
14.2

Baseline

Average number of medication administrations given to a resident per day:
18.7

High volumes of medications can increase the risk for adverse drug interactions and medication errors, through patient-centered medication/dose reductions we can mitigate these safety risks.

Project Goals

Outcome Measures and Goals

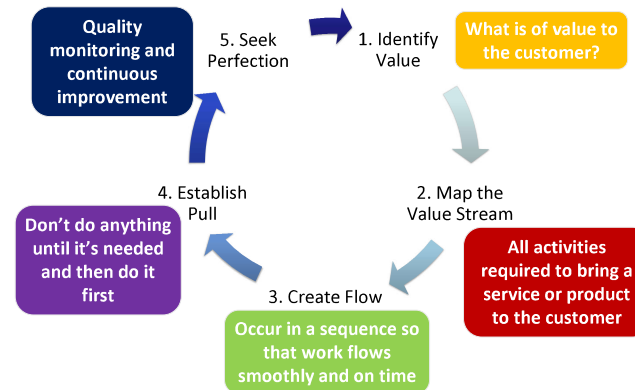
7%
(13.2 medications/Resident) reduction in average unique medications hospital wide

15%
(15.9 administrations per Resident day) reduction in average administrations hospital wide

- Make Laguna Honda Hospital a leader in safe healthcare delivery
- Promote Resident-centered care and well being by reducing Nursing time spent passing medications
- Develop a robust medication simplification system for sustained improvement

Methods

- Lean thinking is a methodology that improves efficiency by eliminating waste and focusing on delivering value to the customer
- There are 5 Core Principles of Lean for continuous improvement



The lean problem-solving tool used in this project:



- PLAN:** Identify a specific problem to focus on
- DO:** Implement the change on a small scale to test its impact in real-world settings
- STUDY:** Analyze data to evaluate the impact of the change, compare results to expectations
- ACT:** Adopt, modify, or abandon based on what was learned

PDSA 1

Physician review for appropriateness of Resident medication regimens. Education on deprescribing practices informed by Beers Criteria

PDSA 2

Concentrated review by clinical pharmacists of the top 50 highest utilizers and Pharmacy driven education series on deprescribing practices

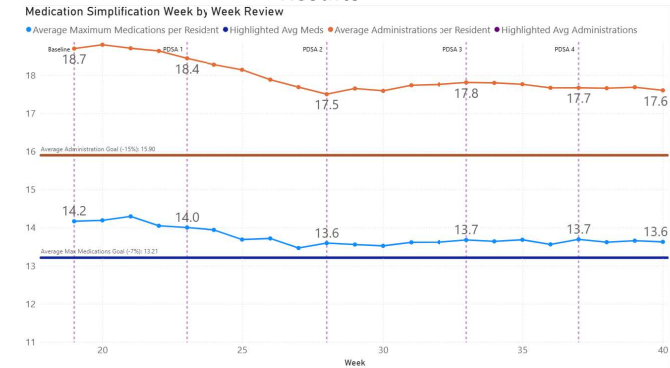
PDSA 3

Integrate Medication Simplification recommendations into the monthly Drug Regimen Review (DRR) process

PDSA 4

Frontline nursing staff collaboration with unit physician

Results



Reduced overall Medications by 5.0%
Reduced overall administrations by 5.6%

Lessons Learned

PDSA 1:

- Unit physicians reviewed all medications for appropriateness and discontinued those no longer indicated.
- While some reductions were achieved, the approach along was insufficient to meet the overall project goal.

PDSA 2:

- Clinical pharmacists were empowered and educated on deprescribing practices, focusing on the top 50 highest utilizers, this resulted in the most significant hospital-wide reduction in medications and doses.
- Despite its effectiveness, the intervention required substantial pharmacist time and resources, making it unsustainable as a long-term solution.

