CALTCM 2015

Spotlight

Patient Safety, Care Coordination & Cutting-Edge Updates

Promoting quality patient care through medical leadership and education

April 24-25, 2015

Omni Los Angeles Hotel at California Plaza
Los Angeles, CA

CALTCM
California Association of Long Term Care Medicine

2015 CALTCM Annual Meeting

Program Introduction

The 41st Annual CALTCM meeting shines a Spotlight on Patient Safety, Care Coordination, & Cutting-Edge Updates. Attendees will be challenged to find ways to integrate advances in medical and post-acute care practices into current care systems, while preparing for the transition to a more efficient and streamlined Post-Acute and Long-Term Care (PA/LTC) delivery system.

The 2015 Annual Meeting was designed for the practical training of essential members of the interdisciplinary team, in areas where PA/LTC has struggled to improve quality. The first half-day workshop, Cutting-Edge Updates, is presented in a format that enables physicians and other interdisciplinary team members to keep up with the ever-expanding medical literature. Our Keynote Speaker, Dr. Joseph Ouslander, sets the stage for an invigorating and interactive second half-day workshop on Care Coordination. Patient Safety is an ever-present issue in PA/LTC, and constitutes the final half-day workshop, with a lively and informative Mock Trial presented as the grand finale.

Learning Objectives

By participation in the annual meeting, participants will have the ability to:

- Explain models and incentives for improving care coordination, and take appropriate steps to improve care integration with their partners;
- Develop at least one QAPI performance improvement project for implementation in the coming year;
- Understand how to effectively integrate recent advances in medical knowledge into their practice within the post-acute continuum;
- Identify and implement two new tools to improve transitions of care and care coordination;
- Identify four preventive steps a facility can take to improve care and thereby reduce its exposure to regulatory or civil actions.

CALTCM Annual Meeting Accreditation Statement

Continuing Medical Education (CME)

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

The California Association of Long Term Care Medicine (CALTCM) designates this Live activity for a maximum of 10 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

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

American Academy of Family Physicians (AAFP)

This Live activity, 41st Annual CALTCM Meeting, Spotlight: Patient Safety, Care Coordination, and Cutting Edge Updates, with a beginning date of 04/24/2015, has been reviewed and is acceptable for up to 10.00 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Board of Registered Nursing (BRN)

SCAN Health Plan® is a provider approved by the California Board of Registered Nursing (Provider #CEP-13453). This activity has been approved for up to 10 contact hours.

California Board of Behavioral Sciences (BBS)

Course meets the qualifications for 10 hours of continuing education credit for MFT's and/or LCSW's as required by the California Board of Behavioral Sciences (BBS). California Association of Long Term Care Medicine (CALTCM) BBS Provider No. PCE-3077.

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

This live activity has been pre-approved by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) for a total of 7 management hours and 3 clinical hours toward certification as a Certified Medical Director (CMD) in post-acute and long-term care medicine. The CMD program is administered by the ABPLM. Each physician should claim only those hours of credit actually spent on the activity.

Nursing Home Administrators Program (NHAP)

This activity has been approved by the Nursing Home Administrator Program for up to 10.0 hours of NHAP credit. Course approval number: 1797010-4875/P

Continuing Pharmaceutical Education

SCAN Health Plan® is accredited by the California Accreditation of Pharmacy Education (CAPE) as a provider of continuing pharmacy education. Pharmacists completing this course on 4/24/2015-4/25/2015 will receive up to 10.00 hours of credit through SCAN Health Plan® (CAPE Provider #199). CEU credits are also accepted by the Pharmacy Technician Certification Board (PTCB) to meet re-certification requirements (please retain program brochure and the certificate in event of an audit).

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

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Education Committee

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Faculty and Planner Disclosures

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

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

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Jennifer Wieckowski, MSG	Faculty/ Planner	None	
Bill Wilson	Faculty	None	
Tom Yoshikawa, MD	Faculty	None	

2015 CALTCM Leadership Award

The CALTCM Leadership Award recognizes individuals who have demonstrated exceptional leadership and made outstanding contributions in the areas of education, practice, administration or policy in long term care. This leadership is characterized by results of increased visibility of critical issues, creation of solutions to significant problems, and positive impacts on the overall quality of care in long term care.

CALTCM is proud to present the 2015 CALTCM Leadership Award to:

Joseph G. Ouslander, MD

Dr. Ouslander is Professor and Senior Associate Dean for Geriatric Programs and Interim Chair of the Department of Integrated Medical Science at the Charles E. Schmidt College of Medicine of Florida Atlantic University (FAU) in Boca Raton Florida. Dr. Ouslander is an internationally recognized geriatrician and is a Past-President of the American Geriatrics Society, and serves as the Executive Editor of the Society's Journal. He is a co-author of Essentials of Clinical Geriatrics and an editor of Principles of Geriatric Medicine and Gerontology.

Special Acknowledgements

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Program Agenda

Friday, April 24, 2015

11:00 a.m.	Registration/Exhibits Open
11:45 a.m.	Industry Supported Lunch
1:00 p.m.	Welcome & Introductions
1:10 p.m.	Opening Comments
1:15 p.m.	Recommendations for Systolic Blood Pressure Management in Very Elderly Patients
1:35 p.m.	New Guidelines for Diabetes Mellitus Management in the Elderly
1:50 p.m.	Controversies in Lipid Management in the Very Elderly Patients
2:10 p.m.	Substance Abuse and Dependence
2:30 p.m.	Delirium Update
2:45 p.m.	Break & Exhibits
3:15 p.m.	UTI Antibiotic Stewardship Including Update on *C. diff.* – Diagnosis and Management in PA/LTC
3:40 p.m.	Oral Health
4:00 p.m.	The Medical Director as a Quality Improvement Champion
4:20 p.m.	Care of Younger Adults Tool Kit
4:40 p.m.	POLST 2014 Update: New Consumer Education on Hydration and Ventilators
5:00 p.m.	Q&A Panel Discussion
5:30 p.m.	CALTCM Update
6:00 p.m.	Poster Session & Reception | Exhibits Close
7:00 p.m.	Industry Sponsored Dinner

Program Agenda

Saturday, April 25, 2015

6:45 a.m.	Industry Supported Breakfast /Exhibits Open
8:00 a.m.	Welcome
8:05 a.m.	Presentation of 2015 CALTCM Leadership Award
8:15 a.m.	Raising the Bar on Care Coordination: Lessons Learned from INTERACT
9:00 a.m.	Overview of INTERACT in California
9:15 a.m.	Incentives to Improve Care Coordination
9:30 a.m.	Break & Exhibits
10:00 a.m.	GeriNet Care Coordination Model
10:30 a.m.	Literate Medical Care
11:00 a.m.	Develop a QAPI Performance Improvement Project (PIP)
11:30 a.m.	Q&A Panel Discussion
12:00 p.m.	Industry Supported Lunches & Exhibits
1:05 p.m.	CALTCM Awards
1:20 p.m.	AMDA
1:30 p.m.	Behavior Mapping for the Care of Dementia Behaviors
1:50 p.m.	Elder Abuse Detection and Prevention
2:10 p.m.	Falls Prevention and Risk Management
2:30 p.m.	Break & Exhibits
3:00 p.m.	Care of the Un-Befriended Patient
3:20 p.m.	Mock Trial
4:40 p.m.	Q&A Panel Discussion
5:10 p.m.	Closing Comments / Evaluations/ Adjourn

Cutting-Edge Updates

Friday
April 24, 2015

Recommendations for Systolic Hypertension in the Very Elderly

Thomas T. Yoshikawa, MD

Deputy Chief of Staff
VA Greater Los Angeles Healthcare System
Distinguished Professor of Medicine,
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CALTCM 2015

Notes:

Disclosure

- I have no relevant financial relationships with commercial interests to disclose.

Notes:

Learning Objectives

- Describe the rationale of less intensive blood pressure management in the long term care population
- Outline the latest recommendations for BP measurement in frail elders
- Devise a strategy to counsel elders and their families about the new recommendations
- Identify the blood pressure agent(s) which are the safest for frail elders

Notes:

Recommendations for Systolic Hypertension in the Very Elderly

1. Treatment of hypertension, specifically systolic hypertension in persons 80 years and older is less clear.
2. Several population studies show higher death rates in those 80 and older if systolic BP is less than 130 mm Hg compared to those with a BP greater than 150 mm Hg.
3. Persons 80 years and older are very heterogeneous, from healthy and independent to frail, chronically ill and disabled. Thus, the need to carefully assess health, functional status and life expectancy for each patient before treating.

Notes:

Recommendations for Systolic Hypertension in the Very Elderly (2)

1. Measure BP and repeat in 10-15 minutes to exclude “pseudo or white coat hypertension”. Also check for orthostatic hypotension.
2. Patient should measure BP at home twice a day: Morning and evening.
3. Patients 80 years and older with newly diagnosed systolic BP of 150 mm Hg or higher (or 145 mm Hg or higher at home) AND diastolic BP of 70 mm Hg or higher **should be treated** with appropriate medications unless there is a contraindication.

Notes:

Recommendations for Systolic Hypertension in the Very Elderly (3)

Consider not treating patients 80 years and older with a systolic BP of 150 mm Hg or higher with the following risks/conditions and risks outweigh benefits:

a. Moderately severe to severe dementia (Mini Mental State Exam <20 or Functional Assessment Score Test stage 6 or 7).
b. Life expectancy of less than 3 years based on underlying disease(s).
c. Frailty as defined by Fried et al.: Presence of at least 3 of the 5 following criteria:
   - Unintentional weight loss (>10 lbs. or >5% body weight in the past 12 months)
   - Exhaustion
   - Slow movement
   - Low physical activity
   - Weakness

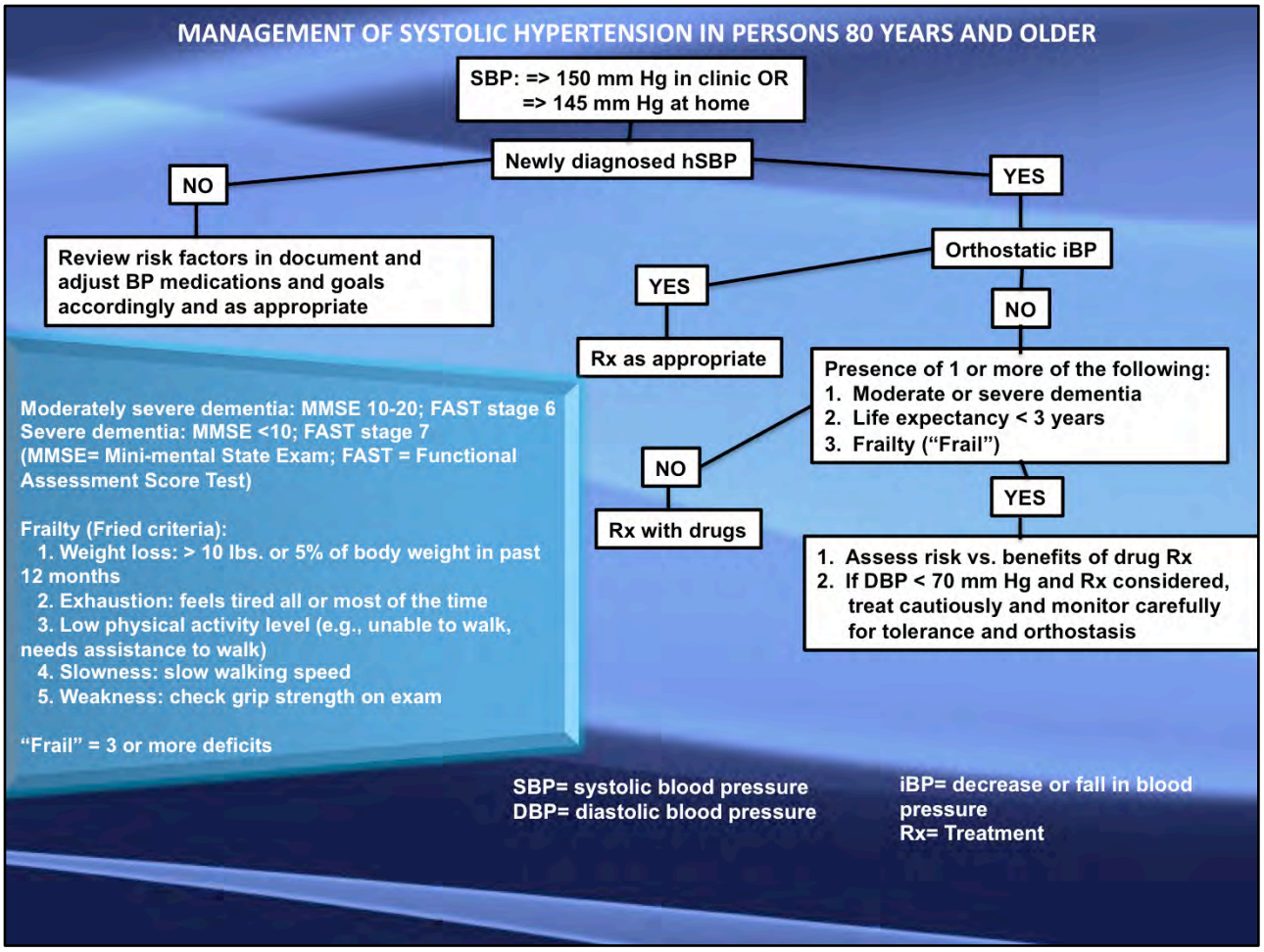
Notes:

Recommendations for Systolic Hypertension in the Very Elderly (4)

Drugs to consider in Treatment of Systolic Hypertension:

a. Diuretics (watch for dehydration, lowering of potassium/sodium/magnesium, increase of uric acid, increase of glucose).
b. Calcium channel blockers: CCB (potential conduction defects).
c. Angiotensin-converting enzyme inhibitor: ACEI (increase in potassium; cough).
d. Angiotensin II receptor blockers: ARB (increase in potassium)

Notes:


MANAGEMENT OF SYSTOLIC HYPERTENSION IN PERSONS 80 YEARS AND OLDER
SBP: => 150 mm Hg in clinic OR
=> 145 mm Hg at home
Newly diagnosed hSBP
NO
YES
Review risk factors in document and adjust BP medications and goals accordingly and as appropriate
Orthostatic iBP
YES
NO
Rx as appropriate
Presence of 1 or more of the following:
1. Moderate or severe dementia
2. Life expectancy < 3 years
3. Frailty ("Frail")
NO
YES
Rx with drugs
1. Assess risk vs. benefits of drug Rx
2. If DBP < 70 mm Hg and Rx considered, treat cautiously and monitor carefully for tolerance and orthostasis
Moderately severe dementia: MMSE 10-20; FAST stage 6
Severe dementia: MMSE <10; FAST stage 7
(MMSE= Mini-mental State Exam; FAST = Functional Assessment Score Test)
Frailty (Fried criteria):
1. Weight loss: > 10 lbs. or 5% of body weight in past 12 months
2. Exhaustion: feels tired all or most of the time
3. Low physical activity level (e.g., unable to walk, needs assistance to walk)
4. Slowness: slow walking speed
5. Weakness: check grip strength on exam
"Frail" = 3 or more deficits
SBP= systolic blood pressure
DBP= diastolic blood pressure
iBP= decrease or fall in blood pressure
Rx= Treatment

Notes:

New Guidelines for Diabetes Mellitus Management in the Elderly

Dan Osterweil, MD, FACP, CMD

CALTCM 2015

Notes:

Disclosures

- I have no relevant financial relationships with commercial interests to disclose

Notes:

Learning Objectives

- Explain the evidence supporting less intensive management of diabetes in the long term care environment
- Outline the latest strategies for Diabetes management in frail elders
- Describe the pros and cons of sliding scale insulin and develop an alternative insulin administration plan for a resident transferring with current orders for sliding scale insulin.
- Identify the most important interventions for diabetes and complication management in a frail elder

Notes:

BACKGROUND

- Diabetes Mellitus type 2 is a common medical conditions in older people
- DM Type 2 is associated with vascular complication, subsequent disability and frequent hospitalization
- Diabetes care in long term care facilities should be individualized and take into account the functional limitation, co-morbidity, and changes in cognitive status

Notes:

Risk of Hypoglycemia

- Retrospective study of 14,000 patients 65 years or older with type 2 DM treated with Sulfonylurea
- Episodes of serious hypoglycemia (associated with stroke, MI, or death) were rare (1.23 per 100 person years)
- Incidence highest in those patients taking chlorpropamide or glyburide
- Other risk factors:
  - missed meals, poor nutrition, alcohol abuse, impaired renal or liver function

Notes:

Objectives

- Individualize Care
- Adhere to acceptable Quality Measures
- Maximize Safety and Minimize Harm
- Promote Overall Well-Being

Notes:

Diabetes Care Plan

- Prevent Hypoglycemia
- Avoid acute metabolic complications
- Decrease risk of infection
- Prevent Hospitalizations
- Tailor care to individual goals consistent with advanced care planning

Notes:

Methods

- Utilize the best practice for long time care residents
- Implement Policy and Procedures to manage Diabetes care
- Evaluate the care process and outcomes against benchmarks quality indicators
- Evaluate the care outcomes against individual goals of care

Notes:

Goal and Targets

HbA1c Goals

- Residents who are functional, cognitively intact, and have significant life expectancy should follow the ADA's A1C goal of <7%
- Residents with a history of severe hypoglycemia, limited life expectancy (<5 years), or extensive co-morbid conditions should have an A1C goal of <8%

Notes:

Goal and Targets

GLUCOSE TARGETS

- The clinician must consider individual comorbidities, and cognitive and functional status when determining what glucose goals should be agreed with the patient and/or care giver.
- In general, on treatment, an HbA1c target range of 53 to 59 mmol/mol (HbA1c 7.0%-7.5 %) should be aimed for.
- To reduce the risk of hypoglycemia, no patient should have a fasting glucose on treatment of less than 6.0 mmol/L (108 mg/dL) : "**Not below 6.**"
- No patient should commence glucose-lowering therapy with drugs until the fasting glucose level is consistently 7 mmol/L or (126 mg/dL) higher**: "Not before 7."**
- Low blood glucose states (levels of glucose of <5.0 mmol/L) (90mg/dL) should be strictly avoided.
- A random glucose level higher than 11.0 mmol/L (200 mg/dL) should be avoided to minimize symptoms and reduce the risk of other
- Diabetes-related complications.
- These values are a guide to treatment and in cases of functional dependence, care home residency, dementia, end-of-life care, and other high dependency states, they may need adjusting to reduce the risk of hypoglycemia and to enhance patient safety.

Notes:

Goal and Targets

HYPOGLYCEMIA

- Hypoglycemia is defined for the purpose of this statement as a blood glucose level less than 4 mmol/L. (72mg/dL)
- In older people, hypoglycemia is a highly prevalent and under recognized disorder with severe consequences (e.g., Falls, cognitive impairment, hospital admission, and so forth.)
- Older people with diabetes on a longer-acting sulphonylurea or an intensive insulin regimen are at high risk of hypoglycemia:
- risk is increased in those with polypharmacy, cognitive impairment, malnourishment, and those recently discharged from hospital or residing in a care home.
- A focused education strategy needs to be used and implemented for both patients and care givers to decrease the risk of hypoglycemia.
- Hospital admission for hypoglycemia should trigger the need for diabetes specialist review.

Notes:

INFLUENCE OF COMORBIDITIES

- Because of the high risk of associated co-morbidities in older people with diabetes, Comprehensive Geriatric Assessment is recommended to identify related functional loss and the impact of disability.
- Older people with diabetes may have varying levels of nutritional impairment that may influence and modified the impact of other co-morbidities. A nutritional screening assessment tool should be used routinely.
- In patients with hypertension, the blood pressure threshold for treatment is 140/80 mm Hg, and 150/90 mm Hg in those subjects 75 years and older. A low systolic blood pressure threshold may be appropriate in those with evidence of renal impairment (estimated glomerular filtration rate - eGFE <60 ml/min /1.73m2.)
- An acceptable blood pressure target in functionally dependent patients with Diabetes is below 150/90.
- Screening for renal impairment in all newly diagnosed patients with diabetes should be carried out. Annual testing of the eGFR is recommended.

Notes:

PATIENT SAFETY

- Increased age and progressive functional loss is a significant risk for patient safety.
- The close relationship between Diabetes and impaired functional status requires all patients to have an assessment of both physical and cognitive function using the CGA, so as to maximize independence, self-management ability and safe adherence to therapy.
- Regular screening for mood disorder, cognitive impairment and hearing and visual loss (annually as minimum) is necessary to enhance patient safety and alert the physician to the need for additional supportive care.
- Avoid polypharmacy and use simplified (once daily where possible) treatment regimens to achieve acceptable glucose target; depending on diabetes control and what other comorbidities are present, the priority list of medications should include a Statin, an ACEI/ARB and glucose lowering agent.

Notes:

Therapy

- All patients should participate as actively as possible in tailored physical activity program involving resistance training, balance exercises and cardiovascular fitness training.
- Restrictive diets should be avoided in those patients 70 years and older and in those with under nutrition.
- Metformin can be considered as first line glucose lowering therapy in older people with type 2 diabetes and as an adjunct to insulin therapy in those recommended for combination therapy
- In those patients at higher risk of hypoglycemia, sulphonylurea therapy should be avoided.
- In selected patients, a basal insulin regimen may be safer in terms of hypoglycemia of hypoglycemia risk than a basal/bolus or premixed insulin regimen.
- In selected older patients not in target or where there is poor tolerance to the glucose lowering agents, the use of a dipeptidyl peptidase 4 (DPP4) inhibitor can be considered as second line therapy.
- In subjects who are obese (body mass index BMI>35) or where there is poor tolerance or lack of response to other agents, a glucagon like peptide 1 agonist can be considered as both second line and third line therapy.

Notes:

Medication Monitoring

Antidiabetic medication
Insulin and oral hypoglycemic e.g.,

- Acarbose
- Acetohexamide
- Chlorpropamide
- Glimepiride
- Glipizide
- Gluburide
- Metformin
- Repaglinide
- Rosiglitazone
- Tolazamide
- Tolbutamide

- **Combination products:**
- Rosiglitazone/Metformin
- Glyburide/Metformin
- Glipizide/Metformin
- Pioglitazone/Metformin

Monitoring

- Use anti-diabetic medications should include monitoring for effectiveness based on desired goals, identity ADR such as hypoglycemia, impaired renal function.
- Need for continued use of sliding scale insulin for non-emergency coverage may indicate inadequate blood sugar control.
- Resident on rosiglitazone should be monitored for visual deterioration due to new onset and/or worsening of macular edema in diabetic patients.

Notes:

Adverse Consequences

- **Metformin** has been associated with the development of lactic acidosis (a potentially life threatening metabolic disorder) which is more likely to occur in individuals with:
- Serum creatinine ≥1.5 mg/dL in males or ≥ 1.4 mg/dl in female
- Abnormal creatinine clearance from any cause, including shock ,acute myocardial infarction or septicemia.
- Age 80 ≥ years unless measurement of creatinine clearance verifies normal renal function.
- Radiologic studies in which intravascular iodinated contrast materials are given.
- Congestive heart failure requiring pharmacological management
- Acute or chronic metabolic acidosis with or without coma. (including Diabetic Acidosis)

Notes:

Adverse Consequences

- **Rosiglitazone and pioglitazone** have been associated with edema and weight gain; therefore, their use should be avoided in residents with stage III or stage IV heart failure.
- **Sulfonylurea** can cause the syndrome of inappropriate anti diuretic hormone (SIADH) and result in hyponatremia.
- **Chlorpropamide and Glyburide** are not considered hypoglycemic agent of choice in older individuals because of the long half-life and/or duration of action and increased risk of hypoglycemia.
- **Adverse consequences** may cause prolonged and serious hypoglycemia (with symptoms including tachycardia, palpitation, irritability, headache, hypothermia visual disturbances, lethargy, confusion, seizure and/or coma.)

Notes:

P&P

Monitor HbA1C	IF resident has DM THEN HbA1C should be measured at least every 12 month OR care goals / records should indicate why this is not indicated	Excluded if advanced dementia or poor prognosis *
Improve Glycemic Control	IF HbA1C >=9 THEN improve glycemic control, offer therapeutic intervention within a month OR care goals / records should indicate why this is not indicated HbA1C <=9	
GLUCOSE >250mg% mmol/L	IF BSG >=250 THEN improve glycemic control offer therapeutic intervention.	
GLUCOSE <90mg% mmol/L	IF BSG <=90 THEN improve glycemic control offer therapeutic intervention.	
Screen for Proteinuria	IF resident has DM THEN Urine protein should be measured at least every 12 month OR care goals / records should indicate why this is not indicated	
Treat Proteinuria	IF NH resident with Diabetes has proteinuria THEN offer therapy with an ACE inhibitor or ARB OR care goals / records should indicate why this is not indicated	
Examine Feet	IF Resident has DM THEN feet should be examined. Ensure all residents with DM diagnosis will be seen by the Podiatry Q 60-70 days as per regulation	
Examine Eyes	IF Resident has DM THEN eyes should be examined for retinopathy. Ensure all residents with DM diagnosis will be seen by the Ophthalmologist at least once a year	
Balanced Diet and Stable Weight	Ensure all residents with DM diagnosis will be seen by RD at least monthly until stable and then Quarterly	

Notes:

P&P

TREATMENT OF HIGH CARDIOVASCULAR RISK		
Measure blood pressure	IF Resident has DM THEN check blood pressure monthly	
Blood pressure control	IF BP is > 160/100 THEN therapeutic intervention to lower BP within 3 month should be considered	
ACE INHIBITOR / ARB Therapy	Resident with the diagnosis of DM should be screened at least annually for protein in urine (proteinuria),to reduce renal disease. MD should Consider ACEI OR ARB treatment or as a prevention.	
Aspirin Therapy	Resident with Diabetes who are not on other anticoagulant or antiaggregant therapy should be offered daily aspirin therapy. OR care goals / records should indicate why this is not indicated. (allergy, intolerance, other adverse reactions)	
Statin Treatment	Residents with diagnosis of DM which are not on cholesterol lowering medication and do not have cholesterol level on admission, consult MD for need of laboratory for base line. And need for medication.	

Notes:

CASE 3 (1 of 3)

- An 84-year-old man who lives in a nursing home is seen for his monthly evaluation.
- History includes moderate dementia, diabetes mellitus, and heart failure.
- Medications include metformin 1000 mg twice daily with meals and glipizide 10 mg q12h.
- He undergoes fingerstick monitoring twice daily; values have ranged between 100 and the low 200s for several months. His most recent HbA1c level was 8.3%.

Notes:

CASE 3 (2 of 3)

Which of the following is the most appropriate next step in the management of this patient's diabetes?

A. Obtain fructosamine level.

B. Increase glipizide to 20 mg q12h.

C. Add sitagliptin.

D. Add NPH insulin at bedtime.

E. Discontinue fingerstick monitoring.

Notes:

REFERENCES

1. American Diabetic Association: Standards of Medical Care in Diabetes – 2011. Diabetes Care 2011;34(suppl. 1):S11-S61
2. Diabetes Mellitus in Older People :Position Statement on behalf of the International Association of Gerontology and Geriatric (IAGG), the European Diabetes Working Party for Older People (EDWPOP),and The International Task Force of Experts in Diabetes. JAMDA -2012;13:497-502
3. British Geriatric Society: Best Practice Guide, Diabetes Published May 2009
4. Quality Indicator for the Management of Medical Conditions in Nursing Home Residents. JAMDA – 2005;6:S36-S48
5. CMS Manual – The Long Term Care Survey

Notes:

Controversies in Lipid Management in the Very Elderly Patients

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Notes:

Disclosure

- I have no relevant financial relationships with commercial interests to disclose.

Notes:

Learning Objectives

- State the evidence supporting less intensive lipid management in long term care settings
- Outline the latest recommendations for lipid management in frail elders
- Develop a plan of care for lipid management and monitoring in an elderly resident transferred from the hospital and a mechanism to discuss this plan with the family
- Identify the safest medications and monitoring plan for lipid management in frail elders

Notes:

Controversies in Lipid Management in the Very Elderly Patient

1. **Hypercholesterolemia** is a major risk factor for arteriosclerotic cardiovascular disease (ASCVD), along with family history of ASCVD, hypertension, diabetes mellitus, smoking, overweight, unhealthy diet, lack of regular physical activity, and aging.
2. **In the past**, treatment of high cholesterol focused on **lowering** total and LDL ("bad") cholesterol and **increasing** HDL ("good") cholesterol to pre-defined target levels (triglycerides were also included although today's discussion focuses on cholesterol only).
3. **New/current approach** (AHA/ACCF) focuses on treatment based on:
   - **Presence of ASCVD (secondary prevention)**
   - **Presence of ASCVD risk factors in absence of clinical ASCVD (primary prevention)**
     - **(Determine 10 year risk for clinical ASCVD combined with broad ranges of elevated LDL levels)**
   - **Shared decision-making between patient and/or patient family and health provider re: risk vs benefits**

Notes:

Controversies in Lipid Management in the Very Elderly Patient (2)

Primary prevention recommendations:

1. Those with LDL cholesterol of 190 mg/dL or greater WITHOUT diabetes: High intensity statin therapy
2. Those with LDL cholesterol of 70-189 mg/dL WITHOUT diabetes: Estimate 10-yr ASCVD risk: Then determine intensity of statin therapy
3. Those with LDL cholesterol of 70-189 mg/dl WITH diabetes: Estimate 10-yr ASCVD risk: Then determine intensity of statin therapy

Notes:

Controversies in Lipid Management in the Very Elderly Patient (3)

1. New approach is **complex, lengthy with multiple different options** BUT no recommendations for persons 80 years and older (some recommendations for 75 years and older).
2. **No randomized clinical trial of lipid management in persons 80 and older**. Thus unclear if there is clinical value of statin therapy for these very old persons.
3. **Adverse drug events** due to statins: primarily liver toxicity and muscle weakness/myopathy increases with age. Also, possible worsening of diabetes and may reduce cognitive function.

Notes:

Controversies in Lipid Management in the Very Elderly Patient (4)

1. **Major concerns for very elderly patient re: treating hypercholesterolemia with statins**:
   - Limited evidence for benefit of statin therapy
   - Higher risk for adverse events: liver toxicity, myopathy (possible worsening of diabetes and cognition)
   - Polypharmacy (>5 drugs): higher risk of drug-drug interactions
   - Multiple morbidities (several co-existing major diseases/ disorders): drug-disease interactions; impacting potential liver and/or muscle adverse events
   - Functional deficits; cognitive impairments; limited life expectancies

Notes:

Controversies in Lipid Management in the Very Elderly Patient (5)

1. **If patient already on statin or plan to start statin, review indications, drug intensity (dosage), any adverse side effects**
2. **Avoid therapy or stop statin therapy if patient**:
   - Is on hospice care
   - Has significant cognitive impairment (e.g., dementia)
   - Life expectancy less than 3 years
   - Has liver disease or high risk for hepatic dysfunction
   - Has muscle disease, weakness or risk factors for myopathy
   - Has adverse drug reactions
3. **Discuss decision re: therapy with patient/family/ caregiver on risk vs benefits**

Notes:

Controversies in Lipid Management in the Very Elderly Patient (6)

1. **If patient already on statin or plan to start statin, review indications, drug intensity (dosage), any adverse side effects**
2. **Avoid therapy or stop statin therapy if patient**:
   - Is on hospice care
   - Has significant cognitive impairment (e.g., dementia)
   - Life expectancy less than 3 years
   - Has liver disease or high risk for hepatic dysfunction
   - Has muscle disease, weakness or risk factors for myopathy
   - Has adverse drug reactions
3. **Discuss decision re: therapy with patient/family/ caregiver on risk vs benefits**

Notes:

Substance Abuse in Long Term Care

Robert M. Gibson, PhD, JD
Psychologist/Attorney

Rebecca Ferrini, MD, MPH, CMD
Medical Director

Edgemoor DPSNF, Santee CA

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Notes:

Our presentation is *not* an official position of the county of San Diego, nor should it be viewed as providing legal advice

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Notes:

Disclosure Statement

Drs. Ferrini and Gibson do not have any relevant financial relationships with commercial interests to disclose.

Notes:

Learning Objectives

Attendees will have the ability to:

- Discuss addictive behaviors/substances likely encountered in LTC, and impact of cognitive deficits/brain injury
- Examine options for management of addictive behavior in LTC, as well as risks and duties associated with treating patients with addiction
- Describe drug treatment approaches in light of current research
- Utilize a pain management contract for patients on opioid therapy to accurately document conversations and means of monitoring therapy for chronic opioid use

Notes:

Do you know these people?

- No-one knew Ms. H took so much valium,--she spent the week in the hospital off it, now she is climbing the walls.
- A lifetime of drinking has resulted in dementia but with confabulation and good vocabulary—so Mr. H seems a lot better than he is.
- Ms. G tells the surveyor that everyone knew she had a problem, but no-one referred her to treatment.
- Mr. X has a long history of substance abuse and now keeps wanting more painkillers and Xanax.

Notes:

Elders are historically less likely to have substance problems, but the incidence is on the rise.

- Younger adults and those with mental illness are entering SNF in record numbers.

Notes:

Screening and assessing

- Are all patients assessed or just when there "seems to be a problem"
- Who does it—MD (H&P), SW, nursing?
- Do you use standardized questionnaires?

Notes:

Case studies

- Ms. H is so sedated and she had been out overnight. To do a thorough workup, you test her urine and it comes back positive for opioids, benzodiazepines and marijuana—

- Mr. Y has an alcohol smell on his breath and falls twice after his wife has come to visit.

Notes:

Substance Abuse/Dependence in LTC

- Risk of dangerous interactions with medication,
- Harm to others
- Impaired relationships with caregivers,
- Inability to operate a power wheelchair or other equipment,
- Behavioral disturbance
- Need/efforts by the facility to discharge.

Notes:

Making the diagnosis

- Based on history
  - ICD 9 versus DSM IV and V
- Tox screens--

Notes:

Substance-Related and Addictive Disorders

- New DSM V classification system
  - Substance use disorders
    - A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least 2 of 11 listed criteria.
    - Severity is determined by number of symptoms
      - Mild: Presence of 2-3 symptoms
      - Moderate: Presence of 4-5 symptoms
      - Severe: Presence of 6 or more symptoms
  - Substance induced disorders, e.g.
    - Intoxication, withdrawal, and other substance/medication-induced mental disorders (psychotic, bipolar, and related disorders, depressive, anxiety, obsessive-compulsive, sleep sexual dysfunction, delirium and neurocognitive disorders)

Notes:

Substance Use Disorder Traits

- Tolerance,
- Withdrawal,
- Using larger quantities/frequency or duration than intended,
- Want to quit but can't,
- More time to get it or recover from it,
- Give up other things for the substance
- Using it despite persistent problems

Notes:

ICD-9 coding

- Focus is on acute versus chronic use and compulsivity
  - Non-dependent use of drugs 305.0: Non-dependent, episodic, acute intoxication, excessive, periodic.
  - Alcohol dependence syndrome 303.0: Dependent, continual, habitual, chronic, acute in alcoholism.
  - Drug dependence 304.0: a state, psychic and sometimes also physical…characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis...and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present.

Notes:

Institutional Remission

- May not be using at time of admission – were they in the hospital? Is there any desire not to use, or has it just been unavailable?
- The ability of residents to exercise their rights in LTC may end institutional remission. E.g., resident leaves and uses, or brings back substances.

Notes:

What Are Our Options?

- Counseling
- Educating
- Referring
- Monitoring
- Medications
- Refer to AA?
- Discharge
- Stopping medications that interact with the substances
- Contracting for safety or documentation of discussion and resident understanding of risks.
- With permission, risk-sharing conversations with family.

Notes:

In our experience…

- Law enforcement response for possession unhelpful; call for dangerous behaviors impacting others.
- Can refuse to care for those intoxicated (out of scope of practice) and send to hospital.
- Can limit visitors, storage, remove pharmacotherapy and privileges such as assistance using power chairs or ability to use on grounds when risky substance abuse is documented.