PDSA 3 & 4: ongoing

- PDSA 3- To sustain the impact of focused pharmacist and physician reviews, pharmacist deprescribing recommendations are not integrated into the monthly DRR process.
- PDSA 4- A unit physician partnered with frontline nursing staff to educate residents on deprescribing decisions, empowering nurses as patient advocates and project champions with greater ownership in the process.

Takeaways

- Interdisciplinary teamwork and communication is critical for sustained process improvement
- Develop a strong data review process to track PDSA outcomes
- Collaborate across every level to strengthen people, processes, and patient outcomes.



San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center



A Six Sigma Approach to Improving Therapy Group Attendance at Mental Health Rehabilitation Centers (MHRC)

Alec Atkin, M.B.A.

Lean Six Sigma Black Belt
Executive Director of Performance Improvement

Shanel Mayo

Director Recovery Education and Leadership

Patricia Blum, PhD

Chief Operating Officer

INTRODUCTION

California Department of Health Care Services (DHCS) requires Mental Health Rehabilitation Centers (MHRC) to have 14 hours/wk of program group therapy available.

A robust recovery education program will have the largest impact on persons served, helping them achieve the following recovery outcomes:

- Enhanced sense of meaning and purpose, self-efficacy, and self-esteem.
- Greater competence in self-regulation skills.
- Reduction of incidents at the campus and for persons served.
- Relapse prevention competencies.
- Shorter lengths of stay.
- Successful re-integration into the community.

MHRCs IN CALIFORNIA



Crestwood currently has 13 MHRCs in California.

INITIAL APPROACH

Ensure recovery principles include such concepts and practices in the groups such as:

- Strengths-based, person-centered focus.
- Recovery language and person first language.
- Recovery as the expectation not the exception.
- Encouraging hopes and dreams.
- Honoring the person as the expert and promoting self-advocacy.

A survey was completed to evaluate the facilitator and material used in order to improve the groups and, thereby, increase attendance.

Evaluators were trained on an instrument developed in-house and deployed to campus sites. It was discovered that:

- 40% of groups were not occurring.
- Campuses lacked the tools and training to have effective groups.

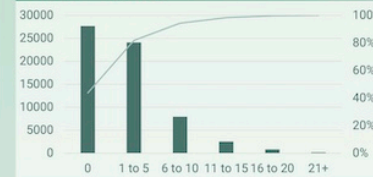
RE-EVALUATION

Expectation of initial project was to improve training and materials. However, a new investigation into why groups were not occurring was required.

ANALYSIS

Data from the EHR system was analyzed to understand group attendance habits.

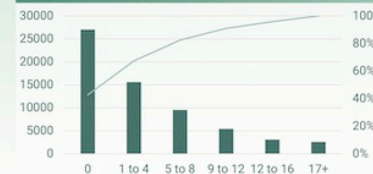
Group Hours Per Week Per Persons Served
Mar 2024 - Feb 2025



2.7% of persons served attend 14 or more hours per week.

Goal is to have 33% of persons served attending 14 hours or more each week.

Groups Attended Per Week Per Persons Served
Mar 2024 - Feb 2025



7.5% of persons served attend 14 or more groups per week.

NEXT STEPS

A *Gemba Walk* (site visit) was done at 12 of the 13 MHRC campuses. Service coordinators (case managers) were shadowed for a day at each location. Observations recorded include:

- Service coordinators (SC) are not on the floor with the persons served. They mainly stay in the office.
- SCs spend about 2 hours/day entering progress notes.
- Persons served use the program office to fulfill requests instead of interacting with SCs on the floor.
- SC take persons served on outings.
- Persons served at many campuses are sleeping in until noon, thereby missing morning groups.

Conclusion: Service coordinators struggle to lead groups consistently, resulting in less opportunities for persons served to attend.

SLEEPING IN UNTIL NOON

It was observed that many of the campuses had persons served sleeping in until noon. To determine a possible "sleep in" rate, the breakfast eaten data was analyzed.

The data was compared against the company goal of persons served attending 14 hours of program groups per week.