Notes:

What about marijuana?

- I have a prescription!
  - Still illegal under federal law.
  - FDA "safe and effective?"
  - Dosage and interactions?

Notes:

What are some goals we can set?

Notes:

SNF Goals

- Will not consume substances while a resident at SNF/within facility.
- Will seek out social worker if experiencing cravings.
- If they choose to use when on pass, will not return until sober.
- Will undergo random urine drug screens.
- Will not prescribe medications with potential to interact with alcohol/drugs with signs of continuing use.

Notes:

"Traditional approaches" have demonstrated poor efficacy

- 12-Step ("Anonymous" programs and related therapies)– AA, NA, CA, OA, etc.
  - Addict is "powerless over alcohol" (or other substance)
  - Spiritually based; reliance on "higher power"
  - Confrontational
  - Abstinence only

Notes:

The Good News…

- In a meta analysis (Hester and Miller, 2003), at least 18 treatment options were effective.
- The top 10 included Brief Intervention (#1), Motivational Interviewing (#2) and medications (Acamprosate (#3) and Naltrexone (#6) for alcohol use, and these are much more suited to LTC.

Notes:

Brief Intervention / Motivational Enhancement

- Four or fewer sessions.
- Time ranges from a few minutes to an hour.
- Designed to be done by health professionals, not addiction specialists.
- Focus on increasing motivation to enter specialized treatment or change behavior.

Notes:

Brief Intervention - FRAMES

- **F**eedback of personal risk.
- **R**esponsibility of the patient for drinking.
- **A**dvice to change.
- **M**enu of strategies to reduce drinking.
- **E**mpathy – a warm, reflective, and understanding style is more effective.
- **S**elf-sufficiency or optimism of the patient is employed to increase motivation.

Notes:

ROLE PLAY BRIEF INTEVENTION

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Notes:

Overview Reference for Brief Intervention/ Motivational Enhancement

- National Institute on Alcohol Abuse and Alcoholism, Alcohol Alert Number 43
  http://pubs.niaaa.nih.gov/publications/aa43.htm
- WHO Manual for Brief Intervention
  http://whqlibdoc.who.int/HQ/2001/WHO_MSD_MSB_01.6b.pdf
- Center for Substance Abuse Treatment.
  Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35.
  http://store.samhsa.gov/shin/content/SMA13-4212/SMA13-4212.pdf

Notes:

Medications used for substance abuse

- Acamprosate (#3) and Naltrexone (#6) have shown efficacy in the treatment of alcohol dependence.

- Others appear to have benefit for opioid dependence but require special certification, e.g., Buprenorphine / Subutex / Suboxone or Methadone.

Notes:

Pain management is challenging in those with known or suspected substance abuse.

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Notes:

The pendulum swings back and forth

Treat pain—avoid opioids—treat pain—avoid opioids

Notes:

Many people have legitimate pain and there is evidence that pain medications increase the quality of their life.

We are not talking about those people here.

Notes:

Have you had these problems?

- Ms. P continually asks for more pain medications and watches the clock for her next dose. Nurses ask—is she addicted?

- Ms. H insists "only Dilaudid works for me." Pain is 10/10 all the time and the nurse wants you to fix it to improve the MDS indicator.

Notes:

Two extremes…

"You're an addict, forget it, I can't prescribe pain meds for you at all."

"I am so tired of his hassles, give him the Vicodin or Percocet or whatever he wants just to make our lives easier."

Notes:

Remember, chronic pain management, goal is not pain "relief," but increased functional capacity and quality of life.

Notes:

Opioid prescribing needs to be done carefully.

Hyperalgesia, dependence, constipation, changed mental status…..

Notes:

Are Opioids helping?

- Mark has 10/10 pain all the time. He is grouchy and refuses to engage in activities, spending all day in bed. He constantly complains of the pain and demands more medication.
- Sarah gets up daily and spends all day in her power chair. She refuses to go back to bed at night and develops skin breakdown. She takes opioids daily for her chronic pain.

Notes:

One strategy…

- Validate pain, commit to the resident and increase opioid medications steadily while monitoring quality of life and functional status.

- If there is no change in pain scale, function or quality of life, then perhaps opioids are not the answer…

Notes:

Aggressive pain management does not have to involve opioids and other drugs with a high potential for abuse.

Notes:

Compassionate but firm….

- "I know you have severe pain, but unfortunately opioids just don't work for you. Don't worry, there are many other options. We will keep trying. "

Notes:

Update on Delirium

Jay S. Luxenberg, M.D., FACP, AGSF
Chief Medical Officer, On Lok
Clinical Professor - University of California, San Francisco

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Notes:

Disclosures

- Disclosures: Dr. Luxenberg owns multiple cases of wine, a major cause of delirium both on consumption and on withdrawal
- No relationships to financial relationships to disclose

Notes:

Learning Objectives

- Cite evidence in support of prophylaxis to prevent delirium
- Draw Conclusions based on the evidence for pharmacologic treatment of delirium
- Draw Conclusions based on the evidence for environmental manipulation for the treatment of delirium

Notes:

Tools

- Recent interesting papers
- Recent randomized controlled trials
- Recent meta-analyses
- Consensus guidelines

Notes:

Main Problem

- There is data on delirium in hospitals, post operative, anesthesia related, and ICU
- There simply is no relevant data in the long term care setting, either post-acute or convalescent.
- All we can do is attempt to extrapolate to our populations.

Notes:

Study in Progress in Nursing Homes

- In 2014 Pilot trial protocol was published for Stop Delirium! (PiTStop)--a complex intervention to prevent delirium in care homes for older people (independent residential and nursing home)

doi: 10.1186/1745-6215-15-47

- Many of these authors prepared the 2014 Cochrane review: Interventions for preventing delirium in older people in institutional long-term care ➜ inadequate data to make any conclusions.

doi: 10.1002/14651858.CD009537.pub2

Notes:

Interesting Recent Papers

- Dexmedetomidine is an IV sedative - like clonidine, it is an agonist of α2-adrenergic receptors
- A recent meta-analysis showed significant reductions in the incidence of delirium, agitation and confusion (298/1,565 [19%] in the dexmedetomidine group v 337/1,464 [23%] compared to the control group [usually receiving midazolam or propafol], RR = 0.68 [0.49 to 0.96], p = 0.03).

Pasin, L., Landoni, G., Nardelli, P., Belletti, A., Di Prima, A. L., Taddeo, D., et al. (2014). Dexmedetomidine reduces the risk of delirium, agitation and confusion in critically Ill patients: a meta-analysis of randomized controlled trials. Journal of Cardiothoracic and Vascular Anesthesia, 28(6), 1459–1466. doi:10.1053/j.jvca.2014.03.010

Notes:

Interesting Recent Papers

- Ramelteon, a melatonin agonist was studied as delirium prophylaxis in elderly (age 65-89) ICU or seriously ill general hospital patients.
- Ramelteon (8 mg/d; 33 patients) or placebo (34 patients) were given every night for 7 days
- Ramelteon was associated with a lower risk of delirium (3% vs 32%; P = .003), with a relative risk of 0.09 (95% CI, 0.01-0.69)

Hatta, K., Kishi, Y., Wada, K., Takeuchi, T., Odawara, T., Usui, C., et al. (2014). Preventive effects of ramelteon on delirium: a randomized placebo-controlled trial. JAMA Psychiatry, 71(4), 397–403. doi:10.1001/jamapsychiatry.2013.3320

Notes:

Interesting Recent Papers

- 5 cases of severe protracted delirium in the ICU were treated with electroconvulsive therapy (ECT) after failure of conventional medical therapy
- Electroconvulsive therapy was effective in controlling delirium in 4 patients. The last patient became calm, relieved of stress, and able to cooperate with the ventilator but remained in a state of posttraumatic amnesia after a head trauma.

Nielsen, R. M., Olsen, K. S., Lauritsen, A. O., & Boesen, H. C. (2014). Electroconvulsive therapy as a treatment for protracted refractory delirium in the intensive care unit--five cases and a review. Journal of Critical Care, 29(5), 881.e1–6. doi:10.1016/j.jcrc.2014.05.012

Notes:

Multicomponent Prevention Programs - 2 recent postive meta-analyses

- Hshieh, T. T., Yue, J., Oh, E., Puelle, M., Dowal, S., Travison, T., & Inouye, S. K. (2015). Effectiveness of Multicomponent Nonpharmacological Delirium Interventions: A Meta-analysis. JAMA Internal Medicine. doi:10.1001/jamainternmed.2014.7779
- Martinez, F., Tobar, C., & Hill, N. (2015). Preventing delirium: should non-pharmacological, multicomponent interventions be used? A systematic review and meta-analysis of the literature. Age and Ageing, 44(2), 196–204. doi:10.1093/ageing/afu173

Notes:

Prevention and Mitigation of Delirium in Intensive Care Units

- Meta-Analyses of multifaceted care approaches with the reduction of delirium in ICU patients
- 14 studies met inclusion criteria
- The cost-effectiveness analysis indicated an average reduction of $1000 in hospital costs for patients treated with a multifaceted care approach

Collinsworth, A. W., Priest, E. L., Campbell, C. R., Vasilevskis, E. E., & Masica, A. L. (2014). A Review of Multifaceted Care Approaches for the Prevention and Mitigation of Delirium in Intensive Care Units. Journal of Intensive Care Medicine, 0885066614553925. doi: 10.1177/0885066614553925

Notes:

Risk Factor Mitigation

- No consensus on special units
- Orientation protocols - Provision of clocks, calendars, windows with outside views, and verbal re-orientation
- Sleep normalization - avoidance of night time interventions including meds and vital signs. Noise reduction.
- Sensory normalization - hearing aids and glasses for those in need
- Early mobilization and minimization of restraints
- Avoiding problematic medications [note one positive study was done in nursing homes]
- Cognitive stimulation - e.g. familiar visitors
- Managing pain
- No convincing evidence supporting prophylactic medication - cholinesterase inhibitors, antipsychotics, HMG-CoA reductase inhibitors, melatonin or melatonin agonist ramelteon.

Notes:

AGS Clinical Practice Guideline for Postoperative Delirium in Older Adults

- Published October 10, 2014
- Free!
- Prevention recommendations are made for all older adult surgical patients at risk of postoperative delirium but in whom delirium has not yet developed
- Treatment recommendations - next slide
- http://geriatricscareonline.org/ProductAbstract/american-geriatrics-society-clinical-practice-guideline-for-postoperative-delirium-in-older-adults/CL018

Notes:

AGS Clinical Practice Guideline for Postoperative Delirium in Older Adults

I. Postoperative Delirium Risk Factors

II. Delirium Diagnosis

III. Delirium Screening

IV. Intraoperative Measures to Prevent Delirium

V. Medications as Risk Factors for Postoperative Delirium

I. Pharmacologic Prevention of Postoperative Delirium

II. Nonpharmacologic Prevention and Treatment of Postoperative Delirium

VIII. Medical Evaluation of Postoperative Delirium

IX. Pharmacologic Treatment of Postoperative Delirium

Notes:

AGS Clinical Practice Guideline for

Recommendation	Strength	Quality of Evidence
Healthcare systems and hospitals should implement multicomponent nonpharmacologic intervention programs delivered by an interdisciplinary team (including physicians, nurses, and possibly other healthcare professionals) for the entire hospitalization in at-risk older adults undergoing surgery to prevent delirium.	Strong	Moderate
Healthcare systems and hospitals should implement formal educational programs on delirium for healthcare professionals	Strong	Low
Healthcare professionals should optimize postoperative pain control, preferably with nonopioid pain medications, to minimize pain in older adults to prevent delirium.	Strong	Low
In older adults not currently taking cholinesterase inhibitors, the prescribing practitioner should not newly prescribe cholinesterase inhibitors perioperatively to older adults to prevent or treat delirium.	Strong	Low

American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults. (2015). Postoperative delirium in older adults: best practice statement from the American Geriatrics Society. *Journal of the American College of Surgeons, 220*(2), 136–148.e1. doi:10.1016/j.jamcollsurg.2014.10.019

Notes:

AGS Clinical Practice Guideline for Postoperative Delirium in Older Adults

Recommendation	Strength	Quality of Evidence
The prescribing practitioner should not use benzodiazepines as a first line treatment of the agitated post-operative delirious patient who is threatening substantial harm to self and/or others to treat postoperative delirium *except* when benzodiazepines are specifically indicated (including but not limited to treatment of alcohol or benzodiazepine withdrawal). Treatment with benzodiazepines should be at the lowest effective dose for the shortest possible duration, and should be employed only if behavioral measures have failed or are not possible and ongoing use should be evaluated daily with in-person examination of the patient.	Strong	Low
The prescribing practitioner should not prescribe antipsychotic or benzodiazepine medications for the treatment of older adults with postoperative delirium who are not agitated and threatening substantial harm to self or others.	Strong	Low
Healthcare professionals should consider multicomponent interventions implemented by an interdisciplinary team in older adults diagnosed with postoperative delirium to improve clinical outcomes.	Weak	Low

American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults. (2015). Postoperative delirium in older adults: best practice statement from the American College of Surgeons. *Journal of the American College of Surgeons*, 220(2), 136–148.e1. doi:10.1016/j.jamcollsurg.2014.10.019

Notes:

AGS Clinical Practice Guideline for

Recommendation	Strength	Quality of Evidence
The prescribing practitioner may use antipsychotics at the lowest effective dose for the shortest possible duration to treat patients who are severely agitated or distressed, and are threatening substantial harm to self and/or others. In all cases, treatment with antipsychotics should be employed only if behavioral interventions have failed or are not possible, and ongoing use should be evaluated daily with in-person examination of patients.	Weak	Low
A healthcare professional trained in regional anesthetic injection may consider providing regional anesthetic at the time of surgery and postoperatively to improve pain control and prevent delirium in older adults.	Weak	Low
There is insufficient evidence to recommend for or against the use of antipsychotic medications prophylactically in older surgical patients to prevent delirium.	NA	Low

American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults. (2015). Postoperative delirium in older adults: best practice statement from the American Geriatrics Society. *Journal of the American College of Surgeons*, 220(2), 136–148.e1. doi:10.1016/j.jamcollsurg.2014.10.019

Notes:

Other Recent Clinical Practice Guidelines

- Dutch guidelines: Leentjens, A. F. G., et al. (2014). Changing perspectives on delirium care: The new Dutch guideline on delirium, 77(3), 240–241. doi:10.1016/j.jpsychores.2014.07.014
- UK NICE guidelines (2010 - reviewed 1/2015): http://www.nice.org.uk/guidance/cg103/resources/guidance-delirium-pdf

Notes:

Non – Urinary Tract Infection
a Burning Issue

Peter P Patterson MD

CALTCM 2015

Notes:

Disclosure Statement

- I have no relevant financial relationships with commercial interests to disclose.

Notes:

Learning Objectives

By participating in this activity, participants will have the ability to:

- Identify an area in your practice which may lead to antibiotic overuse and a strategy to address it
- Describe McGeer's criteria and their utility in post-acute & long term care
- Describe indications, benefits and drawbacks for fecal transplant in C diff colitis and how you might obtain it

Notes:

Future Headline

THE DAILY NEWS

www.dailynews.com THE WORLD'S FAVOURITE NEWSPAPER - Since 1879

ANTIBIOTIC RESISTANCE REVERSED BY DECREASING MISUSE

Lorem Ipsum In libris graecis appetere mea. At vim odio lorem omnes, pri id iuvaret partiendo. Vivendo menandri et sed. Lorem volumus blandit cu has.Sit cu alia porro fuisset.

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In libris graecis appetere mea. At vim odio lorem omnes, pri id iuvaret partiendo. Vivendo menandri et sed. Lorem volumus blandit cu has.Sit cu alia porro fuisset.

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Ea pro natum invidunt repudiandae, his et facilisis vituperatoribus.

Notes:

Today's Headline – 2015

The majority of positive urine cultures (non-catheter) from residents in long term care facilities represent asymptomatic bacteriuria with no clinical signs of infection. Studies have shown that 30-50% of elderly long term care residents can have a positive urine culture - and pyuria - without any clinical evidence of infection. According to recent guidelines by multiple clinical societies, antibiotic therapy is not recommended without clinical signs localizing to the urinary tract.

Interpretive note – adapted from:
Leis JA, McGeer A et al Clin Infect Dis Feb 26, 2014

Notes:

URINE CULTURE

MICROBIOLOGY REPORT COMPLETED: OCT 5, 2014

>100,000 COLONIES/ML

Organism #1: Escherichia coli (esccol)

Antibiotics	esccol	
Amikacin	<=2	S
Ampicillin	<=2	S
Ampicillin/Sulbactam	<=2	S
Cefazolin	<=4	S
Cefepime	<=1	S
Ceftazidime	<=1	S
Ceftriaxone	<=1	S
Ciprofloxacin	>=4	R
ESBL	Neg	-
Ertapenem	<=0.5	S
Gentamicin	<=1	S
Imipenem	<=0.2	S
Levofloxacin	>=8	R
Nitrofurantoin	<=16	S
Piperacillin/Tazobac	<=4	S
Tobramycin	<=1	S
Trimethoprim/Sulfame	<=20	S

BLANK= DATA NOT AVAILABLE, OR DRUG NOT ADVISABLE OR TESTED

S = SUSCEPTIBLE I = INTERMEDIATE R = RESISTANT () = MedCal Drug

The majority of positive urine cultures (non-catheter) from residents in long term care facilities represent asymptomatic bacteriuria with no clinical signs of infection. Studies have shown that 30-50% of elderly long term care residents can have a positive urine culture - and pyuria - without any clinical evidence of infection. According to recent guidelines by multiple clinical societies, antibiotic therapy is not recommended without clinical signs localizing to the urinary tract.

Notes:

The Burning Issue in PA-LTC

- Patients receiving antibiotics for Urinary Tract Infection (UTI) they do not have.

"We Are Awash in a Sea of Antibiotics"
Stan Deresinski MD FIDSA
Stanford Antimicrobial Stewardship Program

Notes:

Case Vignette

- From “cockpit (hallway) voice recorder”

- Patient: V.M. 89 y.o. female

  Situation: “VM is more confused today (than usual)”
  Background: Dementia
  Assessment: (no systemic or localizing signs)
  Request: “Can we get a UA C&S” (RN)
  “ Start Cipro and get UA C&S” (MD/NP)
  and then …

Notes:

Clinical Microbiology - Principles

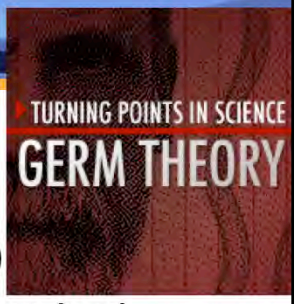
- Bacteria are ubiquitous …
  … and … invisible

- The body's microbial garden
  - Microbiome >10x more diverse than the human Genome
  - 1,000,000+ genes vs. 23,000 genes

  - "Tending the Body's Microbial Garden": NYTimes 9-2012
    "Germs Are Us": The New Yorker 10-2012

Notes:

Microbiology Principles (cont.)



- The “original” germ theory (1800 – 2000)
  - Bacteria make us sick … cause disease … are bad
  - “Pathogens” cause specific diseases (Koch’s postulates)
  - “the only good bug … is a dead one”
- The “new” germ theory (2000 – 2200:-)
  - Humans & our microbial partners co-evolving …
    … as a “super-organism”
  - Bacteria sometimes make us sick …
    … but they also keep us alive
  - Essential to immune system development & digestion

Nature 11:2010

Notes:

Clinical Microbiology – Practices

- Standardized criteria for C&S interpretation

Rule #1

- Just because a bug is growing in your patient, does not necessarily mean it's causing infection …

?colonization vs. ?infection

Rule #2

- There are 2 kinds of cultures …
  - From normally sterile areas (Blood, CSF)
  - From sites with microbiome flora (Urine, Sputum)

Notes:

Practical UTI Diagnosis – 2015

- Positive urine culture:
  - At least 100,000 cfu/ml of one organism
- Positive UTI clinical picture:
  - At least one of the following …
    a. acute dysuria
    b. fever OR leucocytosis AND one of:
      1. acute CVA pain or tenderness
      2. suprapubic pain
      3. gross hematuria
      4. new or marked increase in incontinence/urgency/frequency
    c. IF absence of fever or leucocytosis THEN two (2) or more of 1-4 above.

Notes:

Revised McGeer Criteria – Urinary Tract

- **Both criteria 1 and 2 must be present:**

  At least one of the following signs/symptoms sub-criteria (a-c)present:

  – (a) Acute dysuria or … acute pain, swelling or tenderness of the testes, epididymis or prostate

  – (b) Fever or leukocytosis … AND …

    - At least one of the following localizing urinary tract sub-criteria:
      – Acute costovertebral angle pain or tenderness
      – Suprapubic pain
      – Gross hematuria
      – New or marked increase in incontinence
      – New or marked increase in urgency or frequency

  One (1) of the following microbiology sub-criteria:

  – At least 100,000 cfu/ml of no more than 2 species of microorganism

Notes:

Altered mental status – ?UTI

- An acute change in mental status from baseline
- AMS alone without signs/symptoms localizing to urinary tract has low predictive value for UTI
- Positive culture in this setting likely to reflect resident microflora
- Model protocol to manage clinical uncertainty
  - 24-hour observation order set
    - Vital signs (Temp, …) each shift x 24hr.
    - Offer resident __ oz. water/juice every __ hours.
    - Record fluid intake each shift x 24hr.

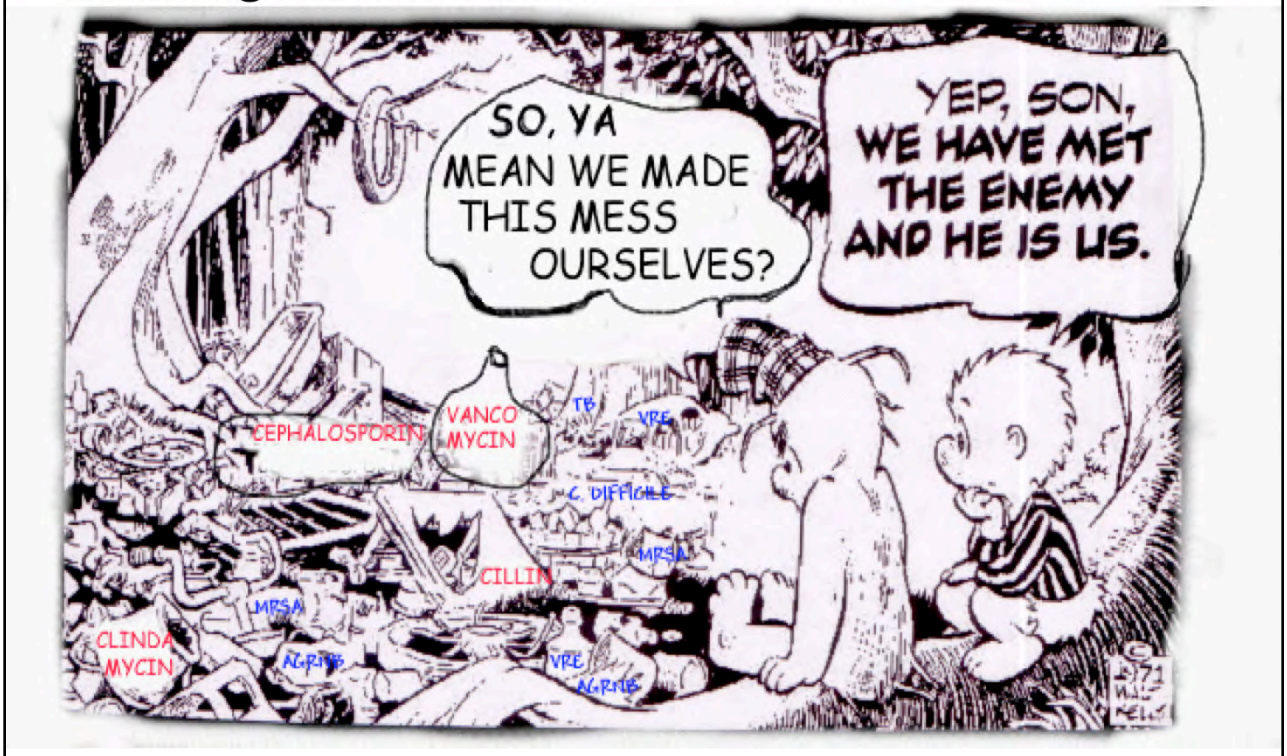
Notes:

Stewardship Quarterly Report

- A pilot program
- Integrates 3 data streams:
  lab, pharmacy, standardized clinical data (McGeer)
- Real data on day-to-day prescribing practices
- Objective metrics (e.g. Days-of-therapy)
- Inappropriate Day-of-therapy
  - Patient receiving antibiotic and has:
    1. low colony count OR
    2. more than 1 organism treated OR
    3. standard clinical criteria not met

Notes:

Dealing with the Mess – C. difficile



Notes:

C. Difficile – diagnosis update

- Molecular methods have revolutionized CDI/CDAD diagnosis
  - C. diff by PCR (toxin A/B genes)
    - Fast (1hr. dwell-time, same-day TAT)
    - Sensitive (>98%)
    - Specific (high “rule-out” power)
  - Only liquid stool should be tested
  - “C diff x3” no longer needed
  - GDH screen + toxin A/B – less expensive ?less sensitive
  - Enhanced virulence (epidemic) strain (BI/NAP1/027) may need more aggressive Rx

Notes:

C. Difficile – treatment update

Job #1: STOP the antibiotic(s)

- Mild/moderate disease
  - Metronidazole 500mg p.o. tid x 10 days
- Recurrent disease
  - 1st – Flagyl ; 2nd – Vancomycin (pulsed)
    3rd – Fecal Microbiota Transplant
- Severe disease
  - Vancomycin 125mg qid x 10 days
- Severe/complicated
  - Vancomycin oral 500mg qid plus intravenous metronidazole ; supportive resuscitation, surgical consult

Notes:

Key Points

- Asymptomatic bacteriuria should not be treated
- Antibiotic Rx is in transition …
  - From: Just-in-Case → To: Just-in-Time
- Treating normal flora as an infection only contributes to multiple drug resistance when the patient gets a real infection …
  and initiates the vicious cycle of antibiotic whack-a-mole …
  and opens the door to post-antibiotic complications

Notes:

Thank you!

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Notes:

Oral Health

Diane Chau, MD

Notes:

Disclosures

- Diane Chau, MD disclosed no relevant financial relationships with commercial interests.

Notes:

Learning Objectives

- Outline the most important components of a brief oral examination;
- Evaluate your facilities policies and procedures in the area of oral health;
- Implement an evidence-based strategy to enhance oral health care in your facility;
- Describe Medicaid's dental provisions and how best to achieve dental care for residents who rely on this system.

Notes:

Medical Director as Quality Champion

James Mittelberger MD MPH CMD

CALTCM 2015

Notes:

Learning Objectives

Attendees will be able to better:

1. Name and use three areas of knowledge required for a fully effective medical director
2. Describe three specific types of actions a medical director can take to drive improved performance
3. Describe and be able to implement three specific examples of a process change that can drive meaningful improvement in nursing home performance

Notes:

Medical Director Knowledge

1. Quality metrics
    1. What outcomes are measured and important
2. Clinical medicine
    1. What clinical practices lead to good outcomes
3. Process improvement
    1. How does one improve clinical practices within the system of care

Notes:

Examples of Each Type of Knowledge

1. Quality metrics
   a. Quality indicators
   b. Five star criteria
   c. Readmission rate
   d. High risk outcomes (eg pressure ulcers)
2. Clinical medicine
   a. Risk of errors at time of transition
   b. Lack of goals of care documentation
   c. Urinary tract infection diagnosis and management
   d. Behavior management and antipsychotic medication use
3. Quality improvement
   a. PSDA
   b. Value of standardized processes (eg INTERACT)
   c. Principles of leadership and engagement and change management

Notes:

Three Ways to Drive Meaningful Improvements

1. Work with leadership team to identify the most important priorities for improvement and get buy-in from clinicians and leadership (Strategy)
2. Support clinical change throughout the organization Teach, clinically review patients, talk to attending physicians and others (Clinical expertise)
3. Reinforce and provide leadership for sustained process change in the organization effort (Focus)

Notes:

Examples of Medical Director Leadership

1. Unplanned discharges and readmission reduction
2. Antipsychotic medication use in patients with dementia

Notes:

Unplanned Discharges

1. **Recognize the importance** of avoidable hospital discharges as a quality and business metric for nursing homes
2. **Engage leadership and nursing staff** to explain why avoidable hospitalizations are adverse outcomes for patients and facilities: **obtain buy-in at multiple levels**, tell stories, share data, listen and get commitment for a SMART goal (specific, measurable, accountable/ actionable, realistic, time-bound)
3. Continued focus on data at each QA meeting and give **positive feedback** when improvement is noted or results are better than expected; be sure results are shared with staff in front lines
4. **Review each adverse case** and identify clinical aspects of care that could have avoided the unnecessary hospitalization. EG treatment errors, failure to identify goals of care, etc.
5. **Initiate new clinical processes** to address care processes that are flawed such as palliative care and care transition programs (Add standardized forms and other changes to improve outcomes)

Notes:

Antipsychotic Medication Use in Patients with Dementia

1. Recognize and get buy-in about the importance of decreasing use of these medications
2. Establish baseline measurement and assure that data are accurate
3. Establish review process for every patient admitted on antipsychotic medication with default option to discontinue without clear rationale
4. Require a detailed meeting about behavioral interventions before medication, and consider other medications than antipsychotics when needed for distress or problematic behaviors.
5. Review each case without appropriate diagnosis; engage all staff, including physicians; offer additional reasources such as IAADAPT and other resources
6. Track data and continue to drive improvement until outcomes are great

Notes:

Addressing the Psychosocial Needs of Younger Residents in Long Term Care

Rebecca Ferrini, MD, MPH, CMD
Medical Director

Edgemoor DPSNF, Santee CA

Notes:

Disclosures

- I have no relevant financial relationships with commercial interests to disclose.

Notes:

This presentation is *not* an official position of the county of San Diego or AMDA, nor should it be viewed as providing legal advice. I am speaking as an individual who participated in the development of a AMDA guideline.

Notes:

Learning Objectives

Attendees will be able to:

- Identify four issues commonly encountered in the care of younger adults and strategies your facility might use to address these
- Identify psychological and developmental differences which inform care practices for younger adults
- Name three resources which might assist in managing problem behaviors in younger adults

Notes:

While America is graying, the fastest growing population in LTC are younger individuals.

THE USA HAS A RECORD NUMBER OF DISABLED ADULTS.

Notes:

AMDA recognizes this unique population and its special needs

YOUNGER ADULT IN THE LONG TERM CARE SETTING *INFORMATION SERIES* TOOL KIT

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Notes:

About the toolkit

- Case study based
- Best practices expert advice and web-based toolkit of sample policies
- Topics include: substance abuse, behavioral problems, sexuality, developmentally disabled, H.D., multiple sclerosis, family dynamics, power wheelchairs, work/school/ money problems, morbid obesity, staff development AND MORE!

Notes:

Psychosocial needs underlie many behaviors

1. Understand resident perspective.
2. Improve the quality of relationships between caregivers and residents.
3. Engagement and meaning are found through a therapeutic community full of love, work and suffering.
4. When problems arise, a strategy of harmonization and negotiation is the most successful.

Notes:

Developmental needs and coping skills may depend on how you got sick in the first place.

- Illnesses from capricious fate
- illness and possibly institutionalization from birth or childhood
- a sudden onset of physical problems related to injury (such as a traumatic brain injury) or unfortunate lifestyle choices.

Notes:

Meet Martin

- Martin suffered a traumatic spinal cord injury resulting in quadriplegia. He now is developing limited use of the upper extremities, but is totally dependent. He is withdrawn, angry and irritable, and complains frequently about staff. He is sure he doesn't belong with all these old people in the SNF.

Notes:

Younger residents may have less mature psychological coping skills and defenses than older persons.

PRESENTING A CHALLENGE AND AN OPPORTUNITY FOR GROWTH.

Notes:

Immature and Mature Coping

Immature

- Denial – It didn't happen; it doesn't exist
- Projection – I feel bad about myself = "they hate me"
- Passive aggression – I hate myself = I miss or refuse treatment
- Acting-out – I don't like you = without reflection, I hit you

Mature

- Suppression – I am angry at the staff member but will not tell them
- Sublimation – I don't like Bob; I beat him at checkers three times
- Altruism – I'm sad and angry about my illness = I'll volunteer to help other residents

Notes:

Create a therapeutic milieu which nourishes healing relationships

Notes:

What makes a good relationship?

- Consistency, trust and the feeling that someone is on your side.
- How mistakes are handled—apologies and forgiveness.
- Knowing each other and accepting idiosyncrasies.
- Clear boundaries.
- Noticing and celebrating efforts in the right direction.

Notes:

Not her, her or her…..

- *Martin keeps finding staff he doesn't get along with and refuses to have them care for him. The facility tries to accommodate, but staff complain. Martin is "heavy care" and so demanding that the staff think his care should be shared/rotated. They "cave" to his wishes because he often makes complaints about staff he doesn't like and they are scared they might lose their license.*

Notes:

What does your facility do to foster healthy relationships?

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Notes:

Traits of healthy relationships

- Not holding grudges
- Caring and kind
- Empathy – the ability to understand the perspective of the other
- In LTC, all needs met and some "wants."
- Understanding that "fair" is based on the person's needs so "rules" may differ.

Notes:

Some ideas about what works…

- Consistent staffing all three shifts, even with registry.
- Let staff be involved in "picking" who they care for which can make relationships form more readily.
- Honoring and using the relationships in difficult times, viewing the primary C.N.A. as the closest advocate for the resident.
- Including direct care staff in care conferences.

Notes:

Some ideas about what works…

- Explicit policies about what is allowed (gifts, care practices, social media, secrets, boundaries and outside contacts)
- Making sure that variances in care are reported and evaluated.
- Communicating the "why" – Addresses "fairness" and needs versus "wants."

Notes:

More ideas about what works

- Making goals simple so you can reach them and really celebrate them. (e.g. get up an hour a day, wear pants instead of pajamas, go to an activity and stay the whole time)
- Include details about care preferences on C.N.A. assignments.
- Facilitate meaningful engagement.
- Reward staff who come forward with questions.

Notes:

Engagement and meaning are found through a therapeutic community and "love, work and the attitude one takes toward unavoidable suffering. "

Victor E. Frankl (1946)

Notes:

Frankl's elements of meaning

- Love – Not romantic love, but on relatedness and positive connections with others.
- Work – Productive activities provide a sense of fulfillment and "generativity."
- Attitude toward unavoidable suffering – Relates to resiliency and whether one responds with despair and hopelessness, or a sense of coping or purpose.

Notes:

"People here are so irritating, but you can't help caring for them."

A 50 YEAR MAN IN LONG TERM CARE FOR THREE YEARS.

Notes:

What fosters engagement and meaning?

- Finding an activity to look forward to (Behavior activation, motivational interviewing).
- Setting and achieving goals.
- Hope for the future.
- Developing relationships with peers, staff, family or members of the community.
- Going to school, being discharged, connecting through technology.

Notes:

What works?

- Adult only poker, Texas hold-em, competitive Bingo
- Outside outings—pow-wow, movies, shopping
- Fine art program
- Opportunities to help others.
- Going to school
- Inside and outside friendships
- Sports activities
- Mentoring
- Rummage sales
- One on one time with volunteers
- Computers, music, cellphones, internet, facebook….
- Engaging in facility committees and QI projects
- Residents as “advocate” for others.

Notes:

What problems do you face with younger adults?

- Power chairs
- Personality disorders
- Substance abuse
- Complaining
- Over-use of facility resources
- Boredom
- clutter
- Developmental disability
- Keeping odd hours
- Dealing with parents
- Poor curb appeal
- Sexuality
- Getting an education

Notes:

What kinds of problems?