Campus	Goal Met	Breakfast Not Eaten
Campus 1	15%	25%
Campus 2	10%	23%
Campus 3	14%	22%
Campus 4	21%	33%
Campus 5	3%	18%
Campus 6	22%	5%
Campus 7	20%	2%
Campus 8	1%	27%
Campus 9	4%	27%
Campus 10	0%	5%
Campus 11	1%	16%
Campus 12	0%	16%
Campus 13	0%	14%
Average	8%	18%

Campus 6 and 7 had both a high percentage of persons served meeting 14 hr/wk target and persons served awake in the morning.

Discussion with them revealed that they proactively get their persons served out of bed, to the dining hall for breakfast, and then onto groups.

IMPLEMENT NEW GROUP MATERIAL

Trials are being conducted at three campuses to determine the effectiveness of purchased learning material taught by trained SCs and implemented in an 8 week closed group setting each week.

There has been 100% group attendance with the with new material and closed groups.

CONCLUSIONS

- A day of observations at a campus revealed more information than could be determined from numerical data.
- Better training and material is needed to increase group attendance.
- Comprehensive library of materials will be developed instead of relying on outdated materials and informal internet searches.
- Persons served need to be proactively motivated earlier in the day, setting them up to engage fully in their recovery.



Improving Behavioral Care Plans: A Structured Historical & Content Analysis of Plans

Anne-Marie Larsen, PhD & Francisco Lopez Jr., BA; Edgemoor DP SNF

ABSTRACT

Dementia is known to cause cognitive, behavioral, and mood changes in individuals. To most effectively provide long term care for individuals with dementia, specific care plans need to be implemented to help guide the residents. This study aimed to test the theory that the behavioral care plans at a 162-bed distinct part skilled nursing facility's behavioral unit were helpful in guiding behavior. A mixed methodology study consisting of a historical analysis and content analysis of behavioral care plans revealed a significant difference in the behaviors still present and those expected in long term care for those with dementia and psychosis.

INTRODUCTION

Few long-term care facilities employ psychologists, yet one of the many features of dementia includes behavioral and psychological changes. Although psychologists understand human behavior and behavioral interventions very well, most behavioral care plans are developed without input from psychologists. Well-developed behavioral plans can help residents in long term care get their needs met in more effective ways. Evaluating behavioral care plans for adherence to best practices in psychology will improve and streamline care planning in the future.

METHODS

Method

This study aimed to test the theory that the behavioral care plans at a 162-bed distinct part skilled nursing facility's behavioral unit were helpful in guiding behavior. The study employed a mixed-methods approach, combining a structured historical analysis and content analysis of existing behavior plans. Using archival data, 23 subjects (16 male, 7 female) were stratified by gender from an initial data set of 32 subjects (24 male, 8 female), with ages of the subjects ranging from 53 to 83 years ($M=65.52$, $SD=9.28$). Many of these residents also have a comorbid psychiatric disorder, including Mood disorders (47.83%), Schizophrenia Spectrum disorders (39.13%), Substance Use disorders (in institutional remission, 39.13%), Personality disorders (21.74%), as well as Anxiety and OCD disorders (30.43%).

Historical Analysis

A checklist designed from meta-analytic findings on behavioral challenges in long-term care settings was utilized to gather data across four domains: demographic information (including age and sex), diagnostic information, behavioral information (such as disruptive behavior, physical aggression, verbal aggression, resisting care, isolation, restlessness, and wandering/elopement), and details on behavioral interventions (both individual care plans and neighborhood specific). Each of the subjects data were coded using grammatical coding for background information/demographics, structurally coded using the checklist of behaviors described above, and In-Vivo coding was utilized for descriptive coding of the behavioral care plans.

Content Analysis

A content analysis was also performed to find patterns between the care plans to make objective conclusions about their content, meaning, and to provide context. This was done by measuring the frequency of specific elements mentioned within the checklist of behaviors. A Chi Square analysis was utilized to see if significant differences in observed frequencies were observed.

Mixed Methodology

Combining the qualitative data from the historical analysis and quantitative data of the content analysis to categorize patterns and themes within the data to make objective conclusions about their meaning within the context of the frequency of the behaviors.

RESULTS

Results

A mixed methods analysis revealed partial support for the hypothesis that behavioral care plans are helpful in guiding behavior. A Chi Square analysis revealed a significant difference between behaviors still present and those expected in long term care for those with dementia and psychosis in a majority of the residents ($X^2=24.53$, $p=0.05$). Historical analysis revealed that while some residents are still resistive care, wander/are elopement risks, and can be verbally aggressive, the majority of the residents are not engaging in high risk behaviors.

Of the behaviors noted in reports for the behavioral unit, wandering/elopement risk and verbal aggression were the highest noted behaviors (65.22%) in this study. Being disruptive (56.52%) and resistive to care (56.52%) were noted in more than half of the residents, while less than half engaged in restless behavior (39.13%), speaking inappropriately (39.13%), physical aggression (39.13%), going into others' rooms (21.74%), isolating (21.74%), and only a small number were hypersexual (13.04%) or engaged in abusive language (8.70%). While these percentages may seem high, some residents accounted for a fairly small number of behaviors, while others engaged in them more often. For example, one resident was disruptive a total of 83 times in a three month period, while another resident was disruptive only three times in that same period. The same resident that was highly disruptive was also much higher than others for resisting care (200 times in a three-month period), restless (78 times), and verbally aggressive (51 times) and also has comorbid psychiatric disorders of depression and psychosis.

When considering individual care plans, it is important to note that this is the behavioral unit, meaning this is the unit that those who have had challenging behavior are put in to help stabilize them. As such, this unit has multiple, unit-specific interventions in place for all residents to provide a safe, secure environment by having specially trained staff, more staff, frequent rounds, limitations to items, monitoring of cognitive, behavioral, mood, and medical changes, consistent/routine staff to attend to the residents' needs promptly. Some of the additional care plans that can be added include reducing stimulation, offering choices to residents, speaking slower and calmer, allowing the residents time to process information, explaining and redirecting as needed, and ongoing support.

CONCLUSION

While the hypothesis that behavioral care plans are helpful in guiding behavior was only partially supported, this study only includes a small amount of data from a short period of time. It does not include qualitative information from the residents themselves, and the data is contextually different across different residents. Given the residents' diagnoses and inability to control their behavior, this data does not emphasize the incredible work being done. However, to facilitate utility, the behavior care plans could be condensed and updated at least quarterly to make sure they are still relevant and not repetitive.

FS.



A Dialectical Behavior Therapy Training Protocol for All Direct Care Staff

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INTRODUCTION

Dialectical Behavior Therapy (DBT) is an evidence-based treatment that combines cognitive-behavioral and mindfulness techniques to enhance emotional regulation, distress tolerance, interpersonal effectiveness, and mindfulness.

Initially developed for individuals with chronic emotion dysregulation, DBT has proven effective in long-term care (LTC) settings, reducing behavioral crises, staff burnout, and use of restrictive interventions.

Training LTC staff in DBT principles fosters compassionate, consistent responses to residents' emotional and behavioral challenges, improving quality of care and staff-resident relationships. Studies show DBT-informed care reduces aggression, self-injury, and psychiatric hospitalizations among LTC residents (Linehan, 1993; Elices et al., 2016; Bohus et al., 2021).

TRADITIONAL DBT TRAINING

Training staff in Dialectical Behavior Therapy (DBT) equips them with tools to manage emotional dysregulation and challenging behaviors in long-term care settings, improving resident outcomes and staff morale. However, implementation can face barriers such as high training costs, time investment, and limited access to certified trainers.

Sustaining DBT requires ongoing supervision and reinforcement, which can strain budgets, yet the long-term benefits often outweigh these initial costs through improved care efficiency and reduced staff turnover.