- Manipulation, demanding, profanity
- Substance abuse, drug seeking (prescription drugs more often the "drug of choice")
- Frequent complaints or demands
- Noise, clutter, night-owl schedules
- Non-adherance, pushing the limits
- Challenges with technology that they know more about than we do.
- Poor curb appeal

Notes:

The best problem solving involves:

- Teams who are creative and thoughtful and able to define problems, pick battles, work with all staff, and follow through.
- Excellent interpersonal and communication skills which convey caring in every interaction.
- Good negotiation skills getting to win-win
- Ability to “sell” the right path.

Notes:

Motivational Interviewing is a technique to better understand the resident point of view, areas of potential negotiation and what motivates them for change.

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Notes:

Identify the specific behavior that is troublesome and approach it systematically.

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Notes:

ASK/OBSERVE

- What is the behavior?
- Why might it be happening?
- Who is it a problem for?
- What things make it worse?
- What things make it better?
- What are we doing now?
- Is any part of it working?
- If not, try something else, even something that doesn't make sense.

Notes:

Know your ABCs for behavioral management.

Antecedents

Behavior

Consequences

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Notes:

Behavioral Management--consequences

- Must make a clinically apparent connection between the behavior and the consequence
- Cannot be a punishment and it must be enforceable.
- Example: Tying prescribing practices to refraining from substance abuse and dangerous behavior

"I cannot give you opioid to reduce pain that is caused by you sitting in your chair all day—you only get opioids if you alternate time in chair and bed)."

Notes:

Behavioral management consequences

- "You cannot have Susie care for you if it takes her 1.5 hours to do the care—this means she cannot care for anyone else. It's quicker with other staff. If you want Susie, you have to pick what you want done and limit to 20 minutes."

Notes:

Behavioral management plans may be codified in a "contract" but we prefer to develop a special care plan.

MANY OF THE CRITERIA OF A TRUE CONTRACT ARE NOT REALISTIC IN THE SNF ENVIRONMENT.

Notes:

Too much pushing causes push-back.

Remember you cannot really control others unless they permit it.

Notes:

Don’t play Whack a Mole

Find and meet the underlying **need** or you will just have a new behavior to contend with.

Notes:

Pearls for difficult people

- Remind yourself that they are sick and you are well.
- Remember, they don't choose to be this way and they are suffering.
- Disengage if you feel strong emotions
- Look for the unmet need
- Do something different
- Support the team
- Don't give up—preserve the relationship.

Notes:

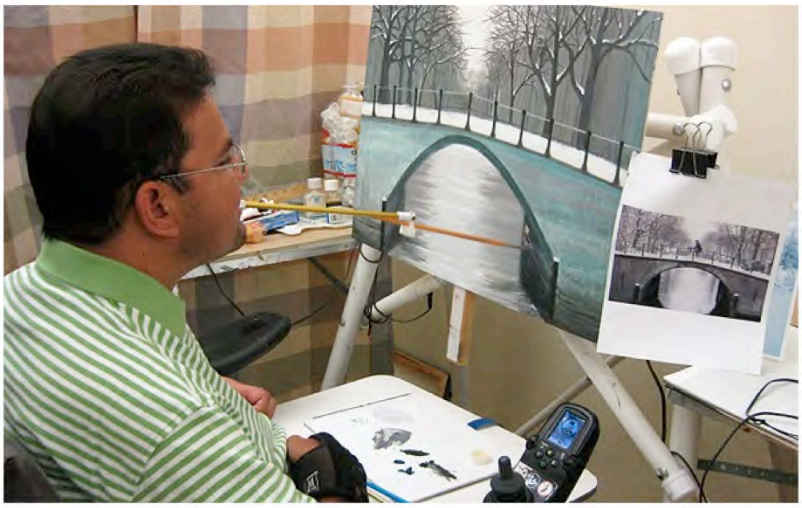
SAN DIEGO
COUNTYNEWSCENTER DIRECT TO YOU

San Diego | *Change*
Scattered clouds | 48.2 °F

HOME VIDEO LATEST NEWS EVENTS BOARD MEETINGS COUNTY WEBSITE

Search

Jesús Montoya: Edgemoor's First Patient to go to College



April 2, 2012 | 7:00am

SHARE

Using a brush tucked into his mouth, Jesús Montoya can turn a blank canvas into beautiful landscapes and other colorful pieces of art.

LATEST NEWS

MORE

- New Tablet? Load It Up at County Library
- Drive Sober or Get Pulled Over
- Pet of the Week - Ms. Daisy
- County Offices to Close January 1
- Pertussis Cases Returning to Normal Levels

ARCHIVE

2012

DEC NOV OCT SEP AUG JUL JUN

MAY APR MAR FEB JAN

2011

FEATURED VIDEOS

MORE

"Explorers" program introduces kids to science

Palms and a Pit

Notes:

Psychosocial needs underlie many behaviors.

1. Understand resident perspective.
2. Improve the quality of relationships between caregivers and residents.
3. Engagement and meaning are found through a therapeutic community full of love, work and suffering.
4. When problems arise, a strategy of harmonization and negotiation is the most successful.

Notes:

POLST 2015 UPDATE
Physician Orders for life Sustaining Treatment

New Consumer Educational Material: Hydration and Ventilation

KJ Page, RN, NHA, ND

CALTCM 2015

Notes:

Disclosure Statement

I have no relevant financial relationships to disclose.

Notes:

Learning Objectives

By participating in this activity, participants will have the ability to:

- Identify changes in the new POLST and POLST conversation
- Feel comfortable having a POLST conversation with a patient andxdocument completely
- Describe new consumer education programs for hydration and ventilators at the end of life

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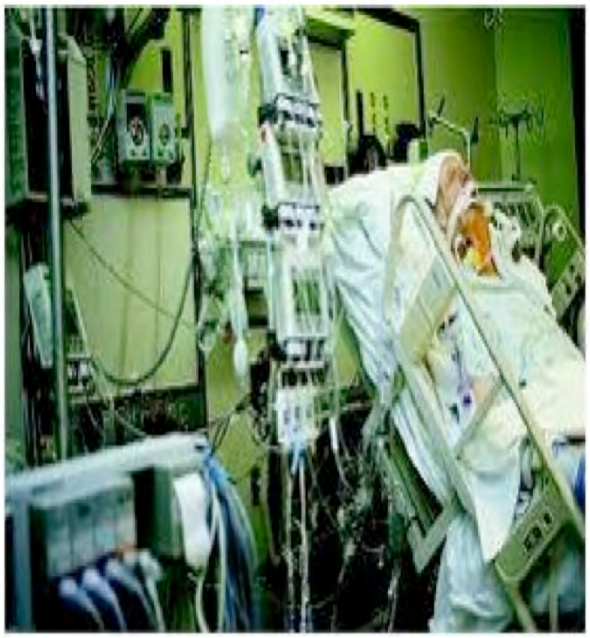
Notes:

Click to edit Master title style



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Notes:

Quick polst reminders

- **POLST** is a **Voluntary** form.
- **Previously completed** POLST forms ***Remain Valid***.
- Copy the **POLST** on ***ultra pink paper (65 pound)*** to help ensure the document stands out and is followed, but **POLST IS VALID when printed or faxed on white** (or any color) paper.
- Ensure the ADVANCED DIRECTIVES and POLST are consistent!

Notes:

Key Changes to POLST form

- In order to be consistent with section A, treatment choices for Sections B and C were reordered so that **each section begins with the most aggressive and invasive treatment choices.**
- In Section B, the choice of **"Limited Additional Interventions"** is **renamed** to **"Selective Treatment**," and the choice of **"Comfort Measures Only"** is **renamed** to **"Comfort-Focused Treatment."**
- In Section D, the term **"Address"** now reads **"Mailing Address."**

Notes:

Each treatment choice in Section B contains goal statements

Full Treatment – primary goal of prolonging life by all medically effective means.

Full Treatment option features a box that can be marked to indicate "Trial Period of Full Treatment:"

Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.

Comfort-Focused Treatment –primary goal of maximizing comfort.

Notes:

California Department of public health, licensing & certification

All Facility Letter (ALF)14-20 September 9, 2014

SUBJECT: Minimum Data Set (MDS) 3.0
"Section S" Coding Updates

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Notes:

MDS "Section S" Coding:

The **revised "Section S"** will crosswalk to the 2014 POLST and earlier POLST versions. **The clinician must read the resident's current POLST form to accurately code MDS Section S.**

POLST 2014 has different responses from 2009 and 2011 POLSTs. Please use codes accordingly.

Notes:

Coalition for Compassionate care of California

www.coalitionccc.org

The **Coalition for Compassionate Care of California** (CCCC) promotes high-quality, compassionate care for all Californians who are seriously ill or approaching the end of life.

CCCC is a statewide collaborative of organizations and individuals representing healthcare providers, assisted living facilities, nursing homes, hospices, consumers, state agencies and others

Notes:

CCCC RESOURCES
Patient and Professional Teaching Material

POLST Model Policies for General Acute Care Hospitals, Hospices and Skilled Nursing Facilities.

Decision Guides- an educational series that explains the complex topics of life-sustaining treatments, using consumer-friendly language with evidence-based information**.**

Topics Include: artificial hydration, cardiopulmonary resuscitation (CPR), mechanical ventilation, and tube feeding.

Languages: English, Chinese and Spanish

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Notes:

What is Artificial Hydration?

Does artificial hydration work?

Who is less likely to be helped by artificial hydration?

Who is most likely to be helped by artificial hydration?

What happens if I decide NOT to try artificial hydration near the end of life?

How do I decide whether or not to try artificial hydration?

When a family member or friend is not able to make their own decisions,

how do I decide if they should try artificial hydration?

How do I make my decisions about artificial hydration known?

Notes:

What is a Ventilator?

- What is it like to be on a ventilator?
- What do people say a ventilator feels like when a breathing tube is placed through their mouth?
- Does a ventilator work?
- How long is a ventilator needed?
- What medical problems could happen from a ventilator?
- Who is most likely to be helped by a ventilator?
- Who is less likely to be helped by a ventilator?
- What happens if I decide NOT to try a ventilator?
- How do I decide whether or not to try a ventilator?
- When a family member or friend is not able to make their own decisions,
- How do I decide whether they should try a ventilator?
- How do I make my decisions about a ventilator known?

Notes:

Notes:

Care Coordination

Saturday
April 25, 2015

Lessons Learned from Implementing INTERACT

Joseph G. Ouslander, M.D.

Professor of Clinical Biomedical Science
Senior Associate Dean for Geriatric Programs
Chair, Department of Integrated Medical Sciences
Charles E. Schmidt College of Medicine
Professor (Courtesy), Christine E. Lynn College of Nursing
Florida Atlantic University

Executive Editor, Journal of the American Geriatrics Society

Lessons Learned from Implementing INTERACT

Objective of this Presentation

- Provide an overview of the ***INTERACT*** (**I**nterventions **T**o **R**educe **A**cute **C**are **T**ransfers) quality improvement program relevant medical directors and primary care clinicians in SNFs, and the lessons learned from implementation projects thus far.

Lessons Learned from Implementing INTERACT

The INTERACT Interdisciplinary Team

Joseph G. Ouslander, MD	Florida Atlantic University
Jill Shutes, GNP	Florida Atlantic University
Ruth Tappen, EdD, RN, FAAN	Florida Atlantic University
Gabriellla Engstrom, PhD, RN	Florida Atlantic University
Nancy Henry, PhD, GNP	Florida Atlantic University
Maria Rojido, MD	Florida Atlantic University
David Wolf, Ph.D., CNHA	Florida Atlantic University
Sanya Diaz, MD	Florida Atlantic University
Laurie Herndon, MSN, GNP-BC	Mass Senior Care Foundation
Alice Bonner, PhD, GNP	Northeastern University
Jo Taylor, RN, MPH	Carolinas QIO
Gerri Lamb, PhD, RN, FAAN	Arizona State University
Annie Rahman, PhD, MSW	USC Davis School of Gerontology
Dan Osterweil, MD	California Association of LTC Medicine
Amy E. Boutwell, MD, MPP	Collaborative Healthcare Strategies
Adrienne Mihelic, PhD	Colorado Foundation for Medical Care
Mary Perloe, GNP	Georgia Medical Care Foundation
John Schnelle, PhD	Vanderbilt University

In collaboration with many participating LTC professionals and facilities

FAU FLORIDA ATLANTIC UNIVERSITY

INTERACT

Lessons Learned from Implementing INTERACT

Disclosures

- Dr. Joseph Ouslander is a full-time employee of Florida Atlantic University (FAU) and has received support through FAU to conduct research evaluating INTERACT from the National Institutes of Health , CMS, The Commonwealth Fund, the Retirement Research Foundation, PointClickCare, Medline Industries, and Think Research.
- Dr. Ouslander and his wife have ownership interest in INTERACT Training, Education, and Management ("I TEAM") Strategies, a business that has a license agreement with FAU for use of INTERACT materials for training and management consulting.
- Work on this and other projects are subject to terms of Conflicts of Interest Management plans developed and approved by the FAU Division of Research Financial Conflict of Interest Committee.

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INTERACT

Lessons Learned from Implementing INTERACT

Keys to Success

- **Feasible interventions**
  - Practicality
  - Cost
  - Targeting of interventions to responders
- **Leadership and staff "buy in"**
- **Incentives**
  - Financial
  - Regulatory
  - Legal
- **Resident/family preferences for care**

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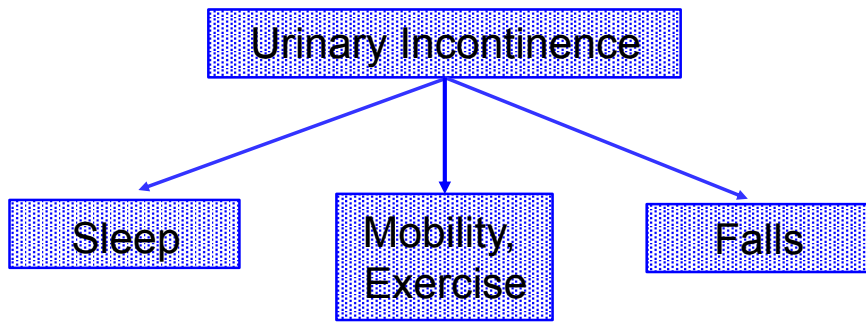
INTERACT

Lessons Learned from Implementing INTERACT

Studying Urinary Incontinence Led to Other Clinical Observations



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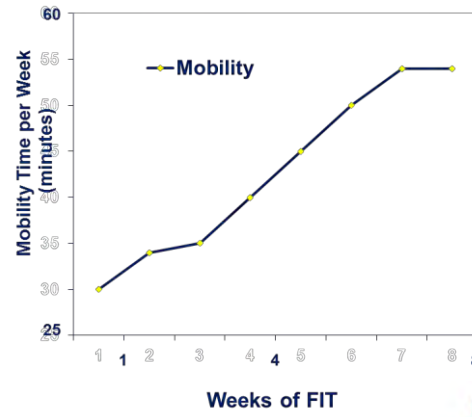
INTERACT

Lessons Learned from Implementing INTERACT

Functional Incidental Training "FIT"



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INTERACT

Lessons Learned from Implementing INTERACT

Functional Incidental Training "FIT"

Does an Exercise and Incontinence Intervention Save Healthcare Costs in a Nursing Home Population?

John F. Schnelle, PhD,† Kanika Kapur, PhD,‡ Cathy Alessi, MD,*† Dan Osterweil, MD,‡ John G. Beck, MD,† Nahla R. Al-Samarrai, MA,‡ and Joseph G. Ouslander, MD§‖*

CONCLUSION: The intervention, which is consistent with federal and clinical practice guidelines, significantly improved functional outcomes but did not reduce the incidence and costs of selected acute health conditions. The cost of implementing these labor-intensive interventions for frail nursing home residents will have to be justified based on functional and quality-of-life outcomes and are unlikely to be offset by savings in medical care costs in this population. **J Am Geriatr Soc 51:161–168, 2003.**

Clinical interventions must be combined with better medical and nursing care of chronic and acute health conditions to impact outcomes and costs.

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Lessons Learned from Implementing INTERACT

Hospitalization

- At the beauty salon
- At risk for complications
  - Delirium
  - Polypharmacy
  - Falls
  - Incontinence and catheter use
  - Hospital acquired infections
  - Immobility, de-conditioning, pressure ulcers

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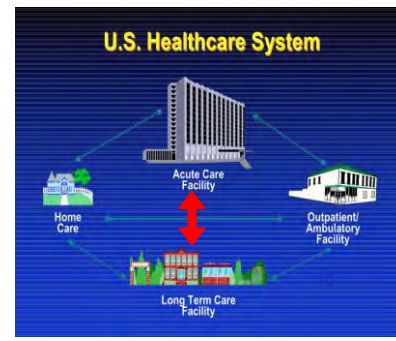
Lessons Learned from Implementing INTERACT

Some Hospitalizations of Geriatric Patients are Preventable

- Research suggests that a substantial percent of hospital transfers, admissions, and readmissions are unnecessary and can be prevented
- Potentially preventable hospitalizations cost the federal government several billion dollars per year



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Changes in Medicare and Health Care Financing

- **Pay-for-Performance** ("P4P")
  - No payment for certain complications; disincentives for avoidable hospitalizations
- **Bundling of payments** for episodes of care
- **Accountable Care Organizations** that include hospitals, physicians, home health agencies, and SNFs that are responsible for the care of a defined group of patients
- **State Duals Programs and Medicaid Managed Care**
- **Other models** – e.g. most recent CMS contracts for reducing unnecessary hospitalizations of long-stay NH residents

Lessons Learned from Implementing INTERACT

Health Care Reform

- The Affordable Care Act is focused on a **"triple aim":**
  - Improving care
  - Improving health
  - Making care affordable
- This presents **major opportunities** to improve geriatric care in the U.S.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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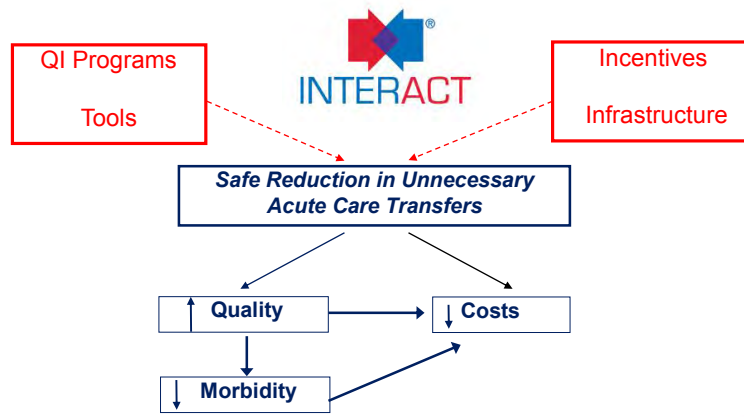
Lessons Learned from Implementing INTERACT

What is Needed for Successful Reduction of Unnecessary Hospitalizations?



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Lessons Learned from Implementing INTERACT

INTERACT

Is a **quality improvement program** designed to improve the care of older people with acute changes in condition in nursing homes, assisted living facilities, and home health care

http://interact.fau.edu

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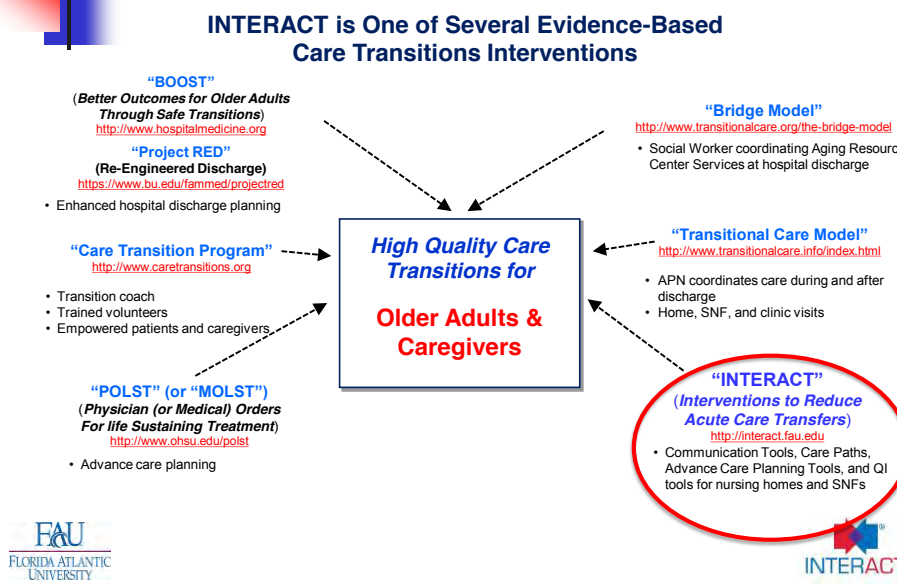
Lessons Learned from Implementing INTERACT



Lessons Learned from Implementing INTERACT

INTERACT

- The goal of INTERACT is to improve care, not to prevent all hospital transfers
- In fact, INTERACT can help with more rapid transfer of residents who need hospital care

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INTERACT

INTERACT Strategies

1. **Prevent** conditions from becoming severe enough to require hospitalization through **early identification and evaluation** of changes in resident condition
2. **Manage** some conditions without transfer when this is feasible and safe
3. **Improve advance care planning** and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents
4. **Improve communication and documentation** within LTC facilities and programs, and between LTC and acute care
5. **Integrate into ongoing QI initiatives** (e.g. QAPI)
6. **Combine INTERACT with other care transitions interventions**
7. **Embed in Health Information Technology** across care settings

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INTERACT

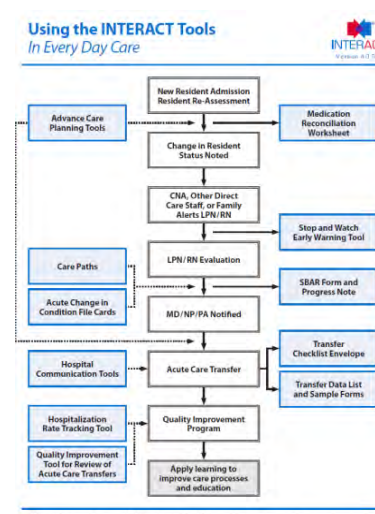
Lessons Learned from Implementing INTERACT

Quality Improvement Tools

Communication Tools

Decision Support Tools

Advance Care Planning Tools



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INTERACT

Lessons Learned from Implementing INTERACT

Implementation Model in the Commonwealth Fund Grant Collaborative

- On site training (part of one day)
- Facility-based champion
- Collaborative phone calls with up to 10 facility champions twice monthly facilitated by an experienced nurse practitioner
  - Availability for telephone and email consults
- Completion and faxing of QI Review (root cause analysis) Tools

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

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INTERACT

Lessons Learned from Implementing INTERACT

Commonwealth Fund Project Results

Facilities	Relative Reduction in All-Cause Hospitalizations
All INTERACT facilities (N = 25)	17%
Engaged facilities (N = 17)	24%
Not engaged facilities (N = 8)	6%

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

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Lessons Learned from Implementing INTERACT

Commonwealth Fund Project Results - Implications

1. For a 100-bed NH, the average would result in:
   - 25 fewer hospitalizations in a year (~2 per month)
   - $125,000 in savings to Medicare Part A (using a conservative DRG payment of $5,000)
2. The intervention as implemented in this project cost of $7,700 per facility
3. Net savings ~ $117,000 per facility per year
   - Medicare could share these savings to support NHs to further improve care

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

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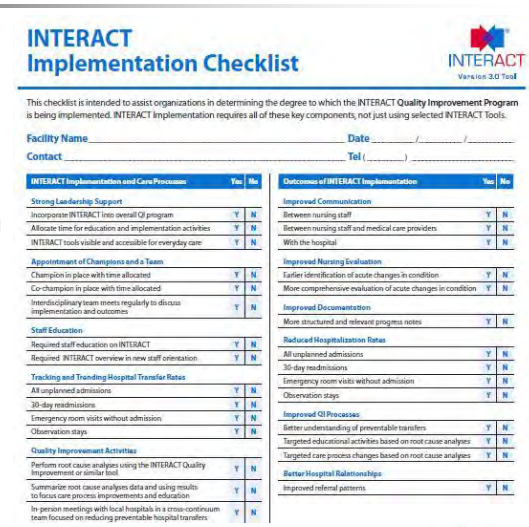
Lessons Learned from Implementing INTERACT

- This **Checklist** is intended to assist organizations in determining the degree to which the INTERACT Program is being implemented.
- Self-reported data are suspect.
- Use of HIT can help monitor care processes more objectively and relate them to outcomes.



INTERACT
Implementation Checklist

INTERACT Version 3.0 Tool

This checklist is intended to assist organizations in determining the degree to which the INTERACT Quality Improvement Program is being implemented. INTERACT Implementation requires all of these key components, not just using selected INTERACT Tools.

Facility Name _____ Date ____/____/____

Contact _____ Tel (____) _____

INTERACT Implementation and Care Processes	Yes	No
Strong Leadership Support		
Incorporate INTERACT into overall QI program	Y	N
Allocate time for education and implementation activities	Y	N
INTERACT tools visible and accessible for everyday care	Y	N
Appointment of Champions and a Team		
Champion in place with time allocated	Y	N
Co-champion in place with time allocated	Y	N
Interdisciplinary team meets regularly to discuss implementation and outcomes	Y	N
Staff Education		
Required staff education on INTERACT	Y	N
Required INTERACT overview in new staff orientation	Y	N
Tracking and Trending Hospital Transfer Rates		
All unplanned admissions	Y	N
30-day readmissions	Y	N
Emergency room visits without admission	Y	N
Observation stays	Y	N
Quality Improvement Activities		
Perform root cause analyses using the INTERACT Quality Improvement or similar tool	Y	N
Summarize root cause analyses data and using results to focus care process improvements and education	Y	N
In-person meetings with local hospitals in a cross-continuum team focused on reducing preventable hospital transfers	Y	N

Outcomes of INTERACT Implementation	Yes	No
Improved Communication		
Between nursing staff	Y	N
Between nursing staff and medical care providers	Y	N
With the hospital	Y	N
Improved Nursing Evaluation		
Earlier identification of acute changes in condition	Y	N
More comprehensive evaluation of acute changes in condition	Y	N
Improved Documentation		
More structured and relevant progress notes	Y	N
Reduced Hospitalization Rates		
All unplanned admissions	Y	N
30-day readmissions	Y	N
Emergency room visits without admission	Y	N
Observation stays	Y	N
Improved QI Processes		
Better understanding of preventable transfers	Y	N
Targeted educational activities based on root cause analyses	Y	N
Targeted care process changes based on root cause analyses	Y	N
Better Hospital Relationships		
Improved referral patterns	Y	N

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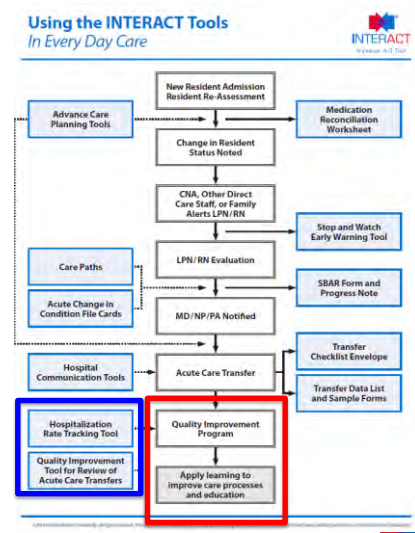
INTERACT

Lessons Learned from Implementing INTERACT

Quality Improvement Tools



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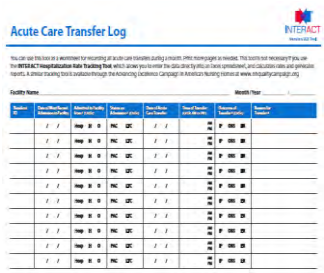
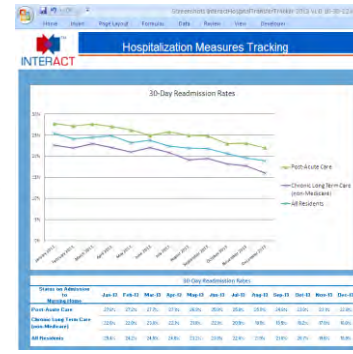
Lessons Learned from Implementing INTERACT

Quality Improvement



HIT



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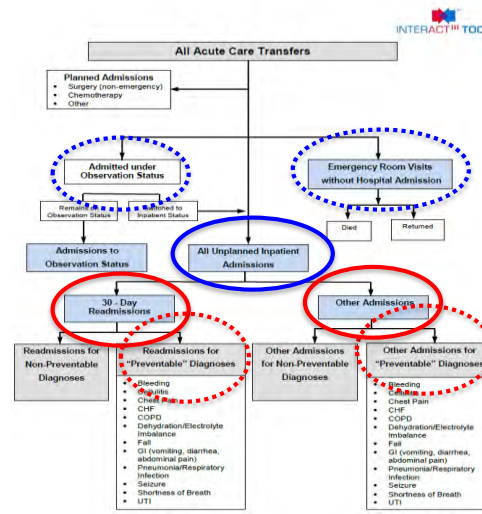
INTERACT

Lessons Learned from Implementing INTERACT

What Measures Should You Track?



Available at:
http://interact.fau.edu

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INTERACT

Lessons Learned from Implementing INTERACT

Tracking 30-day Readmission Rates

- Tracking tools available:
  - INTERACT website (http://interact.fau.edu)
  - Advancing Excellence Website (https://www.nhqualitycampaign.org)
- PointClickCare (incorporates INTERACT program)
- Loopback Analytics (incorporates INTERACT program)
- PointRight (used by AHCA)
- Daylight IQ
- Abaqis
- Others

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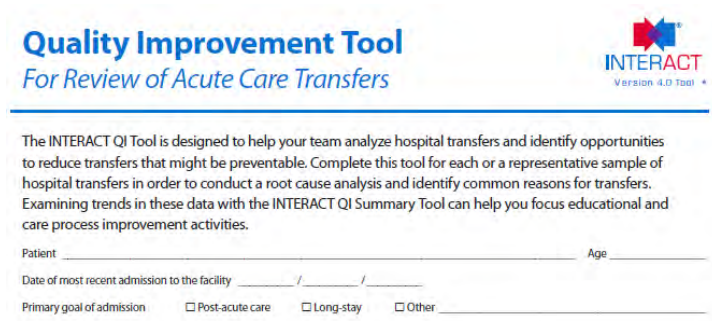
Lessons Learned from Implementing INTERACT



Quality Improvement Tool
For Review of Acute Care Transfers

INTERACT
Version 4.0 Tool

The INTERACT QI Tool is designed to help your team analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

Patient _____ Age _____

Date of most recent admission to the facility ____/____/____

Primary goal of admission ☐ Post-acute care ☐ Long-stay ☐ Other _____

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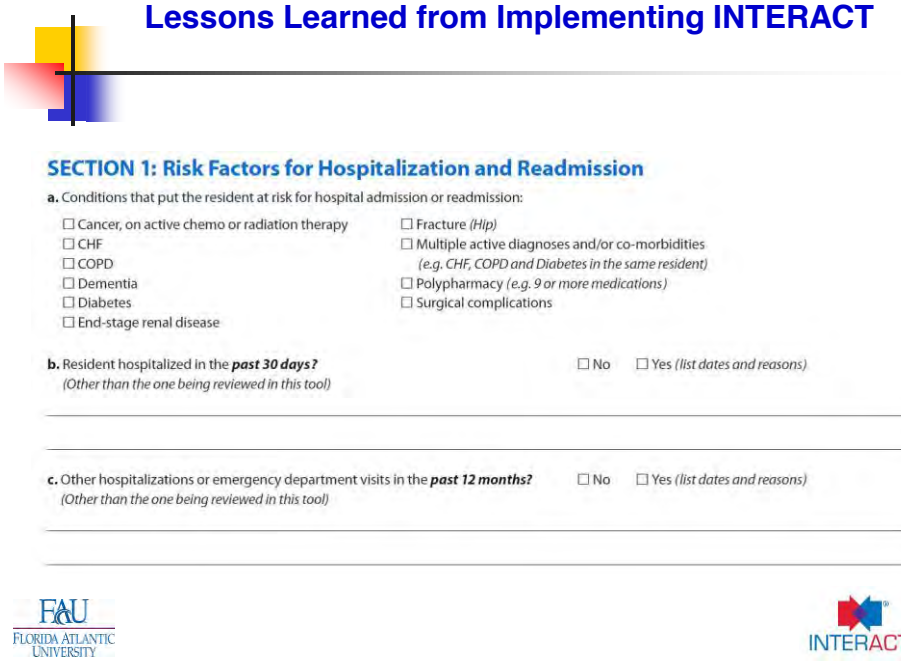
Lessons Learned from Implementing INTERACT



SECTION 1: Risk Factors for Hospitalization and Readmission

a. Conditions that put the resident at risk for hospital admission or readmission:

- ☐ Cancer, on active chemo or radiation therapy
- ☐ CHF
- ☐ COPD
- ☐ Dementia
- ☐ Diabetes
- ☐ End-stage renal disease
- ☐ Fracture *(Hip)*
- ☐ Multiple active diagnoses and/or co-morbidities *(e.g. CHF, COPD and Diabetes in the same resident)*
- ☐ Polypharmacy *(e.g. 9 or more medications)*
- ☐ Surgical complications

b. Resident hospitalized in the ***past 30 days?*** ☐ No ☐ Yes *(list dates and reasons)*
(Other than the one being reviewed in this tool)

c. Other hospitalizations or emergency department visits in the ***past 12 months?*** ☐ No ☐ Yes *(list dates and reasons)*
(Other than the one being reviewed in this tool)

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SECTION 2: Describe the Acute Change in Condition and Other Non-Clinical Factors that Contributed to the Transfer

a. Date the change in condition first noticed _____/_____/_____

b. Briefly describe the change in condition and other factor(s) that led to the transfer and then check each item below that applies

_____

_____

_____

_____

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Lessons Learned from Implementing INTERACT

Quality Improvement Tool
For Review of Acute Care Transfers

INTERACT Version 4.0 Tool *

c. Vital Signs at time of transfer

Temp _____ Pulse _____ Pulse Ox *(if indicated)*_____% on ☐ Room Air ☐ O_2(_____)

Respiratory rate _____ BP _____/_____ Glucose *(diabetics)*_____

d. Check *all* that apply

New or Worsening Symptoms or Signs

- ☐ Abdominal Pain
- ☐ Abnormal vital signs *(low/high BP, high respiratory rate)*
- ☐ Altered mental status
- ☐ Behavioral symptoms *(e.g. agitation, psychosis)*
- ☐ Bleeding *(other than GI)*
- ☐ Cardiac arrest
- ☐ Chest pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Edema *(new or worsening)*
- ☐ Fall
- ☐ Fever
- ☐ Food and/or fluid intake *(decreased or unable to eat and/or drink adequate amounts)*
- ☐ Function decline *(worsening function and/or mobility)*
- ☐ Gastrostomy Tube blockage or displacement
- ☐ GI bleeding
- ☐ Hypertension *(uncontrolled)*
- ☐ Loss of conciousness *(syncope)*
- ☐ Nausea / vomiting
- ☐ Pain *(uncontrolled)*
- ☐ Respiratory arrest
- ☐ Respiratory infection *(bronchitis, pneumonia)*
- ☐ Shortness of breath
- ☐ Seizure
- ☐ Skin wound or ulcer
- ☐ Stroke / TIA / CVA
- ☐ Trauma *(fall-related or other)*
- ☐ Unresponsive
- ☐ Urinary incontinence
- ☐ Weight loss
- ☐ Other *(describe)*

Abnormal Labs or Tests Results

- ☐ Blood sugar *(high)*
- ☐ Blood Sugar *(low)*
- ☐ EKG
- ☐ Hemoglobin or Hematocrit *(low)*
- ☐ INR *(high)*
- ☐ Kidney function *(BUN, Creatinine)*
- ☐ Pulse oximetry *(low oxygen saturation)*
- ☐ Urinalysis or urine culture
- ☐ White blood cell count *(high)*
- ☐ X-ray
- ☐ Other *(describe)*

Diagnosis or Presumed Diagnosis

- ☐ Acute renal failure
- ☐ Anemia *(new or worsening)*
- ☐ Asthma
- ☐ CHF *(congestive heart failure)*
- ☐ Cellulitis
- ☐ COPD *(chronic obstructive lung disease)*
- ☐ DVT *(deep vein thrombosis)*
- ☐ Fracture (site:_____)
- ☐ Pneumonia
- ☐ UTI *(urinary tract infection)*
- ☐ Other *(describe)*

Other Factors

- ☐ Advance directive not in place
- ☐ Resident preference or concerns
- ☐ Family preference or concerns
- ☐ Clinician insisted on transfer despite staff willing to manage in facility
- ☐ Other *(describe)*

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Lessons Learned from Implementing INTERACT

SECTION 3: Describe Action(s) Taken to Evaluate and Manage the Change in Condition Prior to Transfer

a. Briefly describe how the changes in Section 2 were evaluated and managed and check each item that applies.

_____

_____

_____

b. Check *all* that apply

Tools Used	Medical Evaluation	Testing	Interventions
☐ Stop and Watch	☐ Telephone only	☐ Blood tests	☐ New or change in medication(s)
☐ SBAR	☐ NP or PA visit	☐ EKG	☐ IV or subcutaneous fluids
☐ Care Path(s)	☐ Physician visit	☐ Urinalysis and/or culture	☐ Oxygen
☐ Change in Condition File Cards	☐ Other *(describe)*	☐ Venous doppler	☐ Monitor vital signs
☐ Transfer Checklist		☐ X-ray	☐ Other *(describe)*
☐ Acute Care Transfer Form *(or an equivalent paper or electronic version)*		☐ Other *(describe)*	
☐ Advance Care Planning Tools			
☐ Other Structured Tool or Form *(describe)*			

(continued)

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Lessons Learned from Implementing INTERACT

SECTION 4: Describe the Hospital Transfer

a. Date of transfer _____/_____/_____ Day _____ Time (am/pm) _____

b. Clinician authorizing transfer: ☐ Primary physician ☐ Covering physician ☐ NP or PA ☐ Other *(specify)* _____

c. Outcome of transfer: ☐ ED visit only ☐ Held for observation ☐ Admitted to hospital as inpatient

Hospital diagnosis(es) *(if available)* _____

d. Resident died in ambulance or hospital: ☐ No ☐ Yes ☐ Unknown

e. Factors contributing to transfer *(check all that apply and describe)*

☐ Advance directive not in place	☐ Clinician insisted on transfer despite staff willing to manage in the facility
☐ Resident preferred or insisted on transfer	☐ Facility policies do not support care in facility
☐ Family members preferred or insisted on transfer	☐ Resources to provide care in the facility were not available
☐ Discharged from the hospital too soon	☐ Other *(describe)*

_____

_____

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Lessons Learned from Implementing INTERACT

Quality Improvement Tool
For Review of Acute Care Transfers

INTERACT Version 4.0 Tool

SECTION 5: Identify Opportunities for Improvement

a. In retrospect, does your team think this transfer might have been prevented? ☐ No ☐ Yes *(describe)*

If yes, check one or more that apply:

☐ The new sign, symptom, or other change might have been detected earlier
☐ Changes in the resident's condition might have been communicated better among facility staff, with physician / NP / PA, or other health care providers
☐ The condition might have been managed safely in the facility with available resources
☐ Resources were not available to manage the change in condition safely or effectively despite staff willing to manage in the facility *(check all that apply)*
☐ On-site primary care clinician ☐ Staffing ☐ Lab or other diagnostic tests
☐ Pharmacy services ☐ Other *(describe)*
☐ Resident and family preferences for hospitalization might have been discussed earlier
☐ Advance directives and/or palliative or hospice care might have been put in place earlier
☐ Discharged from the hospital too soon in unstable condition ☐ Other *(describe)*

b. In retrospect, does your team think this resident might have been transfered sooner? ☐ No ☐ Yes *(if yes, describe)*

c. After review of how this change in condition was evaluated and managed, has your team identified any opportunities for improvement?
☐ No ☐ Yes *(describe specific changes your team can make in your care processes and related education as a result of this review)*

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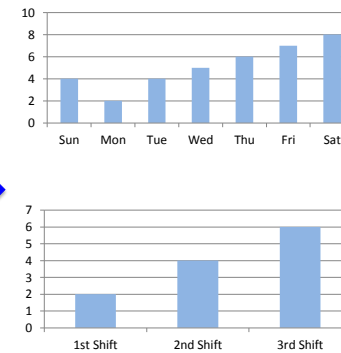
Lessons Learned from Implementing INTERACT

Quality Improvement

SECTION 4: Describe the Hospital Transfer

a. Date of transfer: ____/____/____ Day ____ Time (am/pm) ____
b. Clinician authorizing transfer: ☐ Primary physician ☐ Covering physician ☐ NP or PA ☐ Other *(specify)* ____
c. Outcome of transfer: ☐ ED visit only ☐ Held for observation ☐ Admitted to hospital as inpatient
Hospital diagnosis(es) *(if available)* ____
d. Resident died in ambulance or hospital: ☐ No ☐ Yes ☐ Unknown
e. Factors contributing to transfer *(check all that apply and describe)*
☐ Advance directive not in place ☐ Clinician insisted on transfer despite staff willing to manage in the facility
☐ Resident preferred or insisted on transfer ☐ Facility policies do not support care in facility
☐ Family members preferred or insisted on transfer ☐ Resources to provide care in the facility were not available
☐ Discharged from the hospital too soon ☐ Other *(describe)*

HIT



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Lessons Learned from Implementing INTERACT

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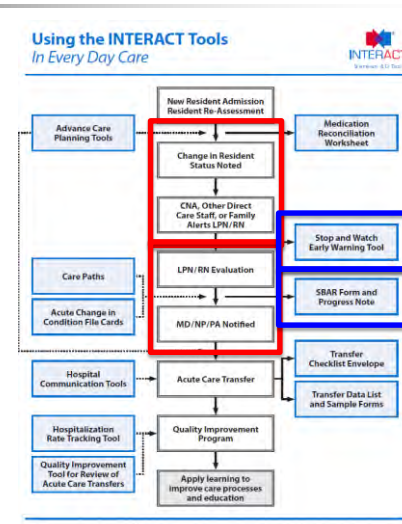
http://www.loopbackanalytics.com

INTERACT

Lessons Learned from Implementing INTERACT

Communication Tools



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Lessons Learned from Implementing INTERACT

Stop and Watch
Early Warning Tool

INTERACT

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Pain – new or worsening; Participated less in activities
a	Ate less
n	No bowel movement in 3 days; or diarrhea
d	Drank less
W	Weight change
A	Agitated or nervous more than usual
T	Tired, weak, confused, or drowsy
C	Change in skin color or condition
H	Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

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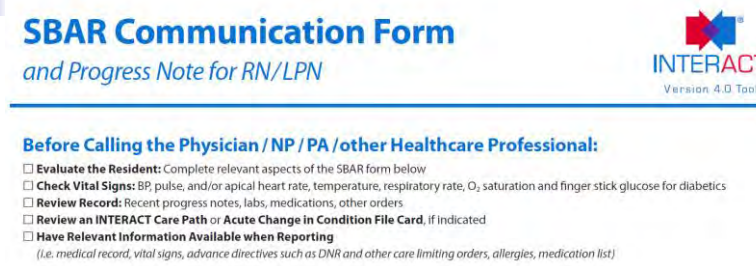
Lessons Learned from Implementing INTERACT



SBAR Communication Form
and Progress Note for RN/LPN

INTERACT
Version 4.0 Tool

Before Calling the Physician / NP / PA / other Healthcare Professional:

- ☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
- ☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, O_2 saturation and finger stick glucose for diabetics
- ☐ **Review Record:** Recent progress notes, labs, medications, other orders
- ☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card**, if indicated
- ☐ **Have Relevant Information Available when Reporting**
  (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

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INTERACT

Lessons Learned from Implementing INTERACT

SBAR Communication Form

and Progress Note for RN/LPN/LVNs in Assisted Living (cont'd)

INTERACT

Resident Evaluation

For the next 10 items, complete only those relevant to the change in condition. If the item is not relevant to the change in condition check the box for not clinically applicable to the change in condition being reported.

1. Mental Status Evaluation *(compared to baseline; check all that you observe)*

☐ Decreased level of consciousness (sleepy, lethargic)
☐ New or worsening behavioral symptoms
☐ New or worsened delusions or hallucinations
☐ Other symptoms or signs of delirium (e.g. inability to pay attention, disorganized thinking)
☐ Unresponsiveness
☐ Other (describe)
☐ No changes observed
☐ Increased confusion (disorientation)
☐ Memory loss (new or worsening)

Describe symptoms or signs _____

2. Functional Status Evaluation *(compared to baseline; check all that you observe)*

☐ Decreased mobility
☐ Needs more assistance with ADLs
☐ Swallowing difficulty
☐ Weakness (general)
☐ Other (describe)
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

3. Behavioral Evaluation

☐ Danger to self or others
☐ Depression (crying, hopelessness, not eating)
☐ Personality change
☐ Physical aggression
☐ Social withdrawal (isolation, apathy)
☐ Suicide potential
☐ Verbal aggression
☐ Other behavioral changes
☐ Other (describe)
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

4. Respiratory Evaluation

☐ Abnormal lung sounds (rales, rhonchi, wheezing)
☐ Asthma (with wheezing)
☐ Cough (☐ Non-productive ☐ Productive)
☐ Inability to eat or sleep due to SOB
☐ Labored or rapid breathing
☐ Shortness of breath
☐ Symptoms of common cold
☐ Other respiratory changes
☐ Other (describe)
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

5. Cardiovascular Evaluation

☐ Chest pain/tightness
☐ Edema
☐ Inability to stand without severe dizziness or lightheadedness
☐ Irregular pulse (new)
☐ Resting pulse >100 or <50
☐ Other (describe)
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

6. Abdominal / GI Evaluation

☐ Abdominal pain
☐ Abdominal tenderness
☐ Constipation (*date of last BM* ____/____/____)
☐ Decreased/absent bowel sounds
☐ Distended abdomen
☐ Decreased appetite/fluid intake
☐ Diarrhea
☐ GI Bleeding (*blood in stool or vomitus*)
☐ Hyperactive bowel sounds
☐ Jaundice
☐ Nausea and/or vomiting
☐ Other (describe)
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

Resident/Patient Name _____ (continued)

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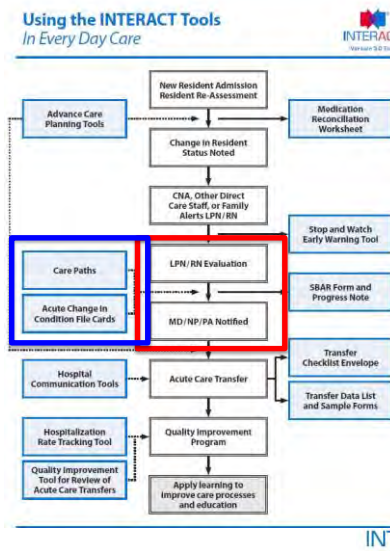
INTERACT

Lessons Learned from Implementing INTERACT

Decision Support Tools



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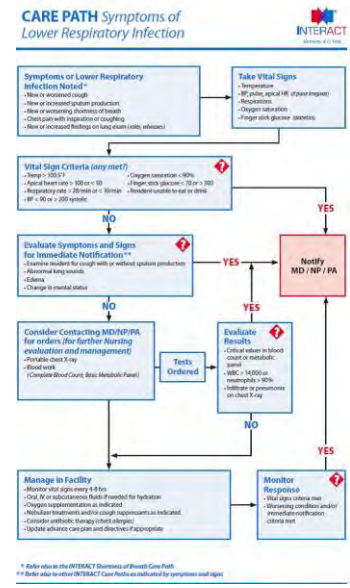
INTERACT

Lessons Learned from Implementing INTERACT

INTERACT Care Paths

- Acute Mental Status Change
- Change in Behavior: New or Worsening Behavioral Symptoms
- Dehydration
- Fall
- Fever
- GI Symptoms – nausea, vomiting, diarrhea
- Shortness of Breath
- Symptoms of CHF
- Symptoms of Lower Respiratory Illness
- Symptoms of UTI



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Lessons Learned from Implementing INTERACT

Sol

An 89 year old long-stay NH resident

- At 10:30 pm, complains moderate diffuse abdominal pain since yesterday
- No fever, nausea, or vomiting
- Afebrile, abdomen mildly tender with decreased bowel sounds
- Recently begun on narcotic for arthritis unresponsive to PT and acetominophen

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INTERACT

Lessons Learned from Implementing INTERACT

Sol

An 89 year old long-stay NH resident

Audience Response

Does the clinician on call need to be notified immediately?

- ❑ **Yes**
- ❑ **No**

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Lessons Learned from Implementing INTERACT

INTERACT Version 4.0 Tool

Signs and Symptoms *A's*

Symptom or Sign	Immediate	Non-Immediate
Abdominal Pain[1]	Abrupt onset severe pain or distention, OR with fever, vomiting	Mild diffuse or localized pain, unrelieved by antacids or laxatives
Abdominal Distention[1]	Rapid onset, OR presence of marked tenderness, fever, vomiting, GI bleeding	Progressive or persistent distension not associated with symptoms
Abdominal Tenderness[1] *(e.g., bloating, cramps, etc…)*	Associated with fever, continuous GI bleeding, or other acute symptoms	Persistent discomfort not associated with other acute symptoms
Abrasion	Accompanied by significant pain or bleeding	If bleeding continues or if associated with evidence of local infection
Agitation[2]	Abrupt onset of significant change from usual, OR associated with fever or new onset abnormal neurological signs	Continued progression or persistence of symptoms
Altered Mental Status	Abrupt significant change in cognitive function from usual with or without altered level of consciousness	Persistent change from usual cognitive function with no other criteria met for immediate notification
Appetite, Diminished	No oral intake 2 consecutive meals	Significant decline in food and fluid intake in resident with marginal hydration and nutritional status
Asthma	Acute episode with wheezing, dyspnea, or respiratory distress	Self-limited episode that was more extensive or less responsive to treatment than the usual

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Lessons Learned from Implementing INTERACT

Sol

An 89 year old long-stay NH resident

- After a dose of Pepto Bismol and Milk of Magnesia Sol is no better
- He had two episodes of vomiting over night
- The morning nurse exams him and finds moderate abdominal tenderness and no bowel sounds
- His temperature is 100.9 F

Lessons Learned from Implementing INTERACT

Sol

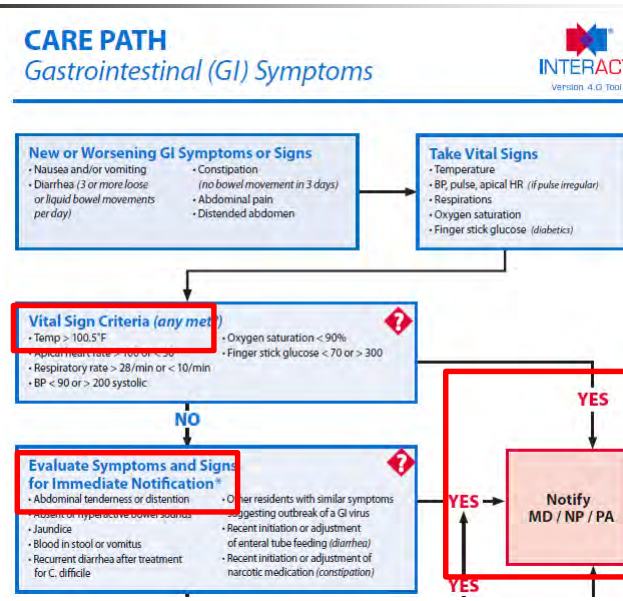
An 89 year old long-stay NH resident

Audience Response

Does the clinician on call need to be notified immediately?

- ❑ **Yes**
- ❑ **No**

Lessons Learned from Implementing INTERACT



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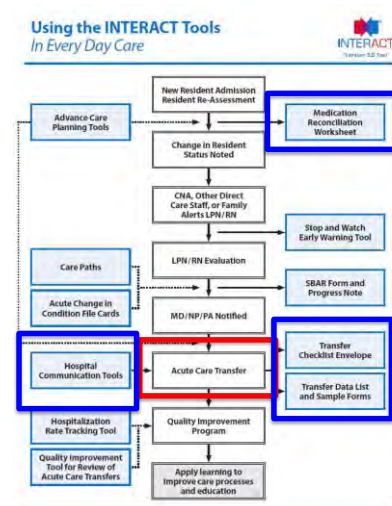
Lessons Learned from Implementing INTERACT

Communication Tools



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Audience Response Question

Does one or more of the facilities you work in or with meet in person regularly with representatives of the hospital in a cross-continuum team approach to reducing unnecessary hospital admissions?

1. Yes
2. No

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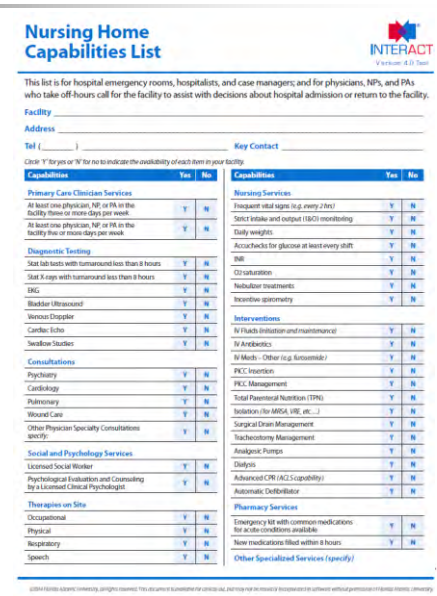
Lessons Learned from Implementing INTERACT

Nursing Home Capabilities List

- Hang it in the ED
- Give it to case managers
- Give it to hospitalists
- Give it to on-call primary care clinicians in your facility



Nursing Home Capabilities List

INTERACT

This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility

Address

Tel (_____) Key Contact

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N
Consultations		
Psychiatry	Y	N
Cardiology	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations specify:	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N
Therapies on Site		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs (e.g. every 2 hrs)	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids (initiation and maintenance)	Y	N
IV Antibiotics	Y	N
IV Meds – Other (e.g. furosemide)	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation (for MRSA, VRE, etc....)	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR (ACLS capability)	Y	N
Automatic Defibrillator	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N
Other Specialized Services (specify)		

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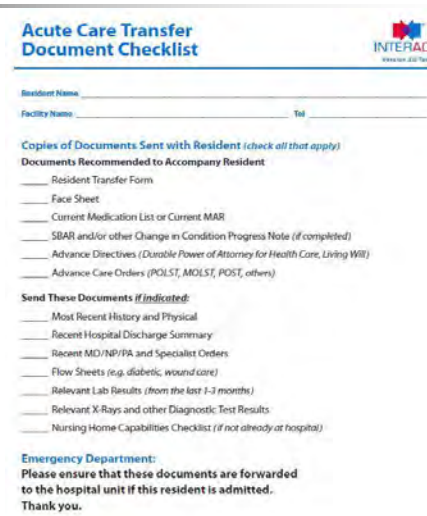
Lessons Learned from Implementing INTERACT

This **Acute Care Transfer Document Checklist** can be printed or taped onto an envelope, and is meant to compliment the Transfer Form by indicating which documents are included with the Form



Acute Care Transfer Document Checklist

INTERACT

Resident Name _____

Facility Name _____ Tel _____

Copies of Documents Sent with Resident *(check all that apply)*

Documents Recommended to Accompany Resident

____ Resident Transfer Form
____ Face Sheet
____ Current Medication List or Current MAR
____ SBAR and/or other Change in Condition Progress Note *(if completed)*
____ Advance Directives *(Durable Power of Attorney for Health Care, Living Will)*
____ Advance Care Orders *(POLST, MOLST, POST, others)*

Send These Documents *if indicated*:

____ Most Recent History and Physical
____ Recent Hospital Discharge Summary
____ Recent MD/NP/PA and Specialist Orders
____ Flow Sheets *(e.g. diabetic, wound care)*
____ Relevant Lab Results *(from the last 1-3 months)*
____ Relevant X-Rays and other Diagnostic Test Results
____ Nursing Home Capabilities Checklist *(if not already at hospital)*

Emergency Department:
Please ensure that these documents are forwarded to the hospital unit if this resident is admitted.
Thank you.

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Lessons Learned from Implementing INTERACT

The **NH to Hospital Transfer Form** has two pages.

- The first page has information that ED physicians and nurses identified as essential to make decisions about the resident
- Consistent and clear clinical terms are used

Hospital to Post-Acute Care Transfer Form

INTERACT

Version 4.0 Text

A. Patient Information
B. Family/Caregiver / Proxy Contact
C. Advance Directives / Goals of Care
D. Transferring Hospital Information
E. Post-Acute Care Information
F. Hospital Physician Care Team Information
G. Key Clinical Information
H. High Risk Conditions/Treatment Information (check all that apply)
I. Procedures & Key Findings (during this hospitalization) - Please Attach Reports
J. Medications and Allergies

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Lessons Learned from Implementing INTERACT

The NH to Hospital Transfer Data List has recommended contents for transfer forms for incorporation into standard forms and electronic sharing of data

Nursing Home to Hospital Transfer Data List

INTERACT

This list is intended to provide guidance on key data elements critical for safe and effective care at the time of transition to an acute care hospital. It is not intended to be comprehensive. The INTERACT **Nursing Home – Hospital Transfer Form** illustrates an example of how these data can be formatted so that the data are readily accessible for receiving clinicians.

Information to be Sent Immediately at the Time of Transfer

Contact Information
- ☐ Resident name
- ☐ DOB
- ☐ Language
- ☐ Date of admission
- Type of stay
  - ☐ Long term care
  - ☐ Skilled nursing facility
- ☐ Primary diagnosis for admission

Facility Information
- ☐ Name of hospital sent to
- ☐ Date of transfer

Nursing Home Information
- ☐ Contact person at nursing home
- ☐ Phone number

Contact Person Information
- Relationship
  - ☐ Relative
  - ☐ Health care proxy
  - ☐ Guardian
- ☐ Contact number

Primary Care Clinician in Nursing Home
- ☐ Name
- ☐ Contact number

Code status
- ☐ Full Code
- ☐ DNR (Do Not Resuscitate)
- ☐ DNI (Do Not Intubate)
- ☐ DNH (Do Not Hospitalize)
- ☐ Comfort Care Only
- ☐ Uncertain

Key Clinical Information
- ☐ Reason for Transfer
- Primary reason for transfer diagnostic testing only:
  - ☐ Yes
  - ☐ No

Relevant Diagnoses
- ☐ CHF
- ☐ COPD
- ☐ CAD
- ☐ DM
- ☐ Ca (active treatment)
- ☐ Dementia
- ☐ Other

Vital Signs
- ☐ BP
- ☐ HR
- ☐ RR
- ☐ Temperature
- ☐ O2 Saturation
  - ☐ Time taken
- ☐ Most recent pain level
  - ☐ Pain location
- ☐ Most recent pain med
  - ☐ Date given
  - ☐ Time given

Usual Mental Status
- ☐ Alert, oriented, follows instructions
- ☐ Alert, disoriented, but can follow simple instructions
- ☐ Alert, disoriented, cannot follow simple instructions
- ☐ Not Alert

Usual Functional Status
- ☐ Ambulates independently
- ☐ Ambulates with assistive device
- ☐ Ambulates only with human assistance
- ☐ Not ambulatory

Additional Clinical Information
- ☐ SBAR Acute Change in Condition Note included
- ☐ Other clinical notes included
- ☐ Date of last tetanus (for residents with lacerations/wounds)

Devices and Treatments
- ☐ Oxygen
  - ☐ L/min per minute
- ☐ Nasal cannula
- ☐ Mask
  - ☐ Chronic
  - ☐ New
- ☐ Nebulizer Therapy
  - ☐ Chronic
  - ☐ New
- ☐ CPAP
- ☐ BiPAP
- ☐ Pacemaker
- ☐ IV
- ☐ PICC line
- ☐ Bladder (Foley) Catheter
  - ☐ Chronic
  - ☐ New
- ☐ Internal Defibrillator
- ☐ Enteral Feeding
- ☐ TPN
- ☐ Other

Isolation Precautions
- ☐ MRSA
  - ☐ Site
- ☐ VRE
  - ☐ Site
- ☐ C. difficile
- ☐ Norovirus
- ☐ Respiratory virus Flu
- ☐ Other

Allergies
- ☐ Yes
- ☐ No

Risk Alerts
- ☐ Anticoagulation
- ☐ Falls
- ☐ Pressures ulcer(s)
- ☐ Aspiration
- ☐ Seizures
- ☐ Harm to self or others
- ☐ Restraints
- ☐ Limited/non-weight bearing
  - ☐ Left / Right
- ☐ May attempt to exit
- ☐ Swallowing precautions
- ☐ Needs medications crushed
- ☐ Other

Personal Belongings Sent with Resident
- ☐ Eyeglasses
- ☐ Hearing Aid
- ☐ Dental Appliance
- ☐ Jewelry
- ☐ Other

Form Completed By
- ☐ Name
- ☐ Title
- ☐ Signature

Report Called By
- ☐ Name
- ☐ Title

Report Called To
- ☐ Name
- ☐ Title
- ☐ Date
- ☐ Time

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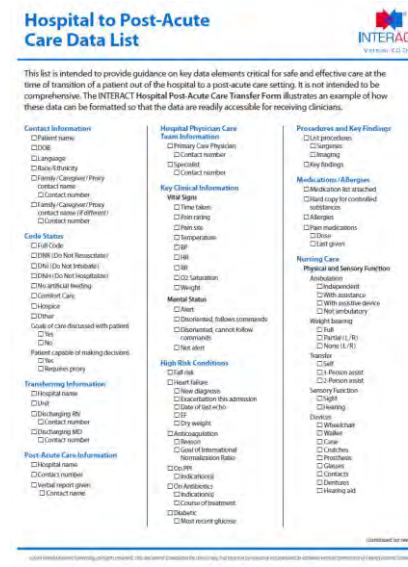
Lessons Learned from Implementing INTERACT

Information Transfer From the Hospital

The **Hospital to Post-Acute Care Data List** has recommended contents for transfer forms for incorporation into standard forms and electronic sharing of data



Hospital to Post-Acute Care Data List

INTERACT

This list is intended to provide guidance on key data elements critical for safe and effective care at the time of transition of a patient out of the hospital to a post-acute care setting. It is not intended to be comprehensive. The INTERACT **Hospital Post-Acute Care Transfer Form** illustrates an example of how these data can be formatted so that the data are readily accessible for receiving clinicians.

Contact Information
- ☐ Patient name
- ☐ DOB
- ☐ Language
- ☐ Race/Ethnicity
- ☐ Family/Caregiver/Proxy contact name
  - ☐ Contact number
- ☐ Family/Caregiver/Proxy contact name (if different)
  - ☐ Contact number

Code Status
- ☐ Full Code
- ☐ DNR (Do Not Resuscitate)
- ☐ DNI (Do Not Intubate)
- ☐ DNH (Do Not Hospitalize)
- ☐ No artificial feeding
- ☐ Comfort Care
- ☐ Hospice
- ☐ Other

Goals of care discussed with patient
- ☐ Yes
- ☐ No

Patient capable of making decisions
- ☐ Yes
- ☐ Requires proxy

Transferring Information
- ☐ Hospital name
- ☐ Unit
- ☐ Discharging RN
  - ☐ Contact number
- ☐ Discharging MD
  - ☐ Contact number

Post-Acute Care Information
- ☐ Hospital name
- ☐ Contact number
- ☐ Verbal report given
  - ☐ Contact name

Hospital Physician Care Team Information
- ☐ Primary Care Physician
  - ☐ Contact number
- ☐ Specialist
  - ☐ Contact number

Key Clinical Information

Vital Signs
- ☐ Time Taken
- ☐ Pain rating
- ☐ Pain site
- ☐ Temperature
- ☐ BP
- ☐ HR
- ☐ RR
- ☐ O2 Saturation
- ☐ Weight

Mental Status
- ☐ Alert
- ☐ Disoriented, follows commands
- ☐ Disoriented, cannot follow commands
- ☐ Not alert

High Risk Conditions
- ☐ Fall risk
- ☐ Heart failure
  - ☐ New diagnosis
  - ☐ Exacerbation this admission
  - ☐ Date of last echo
  - ☐ EF
  - ☐ Dry weight
- ☐ Anticoagulation
  - ☐ Reason
  - ☐ Goal of International Normalization Ratio
- ☐ On PPI
  - ☐ Indication(s)
- ☐ On Antibiotics
  - ☐ Indication(s)
  - ☐ Course of treatment
- ☐ Diabetic
  - ☐ Most recent glucose

Procedures and Key Findings
- ☐ List procedures
- ☐ Surgeries
- ☐ Imaging
- ☐ Key findings

Medications / Allergies
- ☐ Medication list attached
- ☐ Hard copy for controlled substances
- ☐ Allergies
- ☐ Pain medications
  - ☐ Dose
  - ☐ Last given

Nursing Care

Physical and Sensory Function

Ambulation
- ☐ Independent
- ☐ With assistance
- ☐ With assistive device
- ☐ Not ambulatory

Weight bearing
- ☐ Full
- ☐ Partial (L / R)
- ☐ None (L / R)

Transfer
- ☐ Self
- ☐ 1-Person assist
- ☐ 2-Person assist

Sensory Function
- ☐ Sight
- ☐ Hearing

Devices
- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Crutches
- ☐ Prosthesis
- ☐ Glasses
- ☐ Contacts
- ☐ Dentures
- ☐ Hearing aid

(continued on reverse)

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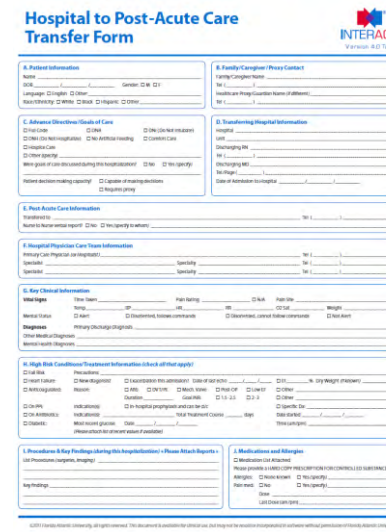
Lessons Learned from Implementing INTERACT

Information Transfer From the Hospital

INTERACT has a sample **Hospital to Post-Acute Care Transfer Form** that puts the data into a format that is easy to read and flows logically for a receiving clinician.


Hospital to Post-Acute Care Transfer Form

INTERACT

Version 4.0 Tool

A. Patient Information

B. Family/Caregiver / Proxy Contact

C. Advance Directives / Goals of Care

D. Transferring Hospital Information

E. Post-Acute Care Information

F. Hospital Physician Care Team Information

G. Key Clinical Information

H. High Risk Conditions / Treatment Information (check all that apply)

I. Procedures & Key Findings (during this hospitalization) – Please Attach Reports

J. Medications and Allergies

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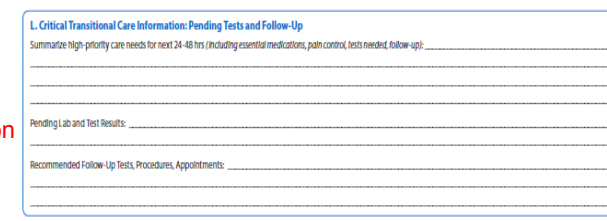
Lessons Learned from Implementing INTERACT

Information Transfer From the Hospital

- The **Hospital to Post-Acute Care Transfer Form** highlights Critical Time Sensitive Information


L. Critical Transitional Care Information: Pending Tests and Follow-Up

Summarize high-priority care needs for next 24-48 hrs (*including essential medications, pain control, tests needed, follow-up*): _____

Pending Lab and Test Results: _____

Recommended Follow-Up Tests, Procedures, Appointments: _____

But, there is no substitute for a **warm handoff**.

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INTERACT

Lessons Learned from Implementing INTERACT

Medication Reconciliation Worksheet for Post-Hospital Care

INTERACT Version 4.0 Tool

Part 1: Hospital Recommended Medications Needing Clarification

Medications Recommended by Hospital at Discharge for which Clarification is Needed	Clarification Needed*	Resolution for Final Medication Orders *(Continue, Stop, Change)*

*Examples: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication

Part 2: Medications Prior to Hospitalization Needing Clarification

Medications Taken Before Hospitalization Not Currently on Hospital-Recommended List	Comments *(e.g. reason for the medication before hospitalization, and reason it was stopped in the hospital, if known)*	Resolution for Final Medication Orders *(Continue, Stop, Change)*

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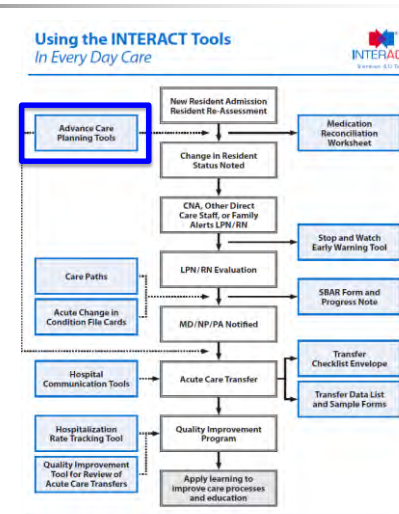
Lessons Learned from Implementing INTERACT

Advance Care Planning Tools



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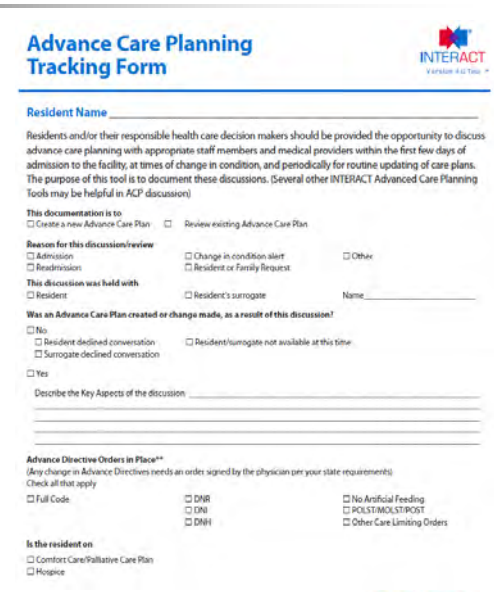
ACP Gone Wrong – A Case Example

- 93 year old living with son and daughter-in-law
- Progressive multi-infarct dementia
- Former LPN, who does not want CPR or other intensive end of life care
  - Had "Yellow DNR form"
- Fell and fractured hip – DNR form lost on the way to the hospital
- Another Yellow form completed in the hospital – lost on the way to the SNF

Lessons Learned from Implementing INTERACT



Advance Care Planning Tracking Form

INTERACT

Resident Name _____

Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans. The purpose of this tool is to document these discussions. (Several other INTERACT Advanced Care Planning Tools may be helpful in ACP discussion)

This documentation is to
☐ Create a new Advance Care Plan ☐ Review existing Advance Care Plan

Reason for this discussion/review
☐ Admission ☐ Change in condition alert ☐ Other
☐ Readmission ☐ Resident or Family Request

This discussion was held with
☐ Resident ☐ Resident's surrogate Name _____

Was an Advance Care Plan created or change made, as a result of this discussion?
☐ No
☐ Resident declined conversation ☐ Resident/surrogate not available at this time
☐ Surrogate declined conversation
☐ Yes

Describe the Key Aspects of the discussion _____

Advance Directive Orders in Place**
(Any change in Advance Directives needs an order signed by the physician per your state requirements)
Check all that apply
☐ Full Code ☐ DNR ☐ No Artificial Feeding
☐ DNI ☐ POLST/MOLST/POST
☐ DNH ☐ Other Care Limiting Orders

Is the resident on
☐ Comfort Care/Palliative Care Plan
☐ Hospice

Lessons Learned from Implementing INTERACT

Advance Care Planning Communication Guide: *Overview*

INTERACT Version 4.0 Tool

The INTERACT Advance Care Planning Communication Guide is designed to assist health professionals who work in nursing homes to initiate and carry out conversations with residents and their families about goals of care and preferences at the time of admission, at regular intervals, and when there has been a decline in health status.