DEMOGRAPHICS

- 151 questionnaires were sent, with a 54% return rate
- 85% of respondents are direct care staff
- 96% of respondents do not have a clinical license
- 61% of respondents been employed for 5+ years

CRESTWOOD'S DBT COMPREHENSIVE TRAINING PROTOCOL

Crestwood Behavioral Health's DBT training protocol is designed to accommodate the diverse needs of full-time staff in both direct and non-direct care roles. Prior education in a clinical degree is not necessary.

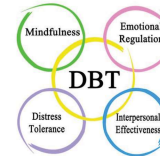
By employing adult learning principles, the training program ensures it is engaging, relevant, and applicable to real-world work scenarios. Recognizing the importance of work-life balance, Crestwood offers flexible training schedules and cost-effective solutions, minimizing disruptions to staff routines. This allows them to complete all assigned job duties during the training.

This approach not only enhances staff competency but also supports retention and job satisfaction, aligning with Crestwood's commitment to providing innovative and cost-effective programs in a socially responsible manner.



Crestwood Skills Group Training

Teaching Distress Tolerance



THE STUDY

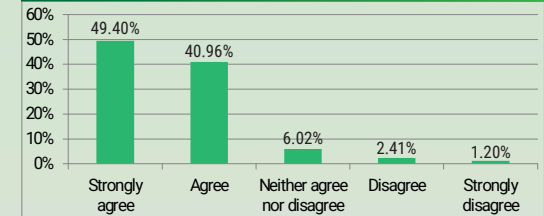
1. How many years of service do you have at Crestwood?
2. I am better prepared to address resident needs than before I was DBT trained.
3. DBT training provided me with enough training to deliver the treatment, including participation in the consultation team.
4. DBT provides me with the skills to improve leading/co-leading groups or writing care plans.
5. I was able to complete the DBT training and keep up with my other job duties.
6. My manager/supervisor was supportive of my DBT training.
7. DBT training changed my job satisfaction for the better.

NARRATIVE ANSWERS

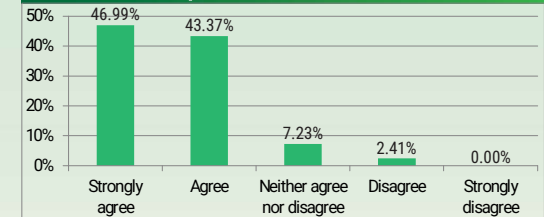
- "I'm grateful to Crestwood for the opportunity. It has been extremely helpful, and I look forward to continuing to use the skills I gained from DBT."
- "Our persons served have expressed so much gratitude for DBT being in our facility, it has made me proud to be able to provide it."
- "I love being in DBT, it has helped me in my role and in my personal life."
- "DBT has improved my overall performance where I work and it has also helped me in my daily personal life."

DATA

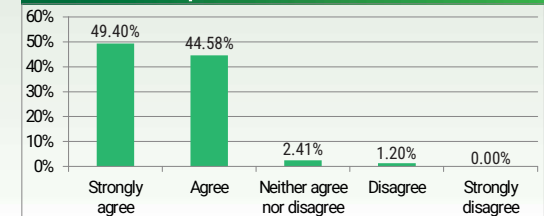
Question #2 Responses



Question #3 Responses



Question #4 Responses



RESULTS

The difference was statistically significant, $t(82), p < .001$ for each question about training in the survey. The training protocol successfully met its goal of training all direct care staff in DBT. Participants demonstrated a marked improvement in both knowledge and application of DBT principles compared to pre-training levels.

These findings indicate that the training protocol effectively enhanced staff competence and confidence in using DBT-informed strategies with residents, and it also increased job satisfaction.



ENGAGING EDMOOR RESIDENTS THROUGH THERAPEUTIC RECREATION ACTIVITIES AND BEHAVIOR ACTIVATION

EDGEMOOR HOSPITAL DP SNF COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES - 655 PARK CENTER DR, SANTEE, CA 92071 619-596-5500

Nancy Adams CTRS, Andrea Adorno RTR, Kristina Seales RTR, Melani Garcia- Resident

THE LADYBUG CLUB

A Resident-Led Therapeutic Recreation Activity Group in a Long-Term Care Facility.