The Guide can be useful for education, including role-playing exercises and simulation training.

Communicating about advance care planning and end-of-life care involves all facility staff

- Physicians must communicate with residents and families about advance directives, but all staff need to be able to communicate about goals of care, preferences, and end-of-life care

This Guide should therefore be useful for:

- Nursing staff
- Primary care physicians, nurse practitioners, and physician assistants
- Social workers and social work designees
- Administrators and others who discuss goals of care with residents and family

The Guide may be helpful in discussions on:

- Advance Directives – such as a Durable Power of Attorney for Health Care document, Living Will, and POLST and other similar directives
- Plans for care when a sudden, life-threatening condition is diagnosed – such as a stroke, heart attack, pneumonia, or cancer
- Plans for care when a resident's health is gradually deteriorating – such as progression of Alzheimer's disease or other dementia; weight loss without an obvious medical cause; and worsening of congestive heart failure, kidney failure, or chronic lung disease
- Considering a palliative or comfort care plan or enrolling in a hospice program

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Lessons Learned from Implementing INTERACT

Deciding About Going to the Hospital

INTERACT Version 4.0 Tool

Older nursing home residents commonly develop new or worsening symptoms. When this occurs, a decision may be needed about whether to continue care in the nursing home or go to a hospital.

Because there are risks as well as benefits of care in a hospital, it is important to make the right decision. The decision depends on a number of factors, and how the nursing home resident and her or his relatives view the benefits and risks of care in the hospital as opposed to the nursing home.

Research has shown that some hospitalizations may be unnecessary. Whether hospitalization can be prevented depends on the resident's condition, the ability of the staff to provide the care necessary in the nursing home, and the preferences of the resident and her or his family.

Benefits of Hospital Care

There are many symptoms and conditions that usually require treatment in the hospital – for example, if vital signs are very abnormal (temperature, heart rate, or breathing rate), or if symptoms are severe and can't be controlled (such as pain or vomiting). Hospital care offers benefits in these situations, including:

- Ready availability of sophisticated lab tests, X-rays, and scans
- Access to doctors and specialists who are in the hospital every day
- Availability of surgery and other procedures if needed
- Intensive care units for people who are critically ill

Risks of Hospital Care

Nursing home residents are prone to many complications of care in a hospital. These complications may occur even in the best hospitals, because older age, chronic medical problems, and the condition that caused the transfer all combine with the hospital environment to put nursing home residents at high risk for complications. These complications include:

- New or worsening confusion
- More time spent in bed, which can increase the risk of blood clots, pressure ulcers, muscle weakness, loss of function, and other complications
- Less sleep and rest due to tests, monitoring, and noise
- Increased risk for:
  - Falls with injuries, such as cuts, bruises, and broken bones
  - New infections
  - Depression due to limited opportunities to socialize with friends and family, as well as being in an unfamiliar environment

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INTERACT

Lessons Learned from Implementing INTERACT

Vendors with INTERACT License Agreements

- ADL Data Systems
- American HealthTech
- AOD Software
- BlueStep Systems
- BV HealthCare Dart Chart
- Health MedX
- Interactive Health Network
- LoopBack Analytics
- MatrixCare/MDI Achieve
- Optimus EMR
- PatientOrderSets/Think Research
- PointClickCare/Wescom
- Think Research/Patient Order Sets

Vendors in the Process of Obtaining License Agreements

- American-Data
- Cerner

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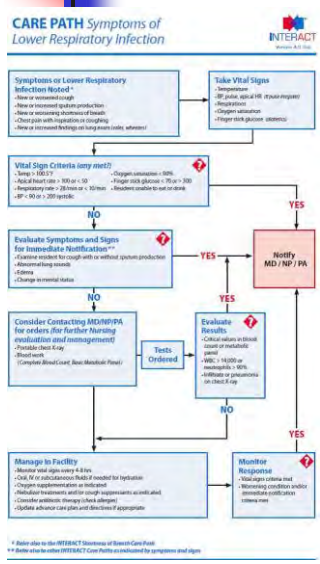
INTERACT

Lessons Learned from Implementing INTERACT

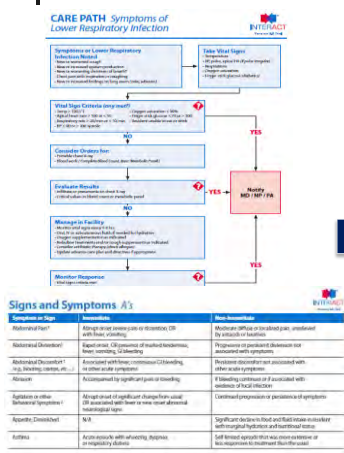
Decision Support



HIT

Lessons Learned from Implementing INTERACT

Decision Support



HIT

- **Automated alerts** to primary care clinicians (MD, NP, PA)
- Standardized evidence-based **order sets**

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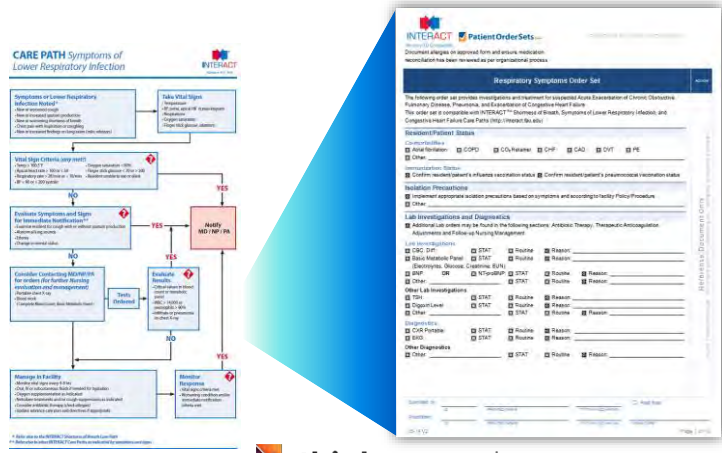
INTERACT

Lessons Learned from Implementing INTERACT

INTERACT Compatible Order Sets



thinkresearch

http://www.thinkresearchgroup.com

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INTERACT

Lessons Learned from Implementing INTERACT

- Full menu of evidence- based ordering options
- Intuitive, standardized format
- Optional and default orders
- Free-text order lines

- Integrated patient demographics
- Customized to situational needs
- Visual alerts for reminders

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INTERACT

Lessons Learned from Implementing INTERACT

INTERACT Compatible Order Sets

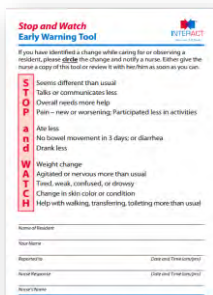
The CNA has notes the resident seems short of breath, completes a **STOP and WATCH** tool and gives it to the RN.

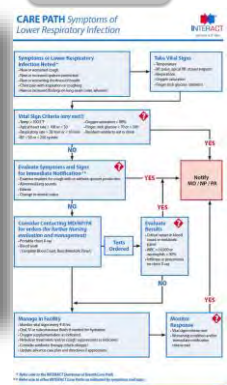
The RN reviews the **Decision Support Tools** (Change in Condition cards and **SOB Care Path**) and determines that further evaluation is indicated

The RN completes a **SBAR Form and Progress Note** prior to calling the clinician (MD/NP/PA)

The nurse calls the clinician and they agree that an **ORDER SET** is appropriate.

The clinician selects an **ORDER SET** and places an order which is automatically queued for processing.





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Lessons Learned from Implementing INTERACT

INTERACT Projects
2012 - 2016

1. **Test INTERACT in clinical trials to improve the evidence-base** (NIH/NINR grant; VA randomized trial)
2. **Refine the program education and implementat online training curriculum** (Retirement Research Foundation, Medline Industries)
3. **Further spread the INTERACT program in conjunction with federal quality improvement initiatives by training "INTERACT educators"** (Commonwealth Fund grant)
4. **Develop ethnically and culturally sensitive person-centered decision tools about hospital transfer** (Patient-Centered Outcomes Research Institute grant)

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INTERACT

Lessons Learned from Implementing INTERACT

INTERACT Projects
2012 - 2016

4. **Further spread the INTERACT program in other settings**
   a. ALFs, home health care (CMS Innovations Grant with UNTHSC and Brookdale Senior Living)
   b. INTERACT NYC (supported by NY state)
   c. Other countries (e.g. UK, Province of Ontario, Singapore) (all involved in INTERACT dissemination)
5. **Embed INTERACT into electronic health records and health information technology** (PointClickCare, Think Research)
6. **Combine INTERACT with other interventions such as enhanced hospital discharge planning** (CMS Innovations Grant with Vanderbilt)
7. **Work with regulators and payers to incentivize INTERACT implementation** (CMS demonstration projects)

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INTERACT

Lessons Learned from Implementing INTERACT

Keys to Success

- **Feasible interventions**
  - Practicality
  - Cost
  - Targeting of interventions to responders
- **Leadership and staff "buy in"**
- **Incentives**
  - Financial
  - Regulatory
  - Legal
- **Resident/family preferences for care**

Lessons Learned from Implementing INTERACT

- Questions?
- Comments?
- Suggestions?

http://interact.fau.edu

Overview INTERACT Training and Implementation - California Experience

Dan Osterweil, MD, FACP, CMD

CALTCM 2015

Notes:

Initiatives

Model I - Interact Boot Camps

Model II - Community based Training and Implementation

Notes:

What is INTERACT?

- Quality improvement program
- Concept proven effective
- Program utilizes care processes and tools addressing:
  - Quality Improvement
  - Communication
  - Clinical Paths
  - Tracking/hospitalization/advance directives

Notes:

Model I: Boot Camps (2012)

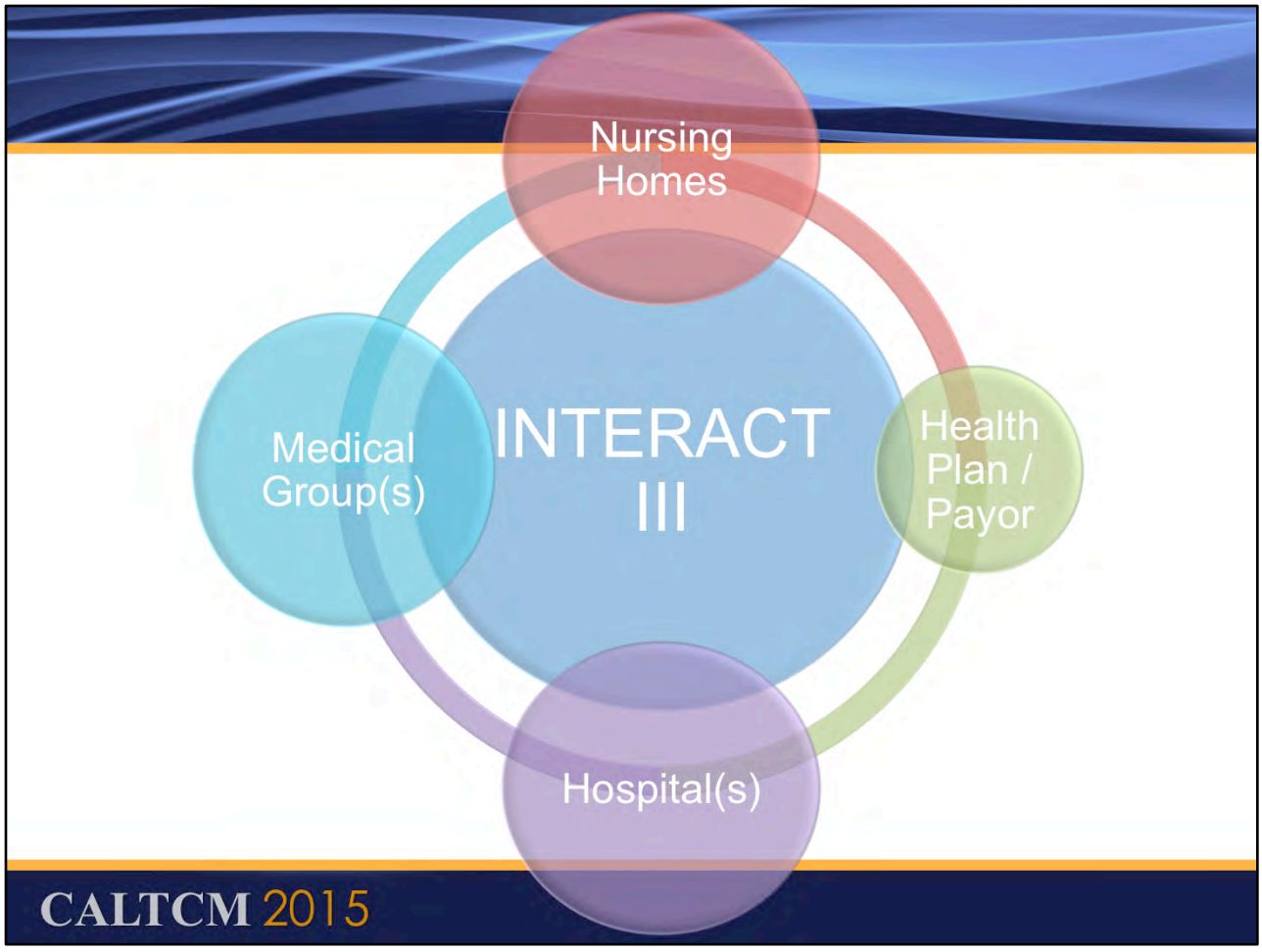
- Conference style
- Action planning
- Group coaching calls
- 200 Nursing Homes
- 598 participants

Notes:

Model II-CALTCM Modified

- Training 6 hours one site
- Teams: RN, MD, Administrator/Social Service
- Collaboration of Hospital, Healthplan Medical provider and NHs
- Action Plan
- Coaching
- Monitoring

Notes:


Nursing Homes
Medical Group(s)
INTERACT III
Health Plan / Payor
Hospital(s)
CALTCM 2015

Notes:

Methods

- Cluster consisting of 13 NHs, one hospital, one medical group, in one Northern California Community
  - 1 day face to face training
  - Followed by 6 months of 1:1 coaching calls
  - Designated champions in each NH
  - Commitment to training staff using INTERACT tools
  - Attendance at cross-setting meetings with hospital

Notes:

Outcome Measures

- 30 day hospital readmission rates
- Self reported communication within and between hospital and the facility
- QI reviews of unplanned admissions
- Percentage of INTERACT implemented
- Participation rate in coaching calls

Notes:

Outcomes

Number of Coaching Calls Attended

- 7 NHs attended 1 – 3 calls
- 6 NHs attended 4 – 6 calls
- Average call attendance = 4

Post Training / Pre Coaching Average Level of Implementation	Post Training / Post Coaching Average Level of Implementation
62%	72%

Pre Training Hospital Admission Rates	Post Training / Post Coaching Hospital Admission Rates
12.4%	11.11%

Summary Results

- Nursing Home engagement is linked to degree implementation
- 9% Reduction in Hospital Readmission Rates
- Single community focused training has promise as it offers shared resources, problems solving, and additional support

Notes:

Secondary Results

- Improved nursing assessment competencies
- Systematic quality improvement process
- Meet QAPI requirements
- Improved communication within the facility
- Improved NH-Hospital communication

Notes:

Conclusions

- Cross cultural collaboration between payor, provider, hospital and NH is an effective mechanism in avoiding unnecessary hospital readmissions
- Three months of engaged facility coaching achieves optimal implementation
- NH Medical Director and other clinician involvement is critical to reducing unnecessary hospital readmissions

Notes:

Resources

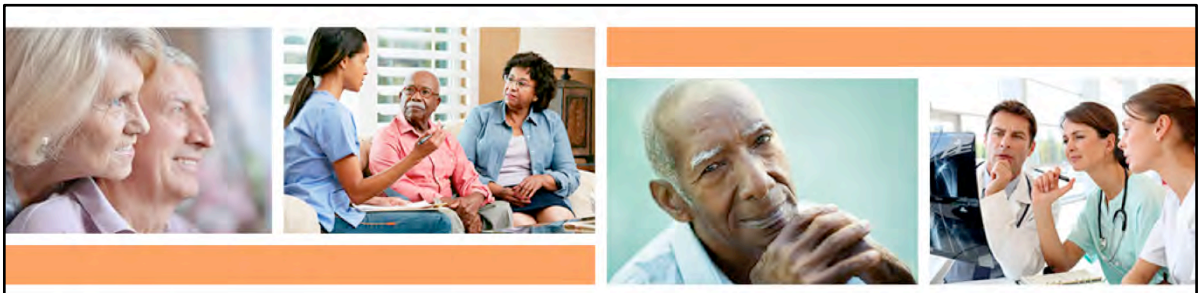
- Website: http://interact2.net/
  - Open to the public
  - Download Tools
- INTERACT III Training
  - Contact the CALTCM Executive Office for details at info@caltcm.org or (888)332-3299 x 1

Notes:

Acknowledgements

- Romilla A. Batra, MD, MBA
- Richard Fraioli, MD
- Jodi Cohn, Dr.PH
- Renee McNally
- Tim Gieseke, MD
- James Hendrickson, MD
- George Louie MD, MBA

Notes:



Incentives to Improve Care Coordination

Jennifer Wieckowski, MSG
State Program Director
Health Services Advisory Group (HSAG)

California Association of Long Term Care Medicine 41st Annual Meeting
April 25, 2015

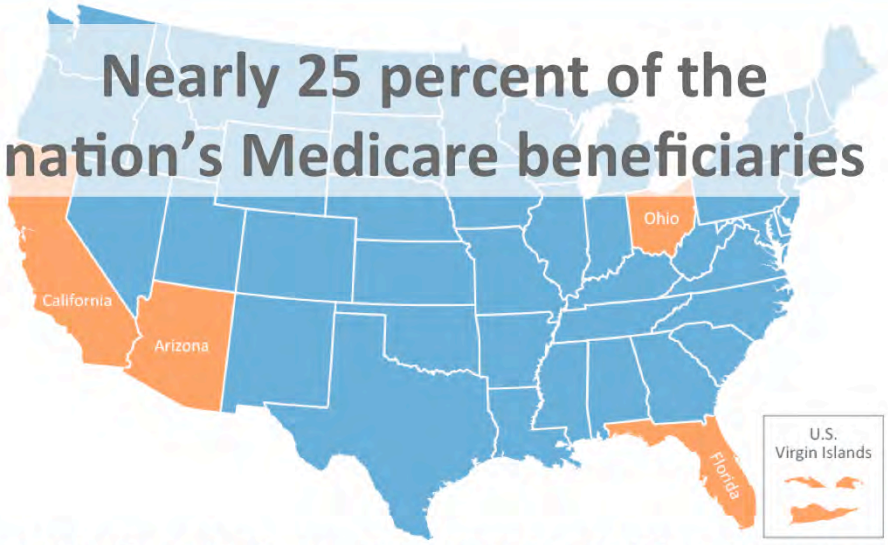
Notes:

HSAG: Your Partner in Healthcare Quality

- HSAG is California's Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO).
- QIN-QIOs in every state and territory are united in a network administered by the Centers for Medicare & Medicaid Services (CMS).
- The QIN-QIO program is the largest federal program dedicated to improving health quality at the community level.

Notes:

HSAG's QIN-QIO Responsibility



HSAG is the Medicare QIN-QIO for California, Arizona, Florida, Ohio, and the U.S. Virgin Islands.

Notes:

California's Progress in Reducing Readmissions

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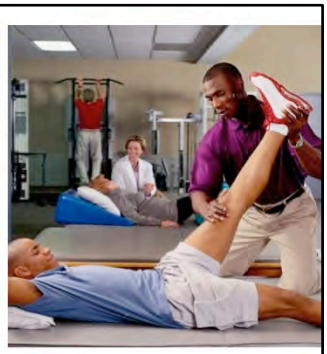
Notes:





Our healthcare system operates in "silos," is setting centered—*not* patient centered—and is incapable of reciprocal operation between organizations.

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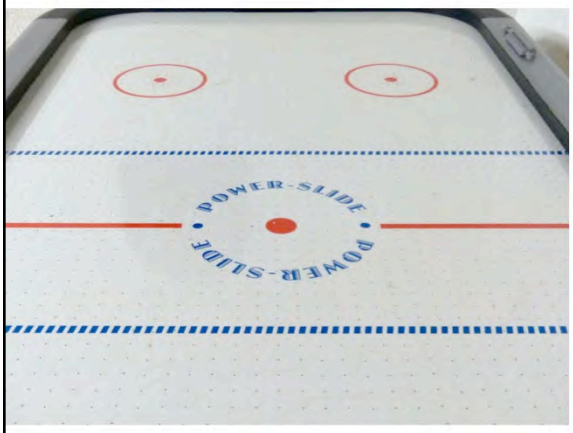
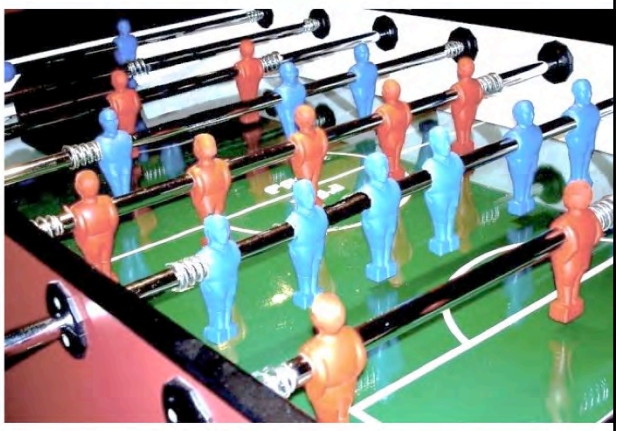
Notes:

Air Hockey vs. Foosball





Notes:

Moving from Volume…

Notes:

…to Value

8

Notes:

Hospital Readmission Penalties

Section 3025 Affordable Care Act of 2010

- October 2014
- 220+ California hospitals were penalized up to 3 percent for excess readmissions:
  - Congestive heart failure
  - Acute myocardial infarction
  - Pneumonia
  - Chronic obstructive pulmonary disease
  - Total knee and hip arthroplasty

Notes:

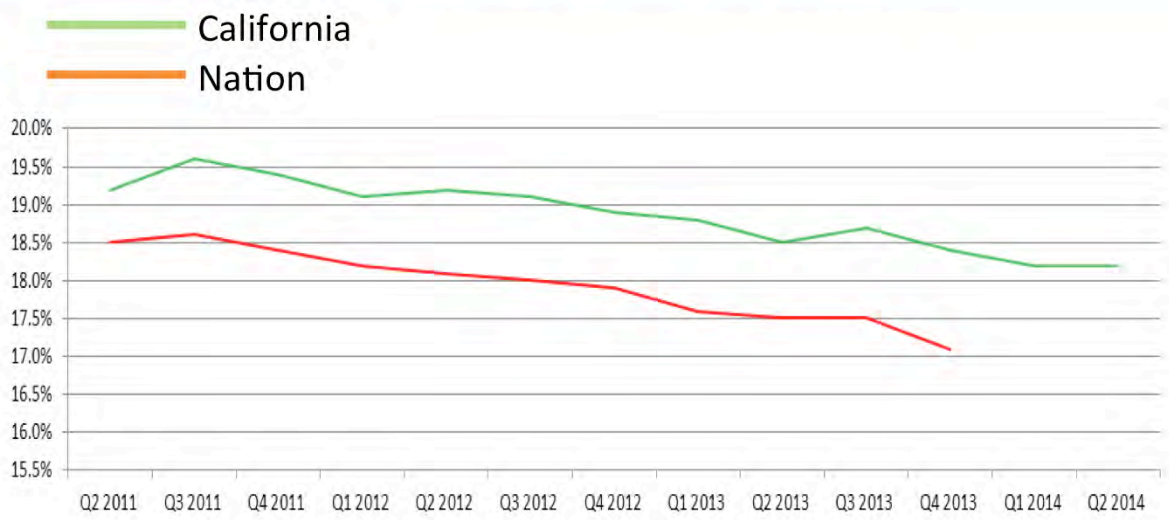
Nursing Home Readmission Value-Based Purchasing Program

H.R. 4302 Protecting Access to Medicare Act of 2014

- October 2017
  - Readmission rates go public on Nursing Home Compare
- October 2018
  - Value-based purchasing program for nursing homes begins

Notes:

California's Progress: All-cause, 30-Day Readmission Rate for Patients Discharged From a Hospital



11 The ASAT data file representing calendar years (CYs) 2010–2013 and Q1-Q2 2014 were used for the analyses in this report. The ASAT data file is provided to HSAG by CMS. The ASAT data file includes Part-A claims for fee-for-service beneficiaries.

HSAG

Notes:

30-Day Readmission Rate by Setting after Inpatient Hospitalization for All Causes: Q3 2013–Q2 2014

Setting Discharged To	30-Day Readmit Rate
Nursing Home	20.8%
Home with Home Health	19.3%
Home	17.3%
Hospice	3.3%
Total	**18.4%**

The ASAT data file representing calendar years (CYs) 2010–2013 and Q1-Q2 2014 were used for the analyses in this report. The ASAT data file is provided to HSAG by CMS. The ASAT data file includes Part-A claims for fee-for-service beneficiaries.

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Notes:

Doing things the same way will NOT reduce readmissions

Notes:

Strategies to Reduce Readmissions

1. Improve processes **within** settings.
2. Improve processes **between** settings.

Notes:

Medication Reconciliation

- When a patient is transferred to the nursing home from the hospital, the standard is that the medication list and physician orders have been reconciled.
- If this works correctly, it means there is accuracy, no delay in patients receiving their first dosages of medications, and medications are available.

Notes:

Medication Reconciliation (cont.)

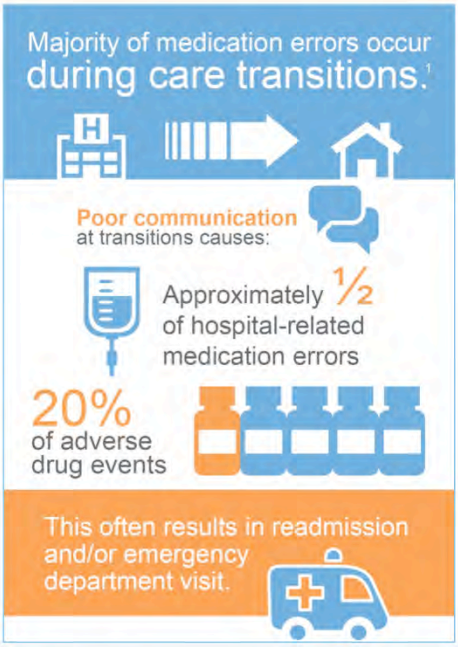
How many in this room think this process is working well at this time?

A. Always
B. Often
C. Seldom
D. Never

If you answered "seldom," the data indicate you are correct.

Notes:

Fast Facts for Medication Management



[1]Understanding and Improving Medication Reconciliation Between Hospitals and Nursing Homes—Patient Safety Risk and Cost in Care Transitions—Stratis Health http://www.stratishealth.org/documents/Stratis-Health-medication-reconciliation-white-paper-2014.pdf.

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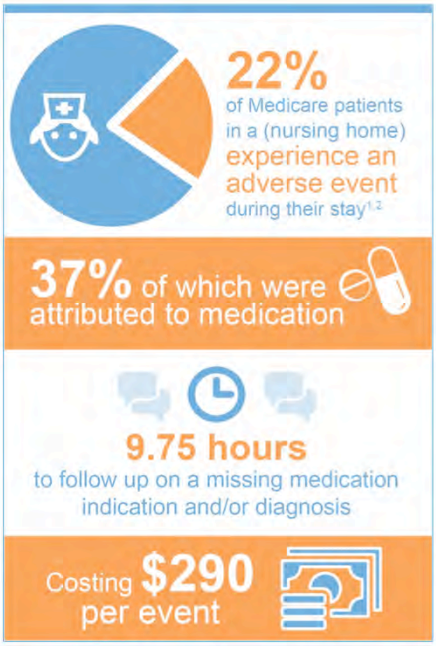
Notes:

Fast Facts for Medication Management (cont.)



[1] Department of Health and Human Services Office of Inspector General. Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries. Daniel R. Levinson Inspector General February 2014 OEI-06-11-00370. Pages 17-18.
[2] http://www.stratishealth.org/documents/Stratis-Health-medication-reconciliation-white-paper-2014.pdf, table 1, page 4.

Notes:

Accurate Medication Reconciliation Reduces Provider Expense

Case Study: Inappropriate Dosing

76-year-old female patient is discharged from hospital to nursing home with an order for Ambien 10 mg at bedtime, which is acceptable in the hospital setting.

The recommended maximum Ambien dose for an elderly female patient is 5 mg at bedtime in the nursing home.

Notes:

Accurate Medication Reconciliation Reduces Provider Expense (cont.)

Case Study: Inappropriate Dosing

Take a guess on time and cost to correct this issue.

A. $70
B. $100
C. $140
D. $180

Notes:

Understanding and Improving Medication Reconciliation Between Hospitals and Nursing Homes

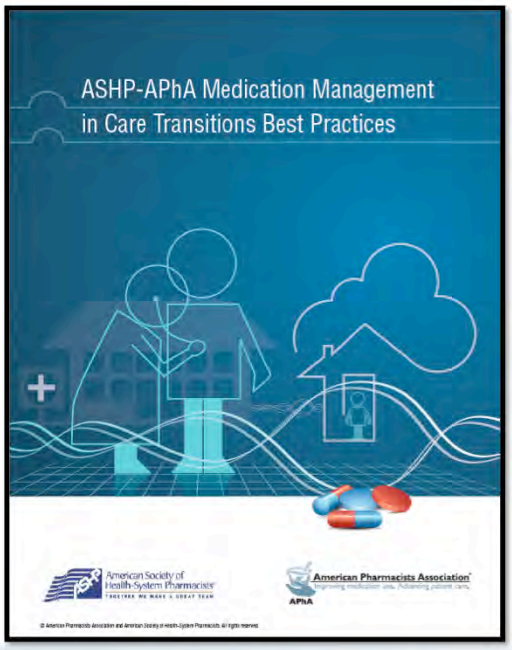
- 4.275 extra hours reconciling medication lists with inappropriate dosing ($187)
- 4.75 extra hours rectifying psychotropic medication prescribed in the hospital ($193)
- 9.75 extra hours reconciling medication lists with missing indications and/or diagnosis ($289)

http://www.stratishealth.org/pubs/qualityupdate/f14/medrec.html

Notes:

Medication Management in Care Transitions Best Practices

- American Pharmacists Association and the American Society of Health-System Pharmacists developed document to ascertain best practices integrating pharmacists
- Profiles eight best practices embracing pharmacy services



http://www.pharmacist.com/medication-management-care-transitions-best-practices

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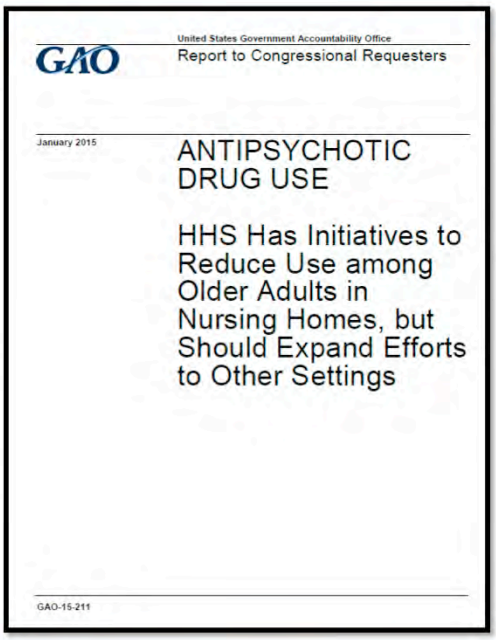
Notes:

Reduce Antipsychotic Drug Use Inside and Outside of Nursing Homes

- January 2015
- Government Accountability Office (GAO) released report on reduction of antipsychotics
- Recommendation to reduce antipsychotic use for older adults with dementia living inside **and** outside nursing homes


United States Government Accountability Office

GAO

Report to Congressional Requesters

January 2015

ANTIPSYCHOTIC DRUG USE

HHS Has Initiatives to Reduce Use among Older Adults in Nursing Homes, but Should Expand Efforts to Other Settings

GAO-15-211

http://www.gao.gov/products/GAO-15-211

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Notes:

Community Model for Improvement

Notes:

Importance of Tracking Measures

- Select interventions to solve problems, identify measures of success, collect data, and report results.
- Tracking measures will tell us if our interventions are working and why or why not.
  - Strengthen effective activities.
  - Eliminate or revise ineffective activities.
  - Where did improvement occur?
  - How did improvement occur?

Notes:

"A person with a problem and no data, is just another person with an opinion."

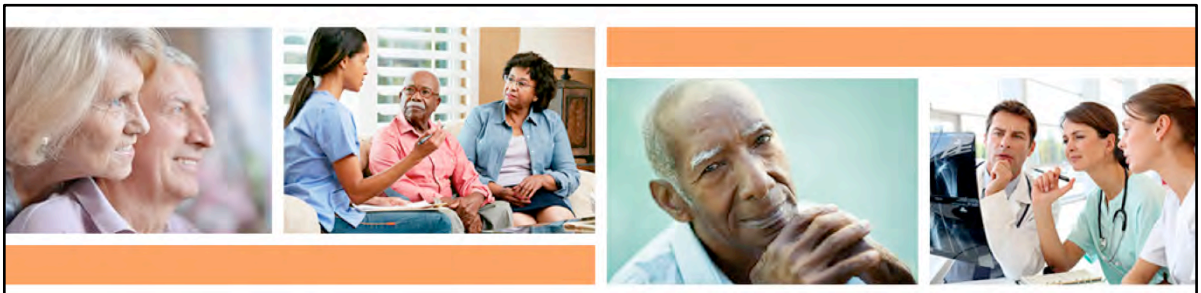
–Unknown

Notes:

Thank you.

Jennifer Wieckowski, MSG
State Program Director, HSAG
jwieckowski@hsag.com
818.409.9229

Notes:



Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

This material was prepared by Health Services Advisory Group, Inc., the Medicare Quality Improvement Organization for California, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. CA-11SOW-C.3-04212015-01

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Notes:

Communication and Collaboration: GeriNet Care Coordination Model

Christine Mlot, MD
Co-founder, Senior Medical Director
Jamie Cureton, MSN, RN, AGNP-BC
GeriNet Medical Associates
A Health Essentials Company

CALTCM 2015

Notes:

Disclosures

Jamie Cureton and Chris Mlot disclosed no relevant financial relationships with commercial interests.

Notes:

Learning Objectives

- Describe the populations served and the specific components of the care model
- Describe the value of the models on outcome measures of care coordination
- Understand the role of Nurse Practitioners and Physician Assistants in the model
- Identify opportunities in your practice to improve care management with health plans and medical groups

Notes:

Overview of GeriNet-Health Essentials

- We are a unique post acute and end of life company focused on:
  - Improving the quality of life for the frail elderly, chronically ill and those with disabilities
  - While reducing the cost to Medicare Advantage, Medicaid and commercial health plans
- We partner with health plans and risk-bearing medical groups to:
  - Coordinate and provide care across the diverse settings where members need care, including post-acute, custodial, assisted living and hospice

Notes:

GeriNet Mission

Our Mission is to revolutionize the healthcare delivery model for the post acute continuum of care by addressing the obvious lack of coordination and resulting suboptimal care and high cost.

April 1996

- One contract
- 100 Nursing homes in LA and OC
- 2 MDs 2NPs
- $35/visit
- 200 sq foot office, 1 fax machine

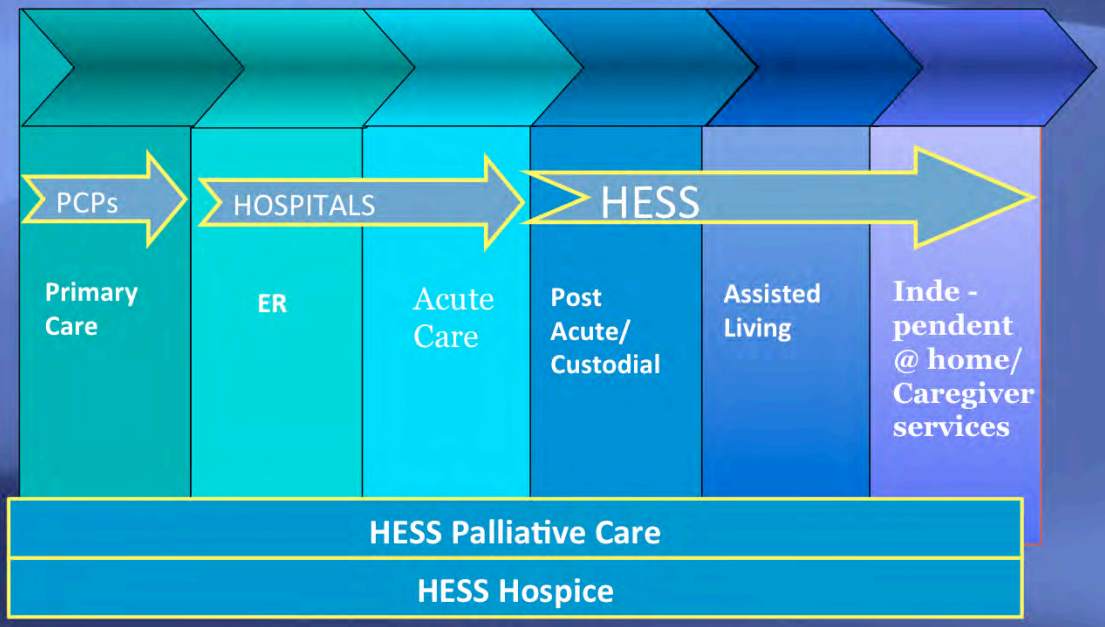
Notes:

GeriNet Post Acute Care Specialists

- GeriNet Medical Associates contracts directly with 50 health plans, PPOs, medical groups and IPAs on a fee-for-service and capitation basis to provide specialty physician service for 70,000 senior and 10,000 commercial lives.
- GeriNet covers more than 300 facilities in Orange, Los Angeles, Riverside, San Bernardino, San Diego counties in California and Las Vegas, NV.

Notes:

Through the use of strategic partners and innovative solutions, HESS offers a solution that covers the Continuum of Care and is a One-Stop Shop for our customers. Future customers are Hospitals, ACOs, and Hospitalist Groups.



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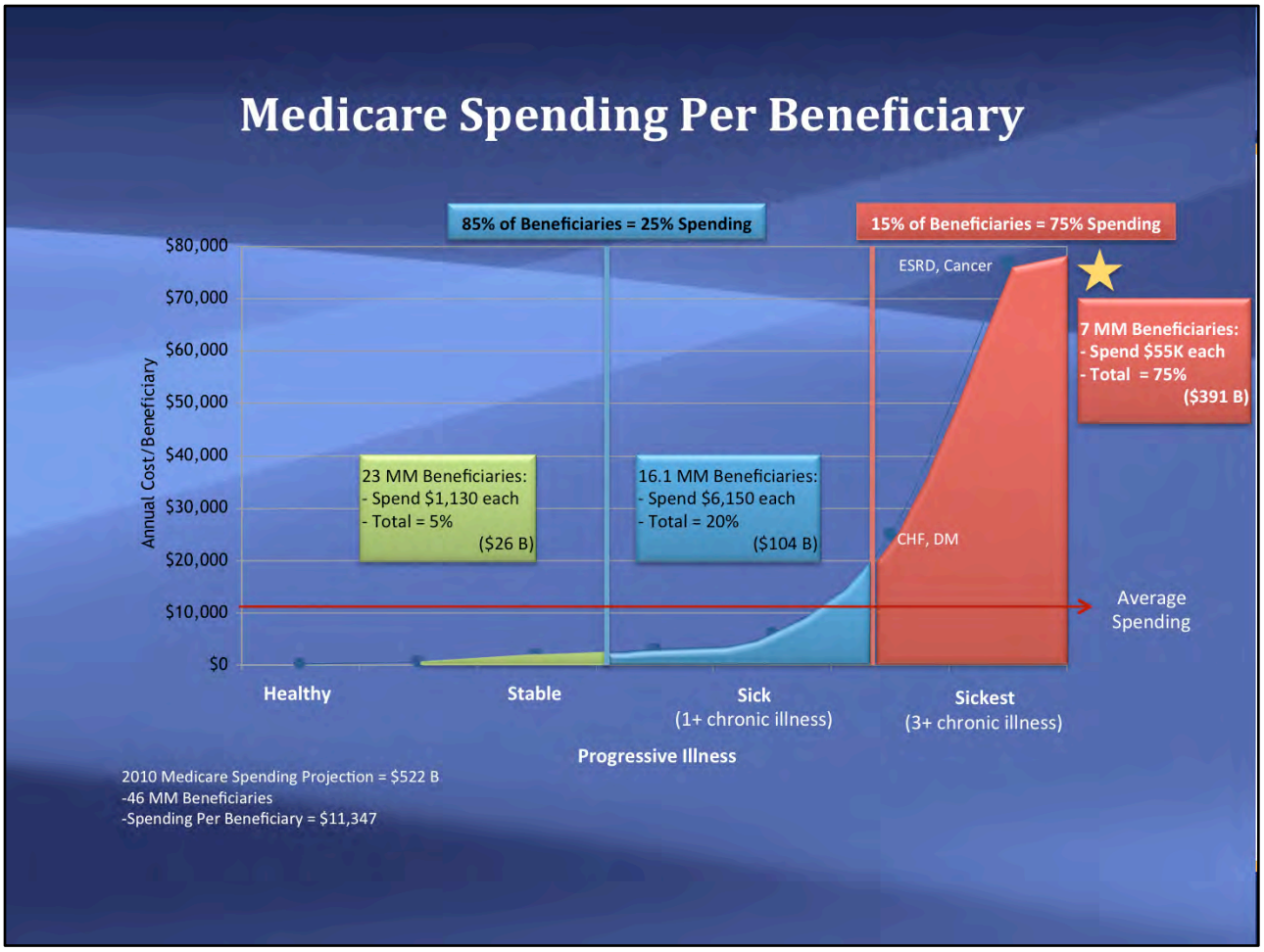

Medicare Spending Per Beneficiary
85% of Beneficiaries = 25% Spending
15% of Beneficiaries = 75% Spending
$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
Annual Cost/Beneficiary
23 MM Beneficiaries:
- Spend $1,130 each
- Total = 5%
($26 B)
16.1 MM Beneficiaries:
- Spend $6,150 each
- Total = 20%
($104 B)
ESRD, Cancer
CHF, DM
7 MM Beneficiaries:
- Spend $55K each
- Total = 75%
($391 B)
Average Spending
Healthy
Stable
Sick
(1+ chronic illness)
Sickest
(3+ chronic illness)
Progressive Illness
2010 Medicare Spending Projection = $522 B
-46 MM Beneficiaries
-Spending Per Beneficiary = $11,347

Notes:

Current Scope of Services

- Skilled/Post Acute/Subacute and LTC Residents
- Dually Eligible Cal Medi Connect
- High Risk Home/Palliative Care
- Comprehensive Evaluations (CE's)/Annual Wellness Exam (HCC Compliance)
- Post-Hospital Home Visits
- Hospice

Notes:

GeriNet Model of Care LTC/SNF

- Physician/NP/PA Teams
  - Up to 4 NPs per MD
- Central Call Center
  - Cell phones, emails
- Geographic Regions
  - 10-25 facilities per team
  - Regional Medical Directors
- Monday-Friday SNF rounding, Weekend admit teams
- On Call 7am-7pm
- New EMR
  - Aprima Post Acute
  - Homebase Homecare Hospices

Notes:

Patient Population Served:

- Medicare/Medicare Advantage Post-Acute
  - Typical SNF Patient: skilled and LTC
- MediCal Skilled and MediCal LTC
  - Health Plans
  - High burden of mental illness
  - Drug abuse, alcoholism
  - Homelessness, noncompliance, AMA
- Duals: HRA, Care Plans, Case Mgmnt, IDT
- Home Bound and Hospice
- Excluded: Pediatric SNF, LTAC.

Notes:

Strategies for Effective Post-Acute Care

- Establish goals of care
- Frequent visits
- Focus on medications
- POLST – EOL, prognosis
- Meaningful Documentation
- Discharge Summaries
- ER Notification
- Hospitalist-SNFist JOC
- Weekly Conference Calls: Case Manager
- Coordinated Discharge Planning

Notes:

Role of Our Nurse Practitioners: A Day in the Life

- General Schedule, Regulatory issues
- Communication with Supervising Physician
- History and Physicals
- Subsequent Skilled and LTC visits
- Discharge Summaries
- Home visits
- Hospice visits
- Nearly daily communication with health plan CMs, Weekly conference calls

Notes:

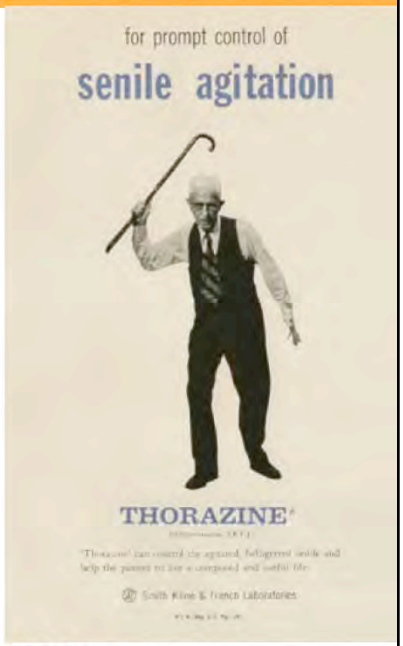
How We Coordinate Care:

- It's all about communication
- Weekly Conference Calls
  - Medical Directors, SWs, CMs, GeriNet team
  - Discuss skilled need, social issues, compliance
- Identify barriers to improved health, compliance
- Discharge planning
  - Medications
  - DME
  - HH Services
  - Social Services, IHSS
  - Clinic and Specialist appointments

Notes:

Discharge Disposition

- Home
- Board and Care
- Assisted Living
- Long Term Care
- Homeless Shelters
- SROs
- Secured Units
- Alcohol and drug rehab programs



Notes:

Value of Coordinated Care

1. Documenting and adapting patient goals of care
   - POLST care, EOL care, Referral to Hospice
2. Manage Resource utilization: “doing more for the patient and less to the patient”…
3. Patient Advocates: We have eyes on the patient
4. Reduce Hospital Admissions, Readmissions and ER Transfers by being proactive
   - Pain control, Bowel management
   - Delirium, treat infections in place
   - Address Noncompliance, Patient and staff education
   - Safety, fall prevention,
5. Patient/Family Satisfaction, Member Retention
6. Achieve Desired Metrics

Notes:

Why Our Model Works

- Speed and Intervention (Integration/ Coordination)
  - For frail patients, hours matter. The integration of our services allows us to intervene earlier and improve overall communication and outcome.
- Partnership with Medical Groups, HPs
- Identify Preferred Facilities
- Focus on transition points
- Hospitalist/SNFist JOCs
- Act on feedback to improve care QI

Notes:

Our Model Produces Desired Outcomes

- High patient and PCP satisfaction with frequent visits
- SNF LOS < 14 days
- RTA (readmissions) < 12%
- 10% of SNF admissions referred to hospice
- 70% of nursing home patients die on hospice
- Timely referrals: ALOS hospice is 69 days

Notes:

Notes:

" The single biggest problem in communication is the illusion that it has taken place."

George Bernard Shaw

Notes:

Health Literacy & Health Literate Care

Jennifer Pearce, MPA
Health Literacy Program Manager
Sutter Health Center for Integrated Care

Notes:

Disclosures

- I have no relevant relationships with commercial interests to disclose.

Notes:

Presentation objectives

- Define health literacy and understand prevalence of low health literacy among adults
- Understand relationship between health literacy and patient engagement
- Identify key health literacy competencies in three domains: knowledge, skills and attitudes
- Identify interventions to reduce health system demand/complexity and increase patient skills/ability

Notes:

Wall Street Journal

December 5, 2006

Chronic Condition

Amid Fight for Life, A Victim of Lupus Fights for Insurance

Lost in U.S. Health-Care Maze, Her Coverage Was Ended As Her Illness Worsened

Skipping a $2,000 CT Scan

Ms. White in 1991, during her senior year of high school

Continued From First Page

says: "If she had insurance, she would have gone to the emergency room sooner."

Nikki White had more advantages than many patients. She went to college, once aspired to be a doctor and worked in a hospital trauma ward. She researched her disease painstakingly. "She always went to doctors with a list of do's and recommendations," her mother says.

Her mother and stepfather, both retired managers at a unit of the pharmaceutical firm GlaxoSmithKline PLC, helped her pick her way through the medical maze. She saw at least a dozen doctors and got care from at least five hospitals. One Tennessee hospital estimates it spent $900,000 on her for which it was never reimbursed.

But the state Medicaid bureaucracy dropped her only to reverse itself months later. Meanwhile, miscommunication with a doctor kept her from getting follow-up care when she needed it. The family didn't always understand every option available to Ms. White. A proudly independent woman, she sometimes refused to seek assistance. All this proved fateful in her struggle against a serious disease.

Nikki White grew up in Bristol, in the

PATIENT SKILLS:

- **College educated**
- **Health care experience**
- **Prepared for medical appointments**
- **Had support system**

SYSTEM BARRIERS:

- **Multiple providers (12)**
- **Had Medicaid, then uninsured**
- **Miscommunication led to lack of follow-up care**
- **Didn't understand options**

Nikki didn't die from lupus, Nikki died of complications of the failing health care system.

- **Dr. Amylyn Crawford PBS Frontline, Sick Around America**

Notes:

What is health literacy?

Source: Parker, R. and Ratzan, S. 2010. "Health Literacy: A Second Decade of Distinction for Americans', Journal of Health Communication" 15: S2, 20 — 33

Notes:

What's for lunch?

- Document literacy
- Prose literacy
- Quantitative literacy
- Numeric literacy

Nutrition Facts

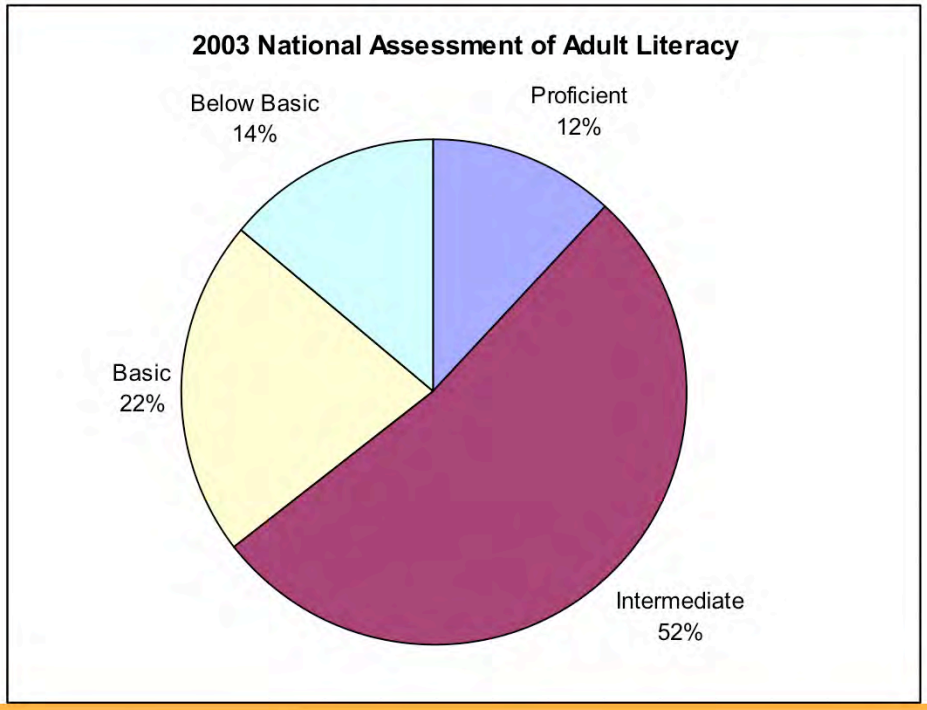
Serving Size	½ cup
Servings per container	4
Amount per serving	
Calories 250	Fat Cal 120
	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 55mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

Notes:

Measures skills in clinical, prevention and navigation domains



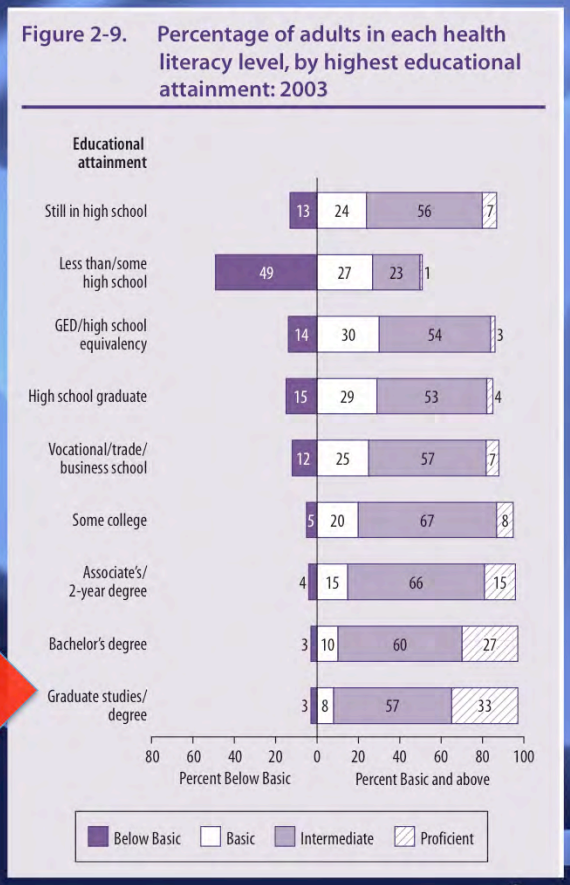
Source: U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy

Notes:

NAAL (2003)

Adult health literacy by highest level of education

Only 1/3 of those with a graduate degree have the skills to effectively manage a chronic illness

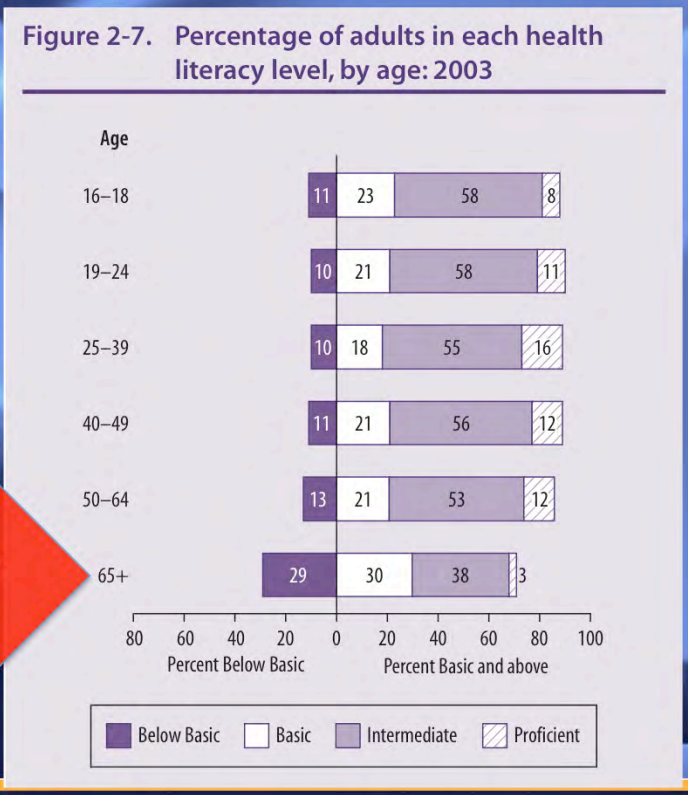


Notes:

NAAL (2003)

Adult health literacy by age

Only 3% of those age 65+ have the skills to effectively manage a chronic illness



Notes:

2010 systematic review of 86 articles on health literacy interventions and outcomes

Is health literacy related to use of health care services?

Yes! All but one study showed a statistically significant association of **increased hospitalization** and use of **inpatient services** with lower health literacy level.

Populations included the **elderly**, patients with asthma, and patients with congestive heart failure. Findings consistent with 2004 findings.

Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Viera A, Crotty K, Holland A, Brasure M, Lohr KN, Harden E, Tant E, Wallace I, Viswanathan M. Health Literacy Interventions and Outcomes: An Updated Systematic Review. Evidence Report/Technology Assesment No. 199. (Prepared by RTI International–University of North Carolina Evidence-based Practice Center under contract No. 290-2007-10056-I. AHRQ Publication Number 11-E006. Rockville, MD. Agency for Healthcare Research and Quality. March 2011.

Notes:

2010 systematic review

Is health literacy related to outcomes?

Yes! The risk of **mortality** for seniors was clearly higher with lower health literacy. The strength of evidence to support this finding was high.

There was also moderate strength of evidence to support a relationship between lower health literacy and poorer ability to, to **interpret labels** and health messages, **take medications** properly and **poorer overall health status** among seniors.

Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Viera A, Crotty K, Holland A, Brasure M, Lohr KN, Harden E, Tant E, Wallace I, Viswanathan M. Health Literacy Interventions and Outcomes: An Updated Systematic Review. Evidence Report/Technology Assesment No. 199. (Prepared by RTI International–University of North Carolina Evidence-based Practice Center under contract No. 290-2007-10056-I. AHRQ Publication Number 11-E006. Rockville, MD. Agency for Healthcare Research and Quality. March 2011.

Notes:

How do health literacy interventions improve outcomes?

- Increase knowledge
- Increase self-efficacy
- Change behavior

Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Viera A, Crotty K, Holland A, Brasure M, Lohr KN, Harden E, Tant E, Wallace I, Viswanathan M. Health Literacy Interventions and Outcomes: An Updated Systematic Review. Evidence Report/Technology Assesment No. 199. (Prepared by RTI International–University of North Carolina Evidence-based Practice Center under contract No. 290-2007-10056-I. AHRQ Publication Number 11-E006. Rockville, MD. Agency for Healthcare Research and Quality. March 2011.

Notes:

Patient engagement and health literacy . . . Is our workforce prepared?

5 of 35

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Journal of Health Communication, 18:82-102,2013.

Notes:

Why does it matter?

JAMA Internal Medicine: Communication and Medication Refill Adherence

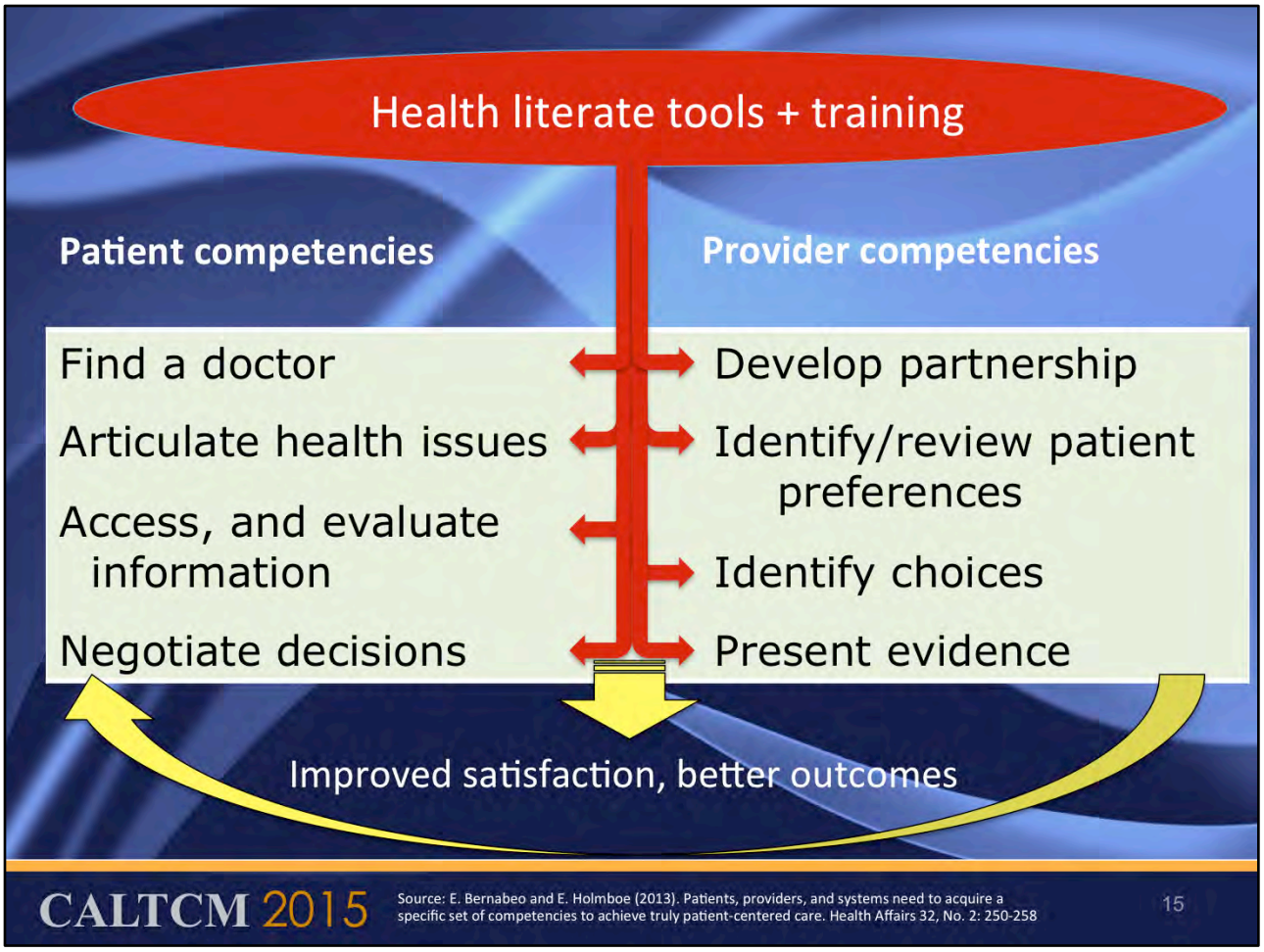
Patients who gave providers lower ratings for

- Involving patients in decisions
- Understanding patients' problems
- Eliciting confidence and trust

Were more likely to have inadequate refill adherence (objectively measured).

JAMA Internal Medicine Volume 173, Number 3, pages210-218, 2.11.13

Notes:


Health literate tools + training
Patient competencies
Provider competencies
Find a doctor
Develop partnership
Articulate health issues
Identify/review patient preferences
Access, and evaluate information
Identify choices
Negotiate decisions
Present evidence
Improved satisfaction, better outcomes
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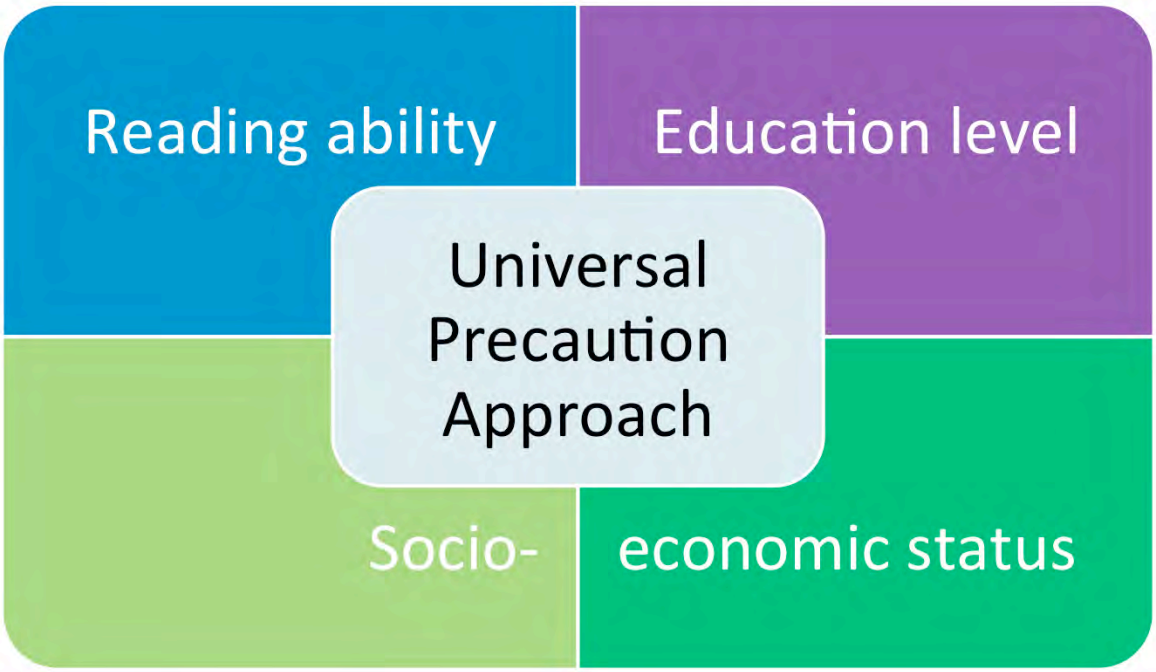
Source: E. Bernabeo and E. Holmboe (2013). Patients, providers, and systems need to acquire a specific set of competencies to achieve truly patient-centered care. Health Affairs 32, No. 2: 250-258
15

Notes:

Best practice: written and verbal communication



Source: Smith, Sandra A. (2001). Patient Education and Literacy in Labus, A. & Lauber, A. (Eds.) Preventive Medicine and Patient Education. Philadelphia: WB Saunders, 266-290.

Notes:

Evidence: Easy-to-read is preferred!

College educated readers' response to health information written at 5th grade level:

- ↑ Recall of key messages
- ↑ Satisfaction

Source: Smith SA. Information giving: Effects on birth outcomes and patient satisfaction. Int Electronic J Health Educ 1998:;3:135-145.

Notes:

For individuals with low health literacy, what are effective interventions to improve outcomes?

- Presenting essential information by itself
- Presenting essential information first
- Reducing reading level
- Adding illustrated narratives
- Adding icon arrays to numerical presentations

Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Viera A, Crotty K, Holland A, Brasure M, Lohr KN, Harden E, Tant E, Wallace I, Viswanathan M. Health Literacy Interventions and Outcomes: An Updated Systematic Review. Evidence Report/Technology Assessment No. 199. (Prepared by RTI International–University of North Carolina Evidence-based Practice Center under contract No. 290-2007-10056-I. AHRQ Publication Number 11-E006. Rockville, MD. Agency for Healthcare Research and Quality. March 2011.

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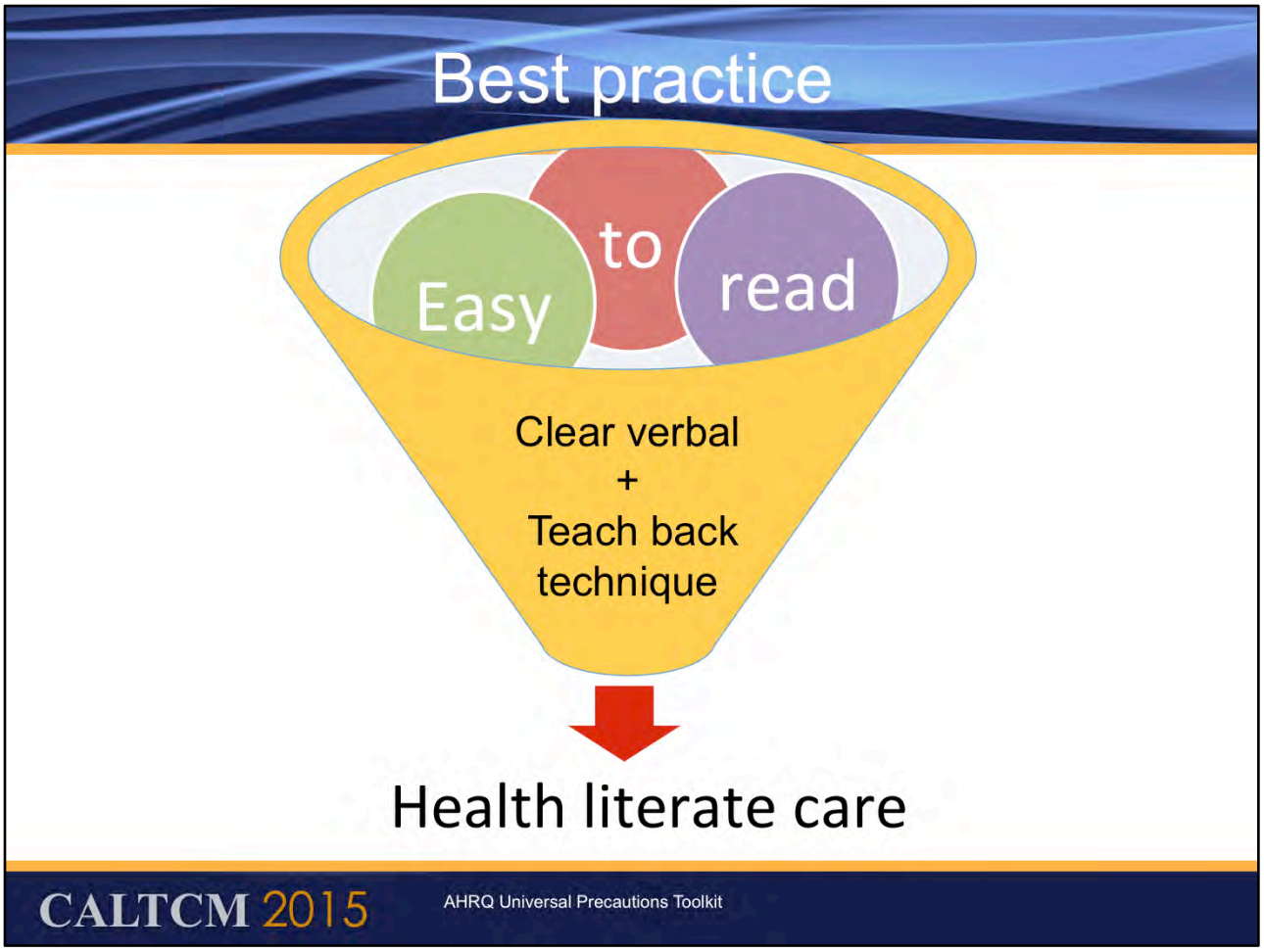
Best practice
Easy
to
read
Clear verbal
+
Teach back
technique
Health literate care
CALTCM 2015
AHRQ Universal Precautions Toolkit

Notes:

Discharge instructions

1. **Content**
   - ❑ Uses first person
   - ✓ Plain language, jargon-free
   - ❑ Limited amount of content – focus on "need to know"
2. **Design**
   - ✓ Information organized for ease of recall
   - ❑ Uses accessible design principles – serif v. sans serif
   - ❑ Avoids ALL CAPS, italics
3. **Understandability**
   - ✓ Clearly explains what needs to be done
   - **?** Field tested with patients in clinical settings
   - **?** Translated

HOME CARE

- Take your heart medicine as told by your doctor.
- **Do not** stop taking medicine unless your doctor tells you to.
- **Do not** skip any dose of medicine.
- Refill your medicines before they run out.
- Take other medicines only as told by your doctor or pharmacist.
- Stay active if told by your doctor. The elderly and people with severe heart failure should talk with a doctor about physical activity.
- Eat heart healthy foods. Choose foods that are without trans fat and are low in saturated fat, cholesterol, and salt (*sodium*). This includes fresh or frozen fruits and vegetables, fish, lean meats, fat-free or low-fat dairy foods, whole grains, and high-fiber foods. Lentils and dried peas and beans (*legumes*) are also good choices.
- Limit salt if told by your doctor.
- Cook in a healthy way. Roast, grill, broil, bake, poach, steam, or stir-fry foods.
- Limit fluids as told by your doctor.
- Weigh yourself every morning. Do this after you pee (*urinate*) and before you eat breakfast. Write down your weight to give to your doctor.
- Take your blood pressure and write it down if your doctor tell you to.
- Ask your doctor how to check your pulse. Check your pulse as told.
- Lose weight if told by your doctor.
- Stop smoking or chewing tobacco. **Do not** use gum or patches that help you quit without your doctor's approval.
- Schedule and go to doctor visits as told.
- Nonpregnant women should have no more than 1 drink a day. Men should have no more than 2 drinks a day. Talk to your doctor about drinking alcohol.
- Stop illegal drug use.
- Stay current with shots (*immunizations*).
- Manage your health conditions as told by your doctor.
- Learn to manage your stress.
- Rest when you are tired.
- If it is really hot outside:
- Avoid intense activities.
- Use air conditioning or fans, or get in a cooler place.
- Avoid caffeine and alcohol.
- Wear loose-fitting, lightweight, and light-colored clothing.
- If it is really cold outside:
- Avoid intense activities.
- Layer your clothing.
- Wear mittens or gloves, a hat, and a scarf when going outside.
- Avoid alcohol.
- Learn about heart failure and get support as needed.
- Get help to maintain or improve your quality of life and your ability to care for yourself as needed.