Purpose: Designed to improve quality of life and support younger female residents (younger than 65 yrs. old) through a resident driven TR program.

METHOD

- Small, resident-led group that meets weekly for up to 2 hours.
- Each session begins with a social discussion using a "Rose" (something positive), "Thorn" (challenging), and "Bud" (to look forward to).
- Resident leader, Melani, works with the club members to create a monthly calendar of structured and unstructured activities (e.g. games, cooking, spa days, crafts, celebrations, and outings).
- Recreation Therapists support by providing resources, locations, materials, and printing event calendars.
- Small group to maintain trust and confidentiality within the group.
- The Ladybugs select members based on engagement, consistency, trust and compatibility.
- Melani includes family members as special visitors to share activities, meals, and cultural traditions.
- This qualitative study focused on observed interactions and resident feedback on themes related to empowerment, trust, sense of purpose, improved self-confidence, and social connection.



RESULTS/ANALYSIS "LADY BUGS"

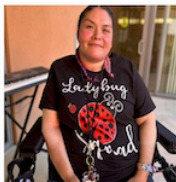
- Participants demonstrated peer support, leadership development, reduced isolation, improved mood, and social connection, often creating crafts or gifts for each other and extending friendships outside of groups.
- Increased cognitive stimulation and emotional well-being were observed through consistent participation and peer engagement.

CONCLUSION

The Ladybug Club demonstrates how resident led activities can foster purpose, connection, and a sense of community and improve feelings of autonomy and emotional wellbeing for younger residents living in Long Term Care.

RECREATION THERAPY

A treatment modality used by Recreation Therapists that uses application of recreational or leisure activities to address cognitive, physical, social and emotional needs of people with illness or disabilities to achieve therapeutic outcomes for improved quality of life and well-being.



"Leading the Ladybug Club gives me a sense of purpose.

We share strength, lift each other up, remind ourselves that our voices matter just as much as anyone else's."

"I feel truly blessed to be part of this dominoes group, where I can share and spend time with people I deeply care about."



BEHAVIOR ACTIVATION THERAPY

A cognitive-behavioral therapy technique used to treat depression and other mental health conditions. Focused on increasing engagement in pleasurable and rewarding activities to improve mood and well being.



THE DOMINATORS

A novel Activity program engaging Justice involved men residing in a Long-Term Care Facility utilizing Recreation Therapy and Behavior Activation.

Purpose: Designed to improve quality of life and emotional well-being of formally incarcerated residents through a specialized Dominoes program.



METHOD

- Group of men, with similar backgrounds, including a history of incarceration, CVA/stroke diagnoses, and an interest in playing "Prison Dominoes".
- Meet weekly for 1 hour, incorporating familiar game rules, socialization, and music to create a meaningful and comfortable environment.
- Peer support is demonstrated when a member is not present at the group, others visit their room to encourage participation.
- This qualitative study focused on observed interactions and resident feedback on themes related to belonging, identity, sense of purpose, improved self confidence, and social connection.



RESULTS / ANALYSIS "DOMINATORS"

- Participants formed a strong bond and named themselves "The Dominators".
- Therapeutic Recreation and Behavioral Activation complement each other and are both effective approaches focusing on positive experiences that lead to improved mood and well-being.
- Participants observed with increased trust within the group, social connection, laughter, and shared memories which improves emotional well-being and decreases social isolation.
- Demonstrated improvements in attention, memory, problem solving, decision-making, and cognitive function.
- The group has evolved to include outings and viewing documentaries together, promoting reintegration and continued motivation.

CONCLUSION

With aging prison populations, and compassionate release or parole of these individuals, more are ending up in skilled nursing care. Recreation Therapy combined with Behavior Activation provides meaningful opportunities for residents to engage, build trust, and find purpose which improves mood, connection, quality of life, and overall emotional well-being.