GET HELP IF:

- You gain 03 lb/1.4 kg or more in 1 day or 05 lb/2.3 kg in a week.
- You are more short of breath than usual.
- You cannot do your normal activities.
- You tire easily.
- You cough more than normal, especially with activity.
- You have any or more puffiness (*swelling*) in areas such as your hands, feet, ankles, or belly (*abdomen*).
- You cannot sleep because it is hard to breathe.
- You feel like your heart is beating fast (*palpitations*).
- You get dizzy or lightheaded when you stand up.

GET HELP RIGHT AWAY IF:

- You have trouble breathing.
- There is a change in mental status, such as becoming less alert or not being able to focus.
- You have chest pain or discomfort.
- You faint.

MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Notes:

Health literate discharge / self monitoring tool

1. **Content**
   - ✓ Uses first person
   - ✓ Plain language, jargon-free
   - ✓ Limited amount of content – focus on "need to know"
2. **Design**
   - ✓ Information organized for ease of recall
   - ✓ Uses accessible design principles – serif v. sans serif
   - ✓ Avoids ALL CAPS, italics
3. **Understandability**
   - ✓ Clearly explains what needs to be done
   - ✓ Field tested with patients in clinical settings
   - ✓ Translated: 10 languages

CLEAR MARK AWARDS

Controlling heart failure at home

Sutter Health
We Plus You

How do I feel today?

	Green zone You are in control.	Yellow zone Take action today. Call: _____	Red zone Take action now! Call: _____
Is my weight up? My healthy weight: _____	No change in my weight.	My weight is up: • 3 pounds overnight • 5 pounds since last week	My weight is up: • 5 pounds overnight
Do I have swelling?	I do not have swelling.	I have swelling in my: • Foot, ankle or shin • Knee or thigh	I have swelling in my: • Belly – feels bloated or pants are tighter • Hands or face
Am I short of breath?	I do not feel short of breath: • Breathing is normal • Sleep is normal	I feel short of breath or cough while: • Walking or talking • Eating • Bathing or dressing I need to use more pillows when I sleep.	I feel: • Short of breath or wheeze at rest • Less alert I need to sleep sitting up to breathe.
How is my energy level?	My energy level is normal.	I am too tired to do most of my normal activities.	I am so tired that I can hardly do any of my normal activities.
My other signs of heart failure:			Chest pain or pressure that does not go away.

Notes:

Health literate approach to medication instructions

- More explicit prescription medicine instructions are better understood.
- Errors are more likely with more complex regimens.
- Consistent instructions could reduce confusion and help patients more safely use multi-drug regimens.

Universal Medication Schedule (UMS)

Take	1 pill in the morning
Take	1 pill in the morning 1 pill at noon and 1 pill at bedtime
Take	1 pill in the morning and 1 pill in the evening
Take	1 pill in the morning 1 pill at noon 1 pill in the evening and 1 pill at bedtime

http://www.ahrq.gov/professionals/quality-patient-safety/pharmhealthlit/prescriptionmed-instr.html

Notes:

Patient friendly medicine list

Medicine schedule for: _____

Medicine name, strength	Morning dose 	Noon dose 	Evening dose 	Bedtime dose 	As needed dose	Notes about medicine: • Why I take it • How I take it

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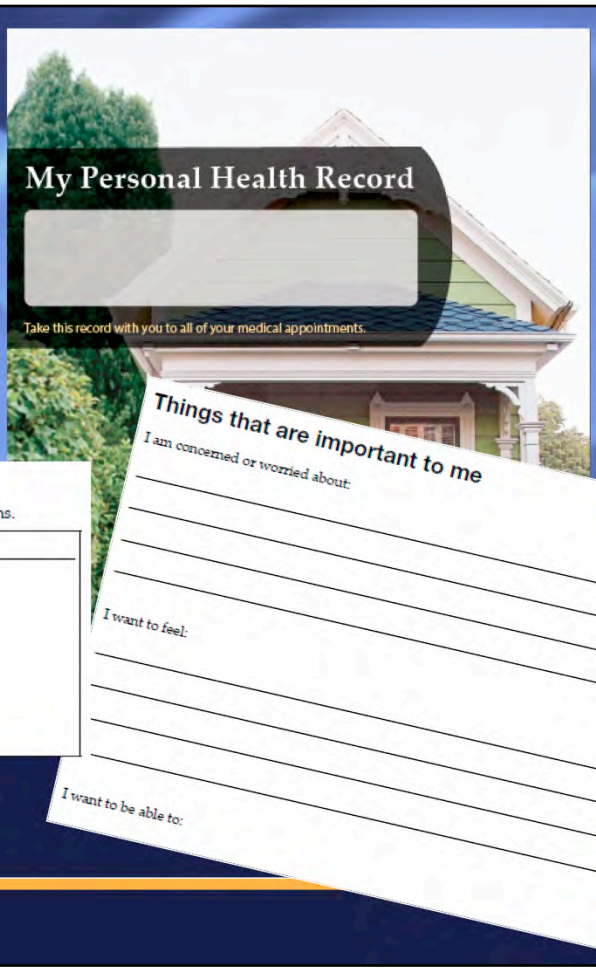
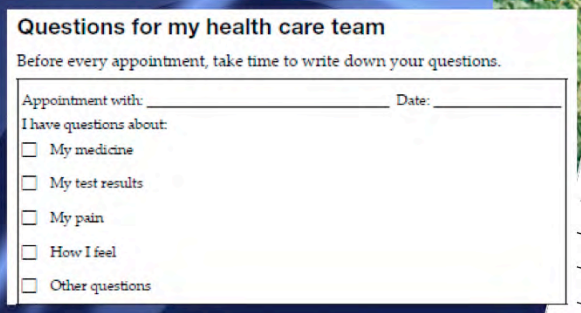
Notes:

Health literate personal health record (PHR)

Patient competencies

- Articulate health issues
- Share information





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Notes:

Health literacy resources

Agency for Healthcare Research & Quality

Health Literacy Universal Precautions Toolkit, 2nd edition
http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/

Health Literacy Tools for Pharmacies (standardized medication instructions in six languages)
http://www.ahrq.gov/professionals/quality-patient-safety/pharmhealthlit/tools.html#exinstructions

Comprehensive resource list

http://www.health.gov/communication/interactiveHLCM/#resources

Notes:

What questions do you have?

Jennifer Pearce, MPA
Health Literacy Program Manager
Sutter Health Center for Integrated Care

pearcej1@sutterhealth.org
SutterCenterforIntegratedCare.org

Notes:

Notes:

Patient Safety

Saturday
April 25, 2015

Behavior Mapping for the Care of Dementia Based Behaviors

Keith Savell, Ph.D, CTRS
Mariposa Training
Geriatric Healthcare Consultants
Keith@MariposaTraining.com
www.mariposatraining.com

(510) 658-4448

CALTCM 2015

Notes:

Learning Objectives

- Define Behavior Mapping
- Interpret the Language of Dementia and Delirium Based Behaviors.
- Analyze the *Human Factor, Environmental, Situational and Delivery of Care* antecedents which may trigger challenging behaviors.
- Implement Behavioral Mapping utilizing the Antecedent Behavior Monitor.
- Utilize the process of Root Cause Analysis and other techniques to isolate behavioral antecedents.

Notes:

Supporting our Residents with Challenging Behaviors:

What are the most common challenging behaviors?

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Notes:

What are the most common challenging behaviors?

- Resisting care
- Obscene or abusive language
- Pacing / Excessive wandering
- Eating inappropriate materials
- Socially inappropriate sexual behavior
- Urinating defecating in inappropriate places
- Exit seeking
- Hoarding
- Wearing too few or too many clothes
- Poor safety awareness
- Attention seeking behavior (calling out)
- Territoriality

Notes:

Understanding WHY?

- Why do our residents exhibit challenging behaviors?
- Do they have a reason?
- Of course they do…and probably the same reason(s) that we would have, if we were in their situation!

Notes:

What are the most common challenging behaviors?

- Resisting care *Fear*
- Obscene or abusive language *Frustration*
- Excessive wandering *Confusion*
- Socially inappropriate sexual behavior *Stimulus Response*
- Urinating in inappropriate places *Misleading Signs*
- Exit seeking *Routine*
- Hoarding *History*
- Wearing too few or too many clothes *Discomfort*
- Attention seeking behavior (calling Out) *Control Seeking*
- Territoriality *Fear*

Notes:

Understanding Challenging Behaviors

- When seeking to understand *why*, it is important to remember that all behaviors have an underlying reason.
- We may not always agree with the reason, nor feel the reason warrants the behavioral response, but there will always be a reason.

Notes:

Understanding WHY?

- This is the secret of
  effective behavior management ….

  Recognizing that

  all behaviors occur for a reason!

Notes:

All Behaviors Occur for a Reason

- Cognitively well residents
- Cognitively impaired residents

Notes:

All Behaviors Occur for a Reason

- **Cognitively well residents**
  - Able to ask for what they want/need
  - Challenging behaviors:
    - Attention seeking
    - Manipulation

Notes:

All Behaviors Occur for a Reason

- **Cognitively well residents**
  - Able to ask for what they want/need
  - Challenging behaviors:
    - Attention seeking
    - Manipulation
- **Cognitively impaired residents**
  - Unable to ask for what they want/need
  - Challenging behaviors may be their way of communicating fear, pain, unattended illness or an unmet need or desire

Notes:

So … if all behaviors occur for a reason …

- then we must learn to become detectives … in order to identify behavioral antecedents … and the triggers to these behaviors …
- **Effective behavior management requires staff to begin to understand the language of resident behavior**.

Notes:

Antecedents to Challenging Behaviors

- Human factor antecedents
- Environmental antecedents
- Situational antecedents
- Delivery of care antecedents

Notes:

Human Factor Antecedents

- Undiagnosed illness (urinary tract infection, constipation)
- Pain
- Fatigue
- Over / Under medication
- The effect of new medications
- The need to feel empowered and in control
- Trauma
- Depression
- Social Isolation
- Dehydration / Malnutrition

Notes:

Environmental Antecedents

- Inappropriate stimulus levels (excessive noise, too many people, social isolation)
- Light levels (changing light levels, glare, striated light through window blinds)
- Temperature
- Lunar cycles

Notes:

Situational Antecedents

- Staff or other residents infringing on the residents' "personal space"
- Fear of contact (fear of injury from others)
- Demands to perform which exceed the residents abilities
- Residential relocation
- Change of environment or routine.

Notes:

Delivery of Care Antecedents

- Need to be treated with respect and dignity
- Lack of timely response to requests for assistance
- Change in care provider - staff unfamiliar with resident needs, interests, routines and preferences
- Misleading stimuli (inaccurate instructions, absence of task-segmentation)
- Staff requests which exceed functional capacity

Notes:

Antecedents to Challenging Behaviors

- Human factor antecedents
- Environmental antecedents
- Situational antecedents
- Delivery of care antecedents

Notes:

Where Do We Begin?

Notes:

Where Do We Begin?

Define *Challenging* Behaviors

- Before we begin the process of Behavior Mapping, we must first *identify whether the behavior is actually a problem!*

Notes:

Questions to ask:

- Is the behavior truly a problem?
- For whom is it a problem?
  - Is it primarily an inconvenience or annoyance for the staff?
  - Is the behavior bothersome to other residents?
  - Bothersome to family/visitors?
- Does the behavior impede the resident's functioning?
- Does the behavior present a danger to the resident or to others?
- Is the behavior "attention seeking"?

Notes:

Where Do We Begin?

- Define Challenging Behaviors
- **Identify Behavioral Antecedents**

Notes:

Identify Behavioral Antecedents

- Utilize behavior mapping to document critical data points.
  - Track/trend behavioral antecedents.
  - Utilize Antecedent Behavior Monitor

Notes:

Antecedent Data Points

- **Who** was around the resident when the behavior occurred?
- **What**: has happened within 24 hours of the behavior (i.e. change in caregiver, room change, family visit, change in medication)?
- **When** - time of day?
- **Where** was the resident when the behavior occurred?

Notes:

DIRECTIONS: Following each behavioral incident, the following antecedent behavior monitor should be completed. When completing each section, provide as much detail as possible. The purpose of this monitor is to gather information which will begin to illuminate causal (antecedent) factors for the demonstrated behavior(s). Refer to the Antecedent Behavior Monitor Guidelines. Use as much space as necessary.

Date	Time	Where was the resident?	What was happening before the behavior occurred?	Describe the behavior. What did the resident do and say?	What did the staff do to intervene?	What was the resident's response?	Antecedent: (HF) Human Factor (E) Environmental (S) Situational (C) Care Delivery	Initial	Charge Nurse Initial

RESIDENT:_____. ROOM #:_____. PHYSICIAN:_____. MED. #:_____.

Developed by: D. Michael Splain, LCSW. Revised by: Savell,/Boothman 2002. Geriatric Healthcare Consultants, LLC (2015)

For Behavior Management Support: Dr. Keith Savell (510) 387-8130 Geriatric Healthcare Consultants, LLC

Notes:

If a Picture Paints and Thousand Words

- Track/trend Behavioral Incidents. Use the facility fire map to identify times and locations where behaviors occur. X may mark the location of a behavior. Red, yellow and green may be used to represent morning, afternoon and evening incidents – look for patterns.

.

Notes:


ELDER ROOM
SPA W/TLT
TCOM
STORAGE
CLEAN
SOILED
ELEVATORS
TLT
PANTRY
KITCHEN
DINING ROOM
HEARTH ROOM
SUN ROOM
DECK W/RAILING
OFFICE
STAIR
DEN

Notes:

What is the Antecedent?

What occurred prior to the onset of the behavior.
This is the time to utilize **Root Cause Analysis** ….

Ask WHY five (5) times!

Notes:

Antecedent

Root Cause Analysis ….

Ask WHY five (5) times!

For example, if a resident falls while walking to the bathroom:
Why: Resident was trying to walk by himself to the bathroom.
Why: He needed to urinate and could no longer wait for assistance from staff.
Why: Staff were not available to provide assistance.
Why: Two CNA's came to work sick, and were sent home.
Why: These two staff did not receive the Influenza vaccine

Root Problem: Not all staff received Influenza vaccine – Staff Developer on vacation when vaccine was delivered and not all staff received vaccine.

Notes:

Conclusion

- When our residents demonstrate challenging behaviors, *they always have a reason*!
- Challenging behaviors may be caused by Human Factor, Environmental, Situational and Delivery of Care factors.
- As care providers, we must strive to identify the underlying cause of the challenging behaviors in order to address the immediate need, as well as prevent the need from recurring.
- Root cause analysis will enable us to identify underlying reasons for challenging behaviors .

Notes:

Conclusion

Effective behavior management simply requires staff to begin to understand the language of resident behavior

Notes:

Geriatric HEALTHCARE CONSULTANTS, LLC

Committed to Change: Optimizing the Quality of our Residents' Lives

Antecedent Behavior Monitor Guidelines

As healthcare providers within long term care environments, we are often called upon to assist residents who present with a variety of challenging behaviors. Central to our ability to address these behaviors is our skill in identifying the root cause of these behaviors – otherwise known as behavioral antecedents. Since all behaviors occur for a reason, our job becomes that of the detective. Indeed, rather than turning to the physician for a psychotropic medication targeting the challenging behavior, we should instead seek to identify the underlying reason for the behavior, thereby addressing the problem rather than the resultant symptom.

The Antecedent Behavior Monitor is based upon the assumption that all behaviors have meaning. In an effort to identify the meaning behind challenging behaviors the facility must first ascertain the antecedent, trigger or cause of the behavior. Once the antecedent has been determined, the facility will then be able to develop a plan of care to proactively meet the resident's need, thereby preventing future occurrences of the behavior.

The Antecedent Behavior Monitor provides a useful tool for identifying the meaning behind challenging behaviors. The monitor requires the staff member who observes the behavioral incident to document the incident – regardless of discipline or role within the facility. The Antecedent Behavior Monitor should be maintained

a) for those residents whose behaviors pose risk for harm to self or others,
b) for those behaviors which negatively effect the resident's ability to function at his/her highest practicable level
c) for those residents for whom psychoactive and/or psychotropic medications are under consideration to control the challenging behaviors.

The Antecedent Behavior Monitor should be located at the nursing station in a binder that is accessible to all staff.

The Antecedent Behavior Monitor requires staff to document:

1. The date of the incident
2. The time of the incident. Be certain to identify whether the behavior occurred in the AM or the PM.
3. The location of the resident. Be as specific as possible. For example, "resident was walking past room 34 in the East Hallway".
4. The events that occurred prior to the behavior. Provide as much information as possible as to what occurred prior to the incident. Remember that the precipitating event may have occurred within 24 hours of the actual behavior (i.e. interrupted sleep the night prior to the behavior).
5. The exact behavior. Describe what the resident did and/or said during the behavioral incident. Be certain to identify the intensity of the behavior.

6. The staff intervention. Describe the staff response. What did the staff do and say in response to the situation. Include both successful and unsuccessful interventions.
7. The resident's response to the intervention. Identify the resident's response to the staff interaction. Be certain to identify both positive and negative responses.
8. Antecedent: Identify whether the *suspected* antecedent is related to:
   - Human factor antecedents (health related conditions such as UTI, dehydration, over/under medication, medication side effect, etc.),
   - Environmental antecedents (noisy or distracting environment, sunlight streaming through a window, temperature, major weather event, lunar cycle, etc.),
   - Situational antecedents (staff or others infringing on resident personal space, fear of contact or injury, change of environment or care provider, etc),
   - Care delivery antecedents (lack of timely response to call bell or requests for assistance, change in care provider, misleading or inaccurate instructions, staff expectations which exceed resident abilities, etc).
9. Signature: The staff member who completed the Antecedent Behavior Monitor must date and sign the entry. The completed entry must then be presented to (and discussed with) the charge nurse to ensure that nursing staff are aware of the incident. The Charge Nurse must co-sign the entry.
10. Communication at Change of Shift Report: To ensure that oncoming shifts are aware of behavioral incidents and behavioral antecedents, the Antecedent Behavior Monitor should be presented for discussion at the Change of Shift Report.

Guidelines:

- Documentation should be objective. Objective documentation includes factual information obtained through observation; it should be stated in specific behavioral terms. For example, rather than writing "resident appeared agitated", it would be more helpful to write "resident appeared agitated as evidenced by (or as manifested by) continuous pacing throughout the facility and constant tugging at shirt sleeve".
- A licensed nurse must co-sign all entries on the Antecedent Behavior Monitor. This will help to ensure consistency in documentation procedures as well as the communication of documented incidents.
- Behaviors which should be documented on the Antecedent Behavior Monitor include:
  1) Behaviors which pose risk for harm to self or others,
  2) Behaviors which negatively effect the resident's ability to function at his/her highest practicable level
  3) Behaviors for which psychoactive and/or psychotropic medications are under consideration to control the challenging behaviors.

- Behavioral incidents documented on the Antecedent Behavior Monitor should be consistent with both Nursing and Social Service documentation.
- The Antecedent Behavior Monitor should be reviewed during the monthly Behavior Management Committee meeting (also referred to as the psychotropic drug review committee), as well as during the resident's Interdisciplinary Team (IDT) conference.
- Entries to the Antecedent Behavior Monitor should be presented for discussion at the Change of Shift Report to the oncoming shifts to ensure that behavioral incidents and behavioral antecedents are discussed.

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DIRECTIONS: Following each behavioral incident, the following antecedent behavior monitor should be completed. When completing each section, provide as much detail as possible. The purpose of this monitor is to gather information which will begin to illuminate causal (antecedent) factors for the demonstrated behavior(s). Refer to the Antecedent Behavior Monitor Guidelines. Use as much space as necessary.

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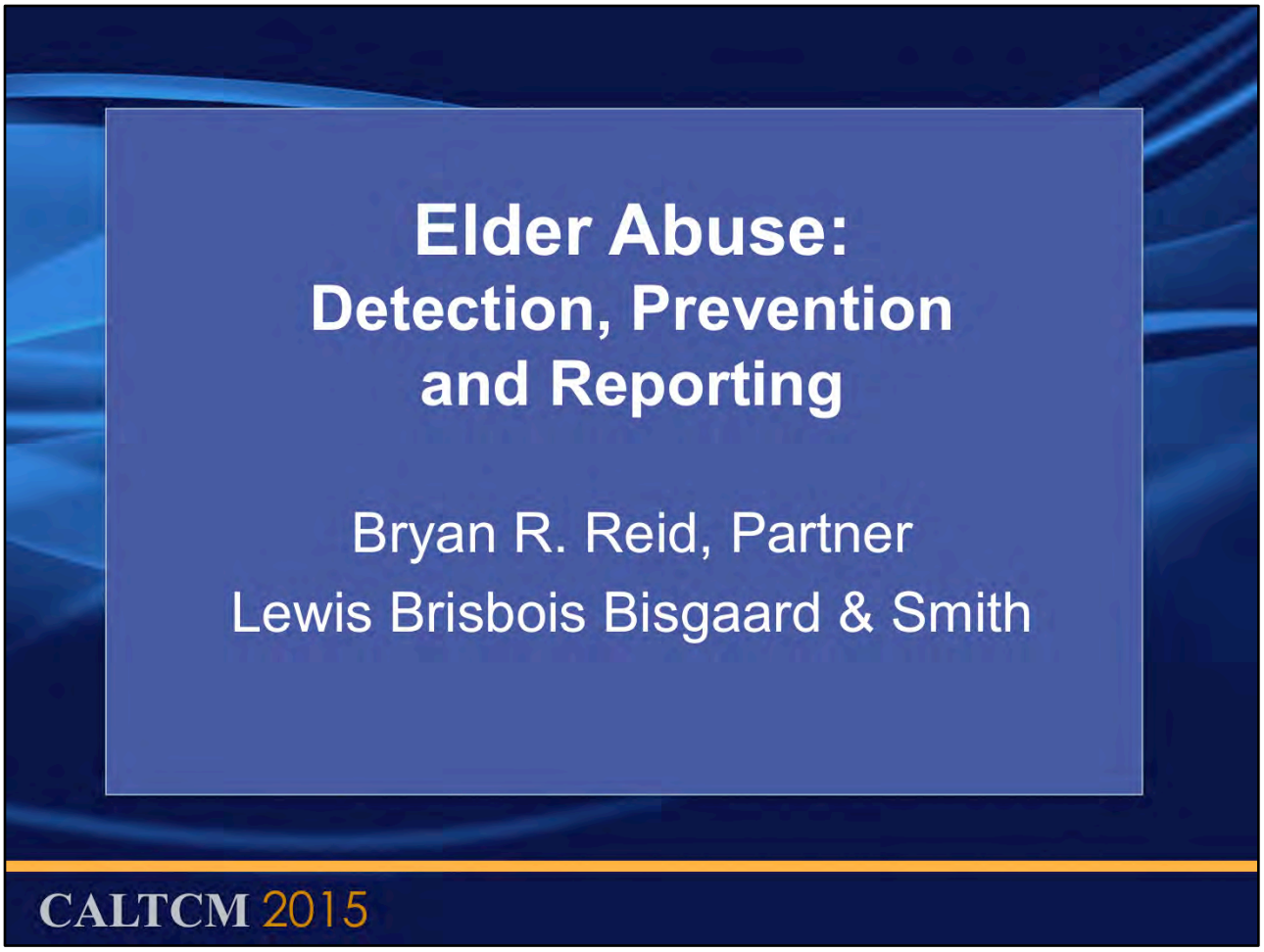
Elder Abuse:
Detection, Prevention and Reporting
Bryan R. Reid, Partner
Lewis Brisbois Bisgaard & Smith
CALTCM 2015

Notes:

Disclosure

I have no relevant financial relationships with commercial interest to disclose.

Notes:

Learning Objectives

- Identify three situations where an elder abuse report must be filed and appropriate time frames
- Explain the elder justice act and be able to review your facility policies on abuse to assure compliance
- Name four strategies which can reduce the risk of abuse occurring in your facility

Notes:

Detecting Abuse: what is it?

- WIC 15610, et. seq.
  - Physical abuse*
  - Neglect*
  - Sexual abuse
  - Financial abuse
  - Abduction
  - Self-neglect
  - Isolation
  - Abandonment

  note broad definitions

Notes:

Reporting of Physical Abuse

- If suspected abuse may be “Physical Abuse” with “Serious Bodily Injury”, then
  - Telephonic report to law enforcement
  - Written report (SOC 341) to local ombudsman, licensing and law enforcement
  - **All within 2 hours**
- If suspected physical abuse does not result in serious bodily injury
  - Report to same agencies by phone and writing within 24 hours
- Satisfies EJA reporting requirements when applicable

Notes:

Reporting Requirements: WIC 15630

- Mandated reporter, professional capacity/scope of employment
- Observed, has knowledge, is told, or reasonably suspects
- Incident that "reasonably appears" to be **other than physical abuse**
- Shall report to local ombudsman or local law enforcement agency
  - By phone or confidential internet reporting immediately or as soon as practicable
  - If by phone a written report (SOC 341) or internet report shall be made within two working days
- But for physical abuse…

Notes:

Reporting Physical Abuse When Caused by Dementia

- Physical abuse by patient with physician's diagnosis of dementia
- No serious bodily injury
- Report
  - By phone to ombudsman or law enforcement immediately or as soon as practicable
  - Written report to same within 24 hours

Notes:

Exception to WIC Reporting

- Report NOT required when:
  - Mandated reporter is MD/RN
  - Told of alleged abuse by patient with dementia or mental illness
  - No independent/corroborating evidence
  - Mandated reporter reasonably believes abuse did not occur based upon clinical judgment

Is your "abuse coordinator an MD or RN"?

Notes:

"Abuse Coordinator" and Individual Reporting Requirements

- "The reporting duties under this section are individual…" However,
- Internal procedures to
  - Facilitate reporting
  - Ensure confidentiality
  - Apprise supervisors/administrators of reports
- May be established as long as they are not inconsistent with reporting requirements

Notes:

How Many Reports are Required?

- When two or more mandated reports “are present and jointly know/suspect…abuse”
- And they mutually agree that one person will report,
  - The call or internet report can be made by the member of the team selected by mutual agreement
  - Only one written report is required (EJA)
- However, the non-designated mandated reporter must report if the other person fails to do so
- Failure to comply is a misdemeanor

Notes:

Reporting Requirements: EJA

- Requires reporting of “reasonable suspicion” of a crime against resident of a LTCHF
- If “serious bodily injury”, report immediately/ not more than 2 hours delay
- Otherwise, report within 24 hours
- Report to local law enforcement and DPH L&C
- Applies to owner, operator, employee, manager, agent or contractor of LTCHF (“covered individuals”)
- One single report satisfies requirement

Notes:

Training/Posting Requirements

- WIC/EJA both require annual training regarding of “mandated reporters” and “covered individuals” regarding abuse and reporting requirements
- Records regarding training must be maintained
- No retaliation/punishment can result from abuse report
- Requirement of “conspicuous posting” of employees’ rights including right to file complaint under EJA and L&C

Notes:

Strategies to Minimize Risk of Abuse

- Annual training (as required by WIC/EJA)
- Identify/discuss potential sources of abuse
  - Residents
  - Families
  - Visitors
  - Vendors
  - Volunteers
  - Staff
- Encourage vigilance/security
- “See something/say something”

Notes:

Mobility & Balance Awareness
Real Interventions That Impact Care
Moving beyond risk assessment, non-skid socks, wrist bands & alarms

Steven C. Castle, M.D.
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310-597-2935

CALTCM 2015

Notes:

Disclosure

I have no relevant financial relationships with commercial interests to disclosure.

Notes:

Learning Objectives

- Recognize risk assessment tick boxes, bed alarms, low beds, non-skid socks and call bells by themselves will **not** reduce falls.
- Make a commitment to develop champions who can support training, competency checks and measure processes to support real improvement in staff skills and behavior
- Focus on aspects of communication –
  - CONNECT-General staff communication to support “four eyed” seeing
  - Specific communication around huddles, handoffs/shift report and teach-back with residents and families: *What Caused the Fall?*
- Identify specific interventions to implement and improve:
  - Mobilization Programs
  - Delirium/Dementia Management
  - Toileting- Assessment, Interventions and Use of Bladder Ultrasound,
  - Protection and Monitoring, and
  - Comprehensive Post Fall Assessment.

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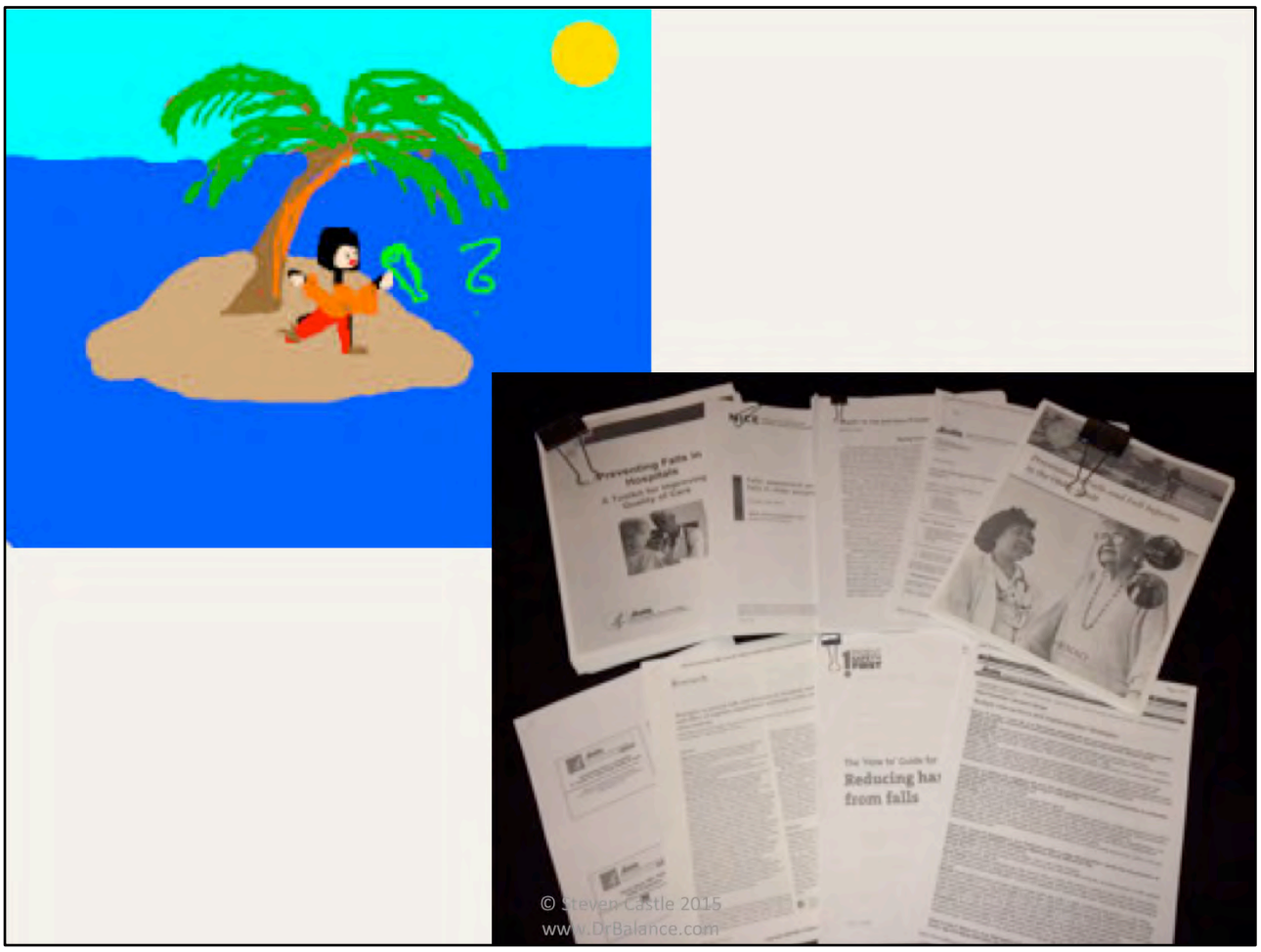
Notes:


Preventing Falls in Hospitals
Reducing ha
from falls
© Steven Castle 2015
www.DrBalance.com

Notes:

Objectives

1. Don't do this:

2. Do you have a Resource Nurse Champion?
   Role of facilitators as the FIRST STEP

2. Communication – Good communication leads to quality

3. Specific Interventions that impact on care
   - **Mobilization**
   - Delirium/Dementia
   - **Bladder Program**

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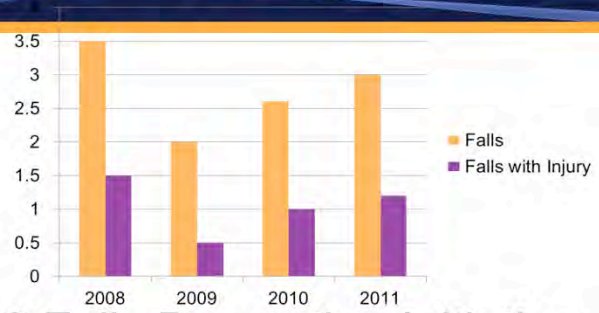
Notes:

Why do you need an MBA?



- ECRI 2009 Falls Prevention Initiative:

Implementation of guidelines in acute care setting

Unable to sustain improvement over 3 yrs

- Medicare Claims data since implementation of no pay for 'never' events
  - 10% decrease in CAUTI's, no change in injurious falls
  - *Waters TM JAMA Intern Med 2015*

Notes:

This is **NOT** impossible: **SAFE from FALLS**

Apold J, Quigley PA J Nurs Care Qual 2012

- Process
  - Self Assessment, 1d training, Collaborative blog
- **S**afe team **A**ccess to data **F**acility exp'tion **E**duc
- **F**all risk **A**ss't of risk **L**inked interv **L**earn **S**afe env
- 121 hosp (2011)
  - 20 % fewer falls, 25% decr death/serious injury
- Keys
  - Assess beyond risk- med review, reduce sedatives, criteria for "at arm's reach" toileting program
  - 12 facilities collaborate -12-18mos
  - Limited tools/intervention options

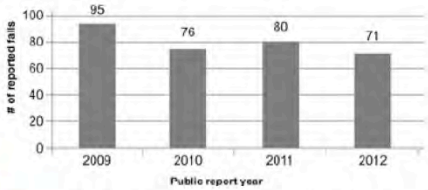


Figure 3. Falls in Minnesota hospitals resulting in serious injury or patient death.

Notes:

Prevailing Attitudes: Nursing Practice

Falls Risk Management- Acute Care

Shever LL West J Nurs Res ***2010***

- 149 Nurse Managers, 51 hospitals: Structured interview
- Assessment
  - Most common Morse Fall Risk- 40%
- Describe interventions used to prevent falls (as many as can think of)

– **Bed alarms**	**90%**
– Rounds	70%
– Sitters	68%
– Close to nurse station	56%
– Sign indicating hi risk status	55%
– Restraints	29%
– Ambulation	9%
– Adjust RN Hrs/Pt/Day	0%

Notes:

Acute Care Falls Risk Mgt: *Limited Success*

"Tools that claim to predict patients' risk of falling as high or low do not work well and may provide a false reassurance that 'something is being done'."

David Oliver, Fran Healy, Nursing Times 2009

- Wrist bands, alarms, hip protectors, *low beds* have similar flaws/ limitations

- Areas of Promise:
  - Post fall review
  - Patient & Staff education
  - Footwear advice
  - Scheduled and SUPERVISED toileting ('Arm's reach')
    - *Recognize Detrusor UNDERactivity**
  - Medication Review

** Castle addition*

Ganz DA AHRQ toolkit 2013

Notes:

Aging Services Claims Report 2014

- Resident Falls Summary- 991 closed claims
  - 45.6% associated with '*failure to monitor*'
    - Many had care plan requiring 1:1 assistance with an ADL
  - 66% occurred in resident's room or bathroom
  - 40.4% resulted in death
  - Avg paid per claim 2014: $211,159 *($278,738 in California)*
- Suggested Actions
  - Focus on areas of greatest risk (bedside, BR)
  - Communication devices for quick help
  - Efficient 1:1 assistance (*staffing plan for toileting*)
  - Improved critical thinking and communication of team
  - Include NA's in resident care planning

Notes:

Don't Do This- See handout for details

- Risk Assessment only: *increases liability*
- Non-skid socks: ***11-14x increased falls risk***
  - 1371 older adults/2yrs- 11x incr risk of falls
  - Prospective 176 older adults, shoe database: 14x incr
- Wrist Bands/Signs: *False security*
- Rails and Restraints: *Fall anyway, increased injury*
- Bed Alarms: *Taking them off decreases falls*
- Low Beds – **This WORKS if 1:3 Ratio**

Notes:

Why is barefoot/socks a **11-14x** increased risk of falling?

Koepsel TD JAGS 2004, Menz HB Gerontology 2006

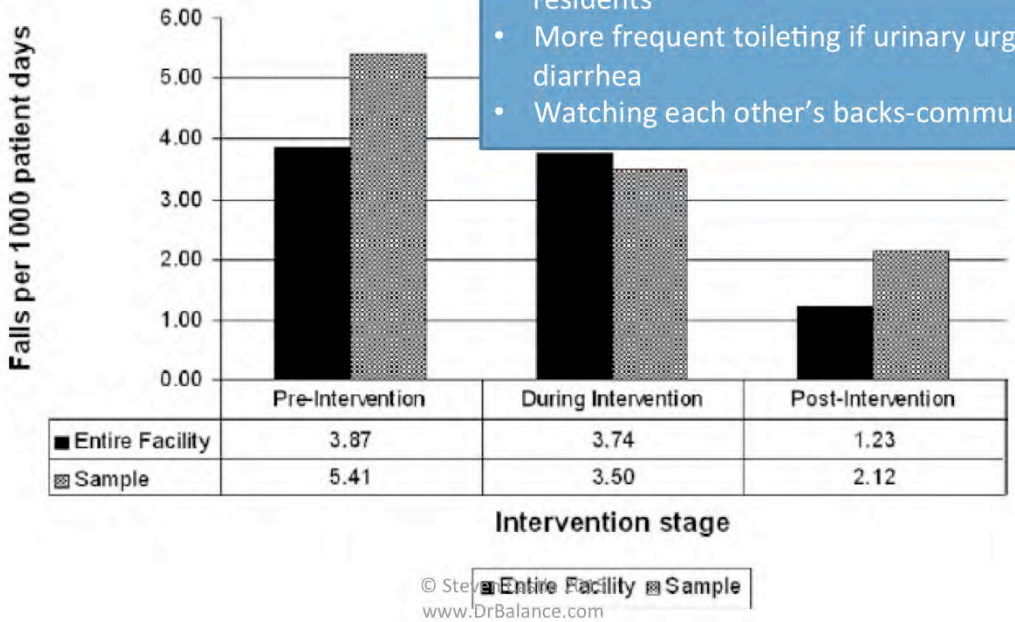
- Decreases proprioception of feet/ankle position
  - 162% decline in position sense of barefoot in older vs. younger adults, improved with shoes with high heel counter *Menant JC JRRD 2008*
  - Active movements in ankle were better discriminated when older adults wore shoes versus barefoot *Waddington GS JAGS 2004*
- Alters dynamics of weight transfer during stride
  - Reduced heel strike shock absorption and less transfer to the balls of feet
  - Less 'defensive' a position for corrective steps/change in direction *Menant JC JRRD 2008*
  - Significant improvement in 100 women in ADHC in Berg Balance Scale in shoes vs barefoot *Horgan HF Age Ageing 2009*
- Barefoot provides better traction on incline testing than non-skid socks *Chari S BMC Geriatrics 2009*

Notes:

Gradual **removal** of bed alarms is associated with reduced falls (Dementia Care Unit)

Bressler K Am J AD&OD 2011

- More Frequent Rounds
- Charting in direct sight of highest risk residents
- More frequent toileting if urinary urgency/ diarrhea
- Watching each other's backs-communication



Notes:

Don’ts and a Do

The ‘How to’ Guide for Reducing Harm from Falls

- Don’t focus on assessment tools or box ticking at the expense of real interventions which alter patient care
- Don’t judge or panic if there is an increase in falls on one unit for a month or two, or fail to drop over the first year
- Don’t Benchmark (case mix differences)
- **Do** post process measures/staff compliance

http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/FALLSHow-to%20Guide%20v4.pdf

Notes:

Quality Control
Kathryn M. Pelczarski, ECRI Institute

- Continuous improvement (QAPI)
- Identify & Address challenges to achieve desired behavior
  - *Staff input, Observe staff & provide feedback*
- Improve Compliance
  - Training — *Do you know what should be done?*
  - Competency — *Are you capable of doing it?*
  - Process Measures — *Did you do it?*
  - Counseling based on data: *Crucial Conversations*

"You can not improve what you can not measure"

- Learn from falls/near falls (natural reaction: 'Phew')

Notes:

Resource Nurse Champion

- Champions must excel in three areas;
  - to educate,
  - to advocate and
  - to sustain.
  - The problem is that in most organizations, these skills are not prevalent nor recognized

personal communication,

June Levine Univ Buffalo Practice Facilitator Instructor

Notes:

Resource Nurse Champion Characteristics

AHRQ pressure ulcer Tool kit 4.1.4: Unit Champion

- Knowledge
  - Program Goals
  - Intervention options/Content
  - Quality Tools
- Skills
  - Cheerleader-program advocate, encourages staff,
    - Explain change and sell it
  - Performance monitoring **and feedback**
    - Leads to personal and group improvement
  - Liaison- leadership expectations with challenges of frontline staff
  - Educator- differing scope of staff, and adult learning methods
  - Support sustainability- help others learn and develop new champions
- Attributes
  - Leadership role with adequate support
  - Respected as a resource
  - Approachable

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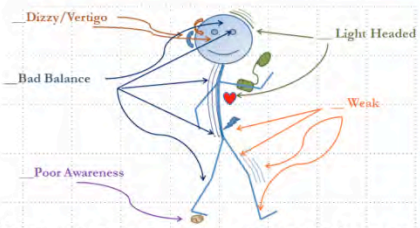
Notes:

Foundation for a New Model

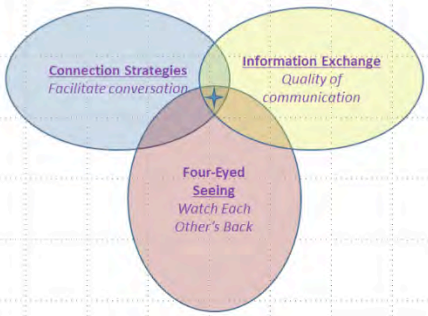
- MBA- Understand Actionable Causes & Contributors



19% reduced falls if CONNECT + FALLS vs. FALLS only
Ruth Anderson, Cathleen Colon-Emeric, Duke/ Durham VA, JAGS 2013

- CONNECT with communication

Ruth Anderson- Duke
  - Informal
  - Purposeful



Notes:

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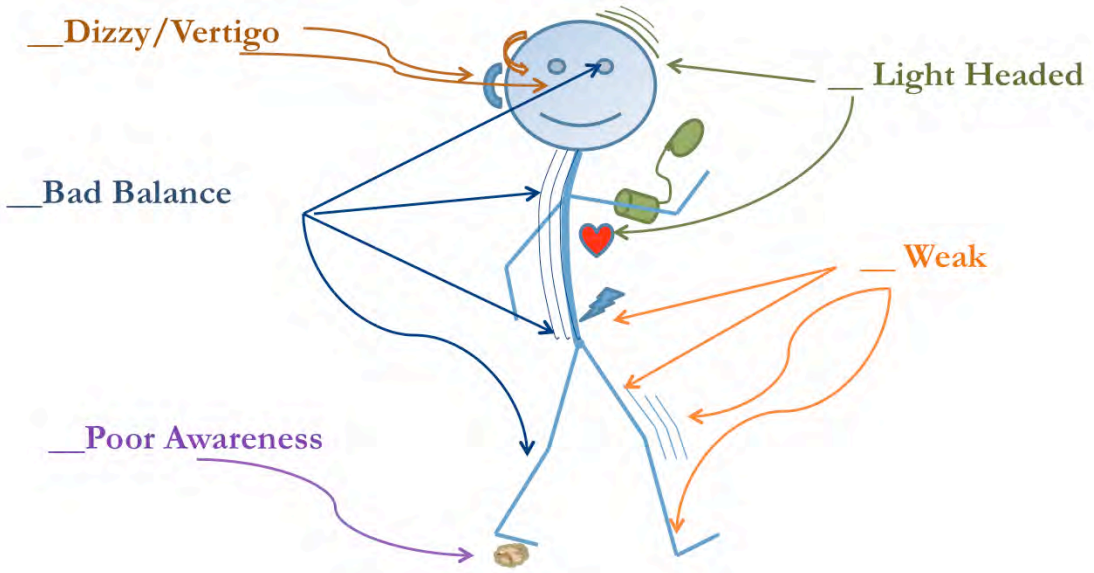
Understanding the 'Causes' of changes in *Mobility & Balance* as we age



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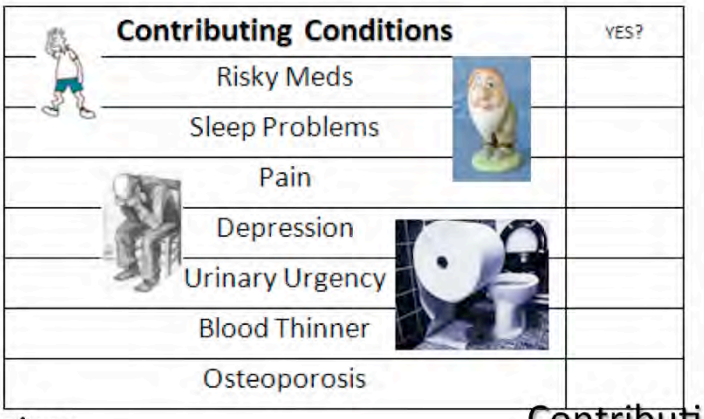


- P **P**sychotropics:
  - Sedatives/antidepressants/antipsychotics
- H^3 **H**TN, **H**eart, **H**ypoglycemic
- D **D**iuretic
- O **O**pioid (watch for delirium)
- C^3 α-**C**holinergic/**C**onvulsant/**C**oagulant

Contributing Factors

- Low Hanging Fruit
  - Feet/Footwear
  - Mobility Aids
  - Vision/Lighting
- Risky Activity
- Distraction/Rushing
- Not asking for help
- Environment

Notes:

INDIVIDUALIZED INTERVENTIONS

IDT Decision – Champion Expertise

1. **Communication**
2. **Mobilization**
3. Delirium/Dementia Behavior
4. **Bladder Program**
5. Medication Review
6. Protection/Monitoring

Notes:

1. Communication Interventions

see handout for more details

Training Guide, Competency Check, Process Audit, Post Fall Review

- Teach-Back
- Huddle
- Handoff/Shift 'Priority Report'
- Family
  - No or minor injury:
    - Teach causes & plan, how they can help
  - Significant Injury (*training in partial apology*)
    - Collect information
    - Determine who gives initial information
    - Meet with family after more information collected
- Collecting data facilitates counseling staff
  - Crucial Conversations method

Notes:

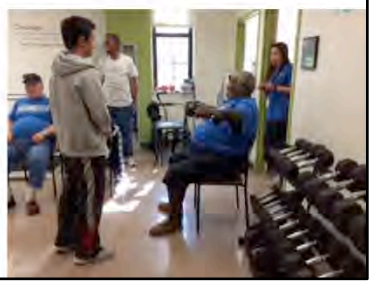
2. Mobilization: Physical Activity
Why don't we do more of this?

- Benefit Demonstrated: Reduces frailty, depression, pain, falls
  - Cameron 2010, de Carvalho 2004, Dechamps 2010, Ouslander 2005, Simmons 2002, Williams 2008
- Low physical activity in LTCF described
  - Bates-Jensen 2004, Egerton 2009, Ruuskanen 1994
- What are the BARRIERS? *Benjamin 2014*
- Strategies to address
  - Track activities
  - Restorative Care Initiative: **Barbara Resnick**

Notes:

Rethink Physical Activity Delivery

- Measure it!
  - Low cost activity monitors, Exercise Cards
- Restorative Care Initiative with *Nurse Assistants*
  - **Focus on getting residents/patients UP**
  - Student Volunteers- Pre med, Pre PT, Nutrition, Gerontology
- **Group** activities- individualized, enables INTERACTION
  - Warm-Up and flexibility
  - Strength training- therabands, dumbbells, chair stands
  - Cardio- walking, upper extremity ergometers
  - Balance and mobility- FallPROOF
    - more than chair exercises are needed
- Facility Identity/Expectations
  - Remove Barriers



Notes:

3. Delirium / Dementia
Sharon Inouye MD, HELP Program

- "My father wound up getting delirious even when I was there at his bedside,"
- "I'm an expert in delirium, and I couldn't prevent it from happening.“
- "It was really hard for me to keep track of everything.
  - You know, I knew there were certain medications he couldn't tolerate, and I told one group of physicians,
  - and then another group of physicians would prescribe it.
  - And so it really just was quite eye-opening for me."

http://www.wbur.org/npr/111623212

Recent Delirium Review
Inouye SK Lancet 2014
NICE to HELP
Yue J JAGS 2014

Notes:

The Confusion Assessment Method (CAM)

Consider delirium Dx if 1 & 2, and 3a or 3b (+)

"A Flu In Dis Attic"

1. Acute Onset and Fluctuating Course

- Acute change in mental status from baseline?
- (abnormal) behavior comes & goes, worse

2. Inattention

- Distractible, can't keep track of conversation?

3a. Disorganized Thinking

- Rambling /irrelevant/unclear/illogical; shift subject

3b. Altered Level of Consciousness – *Not alert*

- Hyper-alert, lethargic , stupor, or coma

Sensitivity: 94%-100%; Specificity: 90%-95%

Ref: Inouye, SK et al Annals Int Med 1990;113:941-48

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Notes:

Dementia Management Guidelines

- UK Alzheimer's Society Best Practice (2011 , update?)
  - http://www.alzheimers.org.uk/bpsdguide
- NICE clinical guide 42: Dementia behavior mgt
  - http://www.nice.org.uk/Guidance/CG42
- AHRQ/National Guideline Clearinghouse
  - http://www.guideline.gov/content.aspx?id=45525
- AMDA
  - http://www.amda.com/tools/guidelines.cfm
- Alzheimer's Society
  - http://alzheimers.org.uk/bpsdguide
- STAR-VA
  - *Teri L Gerontologist 2005* Communication: LRCR

LRCR Communication Mnemonic
Listen, **R**espect, **C**omfort, **R**e-direct

Notes:

Bladder Program

- 40-50% of acute care falls *Tzeng H-M 2012*
  - **OBSERVE Toileting**: New, Recent fall, Very High Risk
  - Toileting "Regimen" if Confused + Mobility problems
    - BIG drop in falls, but POOR Compliance (43%)

    Bakarich A 1997 (acute care setting)
- Detrusor Underactivity (Like constipation)
  - *Taylor JA JAGS 54:1920-32,2006*
  - Increased PVR, No differentiation with obstruction
- Use of Bladder Ultrasound for PVR
  - *Goode PS 2000*
- **Communicate risky toileting observations**

Notes:

Bladder Scanning Meta-Analysis
Effective Intervention in Surgical Wards

Palese A J Clin Nurs 2010

- 61 articles retrieved, 3 met criteria
  - Reduction of CAUTI:
    - OR = 0.27 (0.16-0.47), p<0.000003
    - Bladder scanner in peri-operative period
      - increases the appropriateness of bladder catheterization
      - Reduces incidence of UTI, hospital stay, discomfort
- Geri Rehab: PVR by US within 72h of admission
  - 21.5% had PVR >150ml
  - Hi PVR associated with
    - Male, Lower FIM score, Neurologic disease, Cognitive impairment, Immobile, anti-cholinergic med
    - H/O prostate/bladder/voiding problem/incontinence

  Wu J Arch PM&R 2005

Notes:

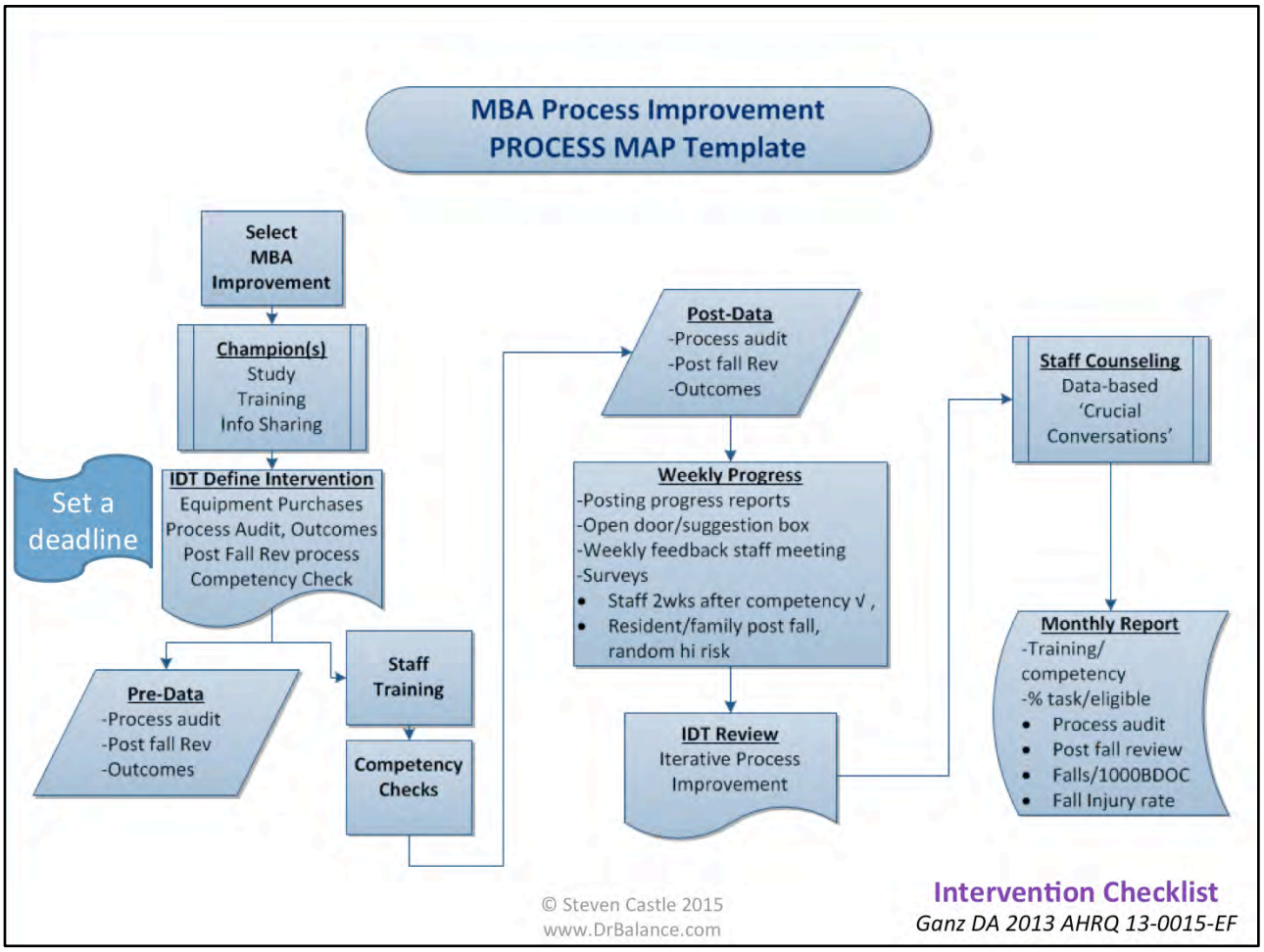
Use of Bladder Ultrasound in Reducing UTI's

Cutright J, JWOCN 2011

- Med-Surg Unit Process Improvement:
  - 4 consecutive weeks- 'Unable to Void' Process Map
    - Voids on own: Post Void Scan within 15min, Call MD if >150
    - No Void in 4 hrs
      - <100 ml; fluids, call MD as indicated
      - 100-300, encourage fluid and rescan in 2hr. , PVR >300 CIC, and follow q4h
      - >300 ml, US in 4hr, persistent >300 -> CIC, 100-300 -> fluids and repeat
  - 79 scans on 47 patients: 4% I&O Cath, 10% Foley Cath
  - **80% reduction in catheter use**

  Another PIP example: *Boyer DR J Nurs Care Qual 2009*

Notes:


MBA Process Improvement
PROCESS MAP Template
Select MBA Improvement
Champion(s)
Study
Training
Info Sharing
Set a deadline
IDT Define Intervention
Equipment Purchases
Process Audit, Outcomes
Post Fall Rev process
Competency Check
Pre-Data
-Process audit
-Post fall Rev
-Outcomes
Staff Training
Competency Checks
Post-Data
-Process audit
-Post fall Rev
-Outcomes
Weekly Progress
-Posting progress reports
-Open door/suggestion box
-Weekly feedback staff meeting
-Surveys
Staff 2wks after competency √ ,
Resident/family post fall, random hi risk
IDT Review
Iterative Process Improvement
Staff Counseling
Data-based 'Crucial Conversations'
Monthly Report
-Training/ competency
-% task/eligible
Process audit
Post fall review
Falls/1000BDOC
Fall Injury rate
© Steven Castle 2015
www.DrBalance.com
Intervention Checklist
Ganz DA 2013 AHRQ 13-0015-EF

Notes:

ROI

- Investment: Redirection of staff time/Training
  - NICHE ($4950 training of 3 leaders + Annual Fee $4700) or
  - HELP ($150,000/yr- 1.7 FTEE outside support)
  - Do it on your own- conferences, literature search (time + $1-2000)
    - INTERACT
  - '*Free Lance*' Process Improvement Proj consultant (targeted $1-5000*)*MHA
- Equipment
  - Restorative Care Initiative
    - Dumbbells ($300-1500), NuStep ($6900), Leg Press ($5100)
  - Delirium/Dementia (HELP)
    - Low Beds ($2-4000/bed, need 1:3 in acute care) , Communication devices ($180+ each)
  - Bladder Program
    - Bladder Scanner ($10-12k)
- Reduced Costs www.ahrq.gov/.../pfp/**interim**hac**rate2013**.pdf
  - Fall
    - CDC estimate community fall $14-20,500
    - In hospital additional cost $7234
    - Cost of empty bed/turnover ?
  - CAUTI
    - UTI additional cost $1000
  - Prog of Chronic Illness/Dementia $1000/case (per HELP website)

www.ahrq.gov/professionals/systems/hospital/qitoolkit/f1-returnoninvestment.pdf

Notes:

Take Home

- Be able to Measure your PROCESS: **Resource Champion**
  - Training, Competency, % Residents Rx/# Appropriate
  - Audit of process in eligible residents, Post Fall Review
- CONNECT- improve communication
  - Why is your balance not like when you were 30?
  - Teach-Back, Huddle, Handoff/Shift Change
- Mobilization- Restorative Care Initiative
- Bladder Program
  - Assessment/Use of Bladder Ultrasound/Staffing Plan
- Dementia/Delirium-
  - VA STAR: LRCR -**L**isten, **R**espect, **C**omfort, **R**e-direct
  - HELP/NICHE

Notes:

Simple Things that Impact Care

- Shoes when out of bed
- Wheelchairs for transportation only
- Training staff in transfers/use of mobility aids
- Monitor
  - Activity per week: Exercise card, activity monitor
  - Quick recognition of change in physical activity
- Bladder Program if high risk/New

Notes:

Care of the Unbefriended Resident

Robert M. Gibson, Ph.D., J.D.
Psychologist/Attorney
Edgemoor DPSNF, Santee CA

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Notes:

This presentation is *not* an official position of the county of San Diego, nor should it be viewed as providing legal advice

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Notes:

Disclosure Statement

I have no relevant financial relationships with commercial interests to disclose.

Notes:

Learning Objectives

- Identify options for surrogate decision makers in California and benefits and drawbacks of each option.
- Identify the major components of health and safety code 1418.8 and how these may be applied to unbefriended patients in your facility.
- Assess decision-making capacity with the UCARE model

Notes:

The "Unbefriended"

- There is no person with legal authority to make medical decisions on behalf of the resident

AND

- Lacks decision-making capacity.
  - A resident lacks capacity when the resident is unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention.

CA Health and Safety Code Section 1418.8

Notes:

Common Areas of Decision-Making Capacity in LTC

- Consent for Admission (not standard of informed consent)
- Medical (Informed) Consent/Refusal
  - Code status?
  - Psychotropics?
  - Hospice?
- Financial
  - Do they need a payee?
- Sexual Consent
- Exercise of rights, e.g., leaving grounds

Notes:

What Are The Decision-making Options For The Unbefriended Resident?

- Conservatorship
  - LPS Mental Health Conservatorship
  - Probate Conservatorship
- Probate Code Sec. 3200 order for single medical procedure
- Interdisciplinary Team (IDT) via HSC 1418.8

Notes:

LPS Conservatorship

- Lanterman-Petris-Short Act (LPS) – Mental health conservatorship. Grave disability requires:
  - Inability to provide for
    - Food
    - Shelter
    - Clothing
  - Due to presence of a mental illness

    AND
  - No other person will provide the needed support

    (*Conservatorship of Davis*, 1981, 124 Cal. App. 3d 317)

Note: WE provide the needed support in most cases.

Notes:

Probate Conservatorship

- Of the person – decision related to care
- Of the estate – decisions related to finances
- Of the person and the estate – both
- With dementia powers
  - Can consent to use of psychotropics for dementia treatment
  - Can consent to secure perimeter facility

Notes:

Conservatorship Issues

- LPS – unless trying to elope or otherwise jeopardize access to basic needs (food, shelter, clothing), criteria is not met when in LTC.
- Probate – costly and time-consuming to file.
  - Who will serve as conservator for unbefriended?
    - Facility might pay a private fiduciary as some hospitals do
  - Most County Public Guardian's will not pursue these unless there is a significant estate.
- In some cases, a resident may have or need both LPS and Probate. Unlikely, but possible with unbefriended (e.g., unbefriended but has an estate).

Notes:

Probate Code 3200

- 3203 – A petition may be filed by… A person acting on behalf of the health care institution in which the patient is located if the patient is in a health care institution.
- 3208 – authorizing the recommended health care for the patient and designating a person to give consent to the recommended health care…
- Focus is on one recommended health care intervention. Multiple petitions needed for multiple interventions.

Notes:

Probate Code Section 3200-3212

Must demonstrate in a petition to the court*:

(1) The existing or continuing condition of the patient's health requires the recommended health care.

(2) If untreated, there is a probability that the condition will become ***life-endangering or result in a serious threat to the physical or mental health of the patient.***

(3) The patient is unable to consent to the recommended healthcare.

How many facilities have attorneys to file these? Or the time or the money?

*Probate code section 3208

Notes:

Health and Safety Code 1418.8

- Allows IDT to provide informed consent for unbefriended and incapacitated residents
- Currently under court review in *CANHR v. CHAPMAN* after petition by CANHR to have HSC 1418.8 deemed unconstitutional
- Outcome????
- Possible effect would be to eliminate IDT decision-making in LTC – Ethics committees??

Notes:

Health and Safety Code 1418.8

- Requires:
  - Resident is incapacitated as determined by MD*

    AND

  - There is no one available to serve as a surrogate decision-maker
    - May not have any known family or associates
    - Family or others may be unwilling or unable to serve

* Probate Code Section 4658 – "Unless otherwise specified in a written advance health care directive, for the purposes of this division, *a determination that the patient lacks or has recovered capacity, or that another condition exists that affects an individual health care instruction or the authority of an agent or surrogate, shall be made by the primary physician.*"

Notes:

Health and Safety Code 1418.8 Documentation

- Physician assessment of resident condition.
- Reason for medical intervention.
- Discussion of patient desires through interview, medical records, consultation with family members or friends.
- The type of medical intervention to be used in the resident's care, including its probable frequency and duration.
- Probable impact on the resident with/without medical intervention.
- Reasonable alternatives considered and reasons for their discontinuance or inappropriateness.

Notes:

Common Areas of Decision-Making Capacity in LTC – HSC 1418.8?

- Consent for Admission (not standard of informed consent)
- Medical (Informed) Consent/Refusal
  - Code status?
  - Psychotropics?
  - Hospice?
- Financial
  - Do they need a payee?
- Sexual Consent
- Exercise of rights, e.g., leaving grounds

Notes:

Assessment of Decision-Making Capacity (UCARE)

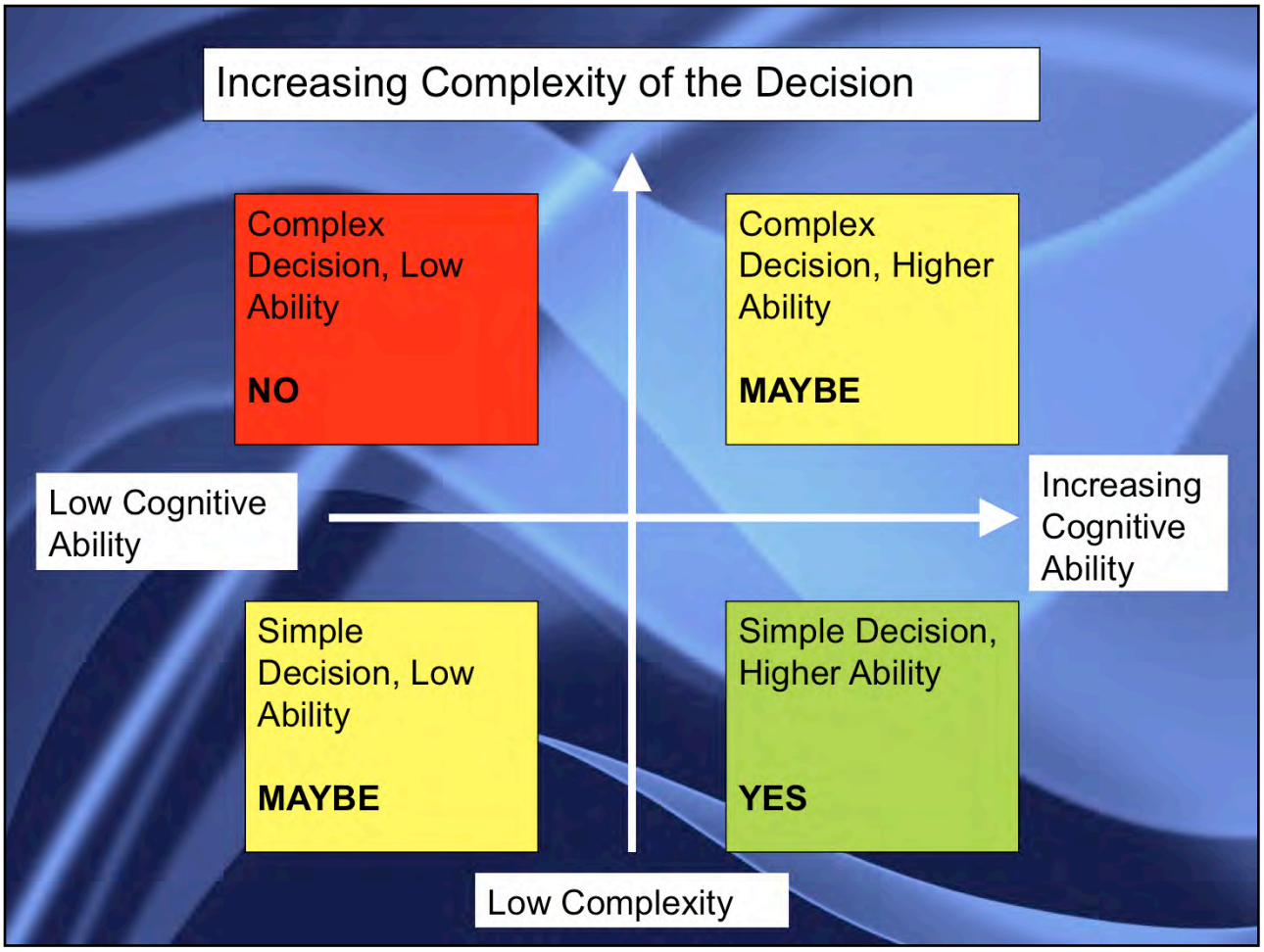
- **U**nderstanding of the relevant information
- **C**onsistency - responses are consistent over time, when questions are asked a different way and by different people
- **A**ppreciation of the significance of information as it applies to the person's situation
- The ability to **R**eason with relevant information logically weighing options
- Ability to **E**xpress a choice

Notes:

Decision-Making Capacity

- Rarely a fixed determination (exception comatose).
- Must be re-evaluated for each decision and at various points in time.
- Consider the complexity and seriousness of a decision.

Notes:


Increasing Complexity of the Decision
Complex Decision, Low Ability
NO
Complex Decision, Higher Ability
MAYBE
Low Cognitive Ability
Increasing Cognitive Ability
Simple Decision, Low Ability
MAYBE
Simple Decision, Higher Ability
YES
Low Complexity

Notes:

Goal: Preserve Autonomy

- Does the resident have capacity to make any decisions?
  - Perhaps serious but less complex? E.g., "I have a really bad infection and you need to cut off my leg or I'll die."
  - Maybe complex and serious? E.g., metastatic cancer with options of chemotherapy, radiation, or both, but with significant side-effects and generally a poor prognosis…
- Might be able to make the first, but not the second.

Notes:

Conclusion

- Care of the unbefriended requires:
  - Meeting the definition of "unbefriended"
  - Assessing decision-making capacity
  - Applying decision-making options to best reflect the resident's wishes and maintain autonomy to the degree possible
- Document decision-making process via interaction with appointed/identified decision-makers or per HSC 1418.8.

Notes:

Mock Trial

Karl Steinberg, MD, CMD
William C. Wilson
Randall R. Walton

Notes:

Disclosures

- Mr. Walton and Willson and no relevant financial relationships to disclose.
- Dr. Steinberg is a speaker on non-branded transition talks for Boehringer Ingelheim.
- All potential conflicts of interest have been resolved.

Notes:

Learning Objectives

- Identify four preventive steps a facility can take to reduce its risk of being threatened or served with a lawsuit
- Describe the top 5 reasons facilities are sued.
- Name steps a facility should take immediately after an adverse incident to reduce the risk of lawsuit

Notes:

Notes: