CALTCM 44th ANNUAL MEETING

Stronger & Smarter

Innovation and Collaboration in Post-Acute and Long-Term Care

Promoting quality patient care through medical leadership and education

May 18 & 19, 2018

44th Annual Meeting & Pre-Conferences:

May 17-19, 2018

Omni Los Angeles Hotel at California Plaza
Los Angeles, California

CALTCM 44th Annual Meeting
Stronger & Smarter:
Innovation and Collaboration in Post-Acute and Long-Term Care
Friday, May 18, 2018 & Saturday, May 19, 2018

Program Overview
CALTCM is dedicated to improving the lives of the providers and patients of the California Post-Acute and Long-Term Care (PA/LTC) community. This year's Annual Meeting continues this commitment. Learn how to strengthen your community through teamwork and collaboration as well as working smarter through clinical and administrative updates.

Friday is a full day of team-focused, active-learning sessions, intended for your whole IDT. Friday morning we will hear from people like you all over California who were identified as having best practices--great ideas you can implement in your practice. Friday afternoon is an active adult learning session all about making our work environments safer and more enjoyable through collaboration and culture change.

Saturday is clinical and management focused - featuring hot topics, deep-dives into managing complex patients, problem-solving Q&A sessions and panel discussions with the experts, as well as updates on the regulatory landscape. The California Long-Term Care community is stronger and smarter when we work together.

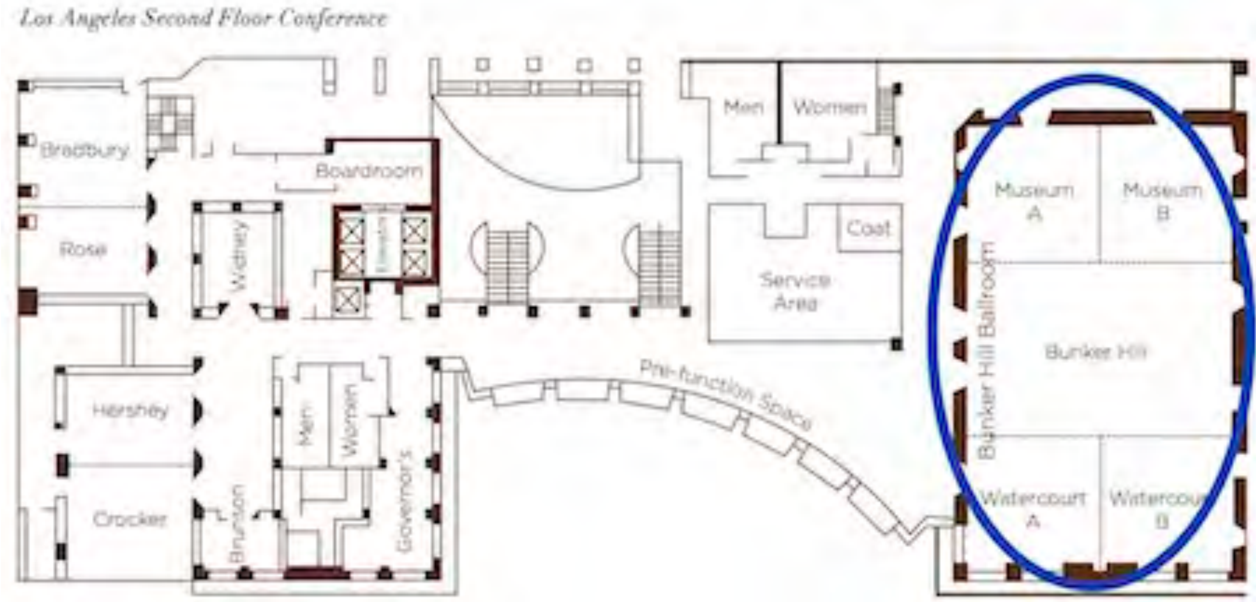
Program Learning Objectives
At the completion of this event participants will be able to:

1. Characterize elder abuse and recognize practices to appropriately manage current and future risks;
2. Define methods to improve the collaborative culture of your facility for achieving success for future improvement projects;
3. Apply updates in caring for medically complex patients in the context of new CMS regulations;
4. Define practices to improve patient centered care using anticipatory care models for palliative and hospice care.

Conference Location & Information

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

Omni Hotel – Second Floor



Continuing Education Information

Participants are required to sign in at the registration desk. The post event evaluations will be emailed to participants, evaluations MUST be completed to receive continuing education credit. The submission deadline is July 31, 2018. If you prefer a hardcopy of the evaluation and credit request, please visit the registration desk to request a copy or call (888) 332-3299.

Product Theaters & Exhibits

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

Program Accreditation Statement

Continuing Medical Education (CME)

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

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

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

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

This live activity has been pre-approved by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) for a total of **10.75 management hours and 2.25 clinical hours** toward certification or recertification as a Certified Medical Director (CMD) in post-acute and long-term care medicine. The CMD program is administered by the ABPLM. Each physician should claim only those hours of credit spent on the activity.

Board of Registered Nursing (BRN)

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

Nursing Home Administrators Program (NHAP)

This activity has been approved by the Nursing Home Administrator Program for up to **12.0 hours** of NHAP credit. Course approval number: 1797012-6310

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

Education Committee

Education Committee Chair

Heather D'Adamo, MD

Education Committee

Debra Bakerjian, PhD, APRN, FAAN, FAANP

Daniel Chambers

Diane Chau, MD

Heather D'Adamo, MD

Rebecca Ferrini, MD, MPH, CMD

Timothy Gieseke, MD, CMD

Janice Hoffman, Pharm.D, CGP, FASCP

Barbara Hulz

Jim Jensen, MHA, MA

Albert Lam, MD

Vanessa Mandal, MD

James Michail, MD

KJ Page, RN-BC, LNHA

Gabriela Sauder, MD

Rajneet Sekhon, MD

Karl Steinberg, MD, CMD, HMDC

Michael Wasserman, MD, CMD

Program Faculty

Elizabeth Akhparyan, PharmD

Debra Bakerjian Ph.D., FNP, FAAN, FAANP, FGSA (Updated 9/2017)

Alex Bardakh, MPP, PLC

Randall Espinoza, MD, MPH

Rebecca Ferrini, MD MPH CMD

Janice Hoffman, PHARM.D. CGP, FASCP

Cindy Keenan

Vanessa Mandal, MD, MS, CMD

Lawrence Stuart Miller, MD, FACP

Jocelyn Montgomery, RN

Leah C. Morris, RN, FNP, MPH, MS

KJ Page, RN-BC, LNHA

Paul L. Schneider, MD

Lisa Seo, MD

Karl Steinberg, MD, CMD, HMDC

Michael Su, MD

Michael Wasserman, MD, CMD

Michelle R. Zeidler, MD

Faculty & Planner Disclosures

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

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

Faculty and Planners	Role	Affiliation / Financial Interest	Name of Organization
Elizabeth Akhparyan, PharmD	Faculty	None	
Deb Bakerjian, PhD, APRN, FAAN, FAANP	Faculty / Planner	Clinical Consultant, Consulting Fee Researcher, Grant Recipient Researcher, Grant Recipient	Wolters-Kluwer HRSA CDPH-CAHF
Alex Bardakh, MPP, PLC	Faculty	None	
Daniel Chambers	Staff	None	
Diane Chau, MD	Planner	None	
Heather D'Adamo, MD	Planner	None	
Randall Espinoza, MD, MPH	Faculty	Chapter Editor, Chair, Honoraria	Up to Date, Inc.
Rebecca Ferrini, MD, MPH, CMD	Faculty/Planner	None	
Timothy Gieseke, MD, CMD	Planner	None	
Janice Hoffman, PharmD	Faculty/Planner	None	

Barbara Hulz	Planner	None	
Jim Jensen, MHA, MA	Planner	None	
Mary Kasem, MD	Planner	None	
Cindy Keenan	Faculty	None	
Albert Lam, MD	Planner	None	
Christopher E. Laxton, CAE	Faculty	None	
Vanessa Mandal, MD	Faculty/Planner	None	
James Michail, MD	Planner	None	
Lawrence Miller, MD, FACP	Faculty	None	
Jocelyn Montgomery, RN	Faculty	None	
Leah Morris, RN, FNP, MPH, MS	Faculty	None	
KJ Page, RN-BC, LNHA	Faculty/Planner	None	
Gabriela Sauder, MD	Planner	None	
Rajneet Sekhon, MD	Planner	None	
Paul L. Schneider, MD	Faculty	None	
Lisa Seo, MD	Faculty	None	
Karl Steinberg, MD, CMD, HMDC	Faculty/Planner	Non-branded Speakers Bureau, Honoraria	Boehringer Ingelheim
Michael Su, MD	Faculty	None	
Mike Wasserman, MD, CMD	Faculty/Planner	Editorial Board, Honoraria	Merck Manual
Michelle R. Zeidler, MD	Faculty	None	

Faculty Biographies

Elizabeth Akhparyan, PharmD
Dr. Akhparyan received her Bachelor's Degree in Biology from the University of California, Los Angeles in 2008 and her Doctorate in Pharmacy from Western University of Health Sciences in 2017. She is currently a PGY1 geriatrics resident at WesternU and is looking forward to expanding her training to provide clinical support and medication communications for the aging population at assisted living facilities in underserved areas, as well as create awareness through interdisciplinary guest lecture series. Her long-term career goal is to integrate and optimize her clinical training in order to become a well-rounded leader in pharmacy, advocating for patient-centered care.

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

Bakerjian is active in both state and national organizations associated with the care of older adults. She is the Immediate Past-President of the California Association of Long Term Care Medicine and has been a member of CALTCM and AMDA since 2001, where she serves on the governance, transitions of care, and innovations committees. She was one of the first nurses to serve on the steering committee for Advancing Excellence in American Nursing Homes' and is currently on the National Quality Forum's Common Formats standing committee. She is a member of the Health Sciences Executive Committee of the Gerontological Society of America. She is a past president of the Gerontological Advanced Practice Nurses Association and past chair of the GAPNA Foundation.

Dr. Bakerjian is a Fellow of both the American Association of Nurse Practitioners, the American Academy of Nursing and the Gerontological Society of America.

Alex Bardakh, MPP, PLC
Alex Bardakh, MPP, PLC, is the Director of Public Policy & Advocacy for AMDA – The Society for Post-Acute and Long-Term Care Medicine. Alex is a tireless worker for the Society's extensive Public Policy agenda through Advocacy in Congress and numerous Federal Agencies. A graduate from the University of Maryland in Political Science/Psychology and Public and Legal Policy, Alex has extensive experience in health policy with a specific focus on areas such as payment models and quality of care initiatives. He has had great success with assembling workgroups that have developed numerous white papers on care transitions and other related issues.

Randall Espinoza, MD, MPH
Randall Espinoza, MD, MPH holds the Muriel Harris Chair in Geriatric Psychiatry at UCLA and is a Clinical Professor in the Division of Geriatric Psychiatry, Department of Psychiatry and Biobehavioral Sciences at the Geffen School of Medicine at UCLA. He has an active clinical practice and leads NIH funded research projects. From 2007 to 2009 he served as Chief of Staff of the Stuart and Lynda Resnick Neuropsychiatric Hospital at UCLA. In 2009 he was selected as Director of the UCLA Geriatric Psychiatry Fellowship Training Program. Since 2000 he has been Medical Director of the Electroconvulsive Therapy Program at the UCLA Neuropsychiatric Institute and Hospital, and he also serves on the Medical IRB of the UCLA School of Medicine. He received his BS degree in bioengineering from Columbia University in New York, MD from the University of Texas Southwestern Medical School in Dallas, and Executive MPH from the University of California, Los Angeles School of Public Health. He is a Master Educator with certification from the Association for Academic Psychiatry and completed the UCLA Medical Faculty Fellowship program. He is actively involved in the American Association for Geriatric Psychiatry, Association for Academic Psychiatry and American Psychiatric Association. He is a Co-Director for the Annual UCLA Geriatric Medicine Intensive Course and Board Review. He is on the Editorial Board of Academic Psychiatry and a reviewer for several journals in geriatric psychiatry, geriatric medicine, and neurology, and regularly contributes to UCLA Healthy Years, a quarterly newsletter of the Division of Geriatric Medicine at UCLA.

Rebecca Ferrini, MD MPH CMD
Dr. Rebecca Ferrini MD MPH CMD is a full-time medical director for the County of San Diego 192 bed distinct part skilled nursing facility serving a younger, safety net population. Her facility is 5 stars (CMS 20/20), has been named a top nursing home for six years by US News and World Report and received the American Health Care Association / National Center for Assisted Living (AHCA/NCAL) 2017 Gold -- Excellence in Quality Award.
She received the 2009 AMDA Medical Director of the Year Award, and speaks and publishes in the areas of decision-making capacity, behavioral management, Huntington disease and younger adults. She has a specialty in hospice and palliative magazine and general preventive medicine. She has five children and one grandchild and plays competitive soccer.

Janice Hoffman, PHARM.D. CGP, FASCP
Janice Hoffman is currently an Associate Professor of Pharmacy Practice and Administration at Western University of Health Sciences in Pomona California. She is a Certified Geriatric Pharmacist and a Fellow of the American Society of Consultant Pharmacists. She received her Pharm.D. from the University of Southern California and completed a Residency in Clinical/Administrative Psychiatric Pharmacy Practice with an emphasis in geriatrics from the University of Maryland at Baltimore. Through her various practice positions, she has been innovative in creating communication channels with physicians, getting Geriatrics into California Senate Bill 493 for Advanced Practice Pharmacy, implementing Interprofessional teams to include a pharmacist in her facilities as well as designing, implementing and achieving an ASHP-accredited PGY-1 residency in a skilled nursing facility – the only one in the United States.

Professionally, she has received accolades from the Commission for Certification in Geriatric Pharmacy (CCGP), Excellence in Geriatric Practice Award winner and has served as National President for Phi Lambda Sigma Pharmacy Leadership Honor Society, Chair of California Pharmacist Association, Academy of Long-Term Care, Board of Directors for California Long-Term Care Medicine and Past President for the California Chapter of the American Society of Consultant Pharmacists. Beyond all the pharmacy related activities Dr. Janice Hoffman Simen is a candidate for an Ed.D. in Organizational Leadership in May 2018 with a goal of moving from full-time faculty to university central administration in a provost or chancellor category position.

Cindy Keenan
Cindy Keenan has been in the healthcare industry for 25 years, from caregiving to leadership management. She earned a Bachelor of Science from the California State University, Sacramento in 1994. She furthered her education by completing a second Bachelor's degree in Physiotherapy at Saxion Hogeschool Enschede in the Netherlands in 1998. Cindy has channeled her passion for quality patient care into co-founding a vibrant hospice in Sacramento, California.

Christopher Laxton, CAE
Christopher Laxton is the Executive Director of AMDA: The Society for Post-Acute and Long-Term Care Medicine. Mr. Laxton has 30 years of experience in non-profit association management as a senior or chief executive at health care-related organizations.

Vanessa Mandal, MD, MS, CMD
Graduate Hahnemann University School of Medicine, Philadelphia Pennsylvania. Elected Internal Medicine Residency and Geriatric Fellowship – Montefiore Medical Center, a Pioneer ACO in the Bronx. Focus on addressing the psychosocial determinants of health through house call visits. Her 17-year career as an Internist and Geriatrician spans academic practice in NY, ambulatory practice Texas, and full-time practice in a post-acute setting in California. Completed Masters in Healthcare Administration and Inter-professional Leadership UCSF in 2016 and continues in leadership roles in Greater Sacramento:

Lawrence Stuart Miller, MD, FACP
Lawrence Stuart Miller MD is a board-certified physiatrist in the field of Physical Medicine and Rehabilitation. He is a clinical professor of medicine at UCLA School of medicine. He has been practicing medicine in Los Angeles since 1975 and has served as medical director for several inpatient rehabilitation programs, skilled nursing programs, and outpatient programs at several prominent hospitals including UCLA. At UCLA, he had served in the Geriatric division (number 1 in the country) for 25 years. He also served in the cancer center, rheumatology division, neurosurgery division, and Rehab VA-UCLA residency program where he continues to teach residents and medical students. Dr. Miller has an extensive background in research with almost 40 years of scientific presentations and over 70 scientific papers and book chapters focusing on clinical studies to improve rehab care and measuring the quality of care and outcome studies. He has served on numerous committees including president of the Calif society of PM&R and the board of the Am Academy of PM&R. He has been a consultant to Medicare (fraud and abuse) and served on two technical expert panels for CMS. He also has served as a medical-legal expert witness in many areas for over 35 years.

Jocelyn Montgomery, RN
Jocelyn Montgomery is a Public Health Nurse and disaster preparedness consultant with over 40 years' experience as a provider of long-term care. She joined the California Department of Public Health, Licensing division as a nursing home surveyor in 1998, and held various positions at Licensing including that of state-wide Disaster Preparedness Coordinator. In her role as Disaster Preparedness Coordinator with the Department, she developed an emergency response plan for Licensing and Certification, and a disaster preparedness self-assessment tool for skilled nursing and intermediate care facilities. She joined the California Association of Health Facilities in April 2006, where she secured federal and state grants to create the CAHF Disaster Preparedness Program which is nationally recognized as an important resource for long-term care emergency preparedness. She retired from CAHF in 2017 and currently consults to PAC on emergency preparedness and quality improvement.

Leah C. Morris, RN, FNP, MPH, MS
Leah Morris, is a Family Nurse Practitioner and a health policy advisor. Leah holds a degree in nursing from Columbia University in the City of New York, a Master of Public Health from UC Berkeley, a Master of Science from UC Davis Betty Irene Moore School of Nursing and a Nurse Practitioner certificate from UC Davis School of Medicine. She spent her early career in the field of managed care, working with national clients to create provider networks. She is also proud to have spent 3 years consulting on the creation of Covered California, the Affordable Care Act Health Benefit Exchange serving nearly 1.4 million Californians. During that time she returned to patient care by becoming a nurse practitioner and with her health policy background, engaged in discussions regarding the new field of palliative care in the community.

While Leah recently semi-retired from the hospice and community based palliative care program she helped create, she looks forward to continuing to stay involved in serving the care needs for people facing, and living with , serious illness.

KJ Page, RN-BC, LNHA
KJ Page is a licensed nursing home administrator and a registered nurse board certified in gerontology. She meddles everywhere at Chaparral House where she has been excited to serve as Administrator since December 2002. KJ has made regulatory compliance skills which have led to Chaparral House becoming one of the few Skilled Nursing Facilities to be Joint Commission Accredited, Post-acute and Memory care certified, as well as star gazing with CMS through their 5-star rating system. Not known for easily accepting NO as an answer, Chaparral House focuses on innovative person-centered solutions to complex problems and communication concerns along the long-term healthcare spectrum.

Paul L. Schneider, MD
Dr. Schneider received his Undergraduate degree with honors in Microbiology at UCLA and his MD from USC. He did a medicine residency at the West Los Angeles VAMC '90-93 and stayed on for a chief resident year in '94. After a brief stint in private practice, Dr. Schneider returned to the VA where he became Assistant Chief of Medicine after 1 year and Associate Director of the Internal Medicine Residency 2 years later.

Dr. Schneider's area of interest is in clinical ethics consultation and education. He is currently President of the Southern California Bioethics Committee Consortium (SCBCC) and Co-Chairman of the Los Angeles County Medical Association/Los Angeles Bar Association Joint Bioethics Committee and directed efforts to coordinate POLST implementation in the West Los Angeles area through 6 regional hospitals. He regularly lectures to house staff, attending physicians and others in the fields of ethics consultation, informed consent and capacity.

Lisa Seo, MD
Dr. Lisa Seo attended Sacramento State University and graduated with Liberal Studies Major. She received Masters in Traditional Chinese Medicine at Academy of Chinese Culture and Health Science and worked as an Acupuncturist before earning her medical degree from Ross University Medical school. Dr. Lisa Seo completed Internal Medicine Residency at Flushing Hospital in New York and received a fellowship in Hospice and Palliative fellowship at MD Anderson University Texas.

Dr. Lisa Seo currently works as Palliative inpatient and outpatient physician supporting the community and providers in Sacramento with Mercy Dignity Medical Group. She started outpatient Palliative services in 2014.

Outside of work, she enjoys traveling to different countries and enjoying different world cuisines. She also enjoys hiking the great outdoors, recently hiked the half-dome, and the ultimate goal is to hopefully complete the 210 miles John Muir trail.

Karl Steinberg, MD, CMD, HMDC
Dr. Karl Steinberg has been a hospice and nursing home medical director in the San Diego area since 1995 and is currently a chief medical officer for Mariner Health Central and medical director at Life Care Center of Vista, Carlsbad by the Sea Care Center, and Hospice by the Sea. He got his bachelor's in biochemistry from Harvard and studied medicine at The Ohio State University College of Medicine, then did his family medicine residency at UCSD. Dr. Steinberg chairs AMDA's Public Policy Committee in addition to serving as editor-in-chief of their monthly periodical, Caring for the Ages. He is immediate past chair of the Coalition for Compassionate Care of California and is active in advance care planning and palliative care initiatives, including education and public policy on a statewide and national level, also serving on the Executive Committee of the National POLST Paradigm Task Force. Dr. Steinberg also serves as a consultant and testifying expert witness on behalf of plaintiffs and defendants. However, Dr. Steinberg is probably best known for taking his dogs on patient care rounds with him on most days.

Michael Su, MD
Michael is a native New Yorker, having completed college and medical school at New York University. He moved to Los Angeles and completed his residency in neurology and fellowship in neurorehabilitation at UCLA and a fellowship in neurocritical care at Cedars Sinai. He is currently an assistant clinical professor of neurology at UCLA.

Michael Wasserman, MD, CMD
Doctor Michael Wasserman is a geriatrician who has devoted himself to serving the needs of seniors for the past thirty years. He presently serves as the Chief Medical Officer for Rockport Healthcare Services. Previously, he served as Executive Director, Care Continuum, for Health Services Advisory Group, the QIN-QIO for California. In 2001, he co-founded Senior Care of Colorado, which became the largest privately owned primary care geriatric practice in the country, before selling it to IPC in 2010. Springer recently published his book, "The Business of Geriatrics," which details how to succeed in Geriatrics in today's healthcare marketplace. He previously was President and Chief Medical Officer for GeriMed of America, a Geriatric Medical Management Company located in Denver, Colorado. While at GeriMed, he helped to develop GeriMed's Clinical Glide-paths in conjunction with Drs. Flaherty and Morley of St. Louis University's School of Medicine Geriatric Division.

Dr. Wasserman is a graduate of the University of Texas, Medical Branch. He completed an Internal Medicine residency at Cedars-Sinai Medical Center and a Geriatric Medicine Fellowship at UCLA. He spent five years with Kaiser-Permanente in Southern California where he opened Kaiser's first outpatient Geriatric Consult Clinic. Dr. Wasserman was a co-founder and owner of Common Sense Medical Management (CSM2), a case management company that helped manage high-risk beneficiaries of Cover Colorado. He is past chair of the American Geriatrics Society's (AGS) Managed Care Task Force and presently serves on the Public Policy Committees for both AGS and AMDA. He was formerly a Public Commissioner for the Continuing Care Accreditation Commission.

Dr. Wasserman was a co-founder of MESA (Medical Experts and Senior Access) a multiyear grant from the Colorado Health Foundation to train primary care physicians in how to effectively care and bill for Medicare patients. He was the lead delegate from the State of Colorado to the 2005 White House Conference on Aging. He also co-chaired the Colorado Alzheimer's Coordinating Council. Dr. Wasserman has actively supported the Wish of a Lifetime Foundation since its inception and now serves as Treasurer on its Board. He served on the Board of the Denver Hospice for fifteen years. He serves as a board member for the American Geriatrics Society's Foundation for Health in Aging. He has spoken extensively and been published on a variety of topic involving geriatrics, quality improvement, geriatric workforce issues, healthy aging, Alzheimer's Disease, the business of healthcare, practice management and managed care.

Michelle R. Zeidler, MD
Michelle Zeidler, MD, MS is a Professor of Pulmonary, Critical Care and Sleep Medicine at the David Geffen School of Medicine, UCLA and the Greater Los Angeles VA Healthcare System. She currently directs the GLA VA Sleep Center as well as the UCLA Sleep Fellowship. Her research interests include the diagnosis and treatment of sleep-disordered breathing in individuals with comorbid conditions.

Program Agenda
Friday, May 18, 2018 - Afternoon Session

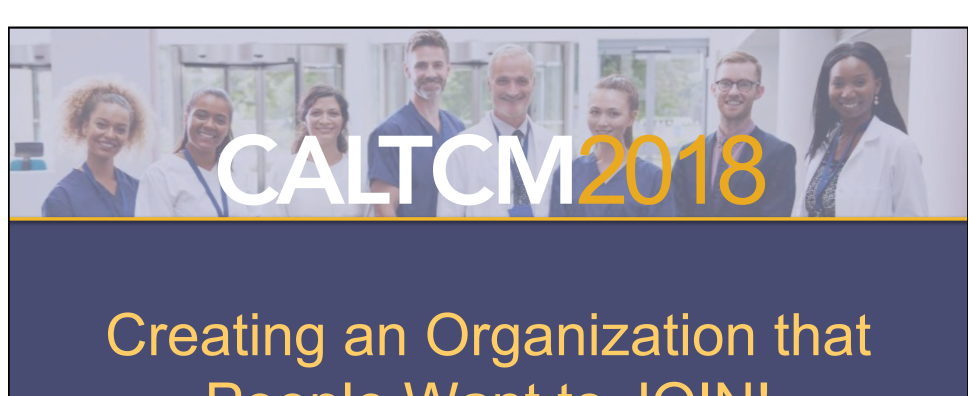
11:00 A.M.	**Registration/Exhibits Open**
11:45 A.M.	**Lunch Product Theater** *(No CME)*
1:00 P.M.	**Welcome & Introductions**
1:10 P.M.	**Opening Comments**
1:15 P.M.	**Creating an Organization that People Want to Join** ***Moderator****: Deb Bakerjian, PhD, APRN, FAAN, FAANP*
2:50 P.M.	**Break/Exhibits**
3:20 P.M.	**Promoting Relationships That Heal and Get Things Done** ***Moderators****: Rebecca Ferrini, MD, MPH, CMD and KJ Page, RN-BC, LNHA*
4:55 P.M.	**Q & A Panel**
5:30 P.M.	**Updates in Post-Acute & Long-Term Care**
6:00 P.M.	**CALTCM Poster Session & Reception**
6:00 P.M.	**Exhibits Close**
7:00 P.M.	**Dinner Product Theater** *(No CME)*

Saturday, May 19, 2018 - Morning Session

7:00 A.M.	**Exhibits Open**
7:00 A.M.	**Breakfast Product Theater** *(No CME)*
8:00 A.M.	**Welcome**
8:05 A.M.	**Diagnosis and Management of Dementia in PA/LTC Settings** *Randall Espinoza, MD, MPH*
8:35 A.M.	**Updates in Acute Stroke Management and What it Means for PA/LTC Patients** *Michael Su, MD*
9:05 A.M.	**Rehab Expectations for Common PA/LTC Situations** *Lawrence S. Miller, MD, FACP*
9:30 A.M.	**Q & A Session #1**
9:50 A.M.	**Break/Exhibits**
10:20 A.M.	**Antimicrobial Stewardship** *Janice Hoffman, PharmD & Elizabeth Akhparyan, PharmD*
10:50 A.M.	**Disaster Preparedness** *Jocelyn Montgomery, RN*
11:20 A.M.	**Update COPD** *Michelle R. Zeidler, MD*
11:50 A.M.	**Q & A Session #2**
12:10 P.M.	**Lunch Break/ Exhibits**

Saturday, May 19, 2018 - Afternoon Session

12:10 P.M.	**CALTCM Lunch: Leadership Award and Lecture** *(CME Event) CALTCM Awards (Best Practice & Poster Session Awards)*
1:25 P.M.	**Regulatory & Policy Landscape** *Christopher Laxton, CAE and Alex Bardakh, MPP, PLC*
2:25 P.M.	**Break/Exhibits**
2:55 P.M.	**Overview of Palliative Care** *Lisa Seo, MD*
3:15 P.M.	**Decisional Capacity / Advance Care Planning** *Paul Schneider, MD, FACP*
3:45 P.M.	**Perspective from a Palliative Nurse Practitioner** *Leah Morriss, RN, FNP, MPH, MS*
4:05 P.M.	**Perspective from the Hospice Team** *Cindy Keenan*
4:20 P.M.	**Panel Discussion: Parsing the POLST (Case Vignettes)** ***Moderator**: Vanessa Mandal, MD, MS, CMD;* ***Panel**: Lisa Seo, MD;* *Paul Schneider, MD, FACP; Leah Morris RN, FNP, MPH, MS; and Cindy Keenan.*
4:50 P.M.	**Closing Comments/Evaluations**
5:00 P.M.	**Adjourn**



Creating an Organization that People Want to JOIN!

Deb Bakerjian, PhD, APRN, FAAN, FAANP, FGSA

CALTCM

Disclosures

- Deb Bakerjian, PhD, APRN, FAAN, FAANP, FGSA, has no relevant financial relationships with commercial interests to disclose.

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Poll Everywhere

- On phone, tablet or computer – sign up for Poll Everywhere
- www.pollev.com/bakerjian

pollev.com/bakerjian

How are you doing today?

GREAT!

Submit

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Learning Objectives

- By the end of this presentation, participants will be able to:
  - Identify challenges to organizational culture
  - Describe the characteristics of a high quality, high functioning, JUST and SAFE culture
  - Practice ways to *personally* address negativity in the organizations
  - Formulate a simple plan to address at least one barrier that is preventing a positive, safe, just culture

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What is CULTURE?

- **According to Merriam-Webster Dictionary…**

  a: the customary beliefs, social forms, and material traits of a racial, religious, or social group;

  b: the set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic

  c: the set of shared attitudes, values, goals, and practices that characterizes an institution or organization- a *corporate* culture

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Culture Change

- So… what do we typically think about when we say "Culture Change" in Nursing Homes?

California Culture Change Coalition
Dementia Partnership
July 31, 2013

Culture Change
"Creating Home within the Nursing Home"

Creating Home in the Nursing Home II:
A National Symposium on Culture Change and the Food and Dining Requirements

THE EDEN ALTERNATIVE REGISTERED HOME

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Culture Change Movement

- Resident centered care
- Home-like atmosphere
- Close relationships
- Staff empowerment
- Collaborative decision-making
- Quality improvement

CALTCM2018

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs*, *29*(2), 312-317.

A *DIFFERENT* ASPECT OF CULTURE

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Organizational Culture

- Think about an organization that you didn't like working in…
  - What about it didn't work for you?
  - How would you describe it?
  - How did you feel working there?
- What did you want to change?

Negative Culture

- In your table group - share your thoughts about what contributes to a negative organizational culture
- Write out 5 things that you think are most important
- As a table, decide on the top 5 issues
- Go to pollev.com/bakerjian

Organizational Culture

- What are the “qualities” of a *positive* organizational culture?
- In your hand out – there is a list of some characteristics & positive attributes
- Take a few minutes at your table and come up with the traits, elements, & characteristics you think are most important

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NOW THINK ABOUT THIS:

Your table consists of the leadership that were asked to run *IDEAL* POST ACUTE & LONG TERM CARE NURSING CENTER

It is now up to YOU to establish the key factors that will impact the organizational culture.

WHAT ATTRIBUTES WILL BE YOUR FOCUS?

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What else should we be thinking about when we talk about Organizational Culture?
What is our goal for our residents?
What about a CULTURE OF PATIENT SAFETY?
Safety Culture
HOW DOES ORGANIZATIONAL CULTURE AFFECT PATIENT CARE?
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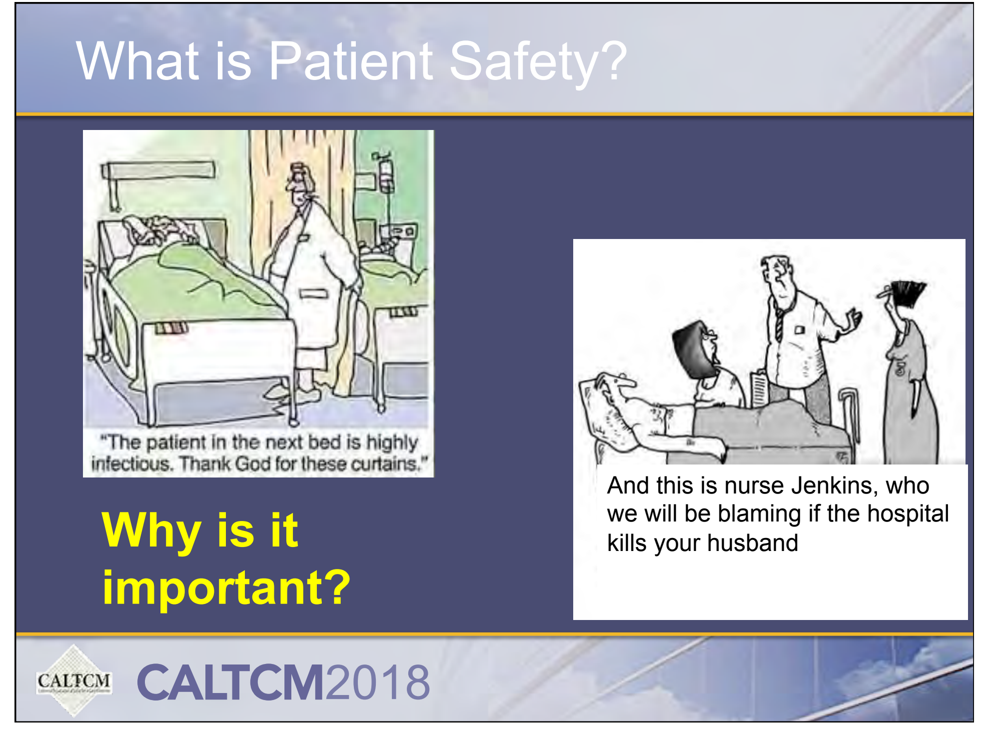
What is Patient Safety?
"The patient in the next bed is highly infectious. Thank God for these curtains."
Why is it important?
And this is nurse Jenkins, who we will be blaming if the hospital kills your husband
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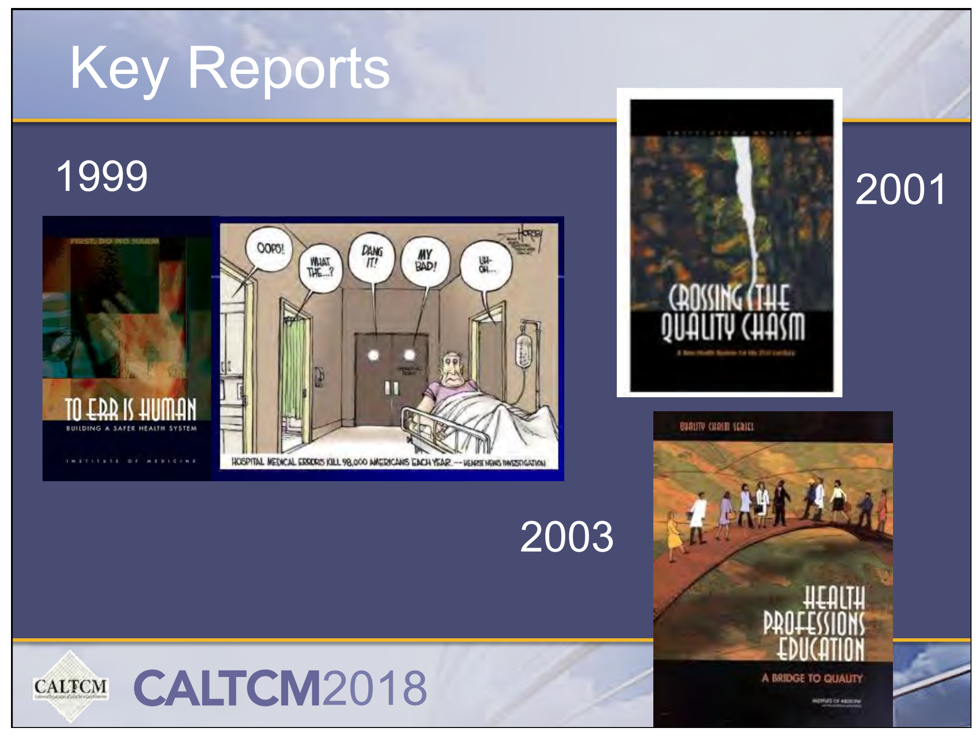

Defining Patient Safety Culture

- **Patient safety** is **defined** by the **IOM** as "the prevention of harm to **patients**."
- Organization with a system of care delivery that:
  1. prevents errors
  2. learns from the errors that do occur
  3. is built on a culture of **safety** that involves health care professionals, organizations, and **residents**

Safety Concerns in LTC*

- 2014 OIG Report[1]
  - 22% of Medicare beneficiaries in SNFs experienced an adverse event
  - Half were considered preventable
  - Medication errors, infections, delirium, falls, pressure ulcers
- 2016 OIG Report[2]
  - 29% of resident experienced adverse events in rehab hospitals

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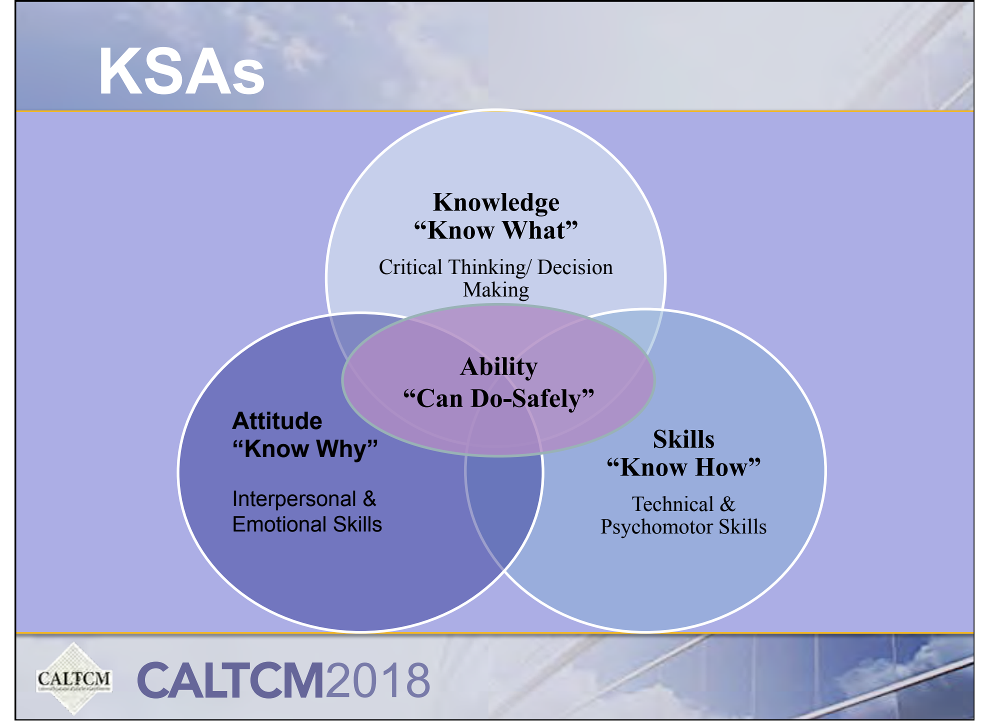
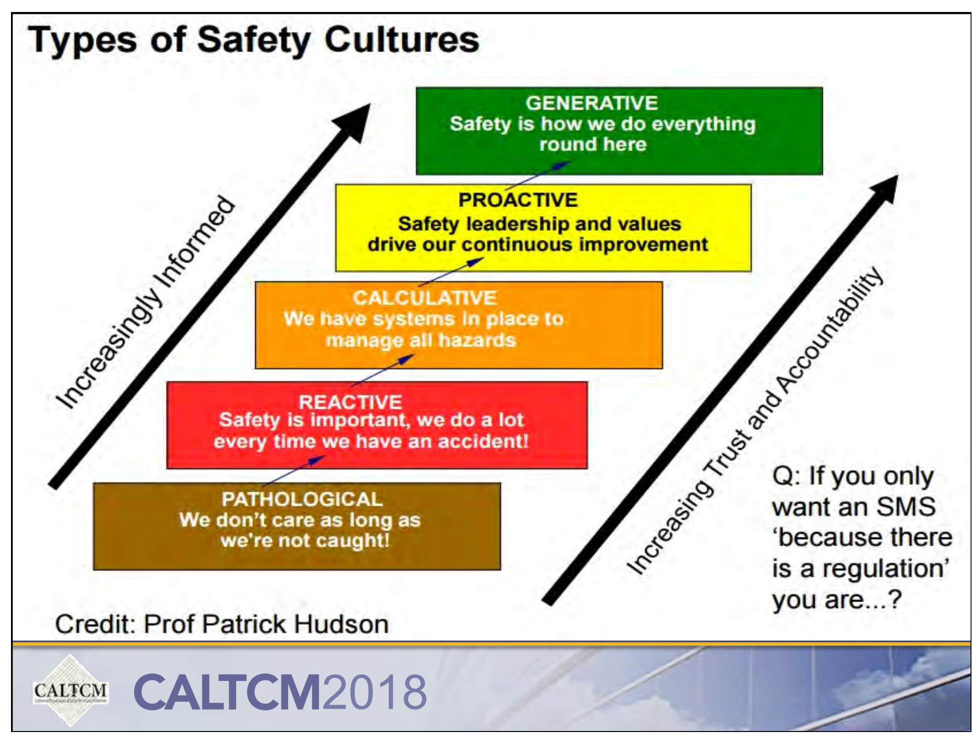
1. 2014 OIG Report-Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries
2. 2. 2016 OIG Report - Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries




Types of Safety Cultures
GENERATIVE
Safety is how we do everything round here
PROACTIVE
Safety leadership and values drive our continuous improvement
CALCULATIVE
We have systems in place to manage all hazards
REACTIVE
Safety is important, we do a lot every time we have an accident!
PATHOLOGICAL
We don't care as long as we're not caught!
Increasingly Informed
Increasing Trust and Accountability
Q: If you only want an SMS 'because there is a regulation' you are...?
Credit: Prof Patrick Hudson
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Where is your organization on the Culture Scale?
1. Pathological
2. Reactive
3. Calculative
4. Proactive
5. Generative
Types of Safety Cultures
GENERATIVE
Safety is how we do everything round here
PROACTIVE
Safety leadership and values drive our continuous improvement
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Q: If you only want an SMS 'because there is a regulation' you are...?
Credit: Prof Patrick Hudson
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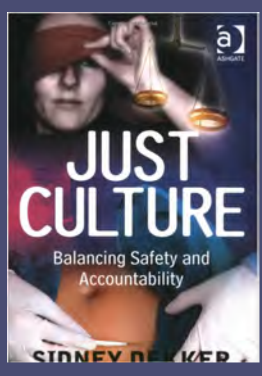
Contributors to Bad Culture

- No clear cut mission, vision or values
- Quality of care may be substandard
- People treated poorly
  - Lack of fairness & transparency
  - Lack of respect & trust
- FEAR of leadership/management
- No teamwork or collaboration
- The *BLAME* Game

The Tension

- To improve patient safety, we must make better use of minor human error events
- The threat of corporate disciplinary action and regulatory enforcement is a major obstacle to event reporting and investigation
- How can we reduce errors if we don't know about them?
- The role of disciplinary action must be addressed

Implementing a Just Culture



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Improving outcomes

- Within the Just Culture model, there are five elements that contribute to improved outcomes:
  1. Mission, values, and expectations
  2. System design
  3. Behavioral choices
  4. Learning systems
  5. Accountability and justice

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NH Mission and Values

- Do you know your NH's mission, vision, values?
- How do you support those?
- What are you doing now?
- What could you be doing that you aren't?

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System Design

- What is system design?
- Think of a "system" in your NH…
  - Human resources
  - Medication management
  - Infection control
- What can YOU do to improve an important system that is not working well?

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Behavioral Choices

- Think of the last few times you were in the NH?
- How did you behave?
- Was your behavior supportive, positive?
- How have others behaved?
- Are there changes that are needed?

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Learning Systems

- Organizations that embrace system-wide learning are often more innovative and have higher levels of performance…
- Healthcare is continuously changing, evolving… we must learn along the way!
  - Collective preferences
  - Goal formation processes
  - Leadership engagement
  - Reflective activities
  - Team processes
  - Tolerance for errors
- What learning systems are in your NHs?

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Creating a Learning Environment

- We need to learn from errors
- To improve patient safety, we must make better use of minor human error events – improve reporting of minor events
- The threat of corporate disciplinary action and regulatory enforcement is a major obstacle to event reporting and investigation
- The role of disciplinary action must be addressed

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Discipline & Accountability for Behaviors

Human Error	At-Risk Behavior	Reckless Behavior
Inadvertent action: slip, lapse, mistake	*A choice: risk not recognized or believed justified*	*Conscious disregard of unreasonable risk*
Console	**Coach**	**Punish**
Manage through:	Manage through:	Manage through:
Processes Procedures Training Design	Removing incentives for At-Risk Behaviors Treating incentives for healthy behaviors Increasing situational awareness	Remedial action Punitive action

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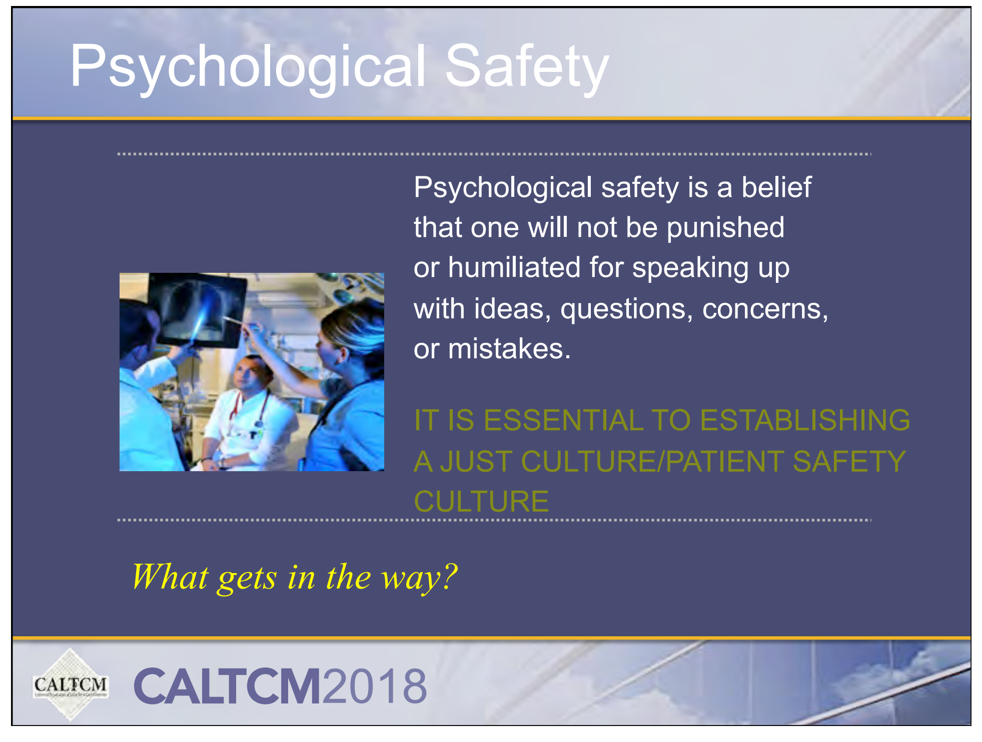
Psychological Safety
Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.
IT IS ESSENTIAL TO ESTABLISHING A JUST CULTURE/PATIENT SAFETY CULTURE
What gets in the way?
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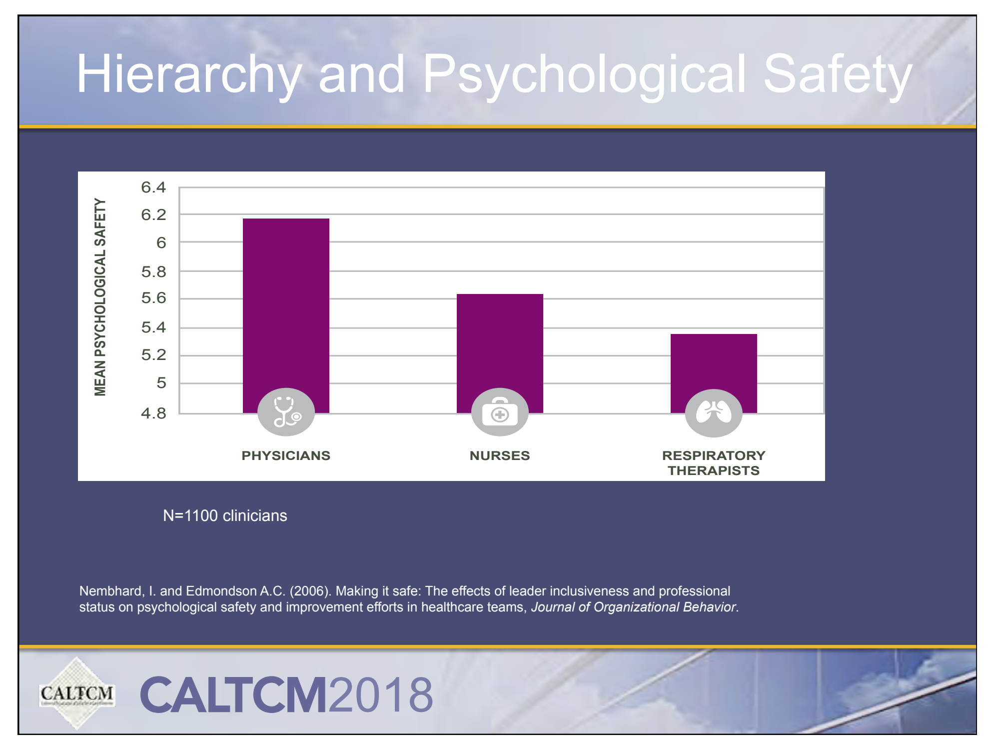
Hierarchy and Psychological Safety
MEAN PSYCHOLOGICAL SAFETY
6.4
6.2
6
5.8
5.6
5.4
5.2
5
4.8
PHYSICIANS
NURSES
RESPIRATORY THERAPISTS
N=1100 clinicians
Nembhard, I. and Edmondson A.C. (2006). Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in healthcare teams, Journal of Organizational Behavior.
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Psychological Safety & Accountability
high
PSYCHOLOGICAL SAFETY
low
Comfort Zone
Learning Zone
Apathy Zone
Anxiety Zone
low
high
ACCOUNTABILITY
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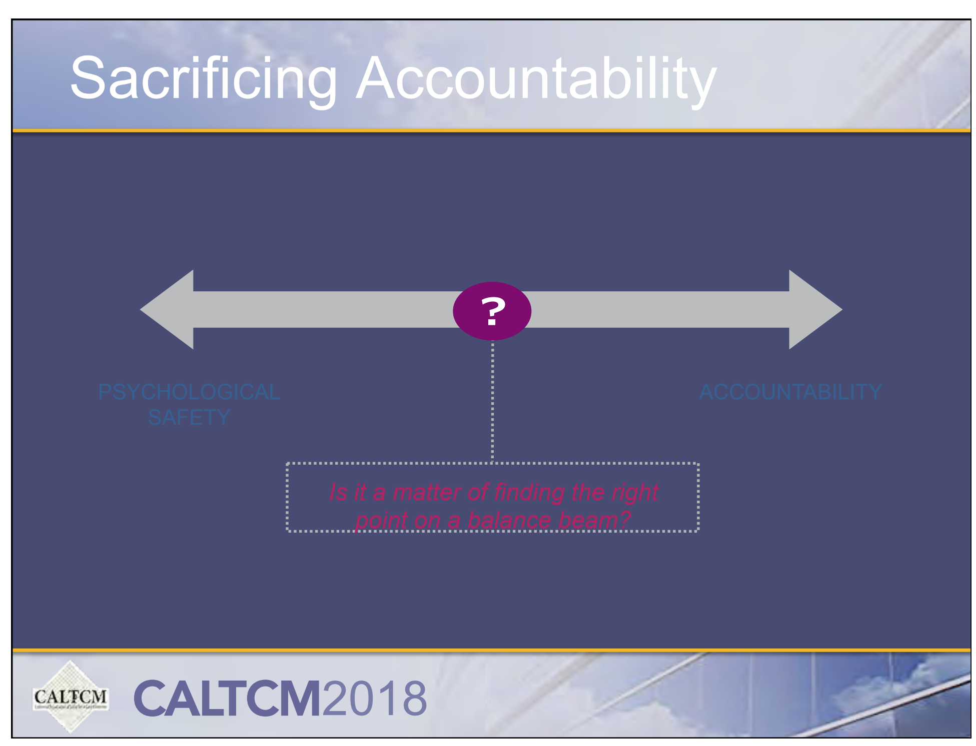
Sacrificing Accountability
?
PSYCHOLOGICAL SAFETY
ACCOUNTABILITY
Is it a matter of finding the right point on a balance beam?
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Leading the Learning Organization
VISION
Set a clear direction that engages hearts and minds
CULTURE
Model and reward beliefs that make it safe for learning
TEAMING
Institute and support team-based processes
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The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes.”
Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on
Health Care Quality Improvement
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WE CAN DO BETTER…

What is YOUR Role?

1. Mission, values, and expectations
2. System design
3. Behavioral choices
4. Learning systems
5. Accountability and justice

- What is YOUR role for each of these steps?
- Choose one that resonates with you and discuss with group

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Individuals and Systems

QSEN Competency	Personal Effort/ Individual Care ⟷			Systems Thinking/ System Care
Patient-Centered Care	Document the presence and extent of my patients' pain	Use common definitions, terms and rating scales in documenting my patients' pain	Formulate pain management plans with my patients, their families, and other health care professionals	Participate in medical record reviews of our unit's pain management documentation
Evidence-Based Practice	Differentiate clinical opinion from research and evidence summaries	Discuss conflicting evidence in the literature with my colleagues	Question the rationale for routine care approaches on my unit that are not evidence based	Participate in writing unit-level standards of practice that area evidence based
Teamwork and Collaboration	Ensure that my patient is ready for discharge by making sure they have their prescriptions	Formulate discharge plan with my patients, their families, and other health care professionals	Solicit input from other team members to improve my team performance	Participate in improving the discharge process through team meetings to structure communication during a patient's hospital stay
Safety	Wash my hands at the appropriate times in the care of my patients	Get patients and families to participate in the campaign to reduce infection by washing hands	Observe other nurse's hand washing technique and provide feedback	Study the workarounds on my unit and create a cause and effect diagram to summarize why nurses do not wash their hands
Quality Improvement	Ensure that I care for central lines using evidenced based practice	Have a peer watch my central line dressing change so that I can improve my performance	Review the data for our units central line infection rates	Participate in a quality improvement project to improve compliance with central line bundle on our unit
Informatics	Protect the confidentiality of my patients' protected health information in the electronic health record (EHR)	Attend in-service training updates to learn about new laws regarding health information protection	Help design patient information flyers describing the patients' and families' rights to confidentiality of information in the EHR	Participate in an agency-wide committee to update the agency EHR system

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The Role of TEAMs

1. Mission, values, and expectations
2. System design
3. Behavioral choices
4. Learning systems
5. Accountability and justice

- Who is your team?
- Who leads your team?
- Who else leads your team?
- Who COULD lead your team?

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The role of leadership

Leadership

- Leadership is a relationship between those who aspire to lead and those who choose to follow
  - Formal & informal leadership
  - Situational leadership
- Empowering others
- What part will you play – who in your team might do this?

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Leadership Role in just culture

- Provide a proactive learning culture
  - It not about seeing things that need to be "fixed"
  - It is about envisioning new opportunities to improve how we understand system and behavior risks
- Build the capacity for "Just Culture"
- Establish and practice transparency
- Use resources wisely to minimize the risk of harm

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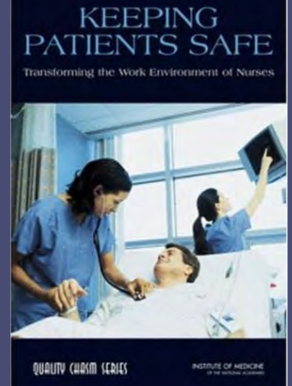
Evidence-based Management



High-reliability organizations:

Flexible decision-making, pushed to the lowest level commensurate with available knowledge

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Create a Safety-Supportive Policy

- State the Purpose
- Set the Expectations
- Focus on processes and outcomes
- Be transparent, expect transparency, and reward transparency

FACILITY WIDE WIDE POLICY
Policy #: 6.350
Page#: 1 of 3
Origination Date:
Reviewed: Revised:

SUBJECT: **NON-PUNITIVE CULTURE**

PURPOSE
To encourage reporting of adverse medical events, near misses, existence of hazardous conditions, and related opportunities for improvement as a means to identify systems changes which have the potential to avoid future adverse events. To provide guidelines for the application of non-punitive processes versus disciplinary actions.

POLICY
PVHMC encourages reporting of all types of errors and hazardous conditions. The organization recognizes that if we are to succeed in creating a safe environment for our patients, we must create an environment in which it is safe for caregivers to report and learn from errors.
It is recognized that competent and caring associates may make mistakes and it is the intention not to instill fear or punishment for reporting them.
There must be a non-punitive, supportive environment for all staff to report errors and near misses.
Error and near miss reporting are a critical component of the PVHMC patient safety and risk management program.
Errors and accidents should be tracked in an attempt to determine trends and patterns to learn from them and prevent a reoccurrence, thus improving patient safety.
The focus is on how systems and processes can be improved to help people avoid mistakes in the future
In the process of evaluating errors and near misses, healthcare providers participate in reporting and developing improved processes

GUIDELINES
The focus of the program is performance improvement, not punishment.
Employees are not subject to disciplinary action when making or reporting errors/ injuries/near misses except in the following circumstances:
The employee repeatedly fails to participate in the detection and reporting of errors/ injuries/near misses and the system-based prevention remedies.
There is reason to believe criminal activity or criminal intent may be involved in the making or reporting of an error/injury.
False information is provided in the reporting, documenting, or follow-up of an error/ injury.
The employee knowingly acts with intent to harm or deceive.
Reckless acts

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Balance of Duties & Org Values

- Duties
  - Duty to avoid causing unjustified risk or harm
  - Duty to produce a good outcome
  - Duty to follow procedural rules or guidelines
- Organizational Values
  - Safety
  - Cost
  - Effectiveness
  - Equity
  - Timeliness
  - Efficiency
  - Patient Centered

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A Changed Culture

Key attributes:

- Staff & residents & families feel "safe" to speak up
- Residents & families make as many decisions as possible
- There is transparency
- Decisions are fair, mission & value based
- The organization values learning

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What is YOUR contribution to Culture?

Talk with your team about things that YOU as individuals might do to affect culture

SO, HOW DO WE GET THERE?

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Steps to Take

- Do a culture self assessment
- Create a QAPI
- Change the way you do work
  - Establish non-punitive culture
  - Huddles
  - Provide feedback to frontline staff
  - Collect patient safety data
- Create Psychological Safety

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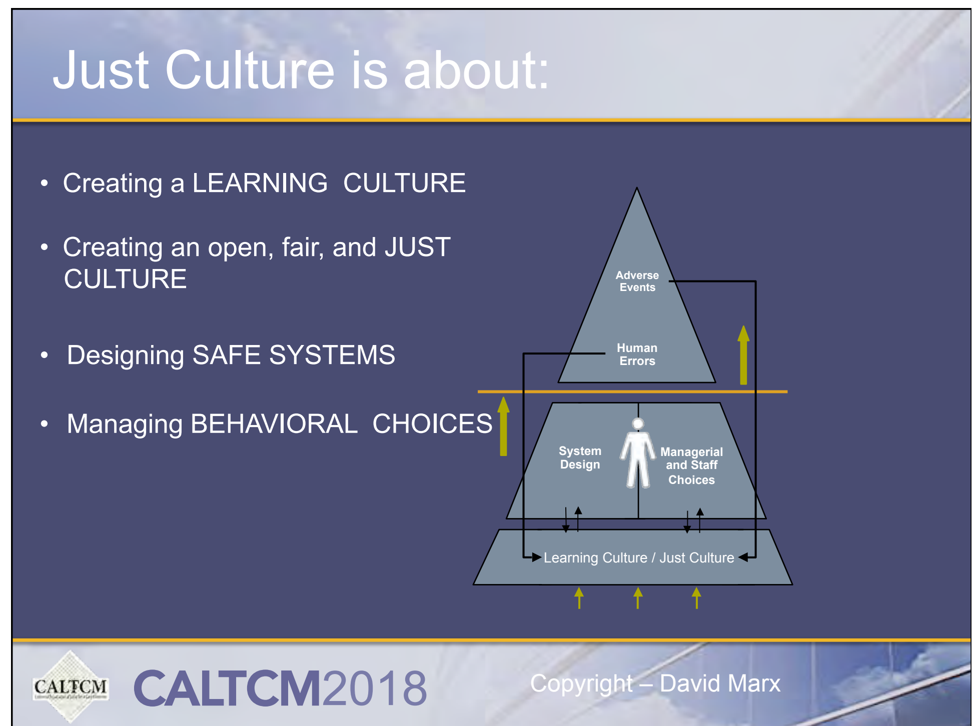

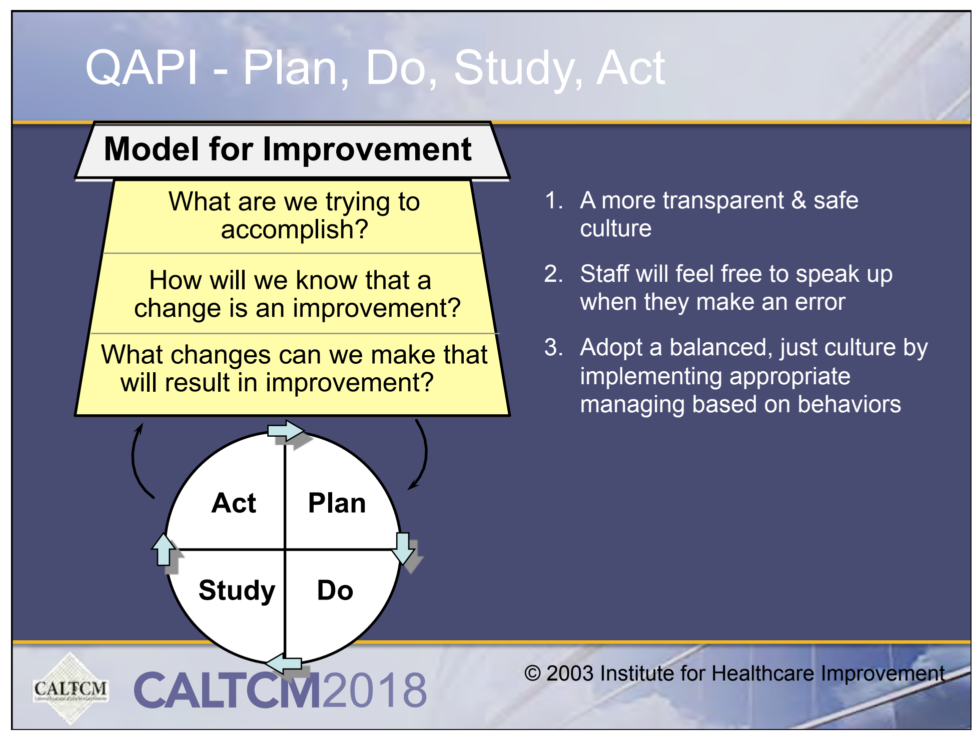
QAPI - Plan, Do, Study, Act
Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What changes can we make that will result in improvement?
Act
Plan
Study
Do
1. A more transparent & safe culture
2. Staff will feel free to speak up when they make an error
3. Adopt a balanced, just culture by implementing appropriate managing based on behaviors
© 2003 Institute for Healthcare Improvement
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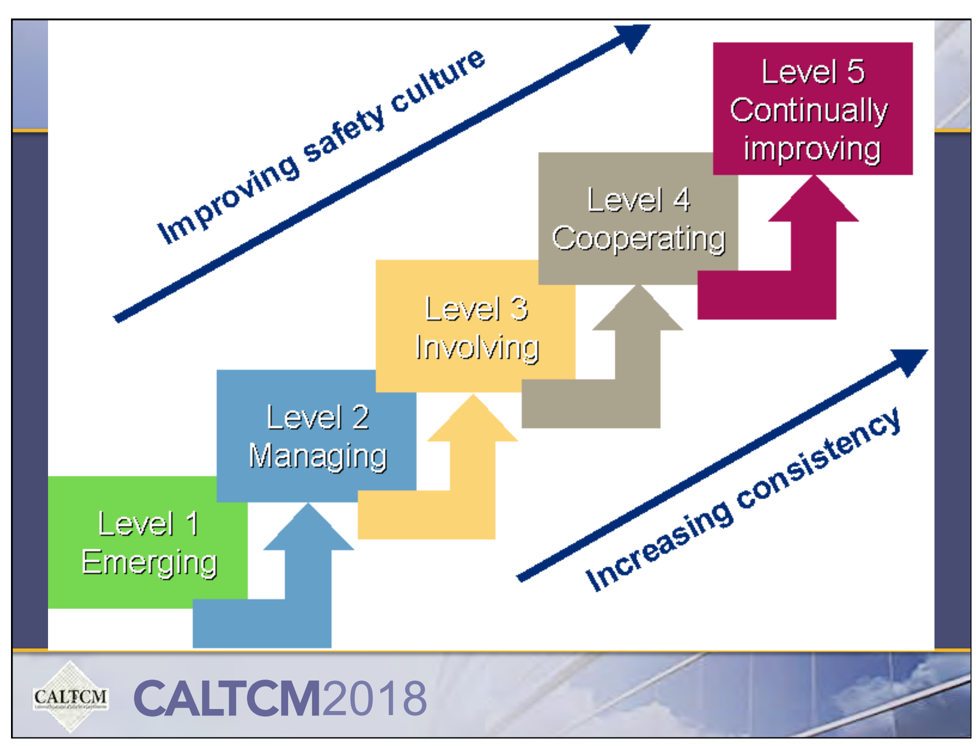
Improving safety culture
Level 5 Continually improving
Level 4 Cooperating
Level 3 Involving
Level 2 Managing
Level 1 Emerging
Increasing consistency
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Work as a TEAM…

- At your table, brainstorm around a QAPI project to improve the culture of your organization…
- Use the model for improvement and action planning handouts in your packets
- Make this practical – something you can take with you and implement… if you are NOT a formal leader, make this about your PERSONAL improvement

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Culture of Safety What does GOOD look like?

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Creating a
Culture of Safety
takes EVERYONE on the TEAM
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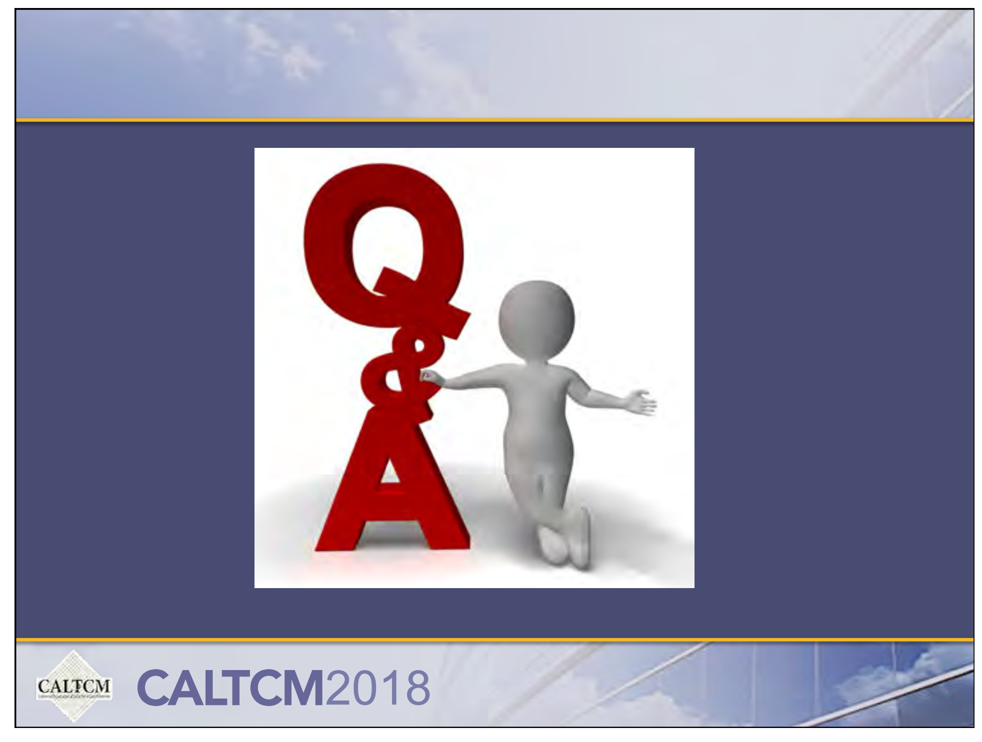
Q&A
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Trauma Informed Systems

KJ Page, RN-BC, LNHA

Disclosures

- Kj Page, RN-BC, LNHA, has no relevant financial relationships with commercial interests to disclose.

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"A non-trauma-informed system punishes and blames your adult actions and asks, 'what's wrong with you?' A trauma informed provider will hold you accountable for your adult actions, but give you space and time to process 'what happened to you?' without adding guilt and more trauma."

Patient at Stephen and Sandra Sheller 11th Street Family Health Services of Drexel University, Philadelphia, PA

Trauma education is mandate in SNF now CMS 483.40, (a)).

- The primary goal is to minimize triggers, avoid re-traumatization, and identify unique needs to achieve person-centered care.
- Learn to recognize trauma reactions!

What is trauma and do we even have to or want to define it?

Adverse Childhood Experience is one place to start

- **WHAT IS YOUR ACE SCORE?**

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No — If yes enter 1 ______

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No — If yes enter 1 ______

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No — If yes enter 1 ______

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No — If yes enter 1 ______

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No — If yes enter 1 ______

6. Were your parents **ever** separated or divorced?
   Yes No — If yes enter 1 ______

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No — If yes enter 1 ______

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No — If yes enter 1 ______

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No — If yes enter 1 ______

10. Did a household member go to prison?
    Yes No — If yes enter 1 ______

Now add up your "Yes" answers: ______ This is your ACE Score

We care about trauma because it impacts health and wellbeing

- Early adversity has lasting effects on the brain, how we manage stress and our behaviors.
- Trauma coping behaviors may not serve you well in adult life.
- Trauma-informed approaches can help health care systems and providers mitigate risks, improve health outcomes

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How Does Trauma Impact Health?

- Changes in stress hormones impact the body and reduce immune function
- May be less likely to seek out and accept care
- Develop poor coping strategies
- Can lead to drug and alcohol abuse or other behaviors that harm health
- May change our genes—trauma's effects can pass to the next generation. (although this is controversial..)

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The trajectory between adverse childhood experiences, the damage they do and the long-term health effects are becoming clearer, as are the ways that clinicians can interrupt and reverse the impacts.

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Trauma's Impact Varies

- Two people with the same trauma may have different reactions –both behaviorally and biologically
- This may differ based on our biology, culture, age, coping strategies, and other experiences.

Positive Experiences Reverse Biology!

- Studies in animals show that a consistent, safe environment can reverse hormonal and even genetic impacts of trauma.
- Improving the coping of adults impacts their ability to relate and reduces the chance they will perpetuate the negative patterns.

How can we avoid causing trauma in our settings?

- BY looking at the systems and practices in our settings we can identify which may need updating
- We can look at socio-emotional and physical factors.
- UNIVERSAL PRECAUTIONS

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Social-Emotional Environment

- Welcome patients
- Ensure staff maintain healthy boundaries;
- Conflict management skills
- Consistent schedules and procedures
- Advance notice and prep for change
- Communication that is consistent, open, respectful, and compassionate; and
- Cultural awareness (trauma, safety, and privacy)

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Physical Environment

- Good lighting
- Avoiding loitering around entrances
- Monitor who is coming and going
- Have security guards
- Keep noise low
- Welcoming language on signage
- Leaving clear passageways to exits

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Key Ingredients of Trauma-Informed Clinical Practices

- Involving patients in the treatment process
- Screening for trauma
- Training staff in trauma-specific treatment approaches
- Engaging referral sources and partnering organizations

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Do we screen for trauma? Should we?

- Argument between universal screening and awaiting until we have trust.
- Screening should benefit the patient—something different should be done
- Don't keep re-screening
- Those who screen need to be trained to be empathetic and culturally sensitive

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Mandated Reporters Have to Report

- Child abuse or neglect is found in California Penal Code Section 11165.7
  - Child abuse of adults should be reported if there is a reasonable suspicion that there may be another potential child victim. (This does not impose an investigatory duty. The investigation is to be done by a local Child Protective Services agency.)

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Mandated Reporters: Adult Abuse

- All suspected abuse reported to Administrator, Law Enforcement, Ombudsman and CDPH within 2 hours (verbal and fax) unless serious bodily injury which is immediate.
- Standard is not longer "reasonable suspicion-" report everything.

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Reporting Abuse--Reminder

Abuse	Timeframe to call	Call	Timeframe written report	Written report to
Abuse of any type or neglect	Immediately and no later than 2 hours after observing, obtaining knowledge of or suspecting abuse	Local law enforcement (sheriff) Facility Administrator	Immediately, and no later than 2 hours of observing, obtaining knowledge of, or suspecting abuse	Sheriff Ombudsman CDPH Administrator

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Being Trauma informed is a Journey—Where are you?

- Changing our language
- Universal precautions
- Training staff on empathetic approaches
- Screening and referring
- Involving peers

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Further reading

- See your handout with links and sample policy and educational materials.

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Promoting Relationships That Heal and Get Things Done

Rebecca Ferrini, MD, MPH, CMD

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Disclosures

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

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Learning Objectives

- Analyze a process through the lens of trauma informed systems and identify opportunities to improve;
- Demonstrate the components of nonviolent communication: observation, feeling, need and request;
- Evaluate the various communication strategies used in long term care and their utility in various situations;
- Develop a plan to analyze and promote relationships in the long term care setting.

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Main Points

- Staff engagement is the root cause – without it, you will not be successful in improving quality.
- Put efforts into systematically improving communication and relationships between caregivers and with residents to create a therapeutic environment for healing and all quality measures will improve.

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EMPATHY

- Emotion researchers generally **define empathy** as the ability to sense other people's emotions plus imagine what someone else might be thinking or feeling.
- “Know what they are feeling, and identify that it is right to feel that way in their situation—and help them meet the needs underlying those feelings”

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Quick Reference of Things to Say

It sounds like you are feeling XXX because you would have wanted XXXX

You are saying you feel XXX which is completely reasonable and justified in your situation.

You are saying XXX, is that correct?

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Nonviolent Communication

- Much communication is “violent”—judgemental, defensive, aggressive.
- NVC is a “language of life” that helps us to transform old patterns into compassion and empathy and to improve the quality of all of our relationships.

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NVC Improves Relationships

- Empathy: Receiving from the heart creates a means to connect with others and share experiences in a truly life enriching way. Empathy goes beyond compassion, allowing us to put ourselves into another’s shoes to sense the same feelings and understand the same needs; in essence, being open and available to what is alive in others. It also gives us the means to remain present to and aware of our own needs and the needs of others even in extreme situations that are often difficult to handle.
- Honesty: Giving from the heart has its root in honesty. Honesty begins with truly understanding ourselves and our own needs, and being in tune with what is alive in us in the present moment. When we learn to give ourselves empathy, we can start to break down the barriers to communication that keep us from connecting with others.

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4 Components of NVC

- Observation: Observation without evaluation consists of noticing concrete things and actions around us.
- Feeling: Not thoughts.
- Needs: All individuals have needs and values that sustain and enrich their lives. When those needs are met, we experience comfortable feelings, like happiness or peacefulness, and when they are not, we experience uncomfortable feelings, like frustration. Understanding that we, as well as those around us, have these needs is perhaps the most important step in learning to practice NVC and to live empathically.
- Request: make clear and present requests. When we learn to request concrete actions that can be carried out in the present moment, we begin to find ways to cooperatively and creatively ensure that everyone's needs are met.

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When I see that__________ (observation)

I feel _______________ (feeling)

because my need for __________________ is/ is not met.

Would you be willing to ____________________(request)?

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Feelings when your needs are satisfied

AFFECTIONATE
compassionate
friendly
loving
open hearted
sympathetic
tender
warm

ENGAGED
absorbed
alert
curious
engrossed
enchanted
entranced
fascinated
interested
intrigued
involved
spellbound
stimulated

HOPEFUL
expectant
encouraged
optimistic

CONFIDENT
empowered
open
proud
safe
secure

EXCITED
amazed
animated
ardent
aroused
astonished
dazzled
eager
energetic
enthusiastic
giddy
invigorated
lively
passionate
surprised
vibrant

GRATEFUL
appreciative
moved
thankful
touched

INSPIRED
amazed
awed
wonder

JOYFUL
amused
delighted
glad
happy
jubilant
pleased
tickled

EXHILARATED
blissful
ecstatic
elated
enthralled
exuberant
radiant
rapturous
thrilled

PEACEFUL
calm
clear headed
comfortable
centered
content
equanimous
fulfilled
mellow
quiet
relaxed
relieved
satisfied
serene
still
tranquil
trusting

REFRESHED
enlivened
rejuvenated
renewed
rested
restored
revived

https://www.cnvc.org/Training/feelings-inventory

Feelings when your needs are not satisfied

AFRAID
apprehensive
dread
foreboding
frightened
mistrustful
panicked
petrified
scared
suspicious
terrified
wary
worried

ANNOYED
aggravated
dismayed
disgruntled
displeased
exasperated
frustrated
impatient
irritated
irked

ANGRY
enraged
furious
incensed
indignant
irate
livid
outraged
resentful

AVERSION
animosity
appalled
contempt
disgusted
dislike
hate
horrified
hostile
repulsed

CONFUSED
ambivalent
baffled
bewildered
dazed
hesitant
lost
mystified
perplexed
puzzled
torn

DISCONNECTED
alienated
aloof
apathetic
bored
cold
detached
distant
distracted
indifferent
numb
removed
uninterested
withdrawn

DISQUIET
agitated
alarmed
discombobulated
disconcerted
disturbed
perturbed
rattled
restless
shocked
startled
surprised
troubled
turbulent
turmoil
uncomfortable
uneasy
unnerved
unsettled
upset

EMBARRASSED
ashamed
chagrined
flustered
guilty
mortified
self-conscious

FATIGUE
beat
burnt out
depleted
exhausted
lethargic
listless
sleepy
tired
weary
worn out

PAIN
agony
anguished
bereaved
devastated
grief
heartbroken
hurt
lonely
miserable
regretful
remorseful

SAD
depressed
dejected
despair
despondent
disappointed
discouraged
disheartened
forlorn
gloomy
heavy hearted
hopeless
melancholy
unhappy
wretched

TENSE
anxious
cranky
distressed
distraught
edgy
fidgety
frazzled
irritable
jittery
nervous
overwhelmed
restless
stressed out

VULNERABLE
fragile
guarded
helpless
insecure
leery
reserved
sensitive
shaky

YEARNING
envious
jealous
longing
nostalgic
pining
wistful

"Feelings" versus attacks

- Insulted
- Criticized
- Judged
- Attacked
- Punished
- Belittled
- Hurt
- Vulnerable
- Sad
- Inadequate
- Fragile
- Unworthy

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Needs Inventory

CONNECTION
acceptance
affection
appreciation
belonging
cooperation
communication
closeness
community
companionship
compassion
consideration
consistency
empathy
inclusion
intimacy
love
mutuality
nurturing
respect/self-respect

CONNECTION continued
safety
security
stability
support
to know and be known
to see and be seen
to understand and be understood
trust
warmth

PHYSICAL WELL-BEING
air
food
movement/exercise
rest/sleep
sexual expression
safety
shelter
touch
water

HONESTY
authenticity
integrity
presence

PLAY
joy
humor

PEACE
beauty
communion
ease
equality
harmony
inspiration
order

AUTONOMY
choice
freedom
independence
space
spontaneity

MEANING
awareness
celebration of life
challenge
clarity
competence
consciousness
contribution
creativity
discovery
efficacy
effectiveness
growth
hope
learning
mourning
participation
purpose
self-expression
stimulation
to matter
understanding

Requests

- Remember you cannot control people, you can influence
- Tell them what you want them to do not what you don't want
  - (Stop screaming! versus, Can you use an indoor voice in the dining area?)
- Make it simple and immediate
- Have a plan if they say no….

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Let Us Try

- Each table is a group/divided into groups of 7 or more for vignette
- Two people read first interaction, then two more create a new reality with busy, but empathetic clinician.
- DOCUMENT
- Discuss needs, feelings, review each others notes.
- Choose a note or dialogue to bring to large group.

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Relationship Management Plan

- Initiation
- Developing and sustaining
- Dealing with conflict, repairing
- ending

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This patient is so difficult, we are taking two hours for morning care!

- You need to set firm limits and enforce them.
- She seems nice to me.
- It is our job to take care of the difficult people.
- She complained that you do not clean her properly so please in-service staff on proper methods to clean.

- I know this came to me and that means you feel you have done all you could. I am here to help! Gather staff together and I will be there. We cannot let this go on as it may burn out staff, and it may pose a risk of taking essential care away from others. We are putting this as a top priority—thank you for coming forward.

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What can You do to improve relationships?

- Listen.
- Make systems so that people who tell the truth are not punished for it.
- Empower communication and relationship expert to come to RCC to teach, listen, support and model
- Identify unhappy employees and give them more attention. Identify quiet awesome employees and recognize.
- CNA at all care conferences speaks first to honor role
- Consistent assignments
- Physician and administration supports primary team.
- Treat those who make errors with compassion. Make sure you can do it before you ask them to do it.

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Complaint Management

- What happens when people complain?
- Who listens? Who solves it?
- Do you attend to the “feelings” as well as the “facts”
- How do you measure if there is satisfaction/resolution?

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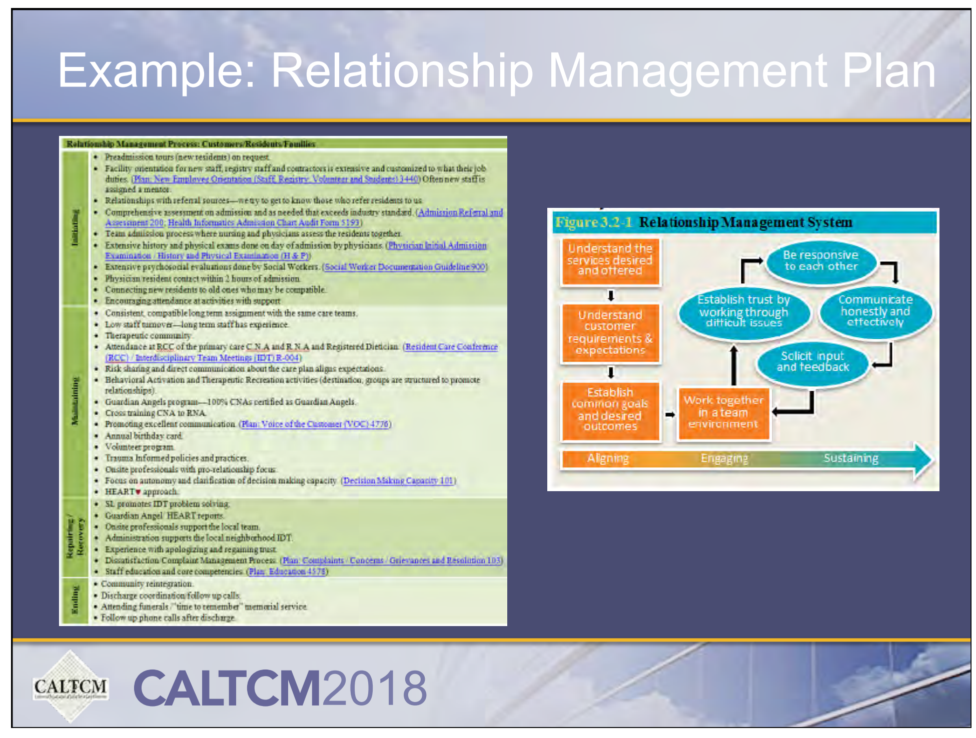


Example: Relationship Management Plan

Relationship Management Process: Customers/Residents/Families	
Initiating	• Preadmission tours (new residents) on request. • Facility orientation for new staff, registry staff and contractors is extensive and customized to what their job duties. (Plan: New Employee Orientation (Staff, Registry, Volunteer and Students) 3440) Often new staff is assigned a mentor. • Relationships with referral sources—we try to get to know those who refer residents to us. • Comprehensive assessment on admission and as needed that exceeds industry standard. (Admission Referral and Assessment 200; Health Informatics Admission Chart Audit Form 5193) • Team admission process where nursing and physicians assess the residents together. • Extensive history and physical exams done on day of admission by physicians. (Physician Initial Admission Examination / History and Physical Examination (H & P)) • Extensive psychosocial evaluations done by Social Workers. (Social Worker Documentation Guideline 900) • Physician resident contact within 2 hours of admission. • Connecting new residents to old ones who may be compatible. • Encouraging attendance at activities with support.
Maintaining	• Consistent, compatible long term assignment with the same care teams. • Low staff turnover—long term staff has experience. • Therapeutic community. • Attendance at RCC of the primary care C.N.A and R.N.A and Registered Dietician. (Resident Care Conference (RCC) / Interdisciplinary Team Meetings (IDT) R-004) • Risk sharing and direct communication about the care plan aligns expectations. • Behavioral Activation and Therapeutic Recreation activities (destination, groups are structured to promote relationships). • Guardian Angels program—100% CNAs certified as Guardian Angels. • Cross training CNA to RNA. • Promoting excellent communication. (Plan: Voice of the Customer (VOC) 4776) • Annual birthday card. • Volunteer program. • Trauma Informed policies and practices. • Onsite professionals with pro-relationship focus. • Focus on autonomy and clarification of decision making capacity. (Decision Making Capacity 101) • HEART♥ approach.
Repairing / Recovery	• SL promotes IDT problem solving. • Guardian Angel/ HEART reports. • Onsite professionals support the local team. • Administration supports the local neighborhood IDT. • Experience with apologizing and regaining trust. • Dissatisfaction/Complaint Management Process. (Plan: Complaints / Concerns / Grievances and Resolution 103) • Staff education and core competencies. (Plan: Education 4578)
Ending	• Community reintegration. • Discharge coordination/follow up calls. • Attending funerals /"time to remember" memorial service. • Follow up phone calls after discharge.

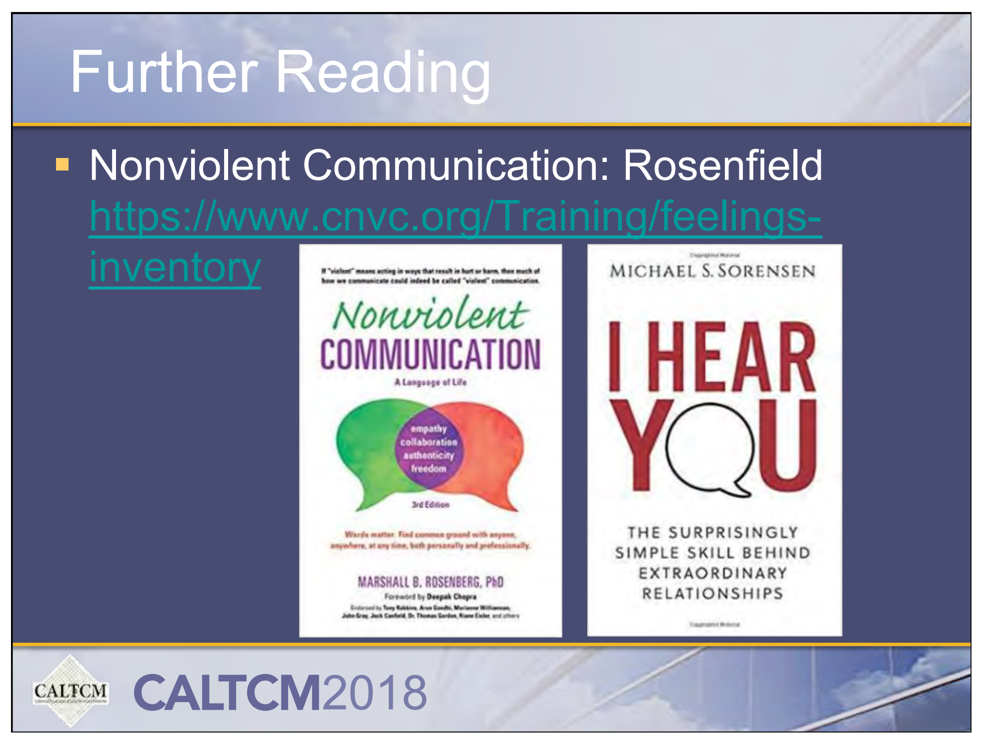
Communication Planning

- Communication—listening to your customers—how do you do it?
- Communication between leadership and staff and back—how s it done?

Focus on Communication:
Needs of the audience, best methods.

- Email/text/phone, communication books?
- Meetings/Minutes
- Change of shift
- Between disciplines
- Policies
- Rounds
- In-service education

- Contact Rebecca.ferrini@sdcounty.c.agove for copies of resources


Further Reading
Nonviolent Communication: Rosenfield
https://www.cnvc.org/Training/feelings-inventory
Nonviolent
COMMUNICATION
A Language of Life
empathy
collaboration
authenticity
freedom
3rd Edition
MARSHALL B. ROSENBERG, PhD
Foreword by Deepak Chopra
MICHAEL S. SORENSEN
I HEAR YOU
THE SURPRISINGLY SIMPLE SKILL BEHIND EXTRAORDINARY RELATIONSHIPS
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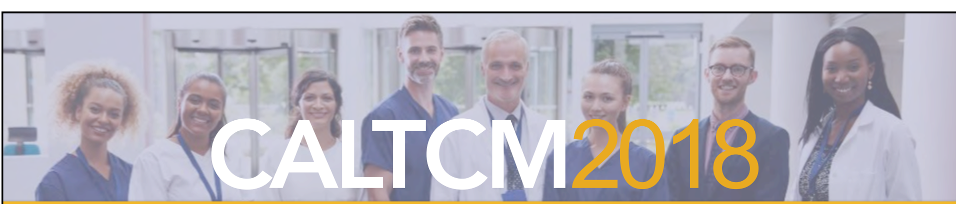
Welcome to the 44th Annual CALTCM Meeting!



Diagnosis and Management of Dementia in PA/LTC Settings

Randall Espinoza, MD, MPH
Clinical Professor of Psychiatry
Muriel Harris Chair of Geriatric Psychiatry
Geffen School of Medicine at UCLA

Disclosures

Dr. Randall Espinoza has disclosed that he receives:

- NIMH grant support
- LA County DMH contract support
- UpToDate, Inc – royalties from a chapter, Depression in Late-life, co-author with Jürgen Unützer, MD

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Learning Objectives

- Identify and differentiate among the 5 most prevalent dementia syndromes in LTC
- Apply bedside assessments to evaluate cognitive and behavioral symptoms
- Understand the best uses of cognitive and psychotropic medications in this population

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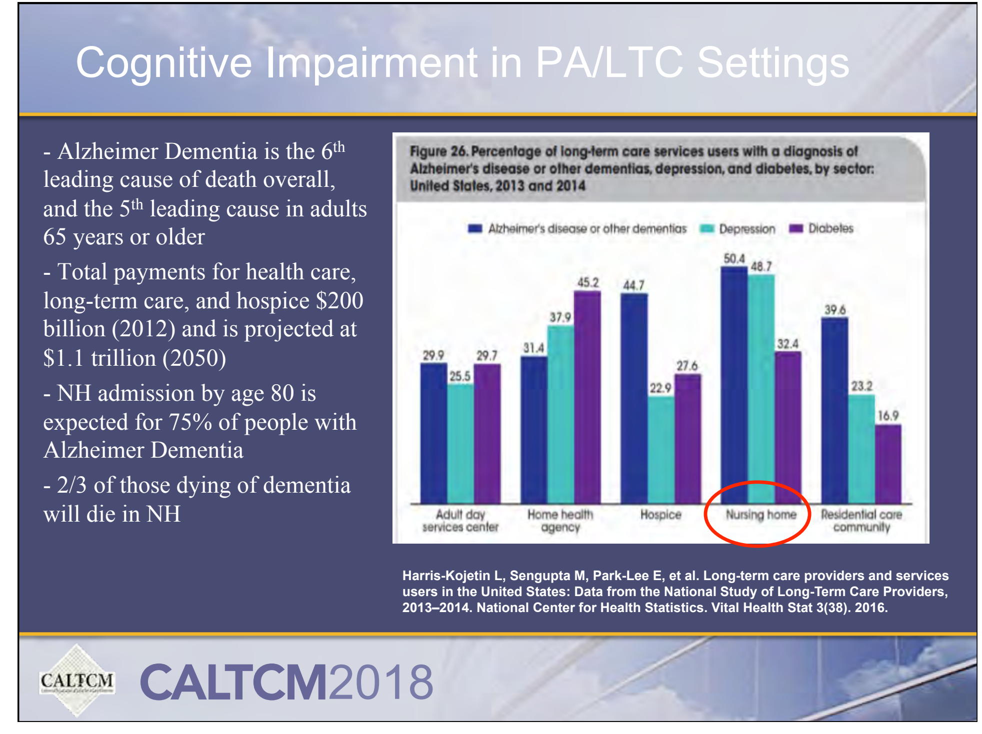
Cognitive Impairment in PA/LTC Settings
- Alzheimer Dementia is the 6th leading cause of death overall, and the 5th leading cause in adults 65 years or older
- Total payments for health care, long-term care, and hospice $200 billion (2012) and is projected at $1.1 trillion (2050)
- NH admission by age 80 is expected for 75% of people with Alzheimer Dementia
- 2/3 of those dying of dementia will die in NH
Figure 26. Percentage of long-term care services users with a diagnosis of Alzheimer's disease or other dementias, depression, and diabetes, by sector: United States, 2013 and 2014
Alzheimer's disease or other dementias
Depression
Diabetes
29.9
25.5
29.7
31.4
37.9
45.2
44.7
22.9
27.6
50.4
48.7
32.4
39.6
23.2
16.9
Adult day services center
Home health agency
Hospice
Nursing home
Residential care community
Harris-Kojetin L, Sengupta M, Park-Lee E, et al. Long-term care providers and services users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014. National Center for Health Statistics. Vital Health Stat 3(38). 2016.
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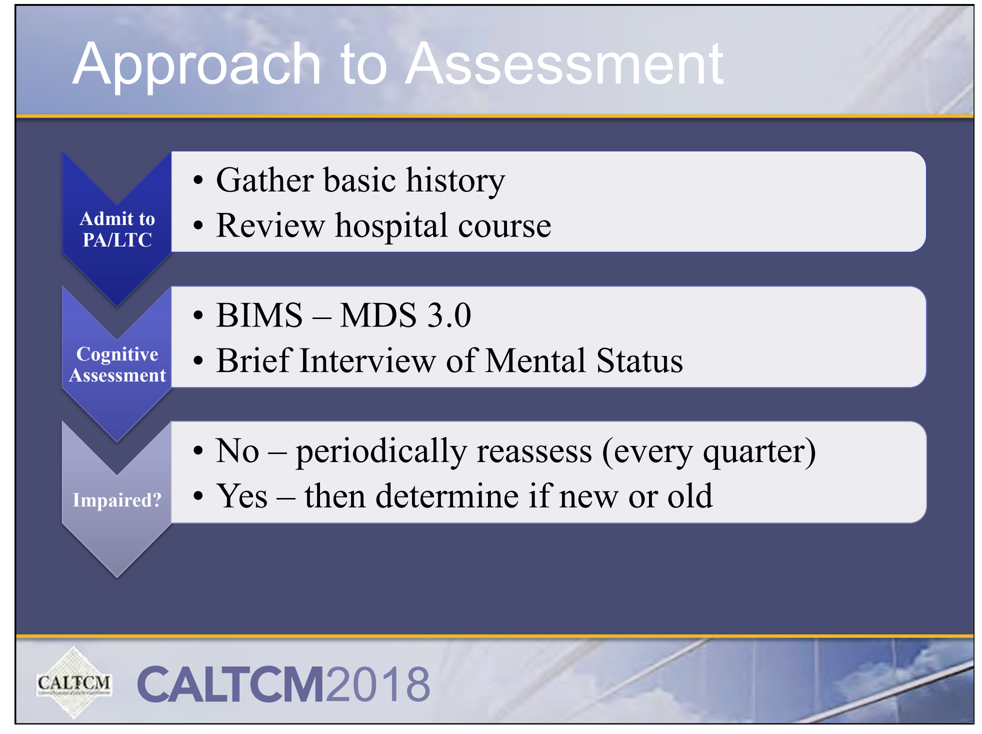
Approach to Assessment
Admit to PA/LTC
• Gather basic history
• Review hospital course
Cognitive Assessment
• BIMS – MDS 3.0
• Brief Interview of Mental Status
Impaired?
• No – periodically reassess (every quarter)
• Yes – then determine if new or old
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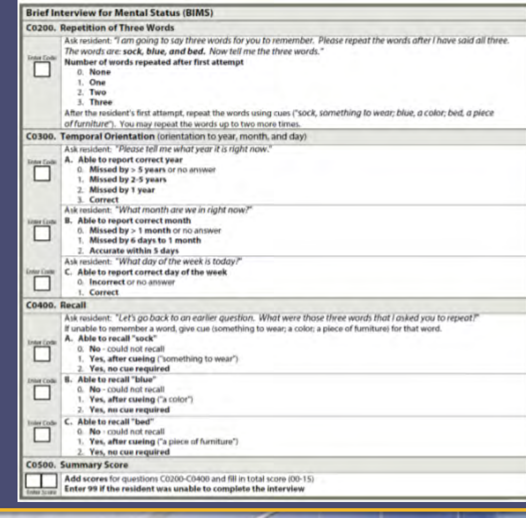
BIMS – MDS 3.0

- Used to assess cognition over time
- Is a screening instrument
- NOT used to diagnose dementia
- Problems with BIMS
  - Not designed to be sensitive to full cognitive continuum
  - Does not stage impairment levels
  - Has poor sensitivity to mild cognitive impairment
  - Makes no assessment of executive capacities or functions
  - Normed on male VA patients
- Scoring
  - 13 – 15: Cognitively intact
  - 8 – 12: Moderately impaired
  - 0 – 7: Severely impaired



Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code
Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*
Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code
Ask resident: *"Please tell me what year it is right now."*
A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code
Ask resident: *"What month are we in right now?"*
B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code
Ask resident: *"What day of the week is today?"*
C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter Code
Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.
A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code
B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code
C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score
Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

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Cognitively Impaired? Yes

Old or Pre-existing

- Type or diagnosis
- History
  - Duration
  - Behavior
  - Function
  - Past psychiatric history
  - Work up
- Treatment
  - Cognitive
  - Psychotropic
  - Psychosociobehavioral

New

- Determine type and extent of cognitive and behavioral deficits
- Corroborate info whenever possible from reliable sources
- Review medical history
- Review psychiatric history
- Review medication and OTC list
- Bedside neurobehavioral exam
  - Elemental neuro exam
  - Mental status exam
  - Cognitive screens

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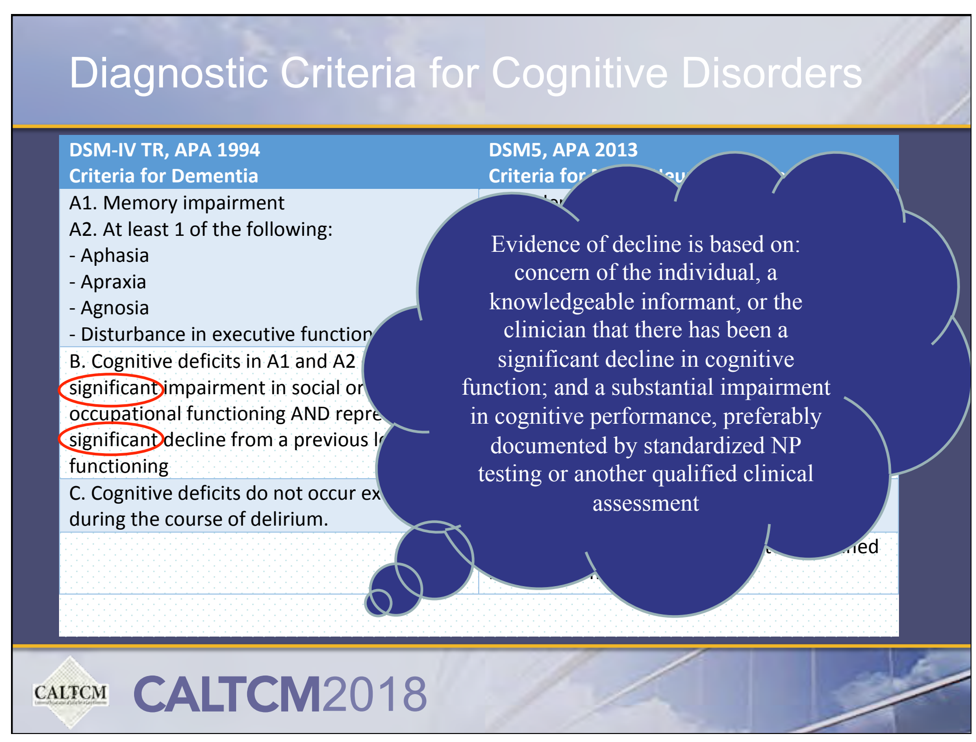

Diagnostic Criteria for Cognitive Disorders
DSM-IV TR, APA 1994
Criteria for Dementia
DSM5, APA 2013
Criteria for
A1. Memory impairment
A2. At least 1 of the following:
- Aphasia
- Apraxia
- Agnosia
- Disturbance in executive function
B. Cognitive deficits in A1 and A2
significant impairment in social or
occupational functioning AND repre
significant decline from a previous l
functioning
C. Cognitive deficits do not occur ex
during the course of delirium.
Evidence of decline is based on: concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and a substantial impairment in cognitive performance, preferably documented by standardized NP testing or another qualified clinical assessment
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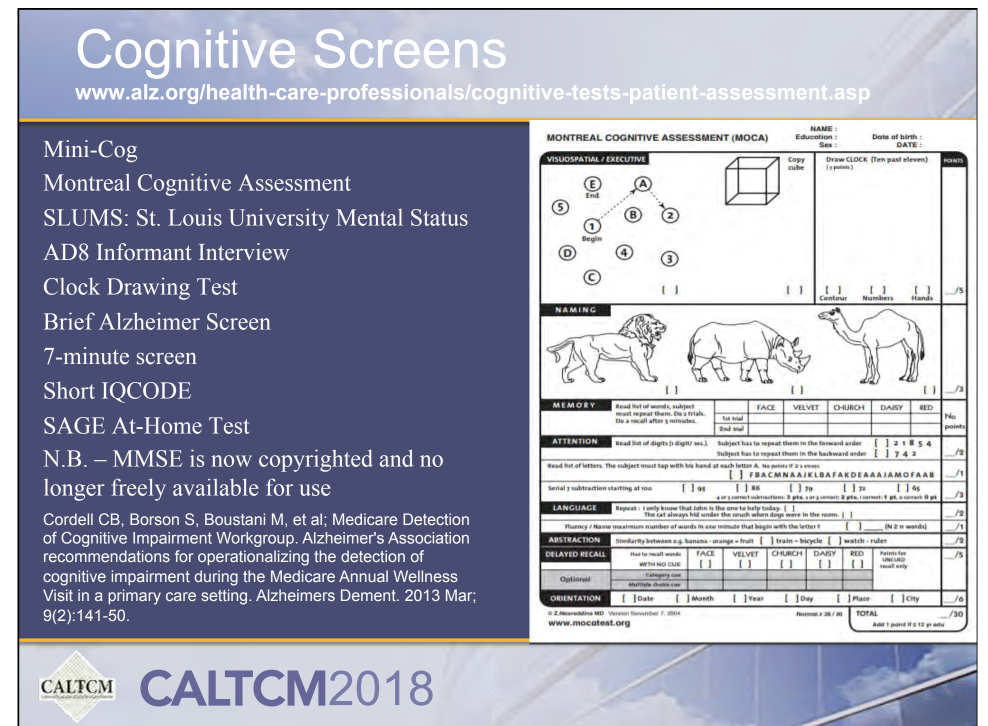

Cognitive Screens
www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp
Mini-Cog
Montreal Cognitive Assessment
SLUMS: St. Louis University Mental Status
AD8 Informant Interview
Clock Drawing Test
Brief Alzheimer Screen
7-minute screen
Short IQCODE
SAGE At-Home Test
N.B. – MMSE is now copyrighted and no longer freely available for use
Cordell CB, Borson S, Boustani M, et al; Medicare Detection of Cognitive Impairment Workgroup. Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting. Alzheimers Dement. 2013 Mar; 9(2):141-50.
MONTREAL COGNITIVE ASSESSMENT (MOCA)
VISUOSPATIAL / EXECUTIVE
NAMING
MEMORY
ATTENTION
LANGUAGE
ABSTRACTION
DELAYED RECALL
ORIENTATION
www.mocatest.org
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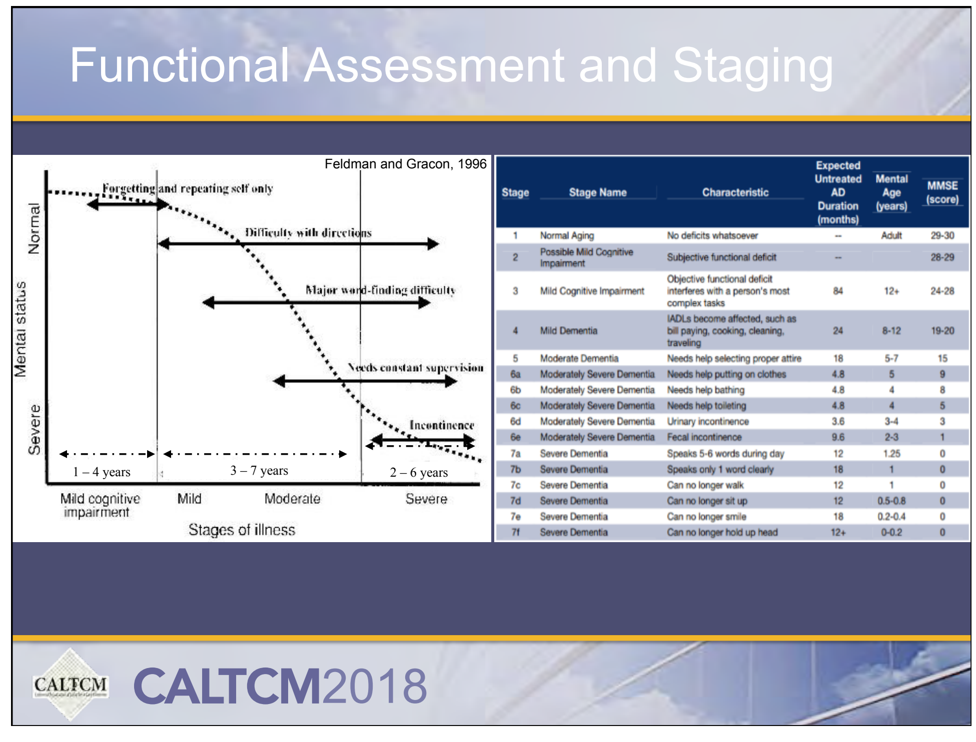

Stage	Stage Name	Characteristic	Expected Untreated AD Duration (months)	Mental Age (years)	MMSE (score)
1	Normal Aging	No deficits whatsoever	--	Adult	29-30
2	Possible Mild Cognitive Impairment	Subjective functional deficit	--		28-29
3	Mild Cognitive Impairment	Objective functional deficit interferes with a person's most complex tasks	84	12+	24-28
4	Mild Dementia	IADLs become affected, such as bill paying, cooking, cleaning, traveling	24	8-12	19-20
5	Moderate Dementia	Needs help selecting proper attire	18	5-7	15
6a	Moderately Severe Dementia	Needs help putting on clothes	4.8	5	9
6b	Moderately Severe Dementia	Needs help bathing	4.8	4	8
6c	Moderately Severe Dementia	Needs help toileting	4.8	4	5
6d	Moderately Severe Dementia	Urinary incontinence	3.6	3-4	3
6e	Moderately Severe Dementia	Fecal incontinence	9.6	2-3	1
7a	Severe Dementia	Speaks 5-6 words during day	12	1.25	0
7b	Severe Dementia	Speaks only 1 word clearly	18	1	0
7c	Severe Dementia	Can no longer walk	12	1	0
7d	Severe Dementia	Can no longer sit up	12	0.5-0.8	0
7e	Severe Dementia	Can no longer smile	18	0.2-0.4	0
7f	Severe Dementia	Can no longer hold up head	12+	0-0.2	0

Cognitive and Behavioral Domains

Cognitive

- Orientation
- Attention and concentration
- Memory
  - Encoding
  - Retrieval
- Language
  - Semantic and phonemic fluency
  - Reading and writing
- Visuospatial
  - Drawing and copying
- Executive function
  - Organizing and planning
  - Information processing
- Social cognition

Behavioral

- Mood
  - Depressed, sad, crying
  - Elated, jovial, manic
  - Irritable, angry, hostile
  - Anxious, worried, ruminative
- Aggression
- Motivation
- Obsession-compulsion
- Environmental dependency
- Psychosis
- Judgement/Insight
  - Aware, denies, oblivious
  - Impulsive, intrusive

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Differential Diagnosis

- It's not dementia, then what might it be?
  - Depression
  - Delirium
  - Primary sensory impairment
  - Age-associated Memory Impairment
  - Mild Cognitive Impairment
  - Polypharmacy
  - Substance induced Cognitive Disorder
  - Vitamin Deficiency
  - Metabolic derangement
  - Endocrinopathy

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Differential Diagnosis

- If it is dementia, then what type is it?
- Distinguishing features
  - Onset and illness course
  - Presentation
    - Cognitive deficits
    - Neuropsychiatric and behavioral symptoms
  - Associated features
  - Risk factors
  - Imaging findings
- **Determine stage of illness**

5 Most Common Dementia Syndromes	
Alzheimer Dementia	60 – 70%
Vascular Dementia	20 – 30%
Lewy Body Dementia	5 – 8%
Frontotemporal Dementia	3 – 5%
Parkinson Dementia	1 – 3%

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5 Most Common Dementia Syndromes

Alzheimer Dementia

- Course: insidious onset and gradual progression
- Presentation
  - Early memory loss and impaired learning
  - Visuospatial and language deficits
    - More difficulty with categories (naming animals, requires semantic memory) than with letter fluency (F words, phonemic fluency)
- Associated features
  - Early: depression and apathy are common
  - Moderate to severe: psychosis, agitation, aggression, wandering
  - Late: gait disturbance, dysphagia, incontinence, myoclonus, seizures

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5 Most Common Dementia Syndromes

Alzheimer Dementia

- Risk factors
  - Age, genes, Down's, traumatic brain injury
  - Family history of AD in 1st degree relative doubles risk
- Imaging
  - Hippocampal and temporoparietal cortical atrophy
  - FDG-PET: bitemporoparietal hypometabolism
- Other
  - Often occurs with Vascular CI/Dementia
  - May present with Lewy Body Disease

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5 Most Common Dementia Syndromes

Vascular Dementia

- Course
  - Presentation based on location and extent of CVE
  - May be stepwise, insidious or mixed
- Presentation
  - Temporal relationship between CVE and onset
  - Memory may be preserved or loss is secondary to frontal executive dysfunction
- Associated features
  - History of CVA or TIAs
  - Personality and/or mood changes
  - Psychomotor slowing or Parkinsonism but not PD

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5 Most Common Dementia Syndromes

Vascular Dementia

- Risk factors
  - HTN, DM, smoking, obesity, hypercholesterolemia, high homocysteine
  - Atrial fibrillation and athero, arteriosclerosis
- Imaging
  - Infarcts and white matter hyperintensities
  - Small vessel disease
- Other
  - Only 5 – 10% have pure Vascular Dementia
  - Often occurs with AD and/or DLB
  - Apathy and depression are often present

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5 Most Common Dementia Syndromes

Dementia with Lewy Bodies

- Course: insidious onset and gradual progression; may be more rapid compared to AD; very late-onset possible
- Presentation
  - Fluctuating cognition with early changes in attention and executive function; may look like delirium
  - Detailed/complex, recurrent, VH early in illness
  - Cognitive symptoms start shortly before or concurrently with motor
- Associated features
  - REM Sleep Behavior may be early sign
  - Nearly 50% have neuroleptic sensitivity
  - Falls, syncope, transient LOC are common
  - Autonomic dysfunction
  - Often history of delirium during illness or surgery

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5 Most Common Dementia Syndromes

Dementia with Lewy Bodies

- Risk factors
  - Genetic risk identified
  - Often no family history in most cases
- Imaging
  - Lewy bodies found primarily in cortex
  - Medial temporal structures preserved
- Other
  - Frequently coexists with AD and/or Vascular CI/Dementia

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5 Most Common Dementia Syndromes

Parkinson Dementia

- Course: insidious onset and gradual progression
- Presentation
  - Established diagnosis of Parkinson disease ≥ 1 year duration before onset of cognitive decline
- Associated features
  - Neuropsychiatric symptoms common
    - Anxiety early in course > depression
    - Apathy
    - Hallucinations – may or may not be related to DA agents
    - Emotional incontinence and catastrophic reactions
    - REM Sleep Behavior Disorder
    - Excessive daytime sleepiness

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5 Most Common Dementia Syndromes

Parkinson Dementia

- Risk factors
  - Exposure to pesticides
  - Duration of disease
- Imaging
  - Lewy bodies found primarily in basal ganglia
  - Medial temporal structures preserved
- Other
  - Neuroleptics can mimic or worsen Parkinsonism
  - May coexist with AD and Vascular CI/Dementia

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5 Most Common Dementia Syndromes

Frontotemporal Dementia

- Course: insidious onset and gradual progression
- Presentation
  - Behavioral variant (bvFTD): impaired social cognition and/or executive dysfunction with disinhibition, apathy, lack of empathy, compulsive behavior, and hyperorality (eating, putting objects in mouth)
  - Language variant: loss of word memory including speech production, word finding difficulties (anomia, paraphasic errors), impaired comprehension, and poor grammar
- Associated features
  - Early onset before age 65 but late onset possible
  - EPS or parkinsonism may be present
  - Overlaps with PSP, CBD, and MND

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5 Most Common Dementia Syndromes

Frontotemporal Dementia

- Risk factors
  - Up to 40% are familial
  - Present in up to 10% with MND
  - Brief cognitive measures are often normal
- Imaging
  - Pattern of atrophy dependent on subtype
- Other
  - May be misdiagnosed as late-onset bipolar, OCD, depression, schizophrenia or other psychiatric disorder
  - Visual hallucinations may be present

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Management and Treatment of Dementia in PA/LTC Settings

- Dementia care
  - Establishing trust
  - Developing patient-centered goals
  - Understanding patient and family values
- All treatment primarily follows a palliative approach
  - Cognitive symptoms: delay progression, improve QoL, and optimize functioning/participation to greatest extent humanely possible
  - Behavioral symptoms: relieve distress and suffering

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Cognitive Treatments in LTC Settings

- Current approved treatments are not a cure for dementia
  - AChEIs
  - NMDAR
- Might be considered for mild to moderate dementia
  - May be worth 6-12 month trial
  - Benefits beyond 1-2 years?
- Likely have no role in advanced or severe dementia
  - Gradual taper over 2-4 weeks dependent on duration of use

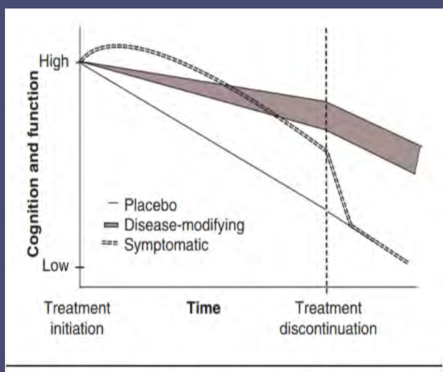

Figure 1. Hypothetical treatment response for symptomatic versus disease-modifying Alzheimer's disease treatments.

Samadi and Sultzer (2011) Expert Opin Biol Therapy

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Cognitive Treatments in LTC Settings

AChEIs

- Failure or intolerance to one does not mean failure to all
- Aim for max tolerated dose
- Beware of AEs
  - Weight loss, anorexia, syncope (bradycardia), falls, Parkinsonism, apathy/depression

NMDARs

- Usually used along with AChEI
- Bothersome AEs
  - Dizziness, headaches, constipation, insomnia, confusion, hallucinations

Diagnosis	Cognitive Medications	
	Start? Continue?	Never start? Stop?
Known	Mild to moderate stage	Advanced or severe stage
	≤ 1-2 years use	≥ 2-5 years use
	Benefits in cognition, care	No perceived benefits
New	Mild to moderate stage	Advanced or severe stage
	Short trial: 6-12 months	Polypharmacy Multimorbidity
	No previous use	Contraindication

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Other Interventions for Cognition

- In development, circa 2017
  - MOA: amyloid, tau or other related approaches
  - Spectrum: preclinical, prodromal/aMCI, mild to moderate, severe AD
    - Disease modifying immunotherapies
    - Symptom-reducing small molecules
    - Disease-modifying small molecules
- Other intervention approaches
  - Cognition vs ADLs
  - Exercise: aerobic or strength-training
  - Control of vascular risk factors
  - Management of OSA
  - Possibly treatment of neuropsychiatric symptoms

Cummings, Lee, Mortsdorf et al (2017) Alz Dementia

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Behavioral and Psychological Symptom Clusters

- Very common across all dementia syndromes
  - May precede full development of cognitive disorder
  - May complicate course of dementia
- Contribute to morbidity
- May be a marker of increased mortality risk
- Impaired language, poor comprehension or lack of insight may impede accurate assessment
  - Look to behaviors (clusters)
  - Get informant input
- Always try non-pharmacological interventions first!

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Ecobiopsychosocial Interventions for BPSD

- Endorsed by various groups – AGS, APA, AAGP, etc
- Not implemented due to lack of provider training, time required to implement interventions, lack of reimbursement, heterogeneity of interventions, immediate safety concerns of patients and staff
- Varying quality of evidence
- Best evidence: caregiver-supportive interventions (e.g., burnout)
- DICE Approach: ***D***escribe, ***I***nvestigate, ***C***reate, ***E***valuate

Psychosocial	Sensory Practices	Structured Care	Environment
• Validation Therapy • Reminiscence Therapy • Music Therapy • Pet Therapy • Meaningful Activities	• Aromatherapy • Massage Therapy • Multisensory stimulation • Bright Light Therapy • Acupuncture	• Mouth care • Bathing	• Snoezelen (soothing and stimulating env.) • Correcting under/over stimulation • Safety • Increased activity and structure • Routine

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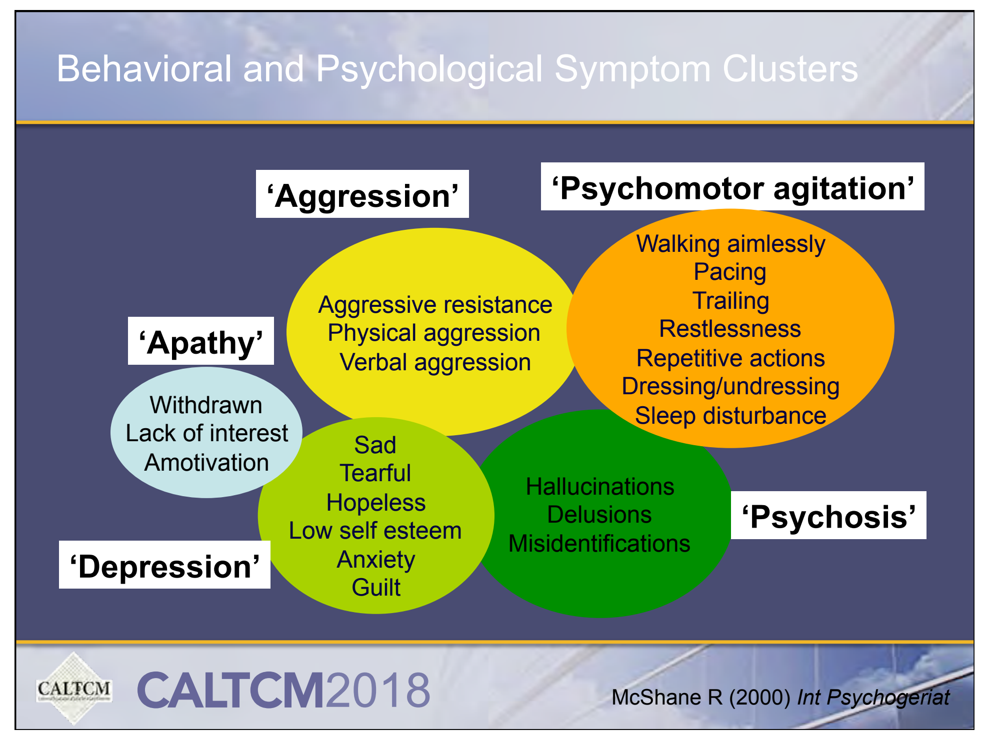
Kales, Gitlin, Lyketsos (2015) BMJ


Behavioral and Psychological Symptom Clusters
'Aggression'
'Psychomotor agitation'
Walking aimlessly
Pacing
Trailing
Restlessness
Repetitive actions
Dressing/undressing
Sleep disturbance
Aggressive resistance
Physical aggression
Verbal aggression
'Apathy'
Withdrawn
Lack of interest
Amotivation
Sad
Tearful
Hopeless
Low self esteem
Anxiety
Guilt
Hallucinations
Delusions
Misidentifications
'Psychosis'
'Depression'
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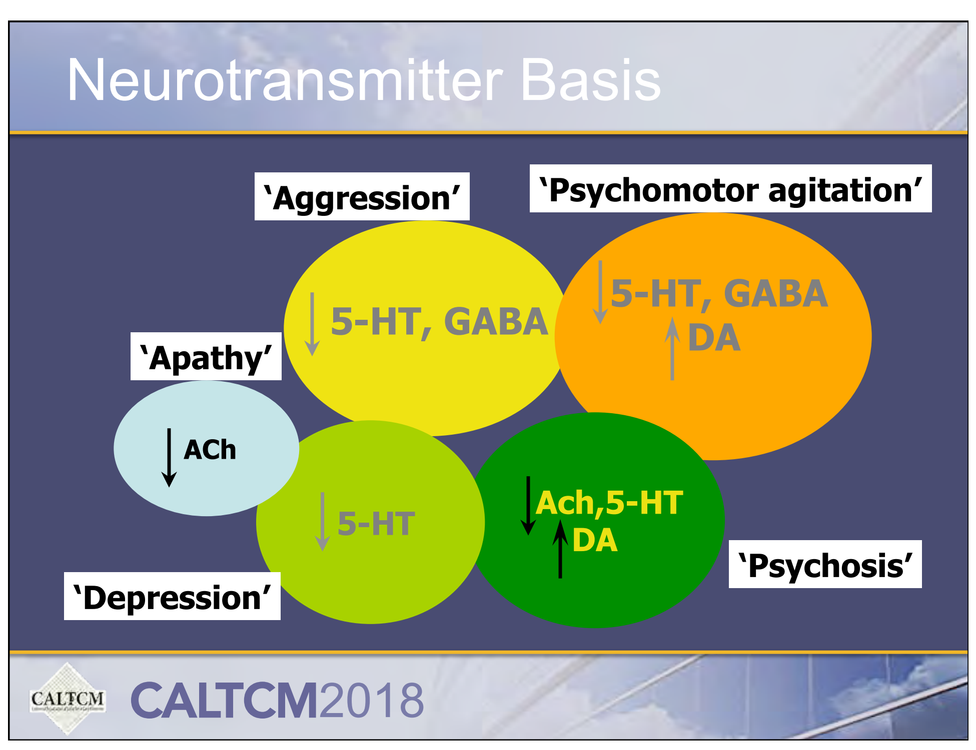
McShane R (2000) Int Psychogeriat


Neurotransmitter Basis
'Aggression'
'Psychomotor agitation'
5-HT, GABA
5-HT, GABA
DA
'Apathy'
ACh
5-HT
Ach,5-HT
DA
'Psychosis'
'Depression'
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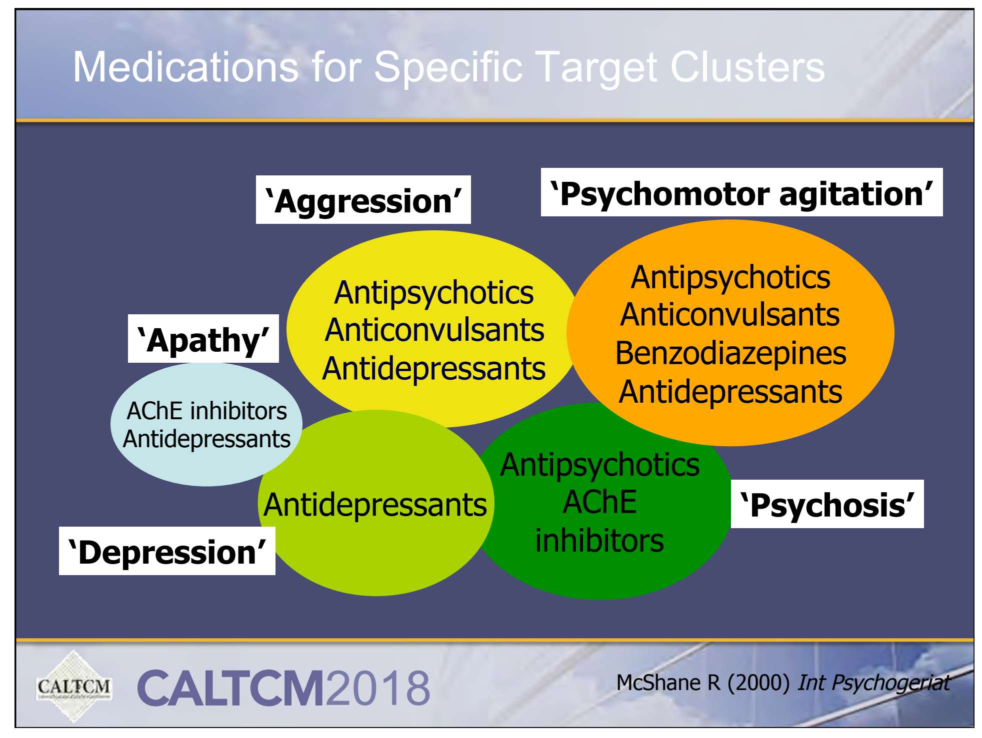

Psychotropics in LTC Settings

- Inappropriate prescribing remains a significant problem
  - Lack of assessment or documentation of target behaviors
    - Core symptoms
    - Functional outcomes
    - Informant input
  - Lack of periodic review to see which goals were or were not met
  - Indiscriminate prescribing
  - Over-prescribing
- Antipsychotics – special class
  - Must have clear rationale
  - Must undergo periodic reduction unless clear indication documented

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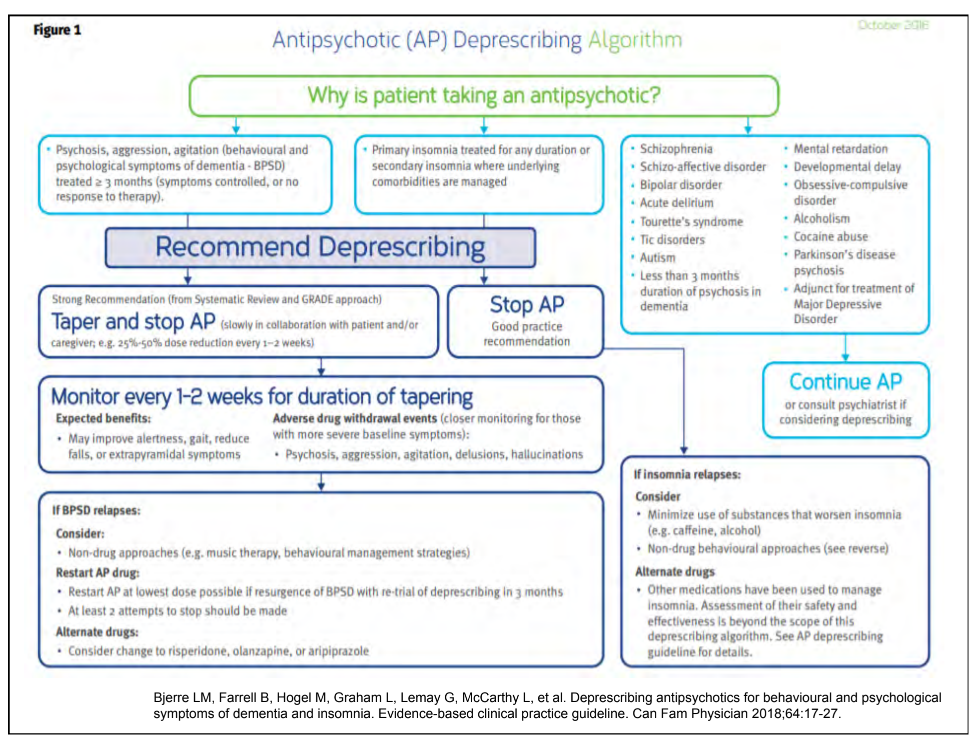
	Antidepressants	Antipsychotics	Mood Stabilizers	BZDs and Non-BZDs	B-blockers; α-adrenergic; other
Agitation	√	Avoid	√	Acute control; short term use only	√ ECT?
Aggression	√	Only if driven by psychosis	√	Acute control; short term use only	√
Anxiety	√	Only if not responsive to other means	Li?	Very cautious; Never long term	Buspirone
Apathy	√?	Avoid		Non-BZD?	Psychostimulants
Depression	√?	√√ Psychotic depression	√√ Bipolar depression		Psychostimulants ECT, tDCS?
Insomnia	?	Avoid		Avoid	
Psychosis		√√ (Caution in LDB, PDD)		Avoid	ECT?



Bjerre LM, Farrell B, Hogel M, Graham L, Lemay G, McCarthy L, et al. Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia. Evidence-based clinical practice guideline. Can Fam Physician 2018;64:17-27.

Summary and Thank You!

- Dementia is prevalent in PA/LTC settings.
- Every patient on admission gets a cognitive screen.
  - Follow positive screens with more thorough history and detailed exam. Include informants when possible.
  - Not all cognitive impairment is dementia, however.
  - Bedside cognitive instruments are readily available.
  - Always inquire about psychiatric history and symptoms.
- The general treatment approach is palliative care.
  - Family and patient goals should be incorporated into care plans.
  - Current cognitive meds manage symptoms temporarily.
  - Psychotropics remain over-used in dementia and most could be withdrawn when following a systematic approach.

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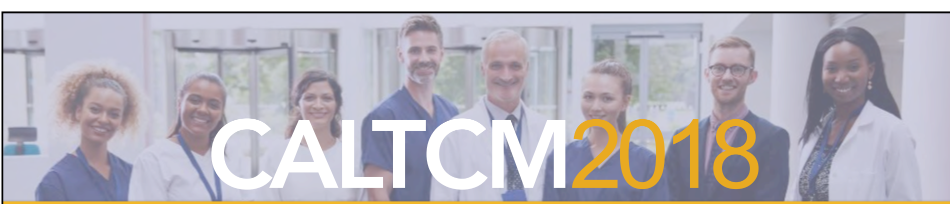

Updates in Acute Stroke Management and What it Means for PAC/LTC Patients

Michael Su, MD

Disclosures

- Michael Su, MD, has no relevant financial relationships with commercial interests to disclose

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Time = Brain

- In a typical large vessel acute ischemic stroke, each minute:
  - 1.9 million neurons,
  - 14 billion synapses,
  - 12 km of myelinated fibers are lost

Saver, 2006

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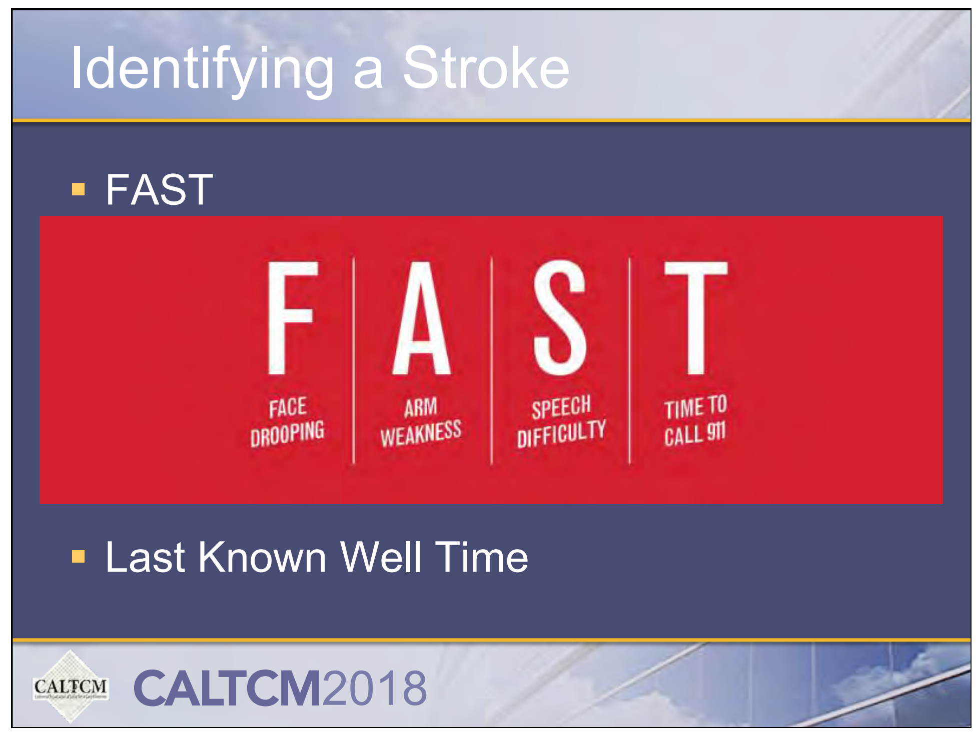

Large Vessel Occlusions

- Rapid Arterial oCclusion Evalution (RACE)
- Los Angeles Motor Scale (LAMS)
- Cincinnati Prehospital Stroke Severity Scale (CP-SSS)

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Bedside Management

- ABCs
- Call 911
- Head of bed 0 to 30deg
- Blood glucose
- Establish IV, keep O2 >94%
- Hold all anticoagulation / antithrombotics
- BP goal up to 220 /120
- NIH Stroke Scale

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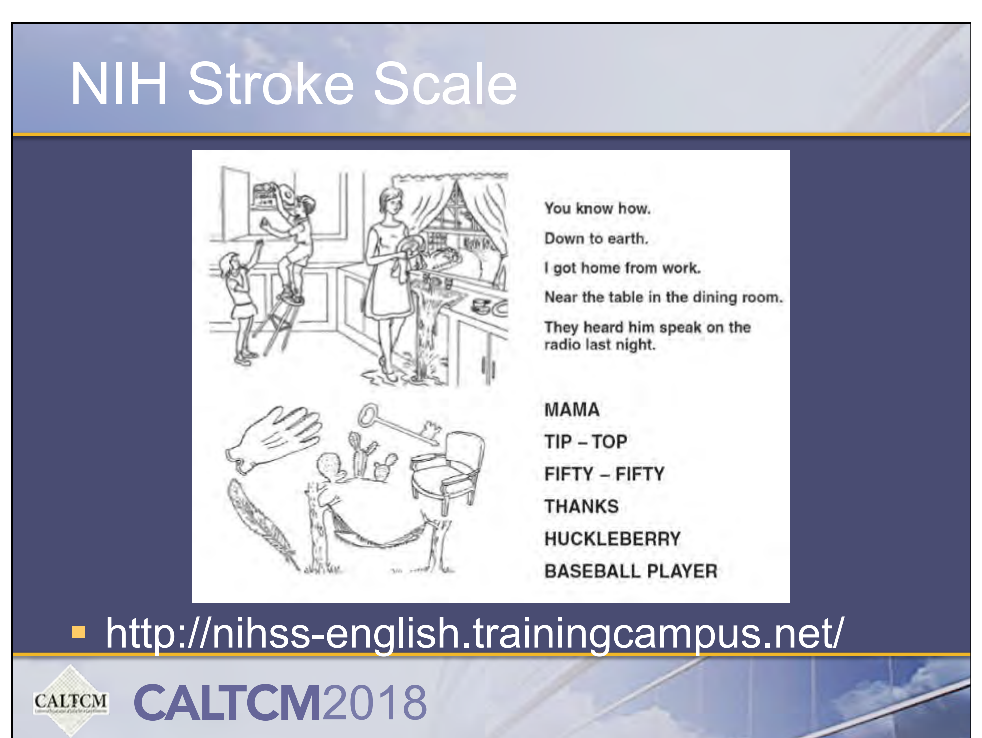
NIH Stroke Scale



- http://nihss-english.trainingcampus.net/

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Recrudescence

- Reemergence of prior stroke related symptoms
- Usually transient, can last days
- Often triggered by toxic, metabolic, or infectious stressors
  - UTI, hypotension, hyponatremia, stress
- Imaging only shows chronic findings

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Revascularization

- Thrombolysis
  - IV rt-PA
  - IA rt-PA
- Mechanical Thrombectomy
  - 1st Generation: MERCI, Penumbra
  - 2nd Generation: stent retrievers

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rt-PA

- NINDS 1995 trial
- Still the mainstay of acute stroke treatment
- Reduced proportion of patients mRS 3-6 (OR 0.85) and increased proportion of mRS 0-1 (OR 1.33) at 3-6 months
- Time dependent
- ~5% of acute ischemic strokes are treated with IV tPA

Inclusion Criteria

- Diagnosis of ischemic stroke
- Onset < 3 hours
- Age ≥ 18 y

Exclusion Criteria

- Major head trauma or stroke < 3 mo
- Prior ICH or sx's of SAH
- Arterial puncture at non compressible site < 7 d
- Prior ICH
- Intracranial neoplasm, AVM, or aneurysm
- Recent intracranial or intraspinal surgery
- Elevated BP (SBP > 185 or DBP > 110)
- Active internal bleeding
- Platelet <100k, heparin < 48 h with aPTT elevation, warfarin usage with INR > 1.7
- NoAC with abnormal aPTT, INR, platelet count, ECT, TT, Factor Xa assays
- Blood sugar < 50 or > 400
- >1/3 cerebral hemisphere hypodensity on CT

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Relative Exclusion Criteria

- Minor or rapidly improving symptoms
- Pregnancy
- Seizure at onset
- Major surgery or trauma < 14 d
- GI or GU hemorrhage < 21 d
- Recent MI <3 mon

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Exclusion Criteria (3 to 4.5 hrs)

- Age >80 yrs old
- NIHSS > 25
- Hx of DM AND prior stroke
- On oral anticoagulant regardless of INR

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Exclusion Criteria – 2016+

- Major head trauma or stroke < 3 mo
- Prior ICH or sx's of SAH
- ~~Arterial puncture at non compressible site < 7 d~~
- Prior ICH
- Intracranial neoplasm, ~~AVM, or aneurysm~~
- Recent intracranial or intraspinal surgery
- Elevated BP (SBP > 185 or DBP > 110)
- Active internal bleeding
- Platelet <100k, heparin < 48 h with aPTT elevation, warfarin usage with INR > 1.7
- NoAC with abnormal aPTT, INR, platelet count, ECT, TT, Factor Xa assays within 48hr
- Blood sugar < 50 ~~or > 400~~
- >1/3 cerebral hemisphere hypodensity on CT
- NEW – ischemic stroke due to infective endocarditis, aortic arch dissection

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Relative Exclusion Criteria – 2016+

- ~~Minor or rapidly improving symptoms~~
- ~~Pregnancy~~
- ~~Seizure at onset~~
- ~~Major surgery or trauma < 14 d~~
- GI or GU hemorrhage < 21 d
- ~~Recent MI <3 mon~~

Exclusion Criteria (3 to 4.5 hrs) – 2016+

- ~~Age >80 yrs old~~
- NIHSS > 25
- ~~Hx of DM AND prior stroke~~
- ~~On oral anticoagulant regardless of INR~~

Other Factors

- Patient should still be treated if:
  - If unable to consent and no representative available
  - Patients have pre existing debility
  - <12 months life expectancy

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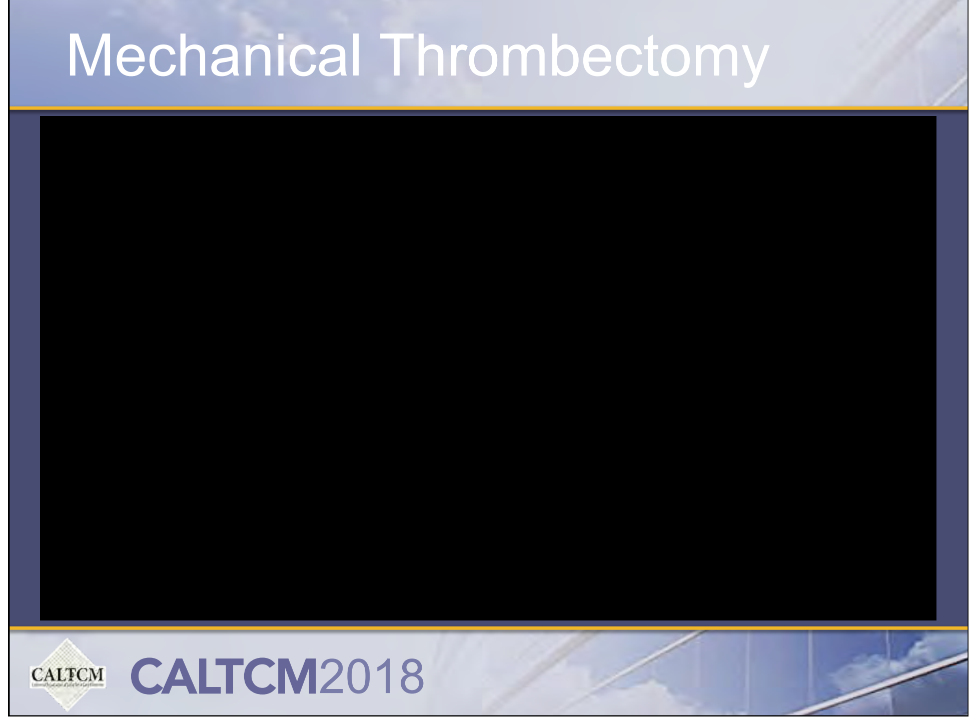
Mechanical Thrombectomy



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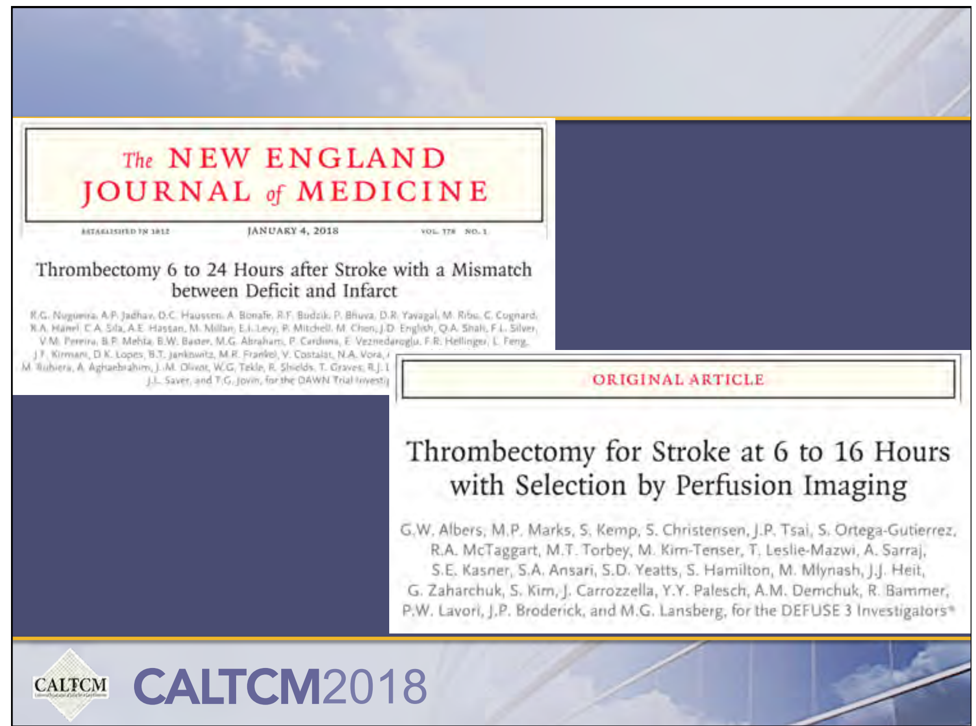
Mechanical Thrombectomy

- First generation devices were studied for patients within 8 hrs of onset, recommended for within 6 hours
- March 2013 – 3 RCTs showed that thrombectomy was no better than standard care (MR RESCUE, SYNTHESIS, IMS III)

Mechanical Thrombectomy

- 2015 – MR CLEAN, ESCAPE, EXTEND IA, SWIFT PRIME, REVASCAT
- 2016 – HERMES meta analysis
  - NNT to reduce disability by at least 1 level of mRS = 2.6


The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JANUARY 4, 2018 VOL. 378 NO. 1

Thrombectomy 6 to 24 Hours after Stroke with a Mismatch between Deficit and Infarct

R.G. Nogueira, A.P. Jadhav, D.C. Haussen, A. Bonafe, R.F. Budzik, P. Bhuva, D.R. Yavagal, M. Ribo, C. Cognard, R.A. Hanel, C.A. Sila, A.E. Hassan, M. Millan, E.I. Levy, P. Mitchell, M. Chen, J.D. English, Q.A. Shah, F.L. Silver, V.M. Pereira, B.P. Mehta, B.W. Baxter, M.G. Abraham, P. Cardona, E. Veznedaroglu, F.R. Hellinger, L. Feng, J.F. Kirmani, D.K. Lopes, B.T. Jankowitz, M.R. Frankel, V. Costalat, N.A. Vora, M. Rubiera, A. Aghaebrahim, J.M. Olivot, W.G. Tekle, R. Shields, T. Graves, R.J. L J.L. Saver, and T.G. Jovin, for the DAWN Trial Investi

ORIGINAL ARTICLE

Thrombectomy for Stroke at 6 to 16 Hours with Selection by Perfusion Imaging

G.W. Albers, M.P. Marks, S. Kemp, S. Christensen, J.P. Tsai, S. Ortega-Gutierrez, R.A. McTaggart, M.T. Torbey, M. Kim-Tenser, T. Leslie-Mazwi, A. Sarraj, S.E. Kasner, S.A. Ansari, S.D. Yeatts, S. Hamilton, M. Mlynash, J.J. Heit, G. Zaharchuk, S. Kim, J. Carrozzella, Y.Y. Palesch, A.M. Demchuk, R. Bammer, P.W. Lavori, J.P. Broderick, and M.G. Lansberg, for the DEFUSE 3 Investigators*

DAWN

- 6 to 24 hrs post stroke onset
- ICA or prox MCA occlusion with clinical mismatch based on core infarct volume or perfusion maps
- Stopped early due to superiority of thrombectomy group
- Utility weighted mRS @ 90d: 5.5 vs 3.4
- Rate of functional independence @ 90d: 49% vs 13%

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DEFUSE 3

- 6 to 16 hrs post stroke onset
- Selected patients based on perfusion maps
- Stopped early due to superiority of thrombectomy group
- mRS @ 90d: OR of favorable outcome 2.77 (adjust 3.36)
- Functional independence @ 90d: 45% vs 17%

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Stroke Centers

Table 1. Some Characteristics of Typical Acute Inpatient Stroke Care Facilities

	Hospital Type			
Characteristics	Non–Stroke Center	ASRH	PSC	CSC
Typical bed count	20–50	30–100	100–400	400–1500
Annual stroke admissions	10–50	25–50	50–300	>300
Rapid neuroimaging 24/7*	No	Performed and read within 45 min of order	Performed and read within 45 min of order	Performed and read within 45 min of order
IV tPA capability 24/7	No	60-min door-to-needle time	60-min door-to-needle time	60-min door-to-needle time
Acute stroke team available	No	At bedside within 15 min	At bedside within 15 min	At bedside within 15 min
Stroke unit	No	No†	Yes	Yes
Neurocritical care unit	No	No	No	Yes§
Access to neurosurgical services	No	Yes, within 3 h or by transfer‡	Yes, within 2 h, in-house or by transfer	Yes, 24/7 coverage and call schedule

ASRH indicates acute stroke–ready hospital; CSC, comprehensive stroke center; IV, intravenous; PSC, primary stroke center; tPA, tissue-type plasminogen activator; and 24/7, 24 hours per day, 7 days per week.
*24/7 Neurological expertise available through telemedicine, on site, or a combination.
†Some ASRHs may have the necessary resources on site or via telemedicine to support a stroke unit.
‡This may vary based on geographic and other considerations.
§Or a defined neurocritical care service operating within the context of a medical or surgical intensive care unit.

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Higashida et al 2013

- Thrombectomy Capable Stroke Centers
  - Dedicated neuro intensive care unit (but not staffed 24/7 with neurointensivist)
  - Neurosurgical services available within 2 hours

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Mobile Stroke Units

- Portable CT head
  - Including angiography and perfusion
- Point of care labs
  - CBC, INR, glucose
- Telemedicine
- Able to deliver IV tPA, reverse anticoagulants
- Triage patients more efficiently

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- Significantly reduces time to treatment with IV tPA
  - Onset to treatment time: 72 min (vs 140)
- More likely to be DC'd home but no significant improvement in short term outcomes, meta analysis suggests no difference in 90 day mRS
- Studies are too small to determine extent of benefit
- Cost effectiveness?
- Efficacy in rural regions?

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Changes for Rehabilitation in SNF and LTC Facilities

Lawrence S. Miller, MD, FACP

Disclosures

- Lawrence S. Miller, MD, FACP, has no relevant financial relationships with commercial interests to disclose.

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Changes for Rehabilitation in SNF and LTC Facilities

1. Bundling
2. Functional Measures
   - Modified CARE Tool
3. Payment for Improvement

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Geriatric Rehab Adages

- Aging doesn't cause disability
- All dementia is not Alzheimer's
- Rehabilitation can improve function

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The dangers of bed rest can be most dramatically summarized in the words of Dr. Richard Asher (1947):

"Look at a patient lying in bed;
What a pathetic picture he makes.
The blood clotting in his veins,
The lime draining from his bones,
The scybala stacking up in his colon,
The flesh rotting from his sweat,
The urine leaking from his distended bladder
And the spirit evaporating from his soul."

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Stasis

PHYSIOLOGIC ALTERATION

- Venous Pooling
- Decreased movement of Pulmonary Secretions
- Decreased movement of ligament

PATHOLOGIC COMPLICATION

- Thrombophlebitis
- Pulmonary Infection
- Pneumonia
- Contracture

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Stasis

PHYSIOLOGIC ALTERATION	PATHOLOGIC COMPLICATION
Urine Stagnation	Bladder Distension
Increased calcium in urine	Stone Formation
Decreased Fecal Excretion	Constipation and Obstipation

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Atrophy

PHYSIOLOGIC ALTERATION	PATHOLOGIC COMPLICATION
Decreased Bone Anabolism	Osteoporosis
Decreased Muscle Use	Muscle Weakness
Decreased Sensory Stimuli	Incoordination

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Atrophy

PHYSIOLOGIC ALTERATION
- Decreased Vasoconstriction
- Decreased Heart Size
- Decreased emotional stimuli

PATHOLOGIC COMPLICATION
- Hypotension
- Decreased Endurance
- Dependency

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Pressure

PHYSIOLOGIC ALTERATION
- Impaired Circulation to Skin
- Impaired Circulation of Nerve
- Impaired Emotional Control

PATHOLOGIC COMPLICATION
- Decubitus Ulceration
- Nerve Palsy
- Anxiety and Hostility

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Self Care

- Feeding
- Grooming
- Bathing
- Dress – UB
- Dress – LB
- Toileting

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Sphincter Control

- Bladder
- Bowel

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Locomotion

- Walking – W/C
- Stairs

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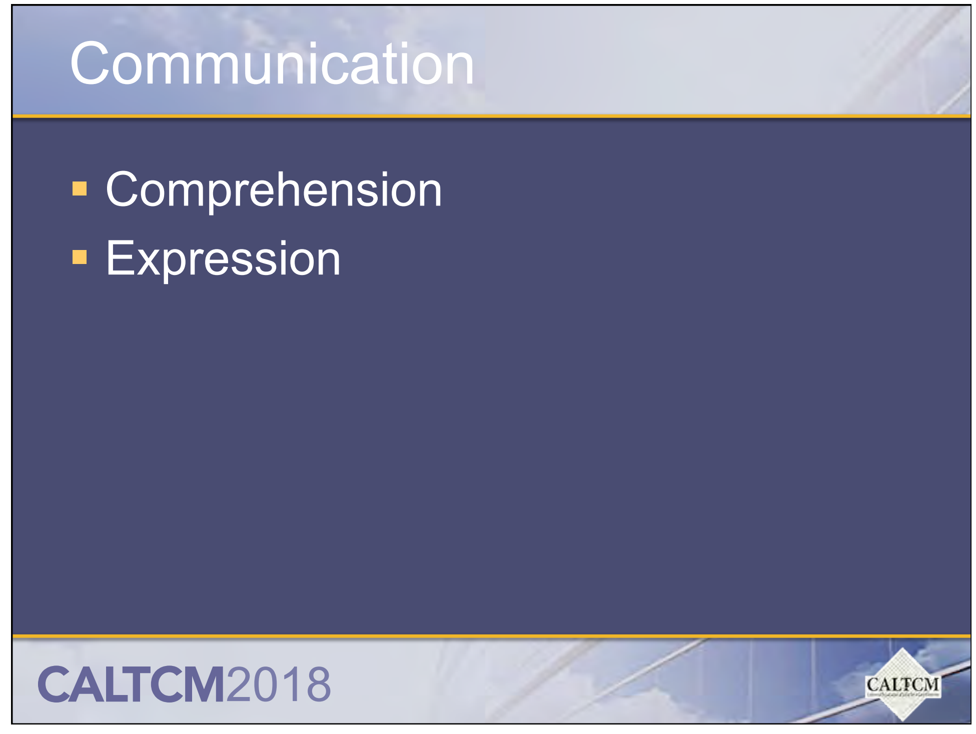

Social Cognition

- Social Interaction
- Problem Solving
- Memory

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Miscellaneous

- Homemaking
- Bed Mobility
- Supine to sit
- Sit to stand

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Measurement

- Unable
- Max assist
- Mod assist
- Min assist
- Stand by/ supervised
- Independent

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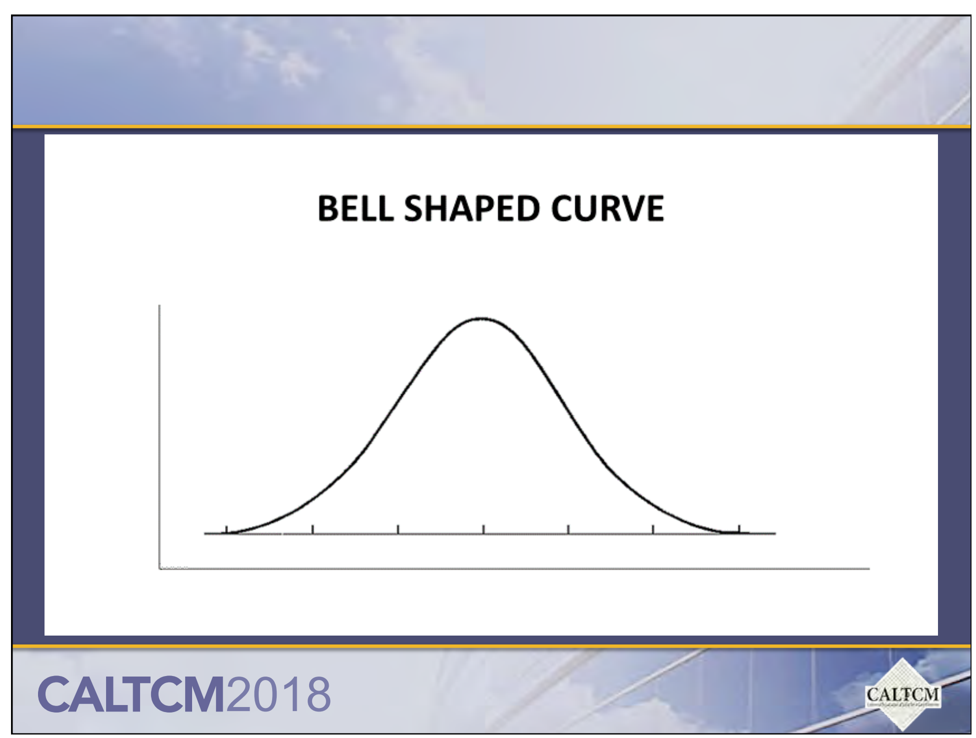

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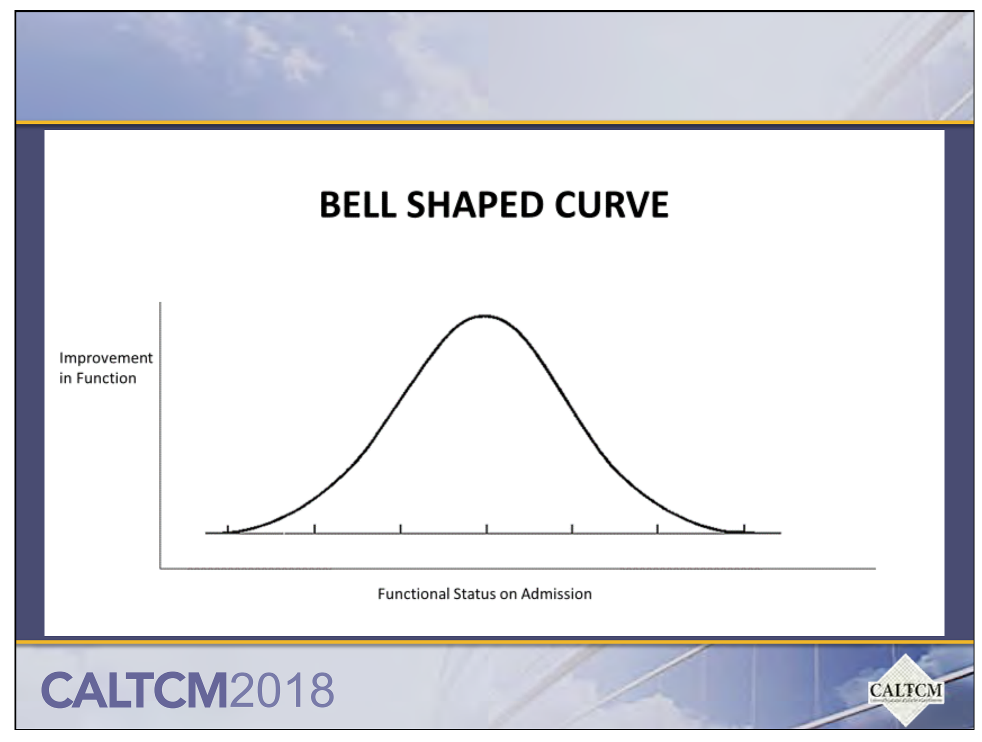

Rehabilitation Goals

1. Data Base
   - Prior living arrangements
   - Prior functional status
   - Patient/Family concerns
   - Potential discharge placement options

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Rehabilitation Goals

2. Potential for Improvement
   - Physiatrist Consultation
   - PT, OT, Speech assessments
   - Nursing, social service, psych
   - Medical condition

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Lack of Expected Progress

Identify Complicating Factors

1. At facility
2. Referral to Acute Hospital

Medically unstable, infection, delirium, behavior issues, pain not controlled, etc.

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Antimicrobial Stewardship Program Time's Up

Janice Hoffman, Pharm.D., EdD, APP, CGP, FASCP
Elizabeth Akhparyan, Pharm.D., Pharmacy Resident

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Disclosure Statement of Financial Interest

- Janice Hoffman and Elizabeth Akhparyan have no relevant financial relationships with commercial interests to disclose
- Propriety Information or results of ongoing research may be subject to different interpretations
- Presentation of this slide indicates my agreement to abide by the non-commercial guidelines

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Learning Objectives

- Explain strategies for antimicrobial stewardship to support appropriate antibiotic use and reduce the development of antibiotic resistance.
- Review a rational approach to stewardship in PAC/ LTC patients that meets quality goals and patient care goals .
- Describe incentives for implementing programs aimed at improving antimicrobial use.

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Antibiotic Use and Resistance: Global Health Crisis [1]

- In the U.S., > 2 million patients contract Antimicrobial Resistant Infections (AMR) on an annual basis
  - Average of 23,000 deaths/year
  - Projected to exceed 10 million deaths /year by 2050
- 30-50% of antibiotic use in hospitalized patients,
  - CDC suggests are inappropriate
- Patients in Long-Term Care Facilities (LTCF)
  - 12% have an infection at any given time
  - > 75% of these antibiotics are misused or inappropriate
    - by indication, dose, or duration of therapy.

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Antibiotic Use and Resistance: Global Health Crisis [2]

- Studies have confirmed that antibiotic consumption correlates with the emergence of resistance.
- Resistance has been linked with:
  - Increased infection-related mortality
  - Increase in the cost of treatment
  - Increase use of broad spectrum antibiotics

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Antimicrobial Stewardship Purpose[2]

- Antimicrobial stewardship programs have been around for decades within acute-care inpatient facilities.
- The purpose of Antibiotic stewardship:
  - Decreased antibiotic expenditures
  - Improved treatment outcomes
  - Reduced inappropriate use of antibiotics

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National Goals for Antimicrobial Stewardship [3]

- Slow the emergence of resistant bacteria and prevent the spread of resistant infections
  - IMPLEMENTATION OF GOALS:
    - Strengthen antibiotic stewardship at all practice sites
    - Implement annual reports of antibiotic use and identify geographic variations and or variations at the provider and or patient level that can help guide intervention.

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Infection In The Elderly [5]

- LTCF residents have a significant risk factor for colonization with multi-drug resistant organisms (MDRO).
  - High proportions of elderly patients are shared between LTCF and acute-care hospitals, acting as reservoirs for MDROs

- In nursing home residents, recent studies reveal :
  - 4-50% of residents are colonized with Clostridium Difficile
  - ≥50% colonized with MRSA
  - 20-30% colonized with Gram-negative Bacilli

- CMS now requires Long Term Care facilities to establish an antibiotic stewardship program effective November 2017
  - CMS will no longer reimburse facilities for patients that have contracted nosocomial infections perceived to be avoidable

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CDC Core Elements for Antimicrobial Stewardship [8]

- Commitment: Demonstrate dedication to and accountability for optimizing antibiotic use and patient safety
  - Identify a single leader to direct antibiotic stewardship activities.
  - Communicate with all staff members to set patient expectations.
- Action: Implement at least one policy or practice to improve antibiotic use, assess whether it is working and modify as needed
  - Use evidence-based diagnostic criteria and treatment recommendations.
  - Use delayed prescribing practice or watchful waiting, when appropriate.
  - Provide communication training.
  - Require explicit written justification
  - Provide support for clinical decisions

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CDC Core Elements for Antimicrobial Stewardship [8]

- Tracking and reporting:
  - Monitor antibiotic prescribing practice
  - Offer regular feedback to clinicians
  - Perform self-assessment on antibiotic use/ Self-evaluate antibiotic practices
  - Participate in continuing medical education and quality improvement activities
- Education and expertise: Provide education resources to clinicians and patients on antibiotic use and ensure access to needed expertise on judicious antibiotic prescribing
  - Use effective communication strategies to educate patients when antibiotics are not needed.
  - Educate patients about the potential harm of antibiotic treatment

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Key Members of an Antimicrobial Stewardship Team [8]

- Core Members
  - Pharmacists:
    - Training in ID preferred
    - Training in Physical Assessment preferred
  - Physician
    - Training in ID preferred
  - Nurses
    - Training in ID preferred
- Translational Members
  - Clinic Leader
    - E.g Direction of Nursing
    - Infection Preventionist
  - Microbiologist/Laboratory representative
    - Track pathogens and susceptibility patterns.
  - Public Health
  - Information Technology Specialist

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Elements Of A Successful Antimicrobial Stewardship Program [6]

- Preauthorization/ Feedback
- Guideline implementation
- Education
- Application of information technology
- Rapid Diagnostic Testing
- Implementing Restricted Agents: Specifically antibiotics associated with CDI
- IV to Oral
- Streamlining/De-escalation
- Dose Optimization
- Antibiotic timeouts

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Elements Of A Successful Antimicrobial Stewardship Program – Preauthorization [6]

Requires approval before prescribing certain agents

- Commonly seen with Broad-spectrum Antibiotics
- Recommended by IDSA/SHEA for antibiotics that treat emerging drug-resistant bacterial infections
- Successful in reducing antibiotic misuse and resistance
- Associated with a significant reduction in the use of restrictive agents and of associated costs
  - Associated with increase in percentage of gram-negative isolates
    - Does not affect hospital length of stay and survival
    - No adverse effects for patients

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Elements Of A Successful Antimicrobial Stewardship Program – Preauthorization [6]

- Most successful when:
  - Clinical pharmacist PLUS infectious disease physician specialist are employed for the approval process
    - Most appropriate agent selected
    - Highest cure rates
    - Lowest treatment failure
- Optimal when charts are directly viewed as opposed to telephone communication

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Elements Of A Successful Antimicrobial Stewardship Program – Feedback [6]

Engages the Provider after the agent is prescribed to improve antibiotic use

- Typically seen ~ days 2 or 3 of treatment
- Involves direct interaction
  - Prescriber to Prescriber
  - Pharmacist to Prescriber – most common
  - Nurse to Prescriber
- Compliance is voluntary
- Proven reduction in antibiotic resistance and antibiotic misuse
- Labor intensive

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Elements Of A Successful Antimicrobial Stewardship Program – Guideline Implementation [6]

To disseminate knowledge and raise awareness:

- Provide electronic or hard copy to Medical, nursing and ALL staff
- Integrate into e-HR order sets → provide easy accessibility
- Must integrate into culture- most effective when led by ID physician

Syndrome Specific Intervention:

- Focus on pneumonia in the winter season
- UTI or SSTI in the fall season

- Guideline is regularly re-evaluated & reflects current medical literature
- Demonstrates improvement in:
  - Use of narrower-spectrum antibiotic
  - Earlier switch from IV to PO therapy
  - Shorter duration of treatment

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Elements Of A Successful Antimicrobial Stewardship Program – Information Technology [6]

- Computerized clinical decision support system at time of prescribing
  - Provides treatment recommendations
    - Based on IDSA guidelines
  - Specific selection of antibiotic of choice
    - based on antibiogram for facility
- Requires financial resources and maintenance
  - Must assess if beneficial for facility
- Potential for alert fatigue

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Elements Of A Successful Antimicrobial Stewardship Program – Dose Optimization [6]

- Optimization (= appropriate dose for infection type) based on characteristics of drug is vital in stewardship
  - individual patient characteristics
  - causative organisms
  - site of infection
  - pharmacokinetic and pharmacodynamics
- Implement interventions and guidelines to reduce antibiotic therapy to shortest effective duration of therapy
  - Based on patient specific factors
  - Systematic reviews and RCT's found (used to make policy & procedures)
    - shorter courses of therapy is associated with similar outcomes of prescriptions of longer courses
    - both adults and children with a variety of infection types

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Elements Of A Successful Antimicrobial Stewardship Program – Streamlining and/or De-escalation of therapy [6]

- Streamlining Changing from initial broad-spectrum (often times combination) empiric therapy to narrow-spectrum, monotherapy on the basis of culture and sensitivity results
- Decreased antimicrobial exposure decrease duration
- De-escalate from IV to PO
- Outcomes:
  - Substantial cost savings
  - decrease resistant and Adverse effects

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Elements Of A Successful Antimicrobial Stewardship Program – IV to PO [6]

- Encouraged for both initiation of therapy and transition from parenteral therapy, when condition allows
- Programs should establish and standardize:
  - Which antibiotic agents qualify for oral conversion
  - Criteria/Candidacy for switching
    - Example: Patients body temperature, WBC count
- Successful outcomes:
  - Reducing costs
  - Length of hospital stay
  - Without compromising safety and efficacy

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Adopting ASP Committee - Long Term Care [7]

- LTCF/PAC ideal ASP committee should include:
  - Infection Preventionist (required usually a nurse)
  - Medical Director or designated physician (required)
  - Pharmacist (required)
  - Director or Asst. Director of Nursing (DON)
- Other members may include:
  - Attending Physician, NP, or PA
  - Administrator
  - Nurse and/or nurse aide
  - Allied health professional
  - representative from Resident and Family council
- Committee chair should have leadership skills & receive advanced training in antibiotic stewardship (facilitated by the LTCF)

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Adopting ASP Principles [1,3,4,5,8]

Responsibilities and functions:

- Committee:
  - Review antibiotic use data
  - identify targets and track outcomes
  - share an annual written report with facility
  - provide education
  - communicate protocol to prescribers and nursing staff
- Pharmacist: assess, monitor, and communicate about antibiotic use in medication regimen review (MRR) and intervene with prescribers and alert Medical Director to concerns (recommended by CMS)
- Medical Director: champion standards for antibiotic prescribing practices & overseeing adherence to standards by prescribers
  - Appropriate & accurate documentation: dose, duration, route, and indication of therapy

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Adopting ASP Principles [1,3,4,5,8]

Adopting or Developing Antibiotic Use Protocol:

1. Diagnostic criteria & appropriate diagnostic tests for common infections
   - Guidance on appropriate indications for ordering tests in LTCF:
     - Example : urine culture results often utilized instead of clinical symptoms, resulting in unnecessary antibiotic use
2. Length of treatment (evidence-based)
   - LTC Infections: UTI, pneumonia, cellulitis therapy require 7 days treatment max (refer to IDSA)
3. Choosing appropriate empiric antibiotic therapy
   - Based on facility antibiogram
   - Reassess after 2-3 days for necessity

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Adopting ASP Principles [1,3,4,5,8]

Consultant from Laboratory & Monitoring Resistance:

- CMS State operations manual recommends monitoring of:
  - C. difficile
  - MRSA
  - Carbapenemase-Resistant Enterobacteriaceae
- LTCF/PAC should work with laboratory or consultant to develop a facility-specific antibiogram
  - Assist in showing susceptibility patterns of isolates collected over the past year
  - Both will serve as means to strengthen and measure antibiotic resistance data

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Adopting ASP Principles [1,3,4,5,8]

- Monitor and Measure Antibiotic Use:
  - Antibiotic use data coupled with indication for prescribing helps identify targets, goals for improvement, and tracks progress
- Effective metrics for measuring antibiotic use:
  - DOT- days of therapy
  - DDD- Defined daily doses
  - Empiric selection based on antibiogram for indication
  - Antibiotic Starts- number of new prescriptions
- Provide periodic report (quarterly) on the facilities antibiotic use, identifying providers prescribing patterns
  - Prescriber comparison can serve as effective as behavioral intervention

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Adopting ASP Principles [1,3,4,5,8]

A combination of active and passive learning is most effective (Education)

Among 900 known publications on AMS, 11 appeared in nursing journals

- Drives idea of nurses reluctance to challenge prescriber orders

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Antibiotic Rounds

- Monitoring of residents on antibiotics
- Physical assessment of resident
- Actions needed for patient safety
- Prescriber trends

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Adopting ASP Principles [1,3,4,5,8]

- Provide education to nursing staff on:
  - Appropriate management of disease status: ex) UTI, urine collection
  - Interpreting antibiograms
  - Disease based guidelines
  - Consequences of antibiotic use
- ✓ Creates a cohesive and uniform foundation for ASP and drives confidence of nurses in patient care

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Adopting ASP Principles [1,3,4,5,8]

Education: Patients and Family

- Expectations on antibiotic treatment play an important role in clinical management in Long Term Care facilities:
- Engage patients and family in the clinical decision process
  - Discuss benefits and risks
  - Provide pamphlets
  - Display posters in visitor areas about safe and effective use of antimicrobials
  - Provide commitment letter
    - Bridges trust of family members, making them more likely to support clinicians decisions and less likely to demand antibiotics

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Questions

WHERE?
WHAT?
WHO?
HOW?
WHY?
WHEN?

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Thank you

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Disaster Preparedness Implications for Post Acute Care

Jocelyn Montgomery, RN, PHN

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Disclosures

- Jocelyn Montgomery, RN, PHN, has no relevant financial relationships with commercial interests to disclose.

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Objectives

- Understand the significant risks and unique concerns for the LTC population during emergencies
- Identify the major requirements for providers under the CMS EP regulations
- Explore the critical role that LTC clinicians play in an emergency response through a case study

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Nursing Home Residents Are Especially Vulnerable

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Evacuation vs. Shelter in Place
Is Evacuation Always the Best Choice?

…preliminary data suggests that evacuation has unintended consequences in terms of mortality, hospitalization, and functional decline.

Vincent Mor, PhD
Center for Gerontology and Healthcare Research, Brown University, Providence, RI, USA

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Transitioning Nursing Home Residents during Hurricane Emergencies: The Mortality & Morbidity Consequences of Evacuating Versus Sheltering in Place

Kathy Hyer, PhD, MPP
School of Aging Studies, University of South Florida, Tampa, FL

David Dosa, MD, MPH
Providence VA Medical Center
Center for Gerontology and Health Care Research
Brown University, Providence, RI

The Safe Haven Study
Grant Funded by NIA AG#30619

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Excess Mortality

	90 Days			
	Expected	Actual	Excess	Fraction Due to Evacuation
Katrina	601	842	**241**	**24**
Rita	823	1016	**193**	**42**
Gustav	405	496	**91**	**28**
Ike	683	737	**54**	**0**

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Excess Hospitalizations

	90 Days			
	Expected	Actual	Excess	Fraction Due to Evacuation
Katrina	1643	1808	**164**	**24**
Rita	2042	2285	**243**	**231**
Gustav	1139	1234	**95**	**90**
Ike	1535	1576	**41**	**0**

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Effects of Hurricane Katrina on Nursing Facility Resident Mortality, Hospitalization, and Functional Decline

- Excess Mortality and hospitalizations at 30 and 90 days
- Additional 148 deaths at 30 days and 230 deaths at 90 days.
- The 30-day hospitalization rate was 9.87% compared with 7.21% and 7.53%, respectively.
- The 90-day hospitalization rate was 20.39% compared with 18.61% and 17.82%, respectively.

- Conclusion: NF residents experienced a significant increase in mortality, hospitalization, and functional decline during Hurricane Katrina

Dosa, D. et al.
Disaster Med Public Health Prep. Sep 2010; 4(0 1): S28–S32

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The Effects of Evacuation on Nursing Home Residents with Dementia

- Included 21,255 residents living in 119 at risk nursing homes over three years of observation.
- Compared to the 2 years before the storm, there was a:
  - 2.8 percent increase in death at 30 days
  - 3.9 percent increase in death at 90 days for residents with severe dementia who evacuated for Hurricane Gustav

Brown, L.M. Am J Alzheimers Dis Other Dem. Sept 2012, Vol 27, No.6 (406-412)

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Function and Response of Nursing Facilities During Community Disaster

- All nursing facilities received limited post disaster assistance.
- Fifty-nine (52%) reported disaster-related admissions from hospitals, nursing facilities, and community residences.
- 56/87 nursing facilities implementing disaster plans cited problems
- Plans did not adequately address
  - absent staff,
  - communication problems, and
  - insufficient water and generator fuel.

Saliba, D, et al
Am J Public Health. 2004;94:1436–1441

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Southern California 2007
FEMA
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Qualcomm Stadium
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Lessons Learned San Diego

Needed:

- Centralized coordination of patient and bed tracking.
- Patient ID bands with critical medical information.
- Staff ID that enabled them to return to facilities.
- LTC evacuation plans that adequately address transport of patients to other facilities.
- Criteria for approval to repatriate facility

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North Bay Fires – Oct 2017

- 245,000 Acres
- Costliest and deadliest wildfire in CA hx
- 44 fatalities
- One senior living facility accused of leaving dozens behind during evacuation
  - Now wrongful death lawsuits (post evac)
  - Facility claims staff were not allowed back, police deny.

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Issues Identified by Providers

- Air quality challenges
- Lack of meds/equip sent to relocation sites
- Long distances to receiving facilities
- Staffing challenges – schools canceled
- Lodging and food for displaced staff
- Multi-pronged communication avenues needed both to get and give info

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Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers

"We believe that, currently, in the event of a disaster, healthcare facilities across the nation will not have the necessary emergency planning and preparation in place to adequately protect the health and safety of their patients."

Federal Register – Published 9/16/16. Effective 11/15/16. Implementation 11/15/17

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Emergency Operations Program

- Based on facility’s and community's risk assessment (HVA)
- Use an “all hazards” approach
- Address the facility‘s at-risk population - their residents’/clients' unique needs
- Include continuity of operations – services that must be provided and succession plan
- Describe process for cooperation with local, state, fed response professionals

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Services That Must Be Continued During Emergencies

- Surveyors will ask facility leadership:
  - ID the facility's residents at risk during emergency event
  - Strategies in place to address the needs of those at risk
  - The types of services the facility can provide during emergencies

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Integrated Response Planning

- Include process for ensuring cooperation and collaboration with local, …state and federal emergency prep officials to maintain an integrated response during disaster or emergency
- Include documentation of the LTC facility's efforts to contact such officials and when applicable of its participation in collaborative/ cooperative planning
- Include contact info in the plan for emergency officials you should be contacting during emergencies

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Policies and Procedures:

Annually reviewed and at a minimum include:

- Subsistence needs for staff and residents
- Safe evacuation
- Shelter in Place
- Emergency admits
- Medical documentation
- Volunteer and staffing strategies
- Communication plan

Policies and Procedures Includes Communication Plan

- Updated annually
- Contact info internal and external
- Alternate means of communication
- Method for sharing medical information to maintain continuity of care
- Reporting info on occupancy and needs
- Sharing info on EP plan with residents, families, and representatives

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Training Requirements

- Initial and annual training to all new and existing staff
- Individuals and entities providing services under arrangement
- Volunteers consistent with their roles
- Documented
- Ensure staff can demonstrate knowledge

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Testing Requirements

- Two annually
- Full scale community-based exercise
- If not feasible a facility-based exercise
- Second exercise can be table top
- Real event can count as one
- Formal scenario, objectives, analysis of performance
- After action report

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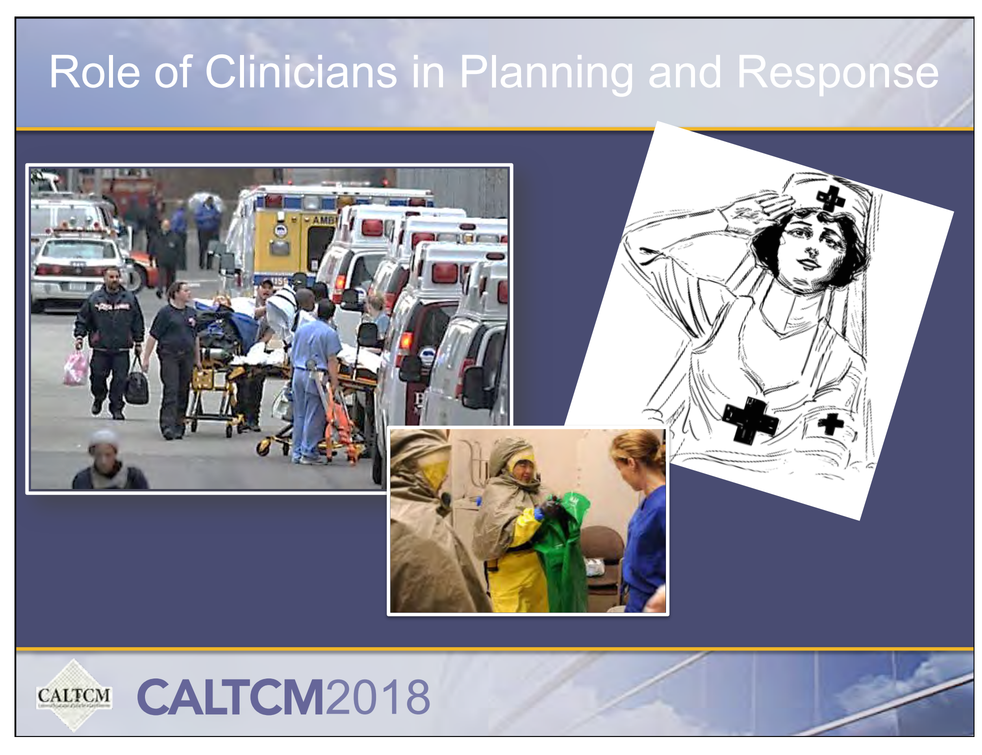
Role of Clinicians in Planning and Response
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Your Population's Unique Needs
Pre – Event Assessment and Planning
WanderGuard
DEPARTURE ALERT SYSTEM
EMERGENCY DRINKING WATER
DATREX
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Realistic Procedures to Mitigate Impact on Residents

- Prolonged power outage
- Heat wave and AC failure
- Air Quality – Smoke
- Disruption to resupply of medications
- Evacuation – what to send
- Emergency admits

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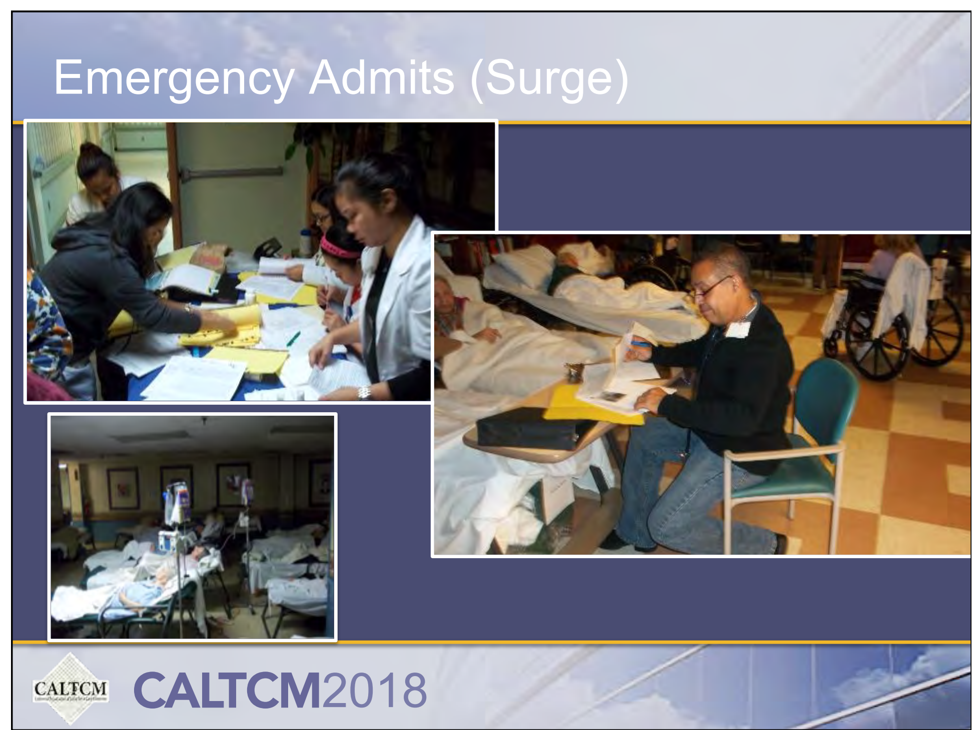
Emergency Admits (Surge)



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Incident Command

- Framework of functions
- Delegation of actions that must be done
- Management by objective
- Standardized process

NHICS 201 | INCIDENT BRIEFING

6. CURRENT ORGANIZATION

(Fill in additional positions as appropriate)

- INCIDENT COMMANDER
  - LIAISON/PUBLIC INFORMATION OFFICER
  - SAFETY OFFICER
  - MEDICAL DIRECTOR/SPECIALIST
  - OPERATIONS SECTION CHIEF
    - RESIDENT SERVICES BRANCH DIRECTOR
    - INFRASTRUCTURE BRANCH DIRECTOR
  - PLANNING SECTION CHIEF
  - LOGISTICS SECTION CHIEF
  - FINANCE/ADMINISTRATION SECTION CHIEF

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Medical Director/Specialist

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Case Study Questions

- What elements would you add to the shelter in place planning and training for this facility to address the clinical gaps in this scenario?
- During the response, what clinical actions would you have taken to change the outcomes for these residents?

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Last Question….

- Based on what you have learned today, what changes will you make to your practice?

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Planning Resources

California Association of Health Facilities
Disaster Preparedness Program

www.cahfdisasterprep.com

TRACIE H.H.S.

https://asprtracie.hhs.gov/cmsrule

THANK YOU
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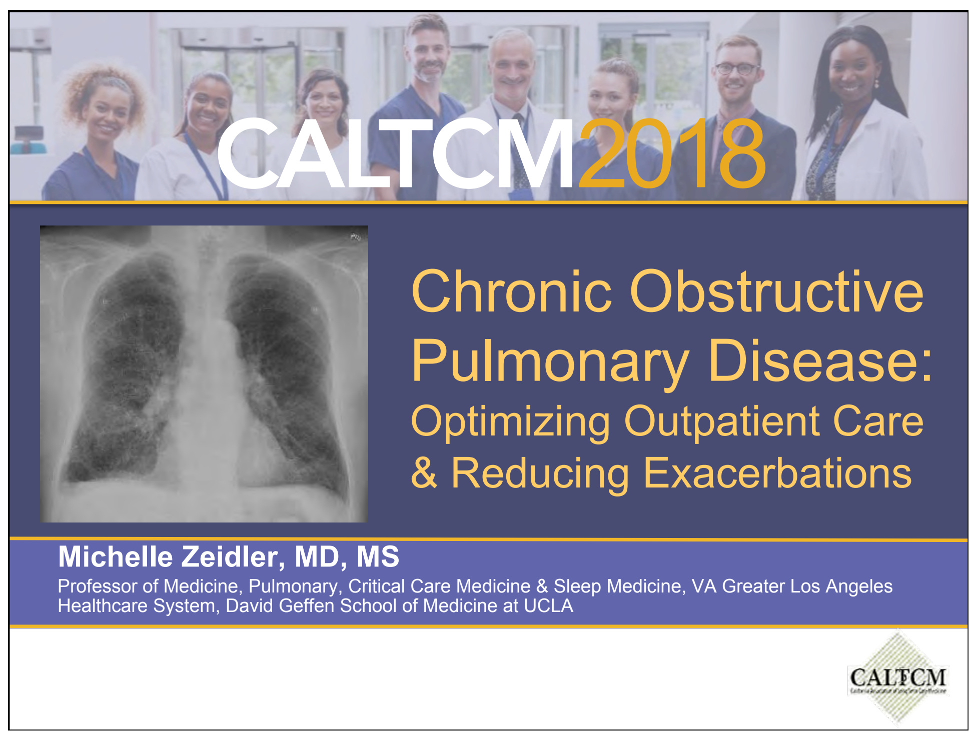

Disclosures

- Michelle Zeidler, MD, MS, has no relevant financial relationships with commercial interests to disclose.

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Chronic Obstructive Pulmonary Disease:
Optimizing Outpatient Care & Reducing Exacerbations

- Epidemiology/Pathophysiology
- Diagnosis
- Phenotypes
- Assessment/Stratification
- Outpatient pharmacotherapy
- Exacerbations
  - Risks
  - Treatments

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GOLD Definition of COPD

"COPD is a
- common preventable and treatable disease,
- characterized by airflow limitation that is usually persistent,
- respiratory symptoms and
- airflow limitation that is due to airway and/or alveolar abnormalities usually caused by significant exposure to noxious particles or gases."

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Scope of the Problem

- 6.3% of US adults (~ 15 million) have a diagnosis of COPD[1]
  Data obtained from the CDC's Behavior Risk Factor Surveillance System, the world's largest on-going telephone health survey system
- NHLBI estimates that another 12 million Americans have undiagnosed COPD
- In the US, estimated direct costs of COPD are $32 billion and indirect costs $20.4 billion (costs mainly due to exacerbations) [2]

[1] *MMWR* 2012;61(46) [2] *CEOR* 2013;5:235-45 [3] *JAMA* 2013;310(6):591-608

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Scope of the Problem

- COPD is a disease with high mortality and morbidity
  - 4th most common diagnosis among hospitalized U.S. Veterans ages 65-74
  - 3rd leading cause of death worldwide, including the US
    - A person with COPD dies every 4 minutes
    - 120,000 die annually in the U.S. alone
  - 2nd leading cause of disability in the U.S.
    - High resource utilization
      - Frequent office visits
      - Frequent ER visits
      - Frequent hospitalizations
      - Need for chronic therapy
- **COPD is often undertreated with many patients receiving suboptimal or NO treatment!**

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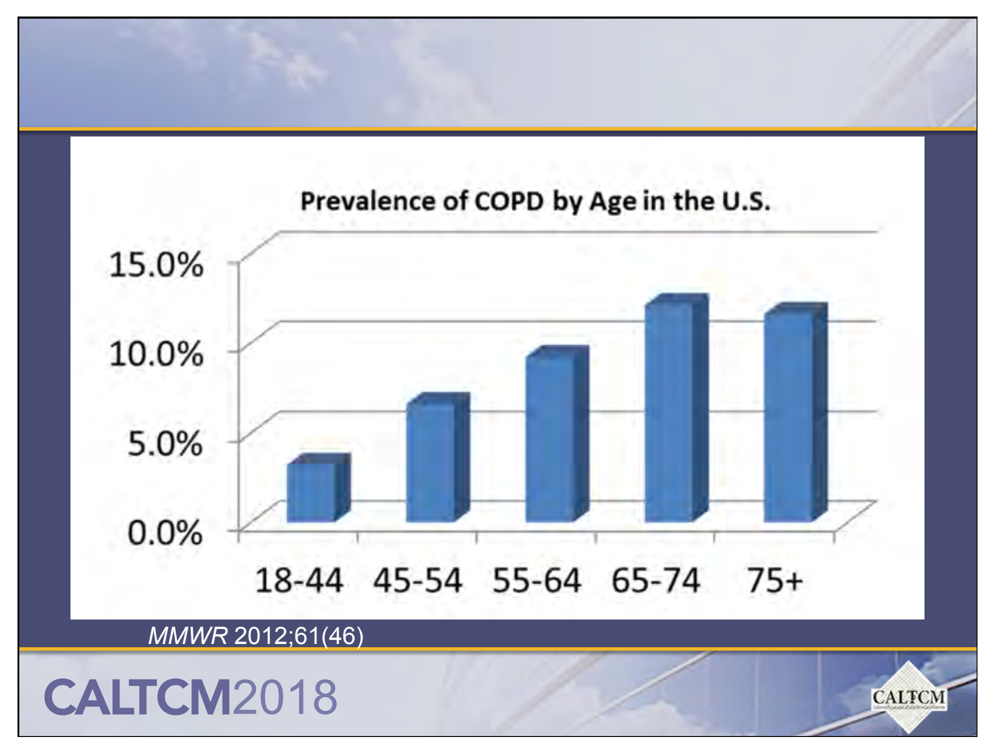
Prevalence of COPD by Age in the U.S.
15.0%
10.0%
5.0%
0.0%
18-44
45-54
55-64
65-74
75+
MMWR 2012;61(46)
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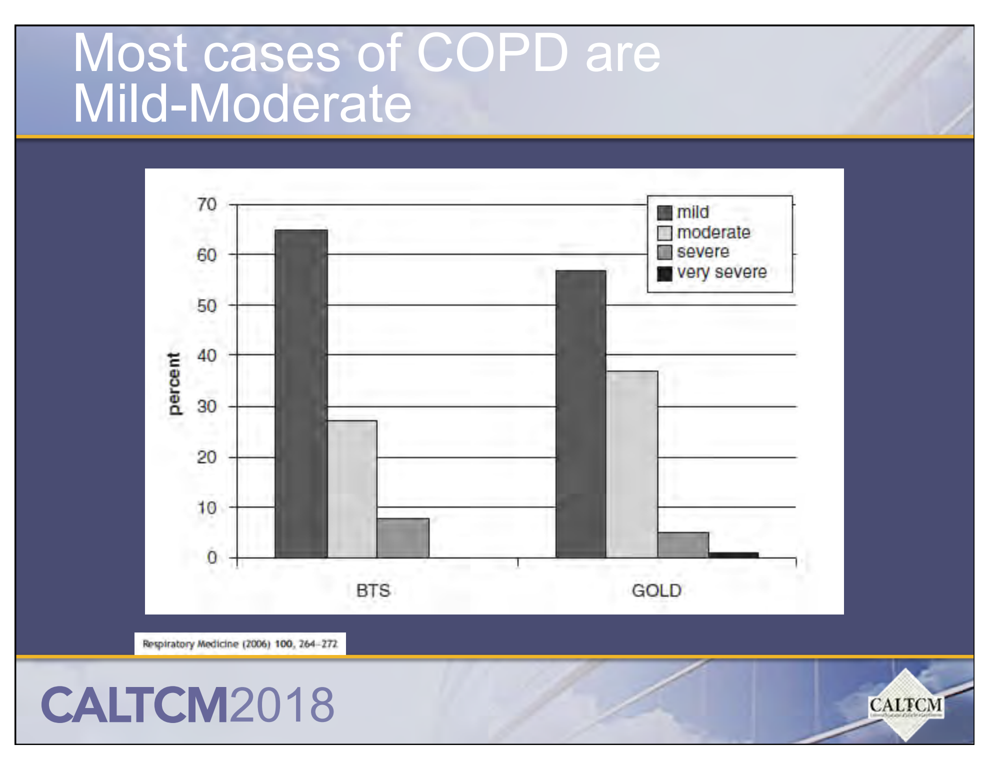
Most cases of COPD are Mild-Moderate
70
60
50
40
30
20
10
0
percent
BTS
GOLD
mild
moderate
severe
very severe
Respiratory Medicine (2006) 100, 264–272
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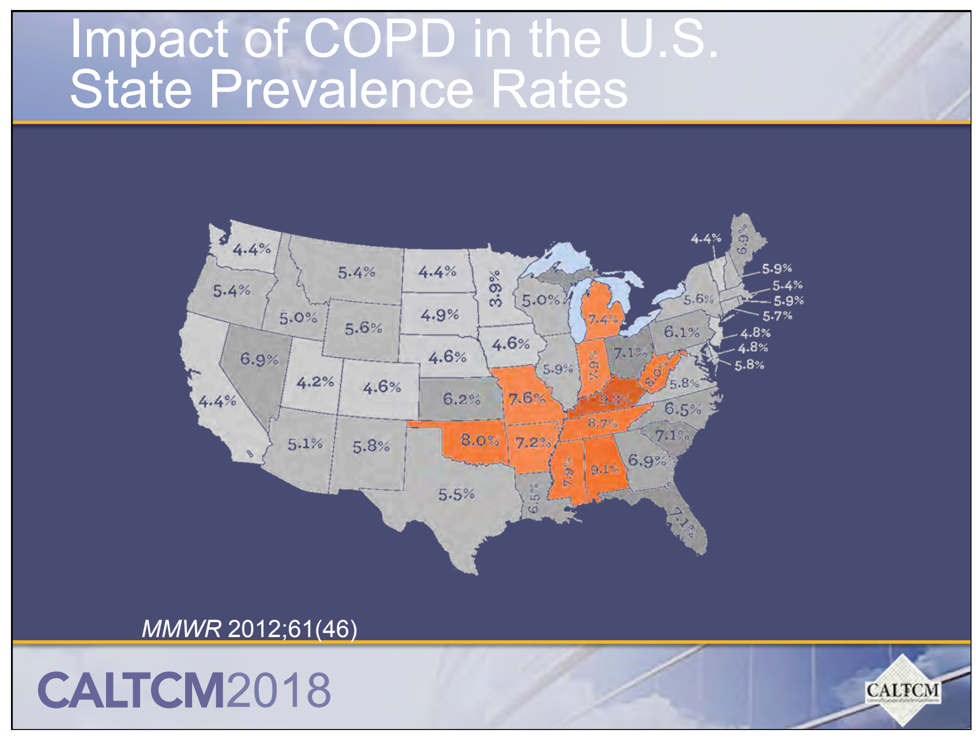
Impact of COPD in the U.S.
State Prevalence Rates
4.4%
5.4%
5.4%
4.4%
3.9%
5.0%
5.6%
4.9%
5.0%
4.6%
7.4%
6.9%
4.2%
4.6%
4.6%
5.9%
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MMWR 2012;61(46)
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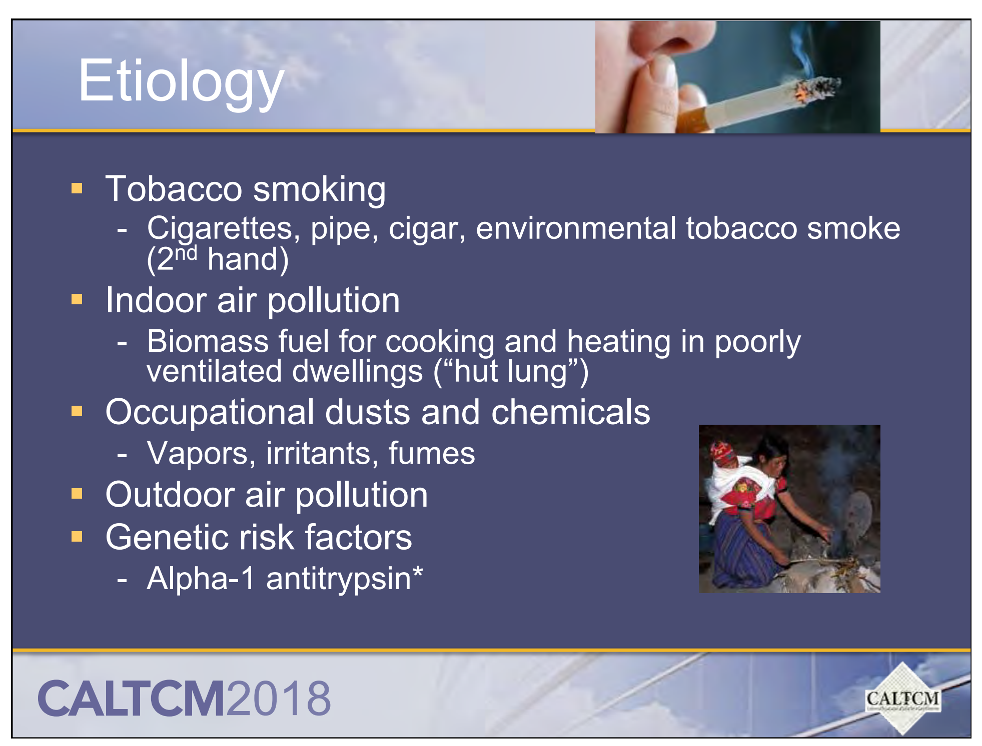
Etiology
Tobacco smoking
- Cigarettes, pipe, cigar, environmental tobacco smoke (2nd hand)
Indoor air pollution
- Biomass fuel for cooking and heating in poorly ventilated dwellings (“hut lung”)
Occupational dusts and chemicals
- Vapors, irritants, fumes
Outdoor air pollution
Genetic risk factors
- Alpha-1 antitrypsin*
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Pathophysiology

- Chronic inflammation leads to narrowing and reduction in the number of small conducting airways (terminal bronchioles) → airway collapse due to loss of tethering caused by alveolar wall destruction

COPD

Distal airway

Alveolar attachments

A No. of Small Airways

No. of 2.0-to-2.5-mm Airways/ Pair of Lungs

GOLD Stage 0 | GOLD Stage 1 | GOLD Stage 2 | GOLD Stage 3 or 4

N Engl J Med 2010;362:1407-16.
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N Engl J Med 2011;365:1567-75.
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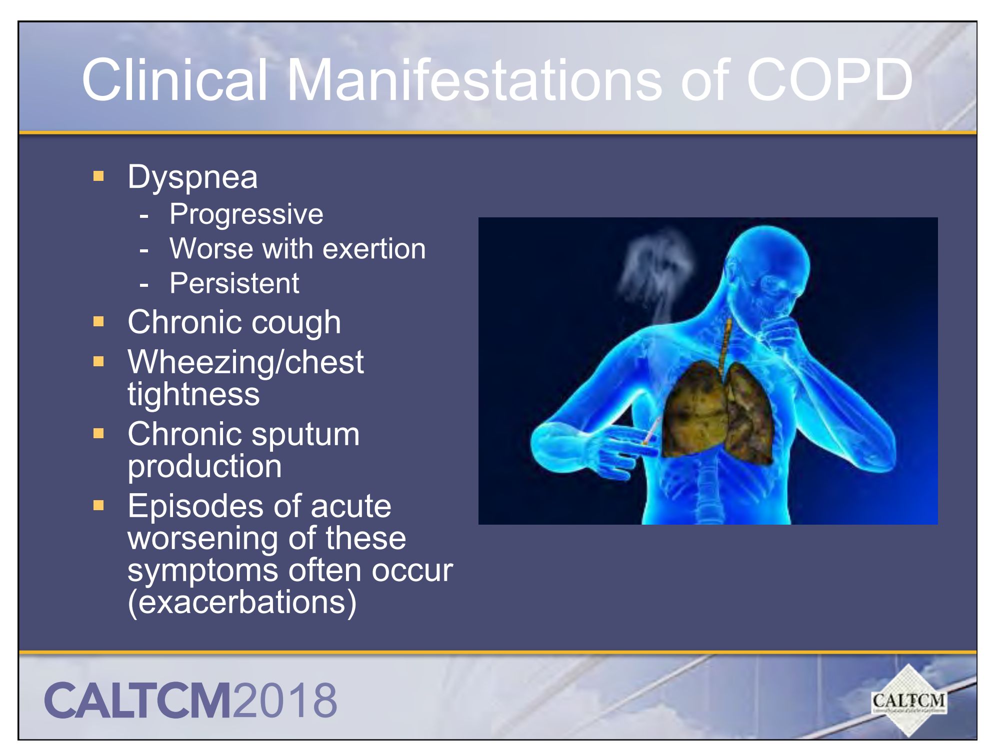

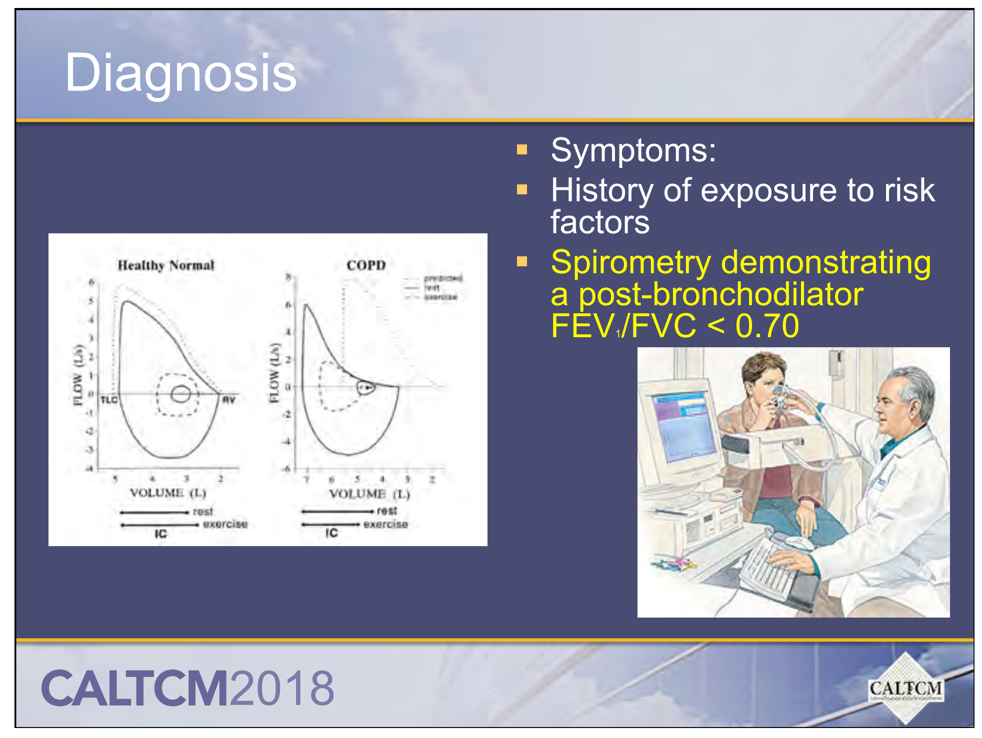

Laboratory Studies

- Consider CBC to evaluate for anemia as a cause of dyspnea
- Consider BNP to rule out CHF and assess for cor pulmonale
- Consider ABG if bicarbonate is elevated to assess for a compensated respiratory acidosis
- WHO: All symptomatic adults with persistent obstruction on spirometry should have alpha-1 antitrypsin level* checked, especially if young (≤45), non-smokers and basilar predominant emphysema

*Normal AAT is > 11 mmol/L

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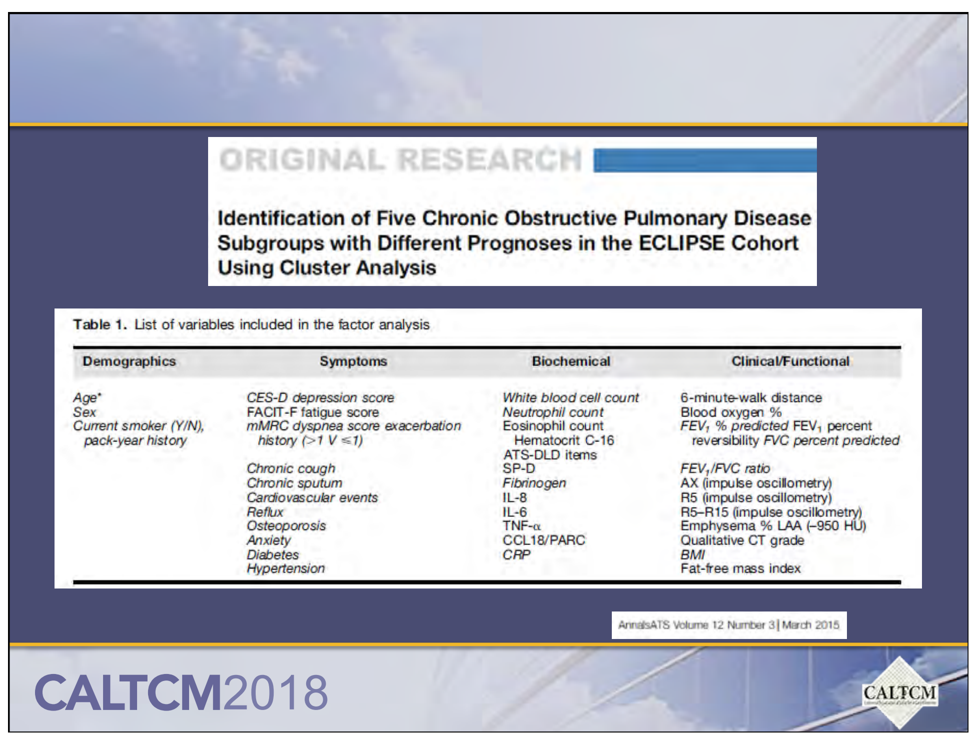


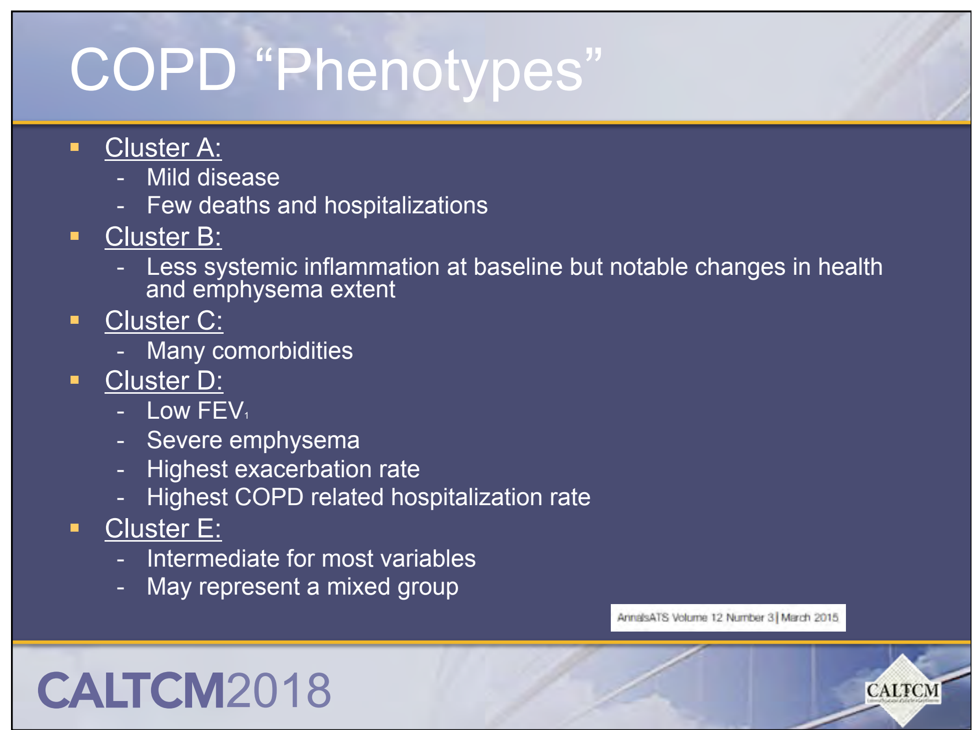
ORIGINAL RESEARCH

Identification of Five Chronic Obstructive Pulmonary Disease Subgroups with Different Prognoses in the ECLIPSE Cohort Using Cluster Analysis

Table 1. List of variables included in the factor analysis

Demographics	Symptoms	Biochemical	Clinical/Functional
*Age**	*CES-D depression score*	*White blood cell count*	6-minute-walk distance
Sex	FACIT-F fatigue score	*Neutrophil count*	Blood oxygen %
Current smoker (Y/N), pack-year history	*mMRC dyspnea score exacerbation history (>1 V ≤1)*	Eosinophil count	*FEV_1 % predicted* FEV_1 percent reversibility *FVC percent predicted*
		Hematocrit C-16	
		ATS-DLD items	
	Chronic cough	SP-D	*FEV_1/FVC ratio*
	Chronic sputum	*Fibrinogen*	AX (impulse oscillometry)
	Cardiovascular events	IL-8	R5 (impulse oscillometry)
	Reflux	IL-6	R5–R15 (impulse oscillometry)
	Osteoporosis	TNF-α	Emphysema % LAA (−950 HU)
	Anxiety	CCL18/PARC	Qualitative CT grade
	Diabetes	*CRP*	*BMI*
	Hypertension		Fat-free mass index

AnnalsATS Volume 12 Number 3 | March 2015



COPD "Phenotypes"

- Cluster A:
  - Mild disease
  - Few deaths and hospitalizations
- Cluster B:
  - Less systemic inflammation at baseline but notable changes in health and emphysema extent
- Cluster C:
  - Many comorbidities
- Cluster D:
  - Low FEV_1
  - Severe emphysema
  - Highest exacerbation rate
  - Highest COPD related hospitalization rate
- Cluster E:
  - Intermediate for most variables
  - May represent a mixed group

AnnalsATS Volume 12 Number 3 | March 2015

COPD Assessment

1. Assess symptoms
   - COPD Assessment Test (CAT)
   - Modified Medical Research Council (mMRC)
2. Assess degree of airflow limitation
   - Spirometry
3. Assess risk of exacerbations
4. Assess comorbidities

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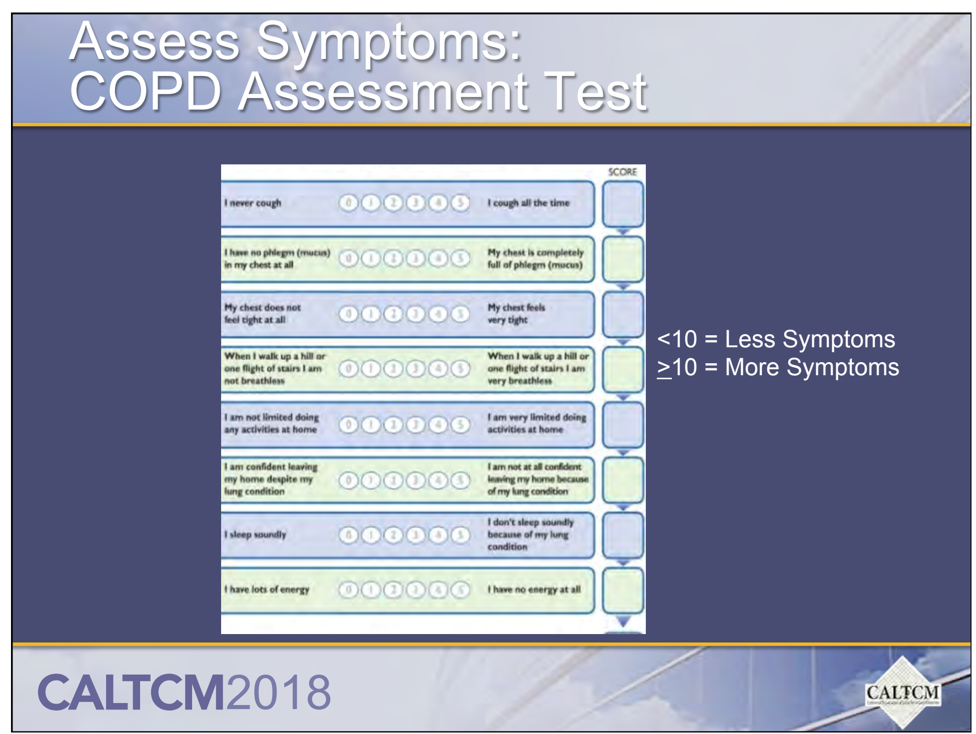
Assess Symptoms: COPD Assessment Test



			SCORE
I never cough	0 1 2 3 4 5	I cough all the time	
I have no phlegm (mucus) in my chest at all	0 1 2 3 4 5	My chest is completely full of phlegm (mucus)	
My chest does not feel tight at all	0 1 2 3 4 5	My chest feels very tight	
When I walk up a hill or one flight of stairs I am not breathless	0 1 2 3 4 5	When I walk up a hill or one flight of stairs I am very breathless	
I am not limited doing any activities at home	0 1 2 3 4 5	I am very limited doing activities at home	
I am confident leaving my home despite my lung condition	0 1 2 3 4 5	I am not at all confident leaving my home because of my lung condition	
I sleep soundly	0 1 2 3 4 5	I don't sleep soundly because of my lung condition	
I have lots of energy	0 1 2 3 4 5	I have no energy at all	

<10 = Less Symptoms
≥10 = More Symptoms

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Assess Symptoms: Modified Medical Research Council

Grade	Patient's description of breathlessness
Grade 0	I only get breathless with strenuous exercise
Grade 1	I get short of breath when hurrying on the level or walking up a slight hill
Grade 2	I walk slower than people of the same age on the level because of breathlessness or have to stop for breath when walking at my own pace on the level
Grade 3	I stop for breath after walking about 100 yards or after a few minutes on the level
Grade 4	I am too breathless to leave the house or I am breathless when dressing

Fletcher CM. *BMJ* 1960;2:1662

mMRC 0-1 = Less Symptoms
mMRC $\geq$2 = More Symptoms

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Assess Degree of Airflow Limitation Using Spirometry

In patient's with FEV_1/FVC <0.70:

GOLD Stage	Classification	FEV1
GOLD 1	Mild	$FEV_1 \geq$ 80% predicted
GOLD 2	Moderate	50% $\leq FEV_1$<80%
GOLD 3	Severe	30% $\leq FEV_1$ <50%
GOLD 4	Very Severe	FEV_1 <30% predicted

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Assess Risk of Exacerbations

- Definition of an Exacerbation
  - An increase in dyspnea, cough or sputum production beyond normal day-to-day variations leading to a change in medication
    - Mild: SABDs
    - Moderate: SABDs plus antibiotics and/or oral steroids
    - Severe: Hospitalization or ER visit
- *Hospitalization for a COPD exacerbation is associated with a poor prognosis and increased risk of death!*

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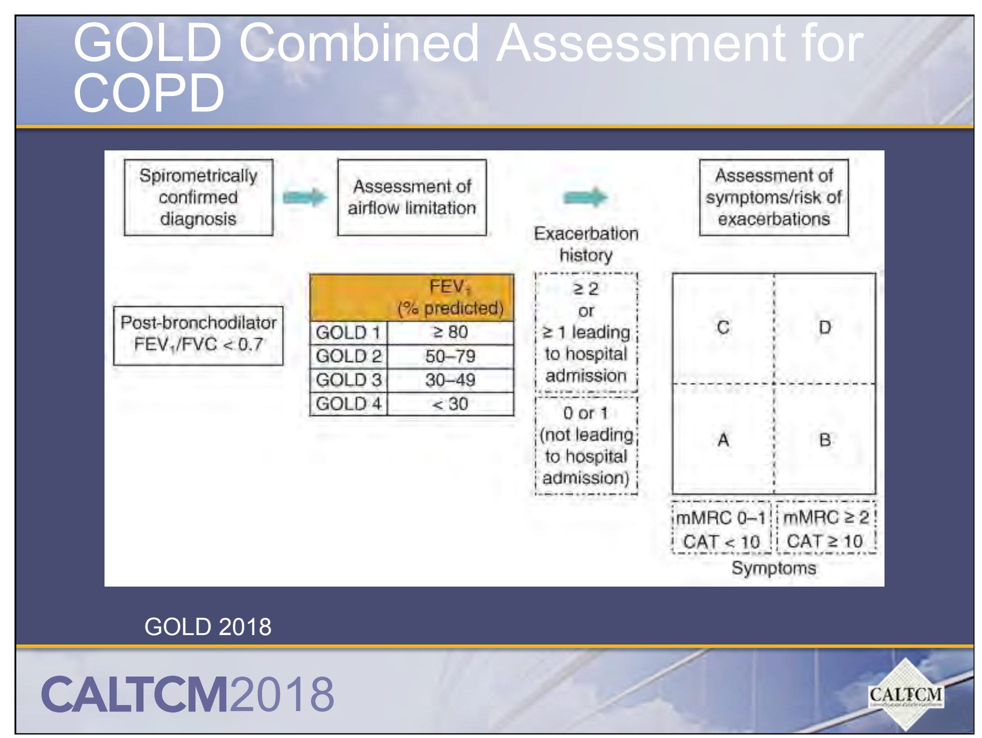
GOLD Combined Assessment for COPD



GOLD 2018

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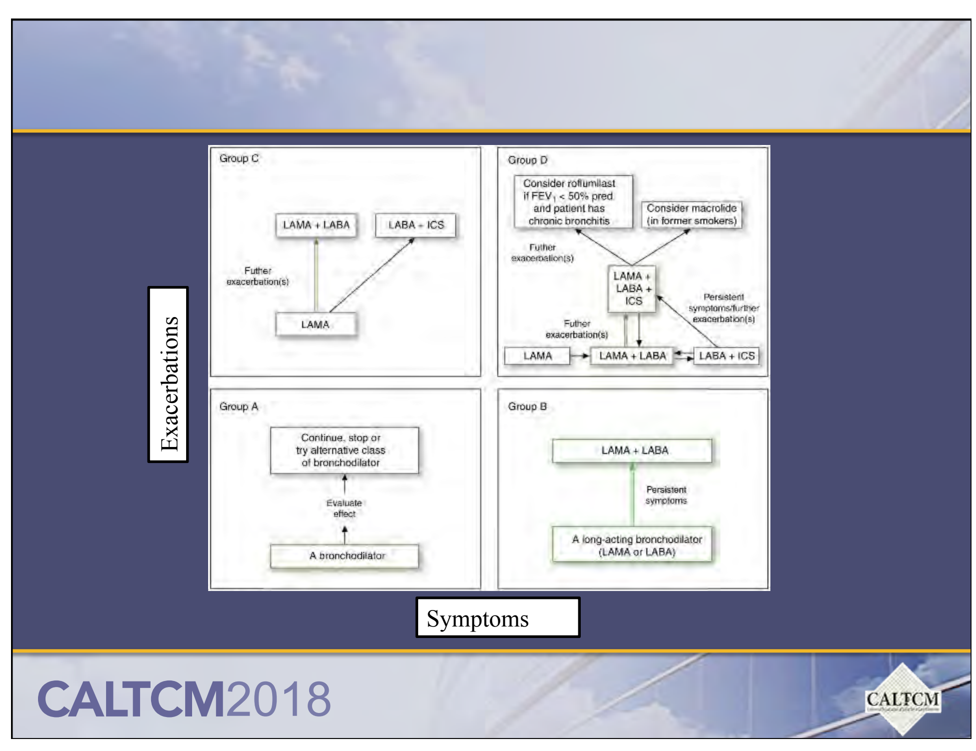
Therapies for COPD

- Smoking cessation
- Short acting beta agonists
- Short acting muscarinic agonists
- Long acting beta agonists
- Long acting muscarinic agonists
- PDE4 Inhibitors
- Azithromycin

Approach to Pharmacotherapy

GOLD 2018 Guidelines


Group C
LAMA + LABA
LABA + ICS
Futher exacerbation(s)
LAMA
Group D
Consider roflumilast if FEV1 < 50% pred and patient has chronic bronchitis
Consider macrolide (in former smokers)
Futher exacerbation(s)
LAMA + LABA + ICS
Persistent symptoms/further exacerbation(s)
Futher exacerbation(s)
LAMA
LAMA + LABA
LABA + ICS
Group A
Continue, stop or try alternative class of bronchodilator
Evaluate effect
A bronchodilator
Group B
LAMA + LABA
Persistent symptoms
A long-acting bronchodilator (LAMA or LABA)
Exacerbations
Symptoms
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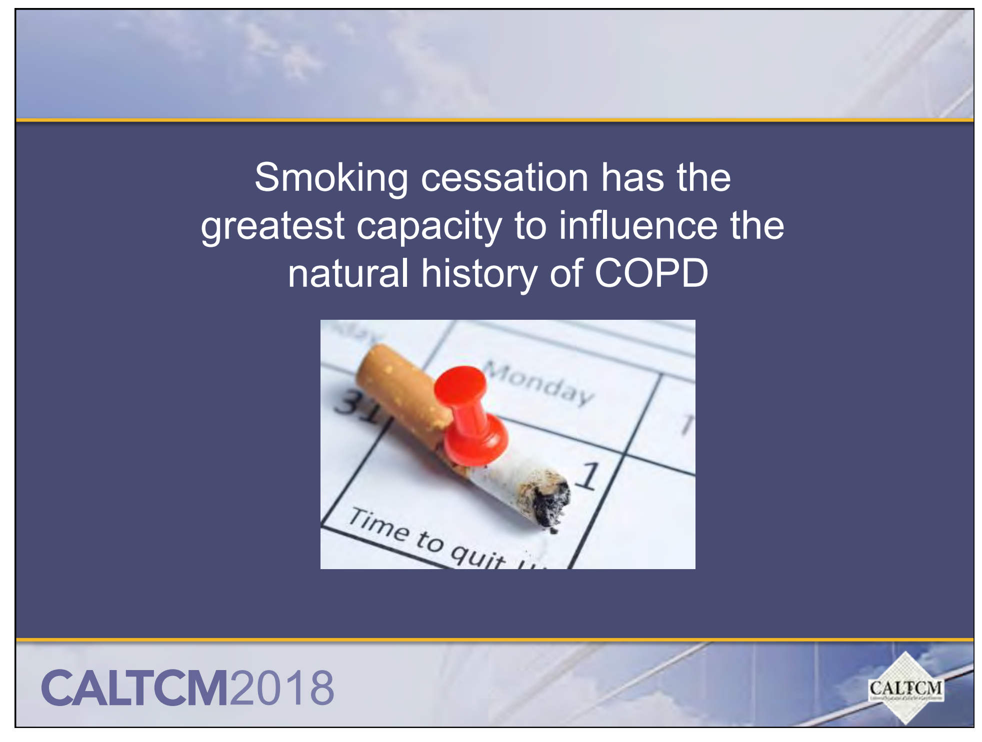
Smoking cessation has the greatest capacity to influence the natural history of COPD
Monday
31
1
Time to quit
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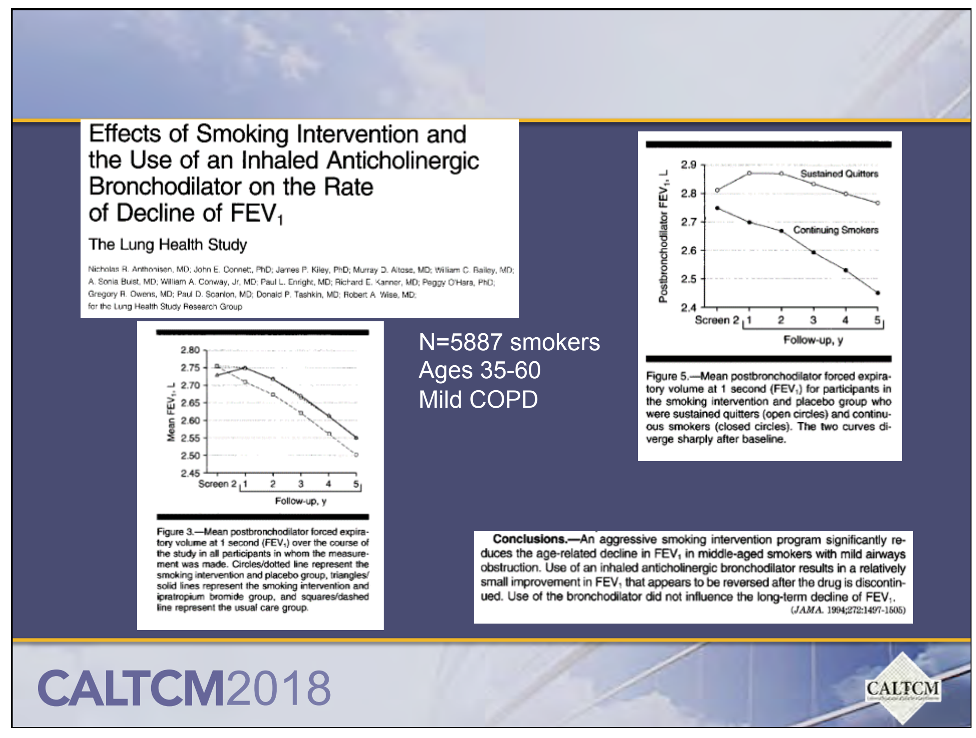
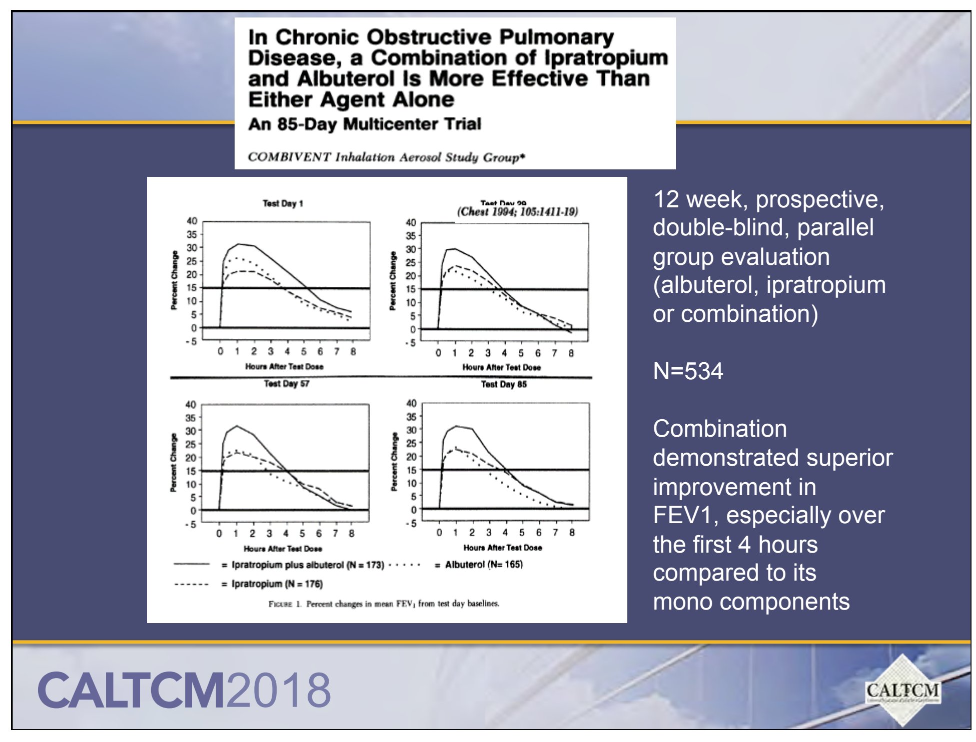


Smoking Cessation

- Smoking cessation best accomplished via counseling **AND** pharmacological therapy
  - Counseling:
    - Increases quit rates over self-initiated strategies
    - A brief (3-minute) period of counseling to urge a smoker to quit can result in quit rates of 5-10%
  - Pharmacological agents:
    - Nicotine Replacement Therapy (NRT)
      - Transdermal nicotine patch
      - Nicotine gum
      - Nicotine lozenge
      - Nicotine sublingual tablet
      - Nicotine inhaler
      - Nicotine nasal spray
    - Buproprion (Zyban)
    - Varenicline (Chantix)



Long Acting Beta2-Agonists (LABAs) "Controller"

- FDA approved as maintenance treatment of bronchoconstriction in patients with COPD
- <u>Not indicated for acute bronchospasm</u>
- Medications:
  - Long-Acting: last 12 hours
    - Formoterol DPI (Foradil Aerolizer) *** no longer available ***
    - Formoterol solution (Perforomist)
    - Arformoterol solution (Brovana)
    - Salmeterol MDI & DPI (Serevent Diskus)
  - Ultra Long Acting: last 24 hours
    - Indacaterol DPI (Arcapta Neohaler)
    - **Olodaterol SMI (Striverdi Respimat)**
    - Vilanterol (only available in combo therapy with LAMA or ICS)

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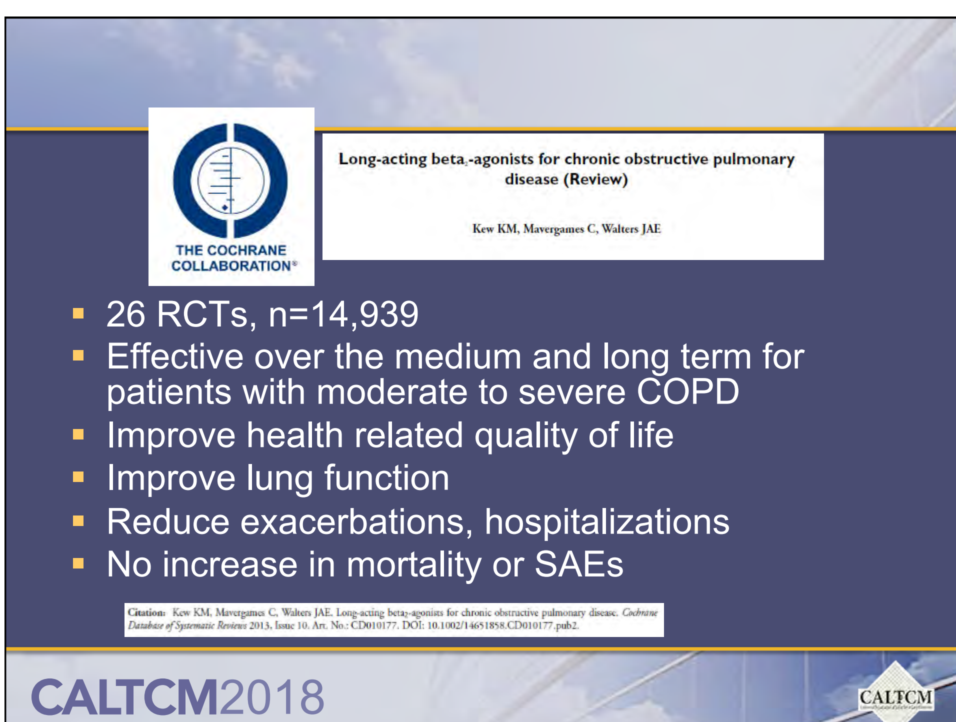

Long Acting Muscarinic Antagonists (LAMAs) "Controller"

- FDA approved for the long term maintenance treatment of bronchospasm associated with COPD
- * Tiotropium also FDA approved for reducing the likelihood of COPD exacerbations
- <u>Not indicated for acute bronchospasm</u>
- Medications:
  - **Tiotropium (Spiriva Handihaler; Spiriva Respimat)**
    - Spiriva HandiHaler: 18 mcg daily
    - Spiriva Respimat: 2.5 mcg/actuation daily
  - Umeclidinium (Incruse Ellipta): 62.5 mcg daily
  - Aclidinium bromide (Tudorza Pressair): 400 mcg twice daily
  - Glycopyrronium (Seebri Breezhaler): 50 mcg once daily

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So, do you add a LABA or LAMA first?

Tiotropium versus long-acting beta-agonists for stable chronic obstructive pulmonary disease (Review)

Chong J, Karner C, Poole P

- 7 studies; n=12,223
- No difference in mortality
- Tiotropium equivocal with respect to LABAs at improving QOL
- Symptom improvement and lung function improvement similar between the two
- Tiotropium more effective than LABAs in preventing COPD exacerbations and disease related hospitalizations
- Less SAEs with tiotropium

Citation: Chong J, Karner C, Poole P. Tiotropium versus long-acting beta-agonists for stable chronic obstructive pulmonary disease. *Cochrane Database of Systematic Reviews* 2012, Issue 9. Art. No.: CD009157. DOI: 10.1002/14651858.CD009157.pub2.

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Combination LABA/LAMA "Controller"

- FDA approved for the long-term maintenance treatment of airflow obstruction in patients with COPD
- Medications:
  - Vilanterol/Umeclidinium (Anoro Ellipta) DPI: once daily
  - Olodaterol/Tiotropium (Stiolto Respimat) SMI: once daily
  - Formoterol/Aclidinium (Duaklir Genuair) DPI: twice daily
  - Indacaterol/Glycopyrronium (Utibron Neohaler) DPI: twice daily
  - Formoterol/Glycopyrrolate (Bevespi Aerosphere) MDI: twice daily

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Combination LABA/LAMA

- Compared to LABA or LAMA
  - Improved lung function (FEV1)
  - Improved quality of life (SGRQ)
  - Decreased exacerbations
- Compared to LABA/ICS
  - Decreased exacerbations

Eur Respir J 2015; 45:869-871
Prim Care Respir J 2012; 21(1):101-8
Cochrane Database Syst Rev 2015;10(10):CD008989
FLAME *N Engl J Med* 2016; 374(23):2222-34

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Inhaled Corticosteroids (ICS)

- Inhaled corticosteroids are FDA approved for maintenance treatment of ASTHMA
- Use of inhaled corticosteroids as monotherapy for COPD is OFF-LABEL
- Consider starting first in patients with ACO (+/- LABA)
- Not indicated for acute bronchospasm
- Medications:
  - Beclomethasone (QVAR)
  - Flunisolide (Aerobid)
  - Ciclesonide (Alvesco)
  - Budesonide (Pulmicort Flexhaler)
  - Fluticasone (Flovent HFA or Diskus)
  - Mometasone (Asmanex Twisthaler)
  - Triamcinolone (Azmacort)

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Combination ICS/LABA

- FDA approved for maintenance treatment of airflow obstruction *and* reducing exacerbations* in patients with COPD
- Consider starting first in patients with ACO
- Not indicated for acute bronchospasm
- Medications:
  - Budesonide + Formoterol (Symbicort)
  - Fluticasone + Salmeterol(Advair)*
  - Fluticasone + Vilanterol (Breo-Ellipta)*
  - Mometasone + Formoterol (Dulera)

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Combination LAMA/LABA/ICS aka "triple therapy"

- Compared to ICS/LABA or LAMA monotherapy
  - Improves lung function
  - Improves symptoms
  - Improves health status
  - Reduces exacerbations

Thorax 2008; 63(7):592-8
Thorax 2015; 70(6):519-27
COPD 2016; 13(1):1-10
Lancet 2016: 388(10048): 963-73

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ICS AEs

- Oral candidiasis
- Hoarse voice
- Skin bruising
- Pneumonia
  - Smokers, >55, hx of prior exacerbations/PNA, BMI <25, poor MRC dyspnea score and/or severe airflow limitation

Annals of ATS 2015; 12(1):27-34
SUMMIT trial *Respir Med* 2017; 131:27-34

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AECOPD

- Increased respiratory symptoms (cough, dyspnea, sputum production, purulent sputum, wheezing) resulting in additional therapy
- Classification:
  - Mild: SABDs
  - Moderate: SABDs + Abx and/or steroids
  - Severe: Hospitalization or ER visit
- Etiology: URI, noxious inhalation, non-compliance w/ meds, bad inhaler technique, UACS, GERD, CHF/arrhythmia
- CXR, EKG (?PE), ABG, CBC, BNP, ECHO
- Rx:
  - Oxygen
  - Inhaled short-acting bronchodilators
  - Antibiotics 5-7 days (FQ, macrolides)
    - Shorten recovery time, reduce risk of early relapse, treatment failure and hospital LOS
  - Systemic steroids
    - Shorten recovery time, reduced risk of early relapse, decrease hospital LOS, improves oxygenation and accelerates recovery of FEV1
  - BiPAP if respiratory acidosis (hold if obtunded, vomiting, secretions)
    - Reduces hospital stay
    - Improves mortality in AECOPD with impending respiratory failure
  - Diuresis? Control arrhythmias? Anticoagulation for PE?

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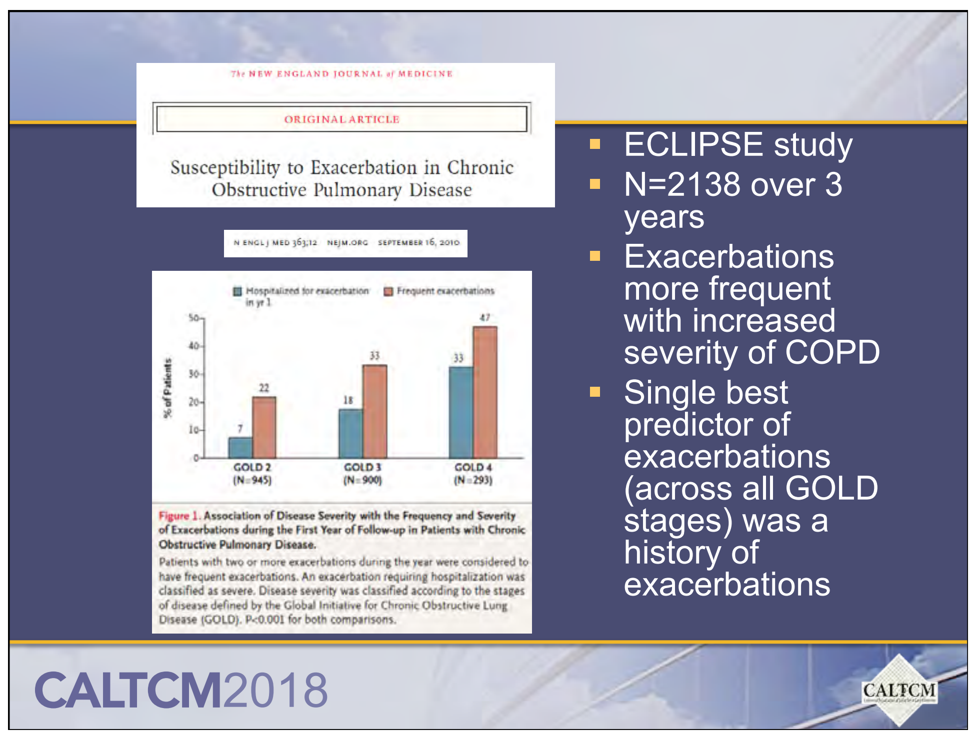

Short-term vs Conventional Glucocorticoid Therapy in Acute Exacerbations of Chronic Obstructive Pulmonary Disease

The REDUCE Randomized Clinical Trial

- Double blind, placebo-controlled, non-inferiority trial (n=314)
- Patients presenting to ER in AECOPD and admitted to the hospital
- 40 mg prednisone daily for 5d vs. 14 d
- Outcome: Time to exacerbation within 180d
- 37.2% reexacerbation in the 5d
- 38.4% reexacerbation in the 14d

JAMA, June 5, 2013—Vol 309, No. 21

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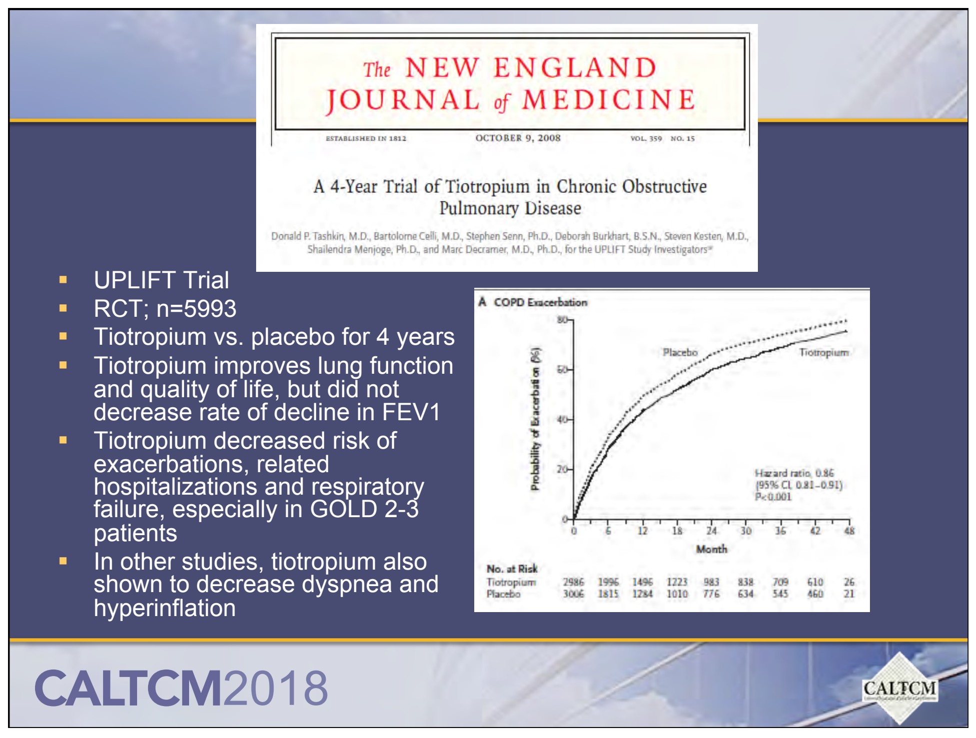
The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812
OCTOBER 9, 2008
VOL. 359 NO. 15
A 4-Year Trial of Tiotropium in Chronic Obstructive Pulmonary Disease
Donald P. Tashkin, M.D., Bartolome Celli, M.D., Stephen Senn, Ph.D., Deborah Burkhart, B.S.N., Steven Kesten, M.D., Shailendra Menjoge, Ph.D., and Marc Decramer, M.D., Ph.D., for the UPLIFT Study Investigators*
UPLIFT Trial
RCT; n=5993
Tiotropium vs. placebo for 4 years
Tiotropium improves lung function and quality of life, but did not decrease rate of decline in FEV1
Tiotropium decreased risk of exacerbations, related hospitalizations and respiratory failure, especially in GOLD 2-3 patients
In other studies, tiotropium also shown to decrease dyspnea and hyperinflation
A COPD Exacerbation
Probability of Exacerbation (%)
Placebo
Tiotropium
Hazard ratio, 0.86
(95% CI, 0.81–0.91)
P<0.001
Month
No. at Risk
Tiotropium 2986 1996 1496 1223 983 838 709 610 26
Placebo 3006 1815 1284 1010 776 634 545 460 21
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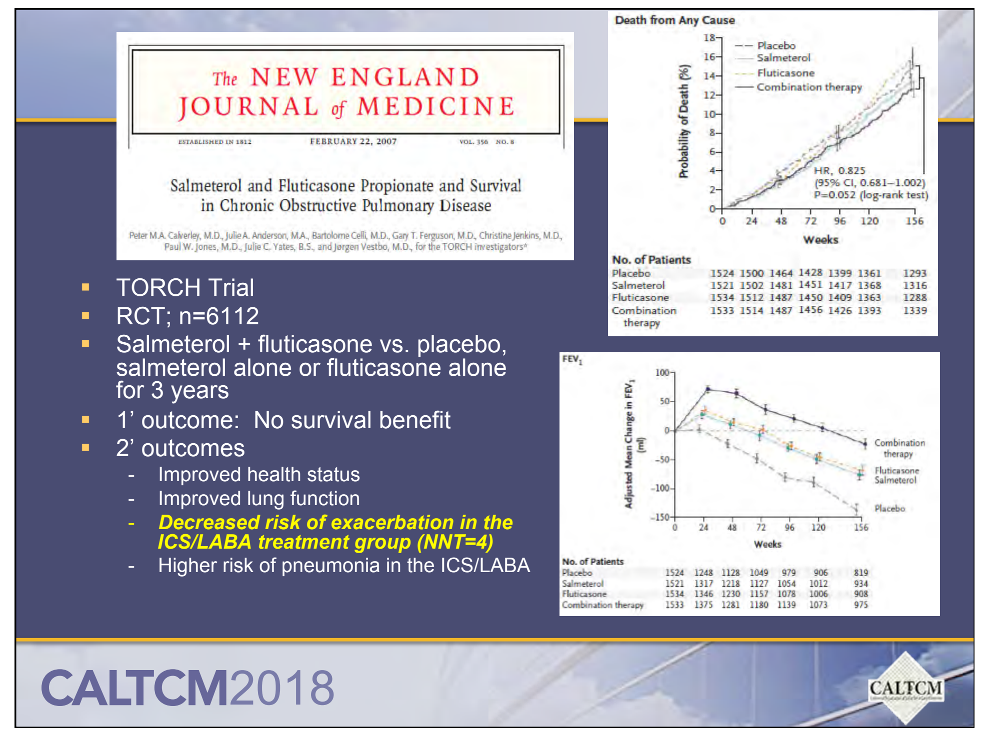
The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812
FEBRUARY 22, 2007
VOL. 356 NO. 8
Salmeterol and Fluticasone Propionate and Survival in Chronic Obstructive Pulmonary Disease
Peter M.A. Calverley, M.D., Julie A. Anderson, M.A., Bartolome Celli, M.D., Gary T. Ferguson, M.D., Christine Jenkins, M.D., Paul W. Jones, M.D., Julie C. Yates, B.S., and Jørgen Vestbo, M.D., for the TORCH investigators*
TORCH Trial
RCT; n=6112
Salmeterol + fluticasone vs. placebo, salmeterol alone or fluticasone alone for 3 years
1' outcome: No survival benefit
2' outcomes
Improved health status
Improved lung function
Decreased risk of exacerbation in the ICS/LABA treatment group (NNT=4)
Higher risk of pneumonia in the ICS/LABA
Death from Any Cause
Probability of Death (%)
Placebo
Salmeterol
Fluticasone
Combination therapy
HR, 0.825
(95% CI, 0.681–1.002)
P=0.052 (log-rank test)
Weeks
No. of Patients
Placebo 1524 1500 1464 1428 1399 1361 1293
Salmeterol 1521 1502 1481 1451 1417 1368 1316
Fluticasone 1534 1512 1487 1450 1409 1363 1288
Combination therapy 1533 1514 1487 1456 1426 1393 1339
FEV1
Adjusted Mean Change in FEV1 (ml)
Combination therapy
Fluticasone
Salmeterol
Placebo
Weeks
No. of Patients
Placebo 1524 1248 1128 1049 979 906 819
Salmeterol 1521 1317 1218 1127 1054 1012 934
Fluticasone 1534 1346 1230 1157 1078 1006 908
Combination therapy 1533 1375 1281 1180 1139 1073 975
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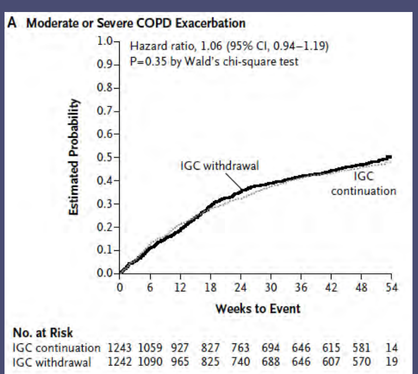
WISDOM Trial

- 12 month, double-blind, parallel-group
- N=2485 w/ hx COPD on LABA + LAMA + ICS; 6 week run in period
- Randomly assigned to continue triple therapy or withdraw ICS in a step-wise fashion over 12 weeks
- 1' endpoint: time to 1st moderate or severe COPD exacerbation
- Results:
  - Risk of exacerbations same
  - Greater decrease in lung function in ICS withdrawal group (~40mL)



N Engl J Med 2014; 371(14):1285-1294

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Phosphodiasterase-4 Inhibitor

- Roflumilast (Daliresp) 500 mcg PO daily
- PD4 inhibitors decrease inflammation and promote smooth muscle relaxation by inhibiting the breakdown of intracellular cyclic AMP
- Indicated as a treatment to reduce the risk of moderate to severe COPD exacerbations in patients with severe COPD to very severe COPD associated with chronic bronchitis and a history of exacerbations (2 or more per year or 1 requiring hospitalization)
- Avoid in patients with unstable mood symptoms, depression, suicidality
- Other AEs: diarrhea, nausea, reduced appetite, weight loss, abdominal pain

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Roflumilast in symptomatic chronic obstructive pulmonary disease: two randomised clinical trials

Peter M A Calverley*, Klaus F Rabe*, Udo-Michael Goehring, Søren Kristiansen, Leonardo M Fabbri†, Fernando J Martinez†, for the M2-124 and M2-125 study groups‡

- Severe COPD, age >40, bronchitis symptoms, history of exacerbations
- n>2000
- Oral roflumilast vs. placebo for 52 weeks
- ICS were not allowed
- 17% reduction in the risk of moderate (requiring steroids) or severe (requiring hospitalization) exacerbations vs. placebo

Lancet 2009; 374: 685–94

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The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 AUGUST 25, 2011 VOL. 365 NO. 8

Azithromycin for Prevention of Exacerbations of COPD

- RCT, n=1557
- >40, COPD with FEV_1<80%, history of exacerbations or O2 dependent
- Azithromycin 250 mg daily vs. placebo + usual care for 1 year
- Decreased median time to first exacerbation
- Decreased frequency of exacerbations
- Improved quality of life
- Decrease in nasopharyngeal colonization with respiratory pathogens, but increased colonization with macrolide-resistant organisms
  - NO effect on exacerbation or pneumonia rates
- Some increased hearing decrement in the azithromycin arm 5%

Figure 2. Proportion of Participants Free from Acute Exacerbations of Chronic Obstructive Pulmonary Disease (COPD) for 1 Year, According to Study Group.

N Engl J Med 2011;365:689-98.

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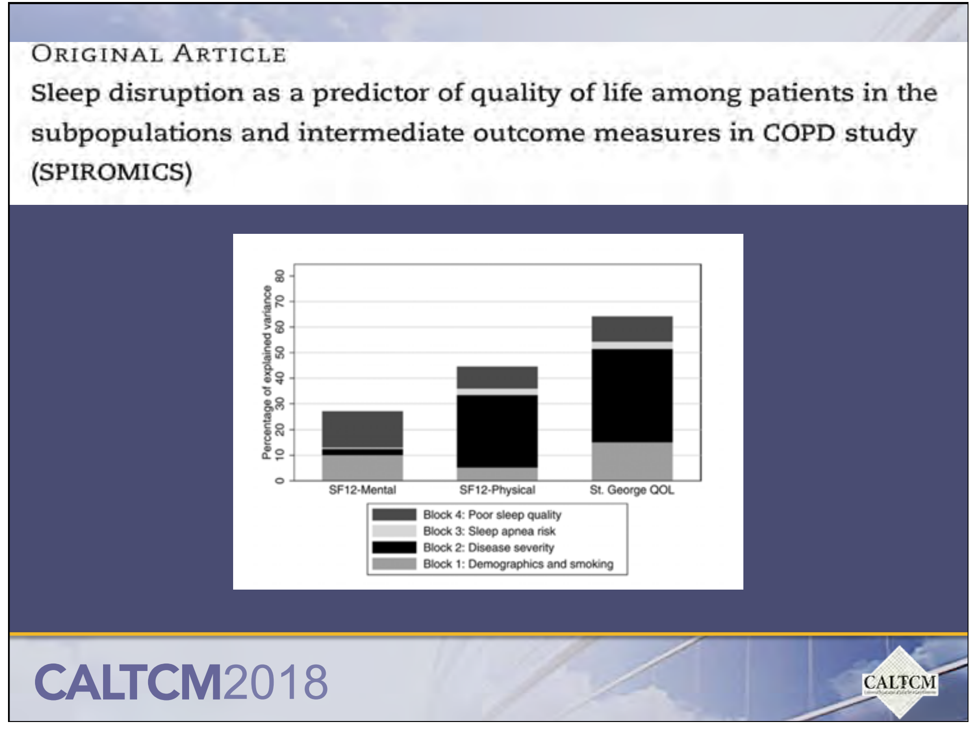
ORIGINAL ARTICLE
Sleep disruption as a predictor of quality of life among patients in the subpopulations and intermediate outcome measures in COPD study (SPIROMICS)
Percentage of explained variance
0
10
20
30
40
50
60
70
80
SF12-Mental
SF12-Physical
St. George QOL
Block 4: Poor sleep quality
Block 3: Sleep apnea risk
Block 2: Disease severity
Block 1: Demographics and smoking
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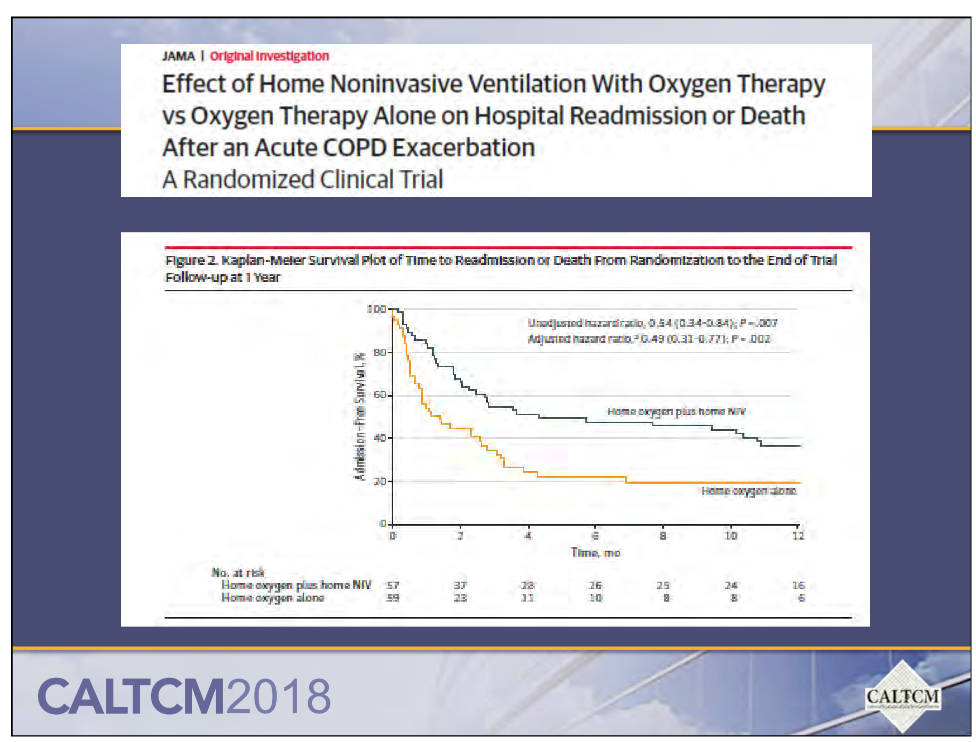
JAMA | Original Investigation
Effect of Home Noninvasive Ventilation With Oxygen Therapy vs Oxygen Therapy Alone on Hospital Readmission or Death After an Acute COPD Exacerbation
A Randomized Clinical Trial
Figure 2. Kaplan-Meier Survival Plot of Time to Readmission or Death From Randomization to the End of Trial Follow-up at 1 Year
Unadjusted hazard ratio, 0.54 (0.34-0.84); P = .007
Adjusted hazard ratio, 0.49 (0.31-0.77); P = .002
Admission-Free Survival, %
Home oxygen plus home NIV
Home oxygen alone
Time, mo
No. at risk
Home oxygen plus home NIV 57 37 28 26 25 24 16
Home oxygen alone 59 23 11 10 8 8 6
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Benefits of Pulmonary Rehabilitation

- Improved dyspnea
- Improved exercise capacity
- Improved health-related quality of life
- Fewer days of hospitalization
- Decreased health care utilization
- Reduces extent of functional decline and hastens recovery after an exacerbation
- May reduce mortality

McCarthy B, Casey D, Devane D, Murphy K, Murphy E, Lacasse Y. Pulmonary rehabilitation for chronic obstructive pulmonary disease. *Cochrane Database of Systematic Reviews* 2015, Issue 2. Art. No.: CD003793. DOI: 10.1002/14651858.CD003793.pub3.

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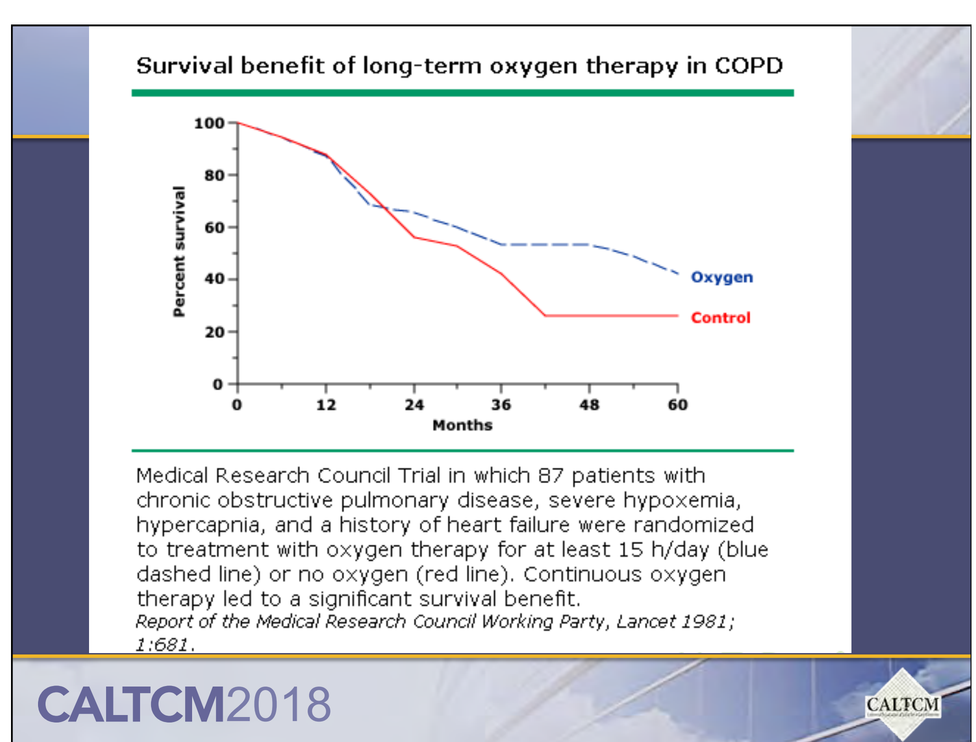

Medical Research Council Trial in which 87 patients with chronic obstructive pulmonary disease, severe hypoxemia, hypercapnia, and a history of heart failure were randomized to treatment with oxygen therapy for at least 15 h/day (blue dashed line) or no oxygen (red line). Continuous oxygen therapy led to a significant survival benefit.
Report of the Medical Research Council Working Party, Lancet 1981; 1:681.

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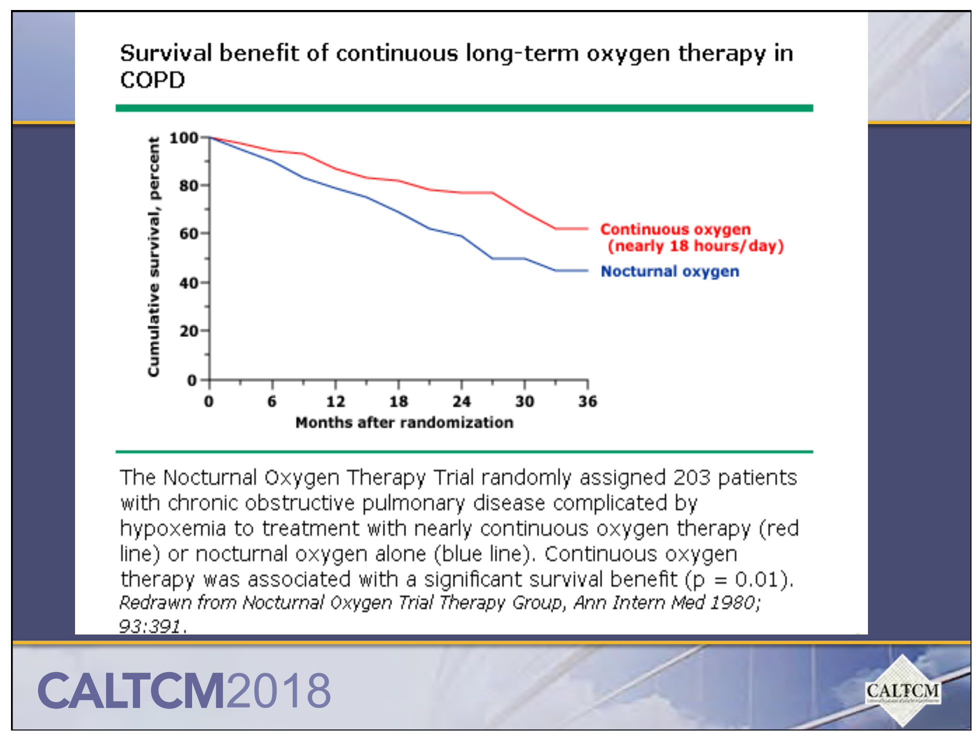

End Stage COPD

- Consider referral to Palliative Care or hospice
- Goals of care discussion, POLST forms
- Rx Short acting opiates (i.e. morphine) for air hunger/dyspnea/anxiety/sleep
- Chest wall vibration, fans blowing face
- Rx Oxygen, irrespective of blood gases, if it improves breathlessness

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info@caltcm.org
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Welcome to the
44th Annual CALTCM
Meeting!

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"We Care"
Timothy L. Gieseke, MD, CMD
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Disclosures

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

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Objectives

- Unexpected Award
- Events shape our lives
- Caring concepts shaped by experience
- Caring partnerships, our way forward

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Mlot Family Foundation

- Dr. Cheryl Philips
- Dr. Joe Ouslander
- David Farrell, MSW, INHA
- Dr. Karl Steinberg
- K. J. Page, RN, NHA, ND

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Unlikely Background

- General Internist practicing in Santa Rosa since 1979 working in all settings of care, but no training in SNF Care
- Connie Sabin DON @ new CCRC - 1986
  - Mailings from AMDA, CAMDA
  - AMDA Clinical Topics
- CAMDA meeting in Anaheim in 1992
- Albania Health Fund (1992) – Annual CME

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Expertise Slowly Developed

- AMDA Med Dir course Fall 95' – Spring 96'
  - Dr. James Pattee
  - "Win as much as you can" game
- AMDA Annual meeting 1997
  - Project ideas
  - AMDA CPGs – learn, teach, & adapt to facility
- SRMH Subacute Unit Med Dir 1998-2008
  - Med Exec Committee / Med Dir for UR

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Learning to Lead

- CALTCM - 2001
  - Dr. Frank Randolph
  - First Inter-professional AMDA State chapter
- Dr. Chris Mlot - 2002
  - "Is it time to give back to CALTCM?"
  - Membership Co-chair
- Dr. Terry Hill - 2004
  - CALTCM on "Life Support" / 3rd year as Pres.

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Difficult Choices

- AMDA Presentations on fulltime SNF work
- Left ½ time office position in 2005
  - Home office (Cheryl G) / Income increased
  - Flexible work with volunteer options
- CALTCM President June 05- June 07
- VNA Hospice Assoc. Med Dir 2006-2012
- UCLA Geriatric Faculty Development 2007
- LGM in 2008 – Dr. Cheryl Osborne

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"Giving Back"

- SC POLST Coalition with Susan Keller
- "Care Recommendations" with CCCC
- Education Committee Chair twice
  - Collaborative evidenced based "Caring"
- AMDA Public Policy Committee
- AMDA Red Eye Rounds
- CALTCM WAVE – a passion for the power of written communication

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Thank you

- Joyce Ameen, RN, DON – perfect surveys
- Dr. Dan Osterweil – Power of Asking
- Dr. Deb Bakerjian – Teacher of Teachers
- K.J. Page – The power of "Yes"
- Dr. David Greene – Adoption of gEHRiMed & pursuit of "Excellence" at our CCRC

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Apple Valley
POST-ACUTE REHAB
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Key Caring Concepts

- Nurture – Mother & wife
- Narrative – Hx & the power of story
- Team Play – Wrestling, Tennis, Cribbage
- Volunteered
- Finding your Calling
- Humility – “There but for the Grace of God go I”

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Key Caring Concepts

- Literacy & Shared decision making
- Value of Precision in face of complexity
- Value of Collaboration – Dr. James Pattee
- Respect for minority reports
- Curiosity & Mystery
- Reflective writing
- Power of “Yes”

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Threats to Caring

- Excuses
  - Too busy, short staffed, overworked
  - Too much debt, too little business margin
  - Computer & technology demands
- Caring Traditions of interventions based on quick guesses rather more labor intensive comprehensive assessments
- Working in Isolation w/o accountability

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Our Future: Caring Partnerships

- Inter-professional collaboration with real-time communication & problem solving
- Develop your niche in your health care market
- Develop tools for more efficient & precise care.
  - EHRs (gEHRiMed & PCC), Telemedicine, Secure fax & texts via smart phone apps
  - Real-time decision support smart phone apps

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We Care

- Each of us is shaped by life events that shape our caring
- We can learn from the caring of others
- Teams are our way forward
- Find your niche and mine it
- Don't let excuses stop you
- "Is it time to give back?"
- Thank you

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Disclosures

- Christopher E. Laxton, CAE, has no relevant financial relationships with commercial interests to disclose.

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Political Update 2018

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Key Issues for the Year

- Politics
  - Midterms for the party not in power: historical trends; presidential popularity
    - Will Congress flip? 24 needed in House; Senate more difficult
  - State Elections/Redistricting
- The Economy: key trends include lower unemployment, wage increases, continued job insecurity and a volatile stock market.
- Policy
  - Trump First Year Accomplishments
  - Consensus Opportunities
  - Issues of Risk for Trump

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Policy and Politics

- Trump Admin First Year Accomplishments
  - Tax Reform
  - Individual Mandate
  - Budget Deal
  - Gorsuch Confirmation (and circuit judges)
- Second Year Consensus Opportunities
  - Infrastructure
  - Opioids
    - Society working on position statement (based on 2017 HoD resolution)
- Will there be agreement on…
  - Immigration
  - Deficit
  - Entitlement Reform

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Administration's Regulatory Goals

- Patients over Paperwork Campaign
  - Reduce Admin Burden
  - Less time spent on things like EHR and Documentation
- Meaningful Measures
  - Too many measures across programs
  - Confusing and meaningless in terms of patient outcomes
  - Streamline measures and measure reporting
- Complete overhaul of Meaningful Use/ACI (latest: ACI/ MU renamed to promoting interoperability)
- My HealthEData Initiative – (latest: hospital COP to require sharing data with patients?)
- Overhaul of E&M Guidelines?

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Society on the Hill

- Workforce – Geriatric Workforce Enhancement Program (GWEP)
- PA/LTC Role in Value-Based Medicine
- Advance Care Planning

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Legislative Victories

- Permanent Repeal Therapy Caps – only 20+ years in the making
- Signed into Law: Recognize, Assist, Include, Support and Engage (RAISE) Family Caregivers Act (S. 1028), requires the development of a national strategy that would identify specific actions that government, communities, providers, employers, and others can take to recognize and support family caregivers.
- Passed out of committee: Good Samaritan Health Professional Act of 2017, a bill that protects health care professionals from being held liable for harm caused by providing health care services during a national or public health emergency, or a major disaster.
- Physician Payment Changes – reduction in MACRA penalty liability; physician payment protections

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MACRA
MIPS / APMs

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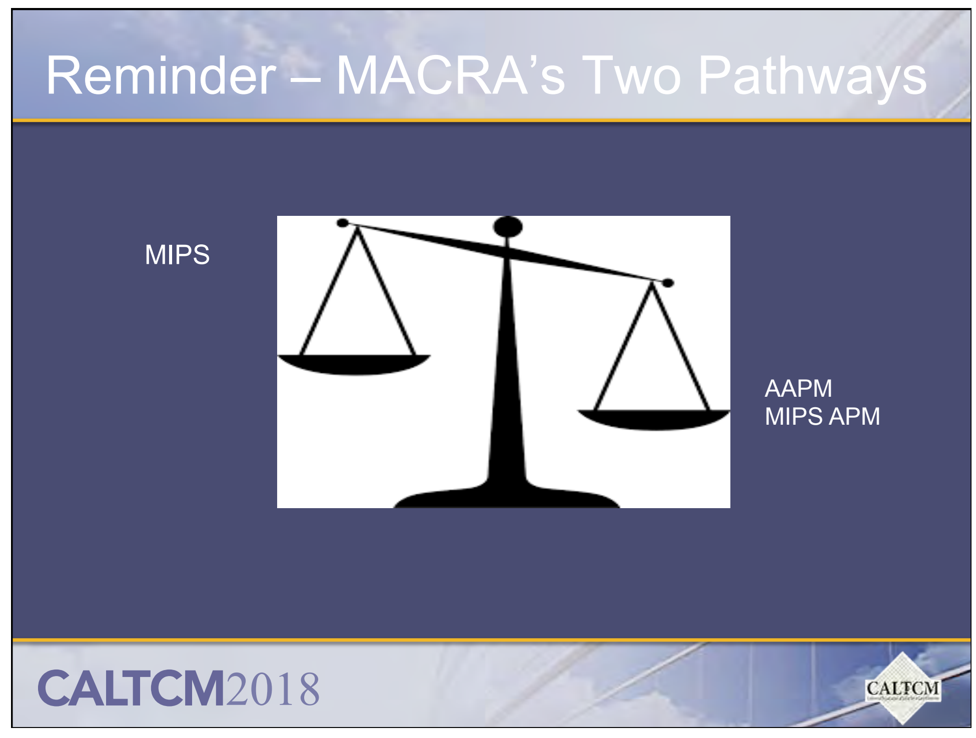

Important MIPS Changes for Year 2

- Low-volume threshold
- Who is excluded?
- Cost category is back but SNF (POS 31) patients excluded!
  - 10% for 2018 Reporting Year
- Minimum performance threshold has changed!
  - Now need to report on more than one measure

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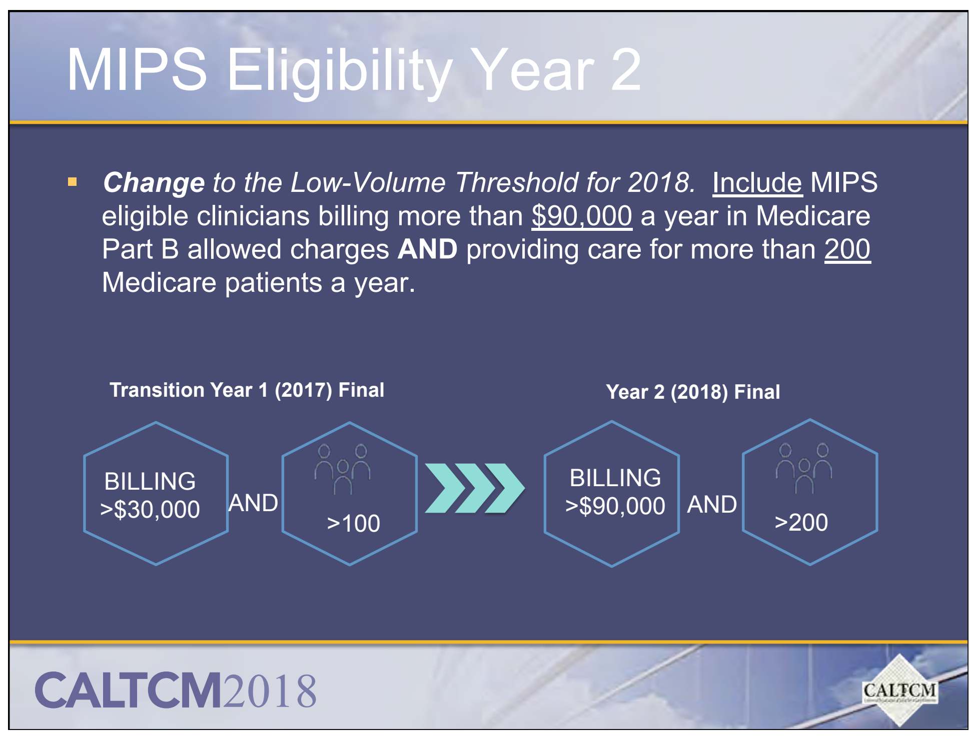
MIPS Eligibility Year 2
Change to the Low-Volume Threshold for 2018. Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges AND providing care for more than 200 Medicare patients a year.
Transition Year 1 (2017) Final
BILLING >$30,000
AND
>100
Year 2 (2018) Final
BILLING >$90,000
AND
>200
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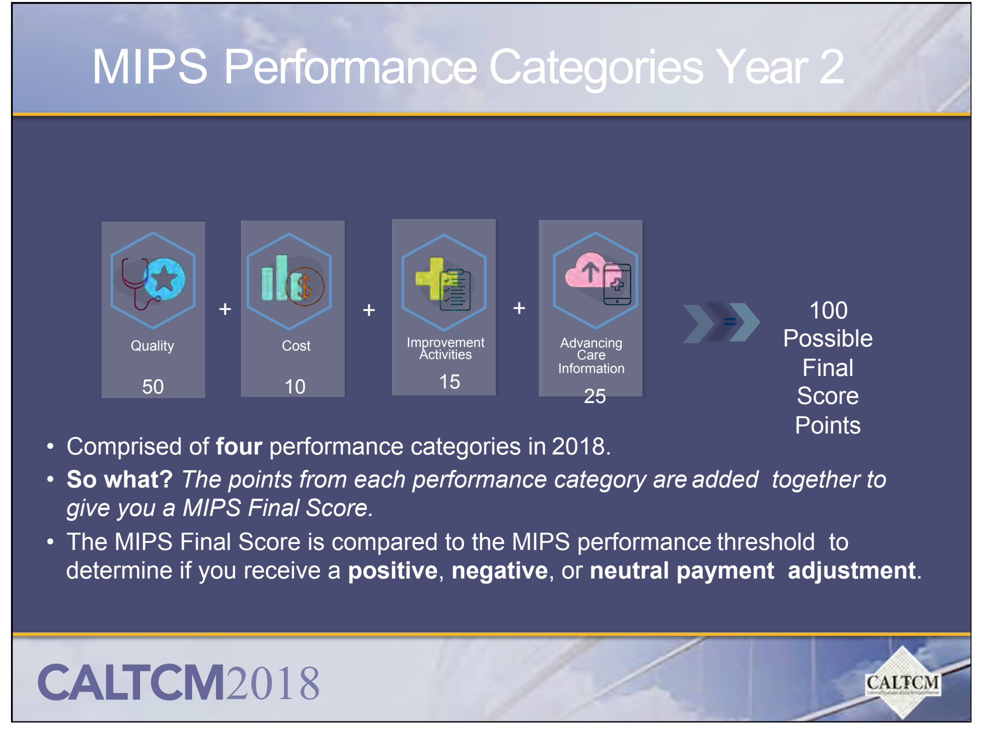
MIPS Performance Categories Year 2
Quality
50
+
Cost
10
+
Improvement Activities
15
+
Advancing Care Information
25
100 Possible Final Score Points
Comprised of four performance categories in 2018.
So what? The points from each performance category are added together to give you a MIPS Final Score.
The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.
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MIPS – Should I stay or should I go?

- MedPAC, President's Budget and Health Affairs articles have all called for repeal of MIPS
- Specialty societies are so far not on board with the idea – continue work on simplification of reporting and scoring
- Something to monitor but continue to participate – MIPS is likely to be with us for the foreseeable future!

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A Quick Overview of Alternative Payment Models (APMs)

- As defined by MACRA, APMs include CMS Innovation Center models (authorized under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law.
- Advanced APMs are a subset of APMs. To be an Advanced APM, a model must meet the following three statutory requirements:
  - Requires participants to use certified EHR technology (CEHRT);
  - Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
  - Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a more than nominal amount of financial risk.
- In order to achieve status as a Qualifying APM Participant (QP) and qualify for the 5% APM incentive payment for a year, eligible clinicians must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance period.

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Advanced APMs in PA/LTC

- No available Advanced APMs for exclusive PA/LTC clinicians
- MIPS APMs available
  - IAH
  - I-SNIP
- Could success of Initiative to Reduce Rehospitalizations Among Nursing Home Residents be scalable to Advanced APMs?
- PTAC has approved two new models
  - End-of Life Model – Submitted by AAHPM
  - Telehealth Model in SNF – Submitted by Avera Health

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Quality: The Other Side of "Value"

- Measures are "reportable" but are not benchmarked for PA/LTC based clinicians
- CMS funding announcement for specialty societies to develop measures – focus on patient reported outcome measures
- Society to submit a MACRA funding application for physician measure development
  - Focus is on UTIs but others will need to be developed later

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Society Advocacy

- Simplify MIPS!
  - Get credit in multiple categories
  - Easier reporting options
  - Flexibility in reweighing categories
  - Create a “facility-based” eligible clinician definition
  - Specialty Designation for better comparison!
- Improve Risk Adjustment in Cost Measures
  - I-SNP
  - Johns Hopkins Model
  - Others

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Your Foundation

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The Foundation for PA/LTC Medicine

- Separately incorporated 501(c)(3) organization formed in 1996 to advance the quality of life for persons in post-acute & long-term care (PA/LTC) through inspiring, recognizing and educating future and current health care professionals.
- In 2016, AMDA-The Society's Board of Directors mandated the Foundation to be the fundraising vehicle for all the Society entities. In addition to changing its name to align with the Society, the Foundation Board restructured and created the Development Committee. Under the guidance of the Board, the committee is directly responsible for raising funds for its programs to support not only the Foundation's mission but that of the Society and ABPLM.
- Proposals from all Society entities were solicited to determine funding priorities. The Board of Directors established the following priorities for fundraising:
  - Development of the PA/LTC workforce
  - Quality measures development
  - Professional impact research that demonstrates the value of our members in this continuum
- In addition to fundraising, the Foundation will continue it's successful awards programs to recognize and educate health care practitioners.

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The Foundation for PA/LTC Medicine

- The Foundation Futures Program:
  - In order to address the workforce issue in PA/LTC in 2001 the Foundation created an intensive learning experience designed to expose residents, fellows and advanced practitioner to career opportunities in PA/LTC Medicine.
- Quality Improvement Awards:
  - To encourage the development of innovative projects to make a direct impact on the quality of long-term care.
  - The program has awarded more than $300,000 in research funding.
- Quality Improvement & Health Outcome Awards:
  - For "Improving the Quality of Life for Persons Living in Nursing Homes"
  - Three facilities are awarded $1,000 each for programs developed by the team that demonstrated improved quality of life for their residents.
- Visit our website at www.paltcfoundation.org and learn how to support YOUR Foundation.

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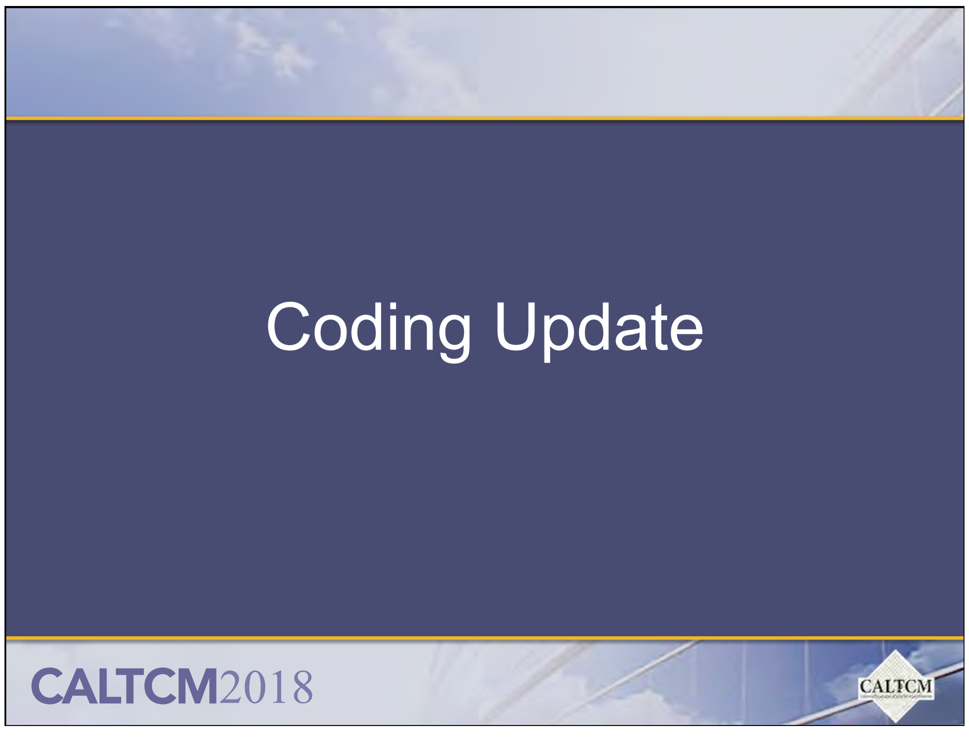

All Those New Codes

- Advance Care Planning codes 99497/99498 - reimbursed since January 1, 2016 (billable in SNF/NF)
- Chronic Care Management Codes 99490 – reimbursed since January 1, 2016 (billable in SNF/NF)
- G0506 – add-on code to the CCM initiating visit
- Complex Chronic Care Management Codes 99487/99489 – reimbursed since January 1, 2017 (billable in SNF/NF)
- Transitional Care Management – 99495/99496 – reimbursed since January 1, 2015 – (NOT billable in SNF/NF)
- Cognitive Assessment and Care Planning 99483 (old G0505) (not billable in SNF/NF* clarifying for NF with CMS)
- Non-Face-to-Face Prolonged Service 99358/99359 – reimbursed since January 1, 2017 (billable in SNF/NF)

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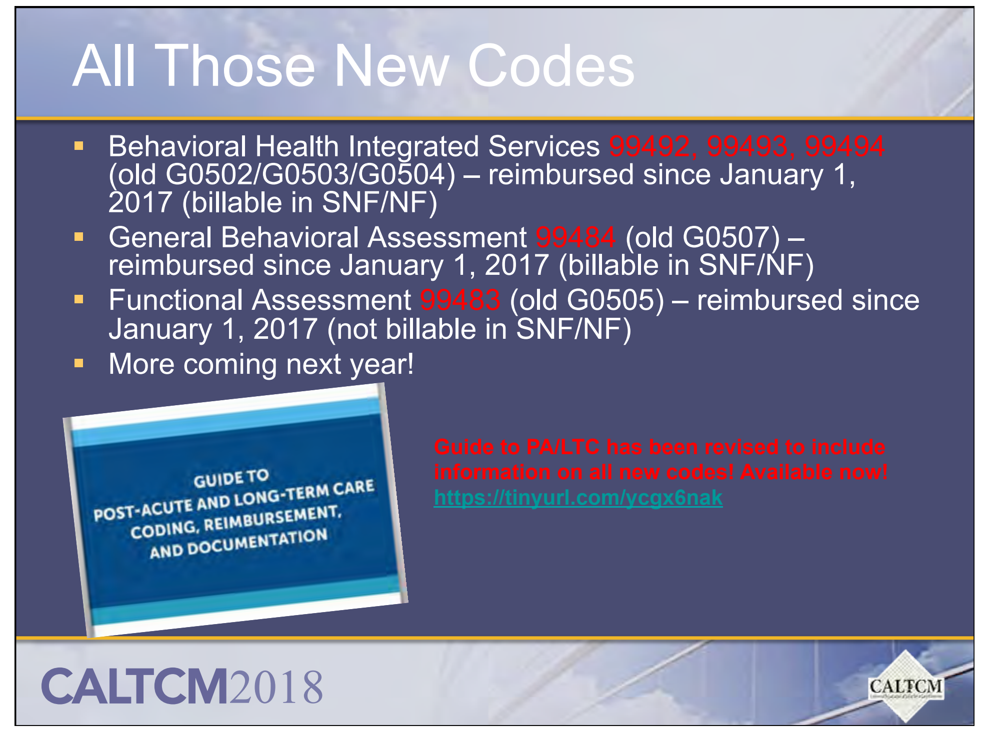
All Those New Codes
Behavioral Health Integrated Services 99492, 99493, 99494 (old G0502/G0503/G0504) – reimbursed since January 1, 2017 (billable in SNF/NF)
General Behavioral Assessment 99484 (old G0507) – reimbursed since January 1, 2017 (billable in SNF/NF)
Functional Assessment 99483 (old G0505) – reimbursed since January 1, 2017 (not billable in SNF/NF)
More coming next year!
GUIDE TO POST-ACUTE AND LONG-TERM CARE CODING, REIMBURSEMENT, AND DOCUMENTATION
Guide to PA/LTC has been revised to include information on all new codes! Available now!
https://tinyurl.com/ycgx6nak
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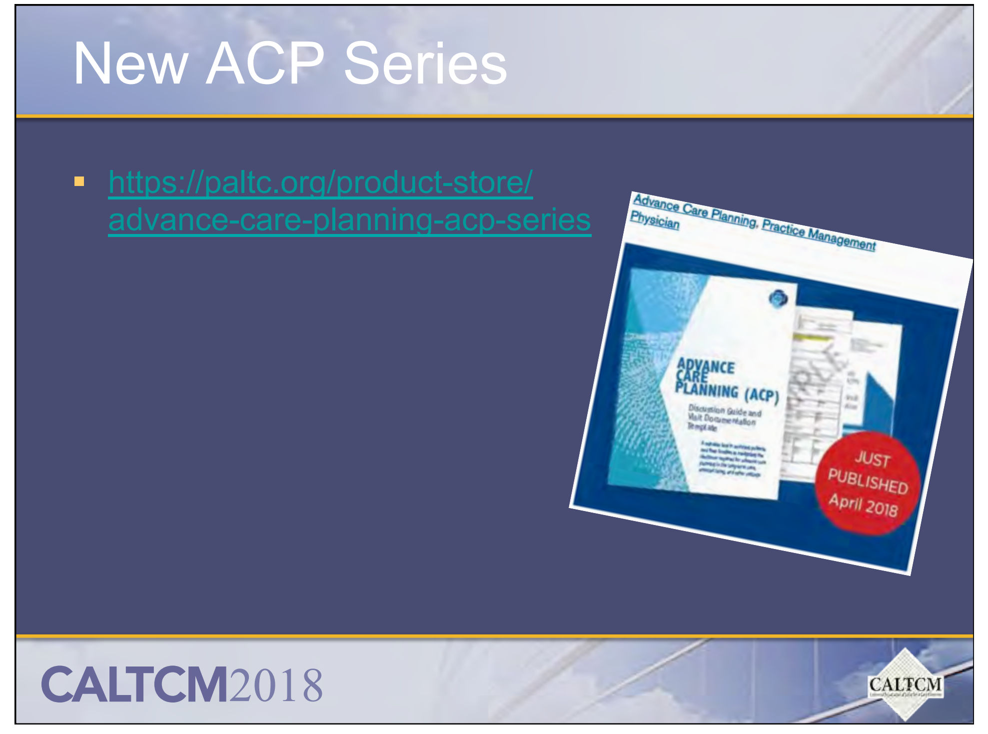
New ACP Series
https://paltc.org/product-store/advance-care-planning-acp-series
Advance Care Planning, Practice Management Physician
ADVANCE CARE PLANNING (ACP)
JUST PUBLISHED April 2018
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Society Updated Synopsis of Federal Regs!

- Updated with all new F-Tags and Recommendations for Medical Directors and Clinicians!
  - https://paltc.org/synopsis-federal-regulations
- Thank you to Steve Levenson, Vicky Walker, Gaby Geise and the entire Clinical Issues Subcommittee!

SYNOPSIS OF FEDERAL REGULATIONS IN THE NURSING FACILITY: IMPLICATIONS FOR ATTENDING PHYSICIANS AND MEDICAL DIRECTORS

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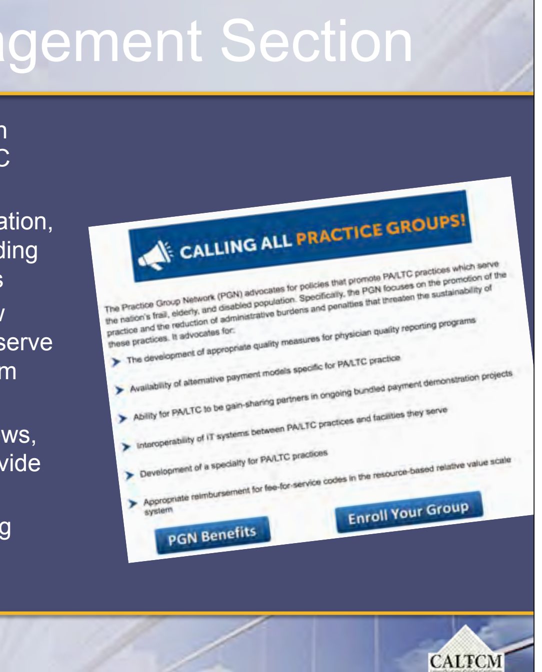
Practice Management Section

- New section established through affiliation with a group of PA/LTC practices
  - Will pursue advocacy, education, membership goals for attending physicians, APRNs and PAs
- Practice Group Network – new benefit structure established to serve the practice's needs, distinct from individual clinician needs
- Quarterly conference calls, e-news, online Forum established to provide networking
- Focused track at Annual Meeting



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Understanding the CMS ROPs

Three-Phase Implementation

- Phase 1:
  - Upon the effective date of the final rule (Nov 28, 2016)
- Phase 2:
  - 1 year following the effective date of the final rule (Nov 28, 2017)
- Phase 3:
  - 3 years following the effective date of the final rule (Nov 28, 2019)

F-tag Renumbering

Old F-Tag
New F-Tag

- The image above is the F Tag Crosswalk showing:
- The original regulatory grouping and the new associated grouping
- The original regulation number and the new associated regulation number
- The original F Tag and the associated new F Tag

Excel Crosswalk Document
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

PDF List of F Tags
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf

Topics Covered in Phase 2

- Share of information on transfer/discharge
- Care plan developed within 48 hours
- Policies and procedures for reporting suspicion of crimes
- Pharmacy Services – limits on use of psychotropic drugs
- Dental Services
- QAPI Plan
- Facility assessment/staff “competency”
- Smoking policy
- Behavioral Health
- Antibiotic stewardship program

Temporary Changes Around Phase 2

- Star rating kept constant from Nov. 2017-2019
- CMP not being assessed for deficiencies in some of new Phase 2 regs
- Advocacy groups upset that nursing homes not being 'punished' appropriately

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What does this mean for me?

- A time of transition – within your centers (and for surveyors too)
- A time to reflect, self-assess, and prioritize your efforts
- A marathon, not a sprint

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IMPACT Act of 2014

- Bipartisan bill passed on September 18, 2014, and signed into law October 6, 2014
- The Act requires the submission of standardized patient assessment data elements by:
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI
- The Act specifies that data "… be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes…".
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

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IMPACT Act: Quality Measures

Measure Domain	HHA	SNF	IRF	LTCH
Functional status	1/1/2019**	10/1/2016	10/1/2016	10/1/2018
Skin integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication reconciliation	1/1/2017	10/1/2018*	10/1/2018*	10/1/2018*
Incidence major falls	1/1/2019**	10/1/2016	10/1/2016	10/1/2016
Transfer of Health Information	1/1/2019**	10/1/2018**	10/1/2018**	10/1/2018**
Resource Use & Other Measures Domain	**HHA**	**SNF**	**IRF**	**LTCH**
Medicare Spending Per Beneficiary	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Discharge to Community	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Potentially Preventable Hospital Readmissions	1/1/2017	10/1/2016	10/1/2016	10/1/2016

* = Implemented, but data collection has not begun
** = Not implemented yet

5

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IMPACT Act Measures Domains

Measure Domain	Measure Name
Functional status	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
Skin integrity	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)
Medication reconciliation	Drug Regimen Review Conducted with Follow-Up for Identified Issues Post Acute Care (PAC)
Incidence major falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Transfer of Health Information	Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from Other Providers/ Settings Transfer of Information at Post-Acute Care Discharge to Other Providers/Settings
Medicare Spending Per Beneficiary	Medicare Spending Per Beneficiary-Post Acute Care (PAC)
Discharge to Community	Discharge to Community-Post Acute Care (PAC)
Potentially Preventable Hospital Readmissions	Potentially Preventable 30-Day Post-Discharge Readmission Measure

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Data Element Standardization

- Achieving Standardization (i.e., Alignment) of Clinically Relevant Data Elements to Improve Care and Communication for Individuals Across the Continuum
  - Enables shared understanding and use of clinical information;
  - Enables the re-use of data elements (e.g., for transitions of care, care planning, referrals, decision support, quality measurement, payment reform, etc.);
  - Supports the exchange of patient assessment data across providers;
  - Influences and supports CMS and industry efforts to advance interoperable health information exchange (HIE) and care coordination in disparate settings.

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A NEW WAY?
PDPM – A Patient-Driven Payment Model

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RCS1 – Resident Classification System

- SNF Prospective Payment System in Place Since 1998 – Criticized Over Time
- CMS hired Acumen to develop a new payment system with 3 goals in mind
  - More accurately compensate SNFs
  - Reduce incentives for SNFs to deliver therapy based on financial considerations, rather than resident need
  - Maintain simplicity, to the extent possible
- CMS Held Expert Panels – AMDA was represented
- Would replace the current RUG based system (RUG-IV)
- SNF Payment Rule released recently begins to implement "money follows the patient approach"
- PDPM is a switch from RCS-1

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BREAKING NEWS: CMS gives skilled nursing 2.4% Medicare pay raise, unveils another new resident classification system

Share this content:

In a flurry of activity late Friday, the Centers for Medicare & Medicaid Services announced an $850 million pay raise for skilled nursing facilities for fiscal 2019 that comes along with major simplifications to a previously pitched resident classification system.

CMS Administrator Seema Verma announced the changes Friday.

The proposed Patient-Driven Payment Model (PDPM), a switch from last spring's originally pitched RCS-1, will replace the Resource Utilization Group system, or RUG-IV, used to categorize Part A residents into various payment groups based on their level of need.

In its announcement, CMS said the new model would reduce the number of payment group combinations by 80%, use more standardized items for payment calculations and "greatly simplify" providers' paperwork.

Advocacy Efforts

- Coalition of Stakeholders worked together to develop and submit comments, concerns
- Meetings with CMS
- Coalition response to SNF PPS rule

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SNF VBP

- What measures will be used in the SNF VBP Program?
- Skilled Nursing Facility 30-Day All-Cause Readmission Measure
- The Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is used in the SNF VBP Program. The SNFRM estimates the risk-standardized rate of unplanned readmissions within 30 days for:
- People with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals.
- Any cause of condition
- SNFs will earn a SNF VBP Performance score (0 to 100) and ranking which is calculated based on that SNF's performance on the measure. The SNF VBP performance score is equal to the higher of the achievement score and improvement score.
- SNFs will be awarded points for achievement on a 0-100-point scale and improvement on a 0-90-point scale, based on how their performance compares to national benchmarks and thresholds.

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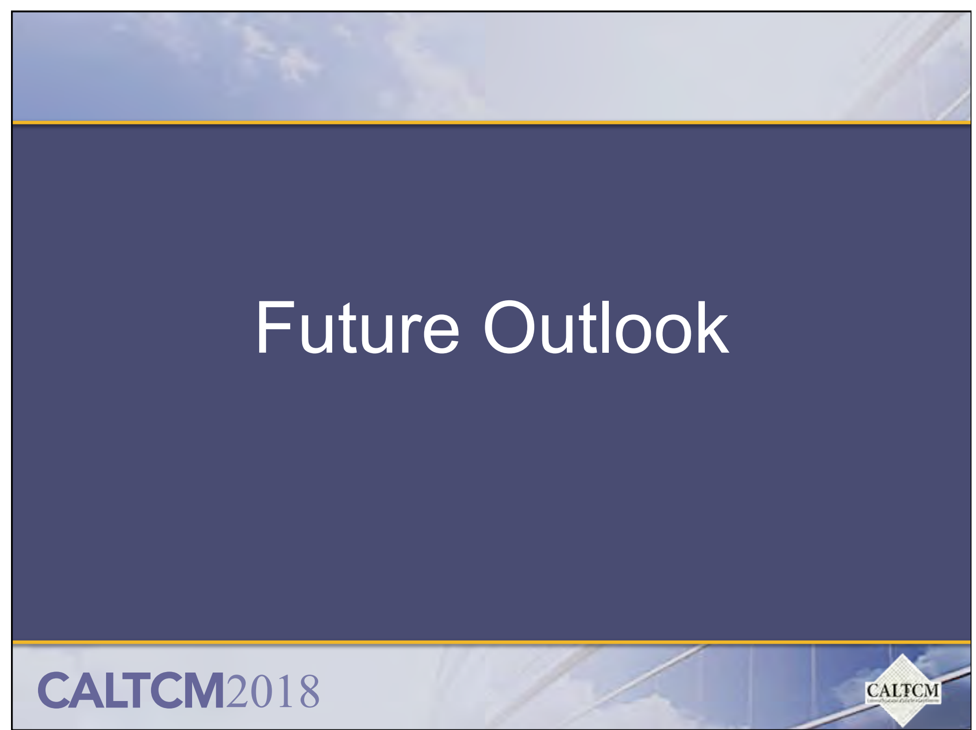
SNF QRP Assessment-Based Quality Measures

NQF Measure ID	Measure Title	Data Collection Timeframe	Data Submission Deadline
NQF #0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	01/01/17-12/31/17	May 15, 2018
NQF #0678	Percent of Patients or Residents with Pressure Ulcers that are New or Worsened	01/01/17-12/31/17	May 15, 2018
NQF #2631	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	01/01/17-12/31/17	May 15, 2018

SNF QRP claims-based measures

Measure	Data Source
Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Medicare FFS claims
Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Medicare FFS claims
Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure	Medicare FFS claims



Looking into the future

- Think big picture
- Role of Preferred Provider Networks (are you seeing this in your market??)
- Predictive Analytics – PointRight; NaviHealth etc, have platforms to help with SNF selection
- Health IT – do you have a strategy for billing; reporting; and tracking performance?
  - Foundation for PA/LTC partnered with HIMSS conduct a major PA/LTC IT readiness study. More to come!
- How do you leverage your clinical expertise in PA/LTC population in value-based environment when others don't understand what you do?

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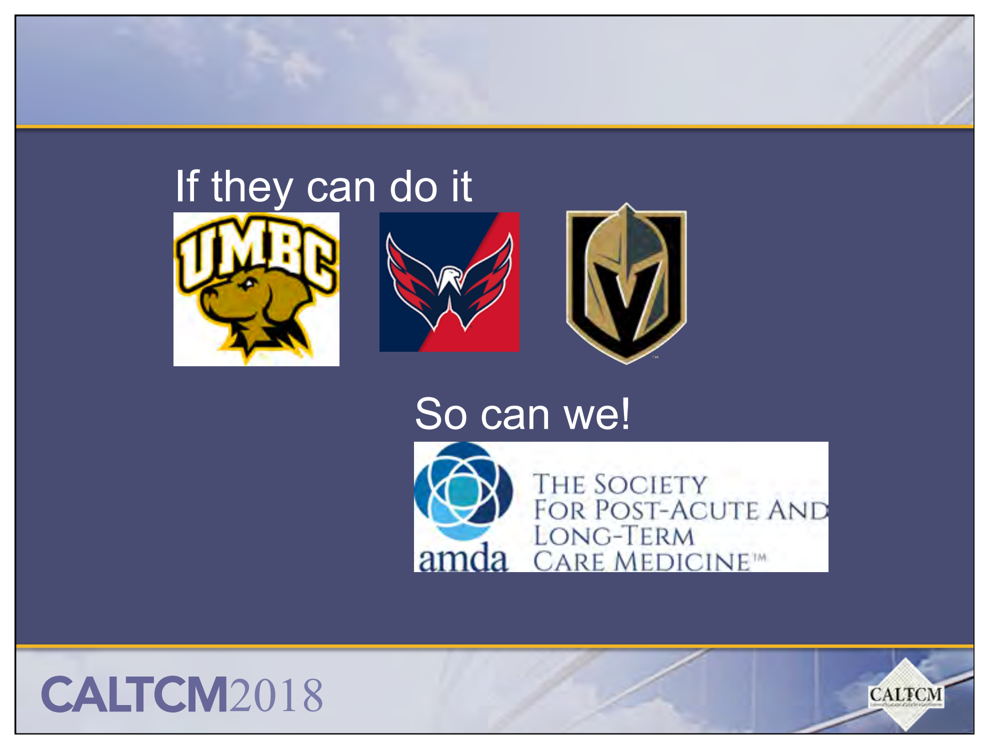

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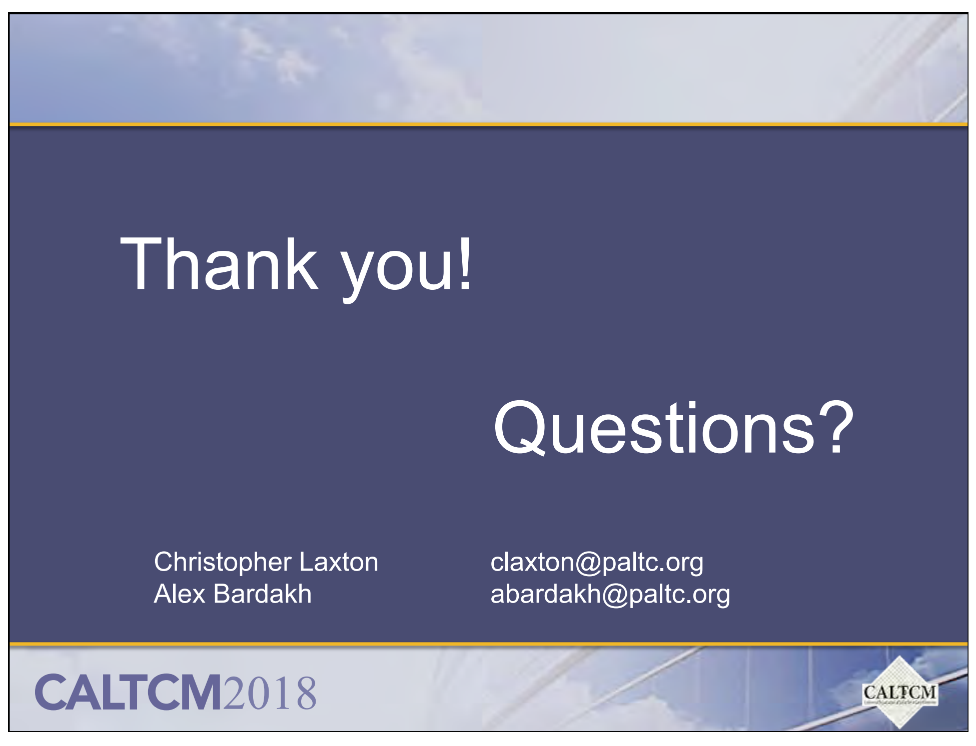
Thank you!
Questions?
Christopher Laxton claxton@paltc.org
Alex Bardakh abardakh@paltc.org
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Overview of Palliative Care
Lisa Seo, MD
CALTCM

Disclosures

- Lisa Seo, MD, has no relevant financial relationships with commercial interests to disclose.

Palliative Definition "Pallium"

- Outer garment that ***covered or cloaked*** a person or object.

Fig. 17. Pallium over Paenula

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World Health Organization in 1986

"**Palliative care** is an approach that improves the ***quality*** of life of **patients** and their **families** facing the problems associated with life-threatening illness, through the prevention and relief of **suffering** by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

http://www.who.int/cancer/palliative/definition/en/

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Roles of Palliative Care
Provides relief from pain and other distressing
Pain relief
http://www.bing.com/images/search?view=detailV2&ccid=Yr6nAnAd&id=96895F2EB1C4C4BB265EE87B55FBCD7DE4DBA038&thid=OIP.Yr6nAnAdRQunRFAP4BG-8gHaHa&mediaurl=http%3a%2f%2fwww.draxelrad.com%2fwp-content%2fuploads%2f2012%2f11%2fPain-Relief.jpg&exph=900&expw=900&q=pain+relief&simid=607999932042316196&selectedIndex=2&ajaxhist=0
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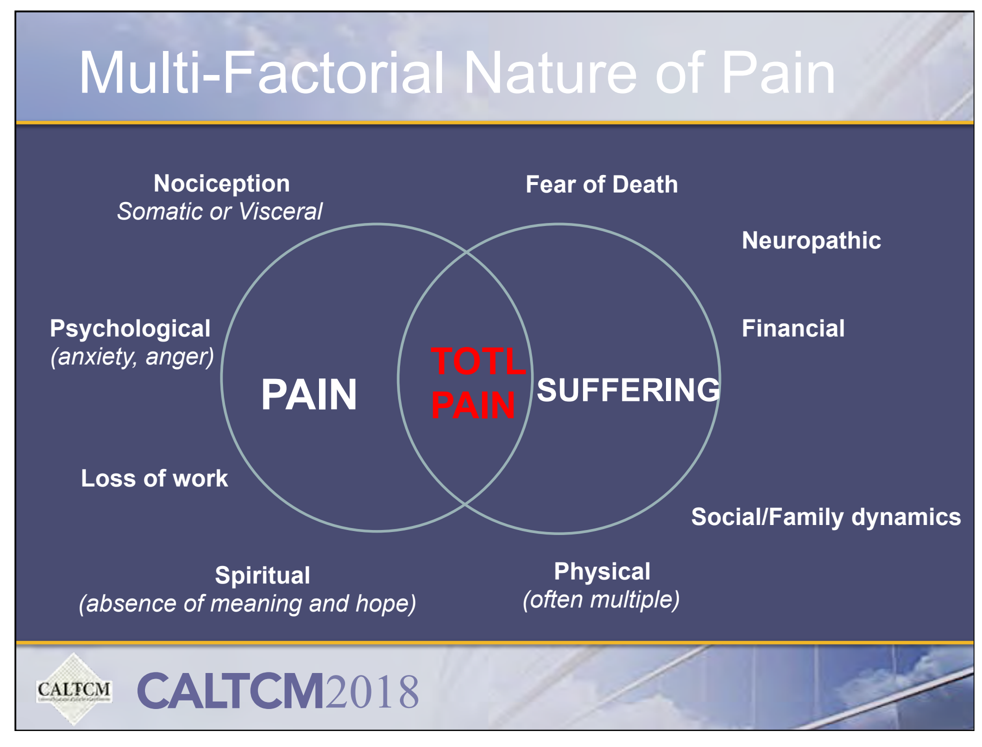
Multi-Factorial Nature of Pain
Nociception
Somatic or Visceral
Fear of Death
Neuropathic
Psychological
(anxiety, anger)
Financial
PAIN
TOTL PAIN
SUFFERING
Loss of work
Social/Family dynamics
Spiritual
(absence of meaning and hope)
Physical
(often multiple)
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Roles of Palliative Care

- Affirms life and regards dying as a normal process;

- Intends neither to hasten or postpone death;

http://www.bing.com/images/search?view=detailV2&ccid=oyY2nxtq&id=905758A58446D3E755856E35712A206463588AAB&thid=OIP.oyY2nxtqPTcxUcut0cYKRAHaE7&mediaurl=https%3a%2f%2ftimenewsfeed.files.wordpress.com%2f2011%2f10%2fhands.jpg%3fw%3d455&exph=303&expw=455&q=dying+peacfully&simid=608051523199307370&selectedIndex=19&ajaxhist=0

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Roles of Palliative Care

- Integrates the psychological and spiritual aspects of patient care;

http://www.bing.com/images/search?view=detailV2&ccid=I9K5dfyA&id=8DFB362C914DFD58E7046232ADBEFA9CF67780ED&thid=OIP.I9K5dfyANVqx9krdhuz6EAHaDt&mediaurl=http%3a%2f%2funveiledwife.com%2fwp-content%2fuploads%2f2012%2f05%2fspriritual-support.jpg&exph=300&expw=600&q=spiritual+support&simid=607987017093287413&selectedIndex=2&ajaxhist=0

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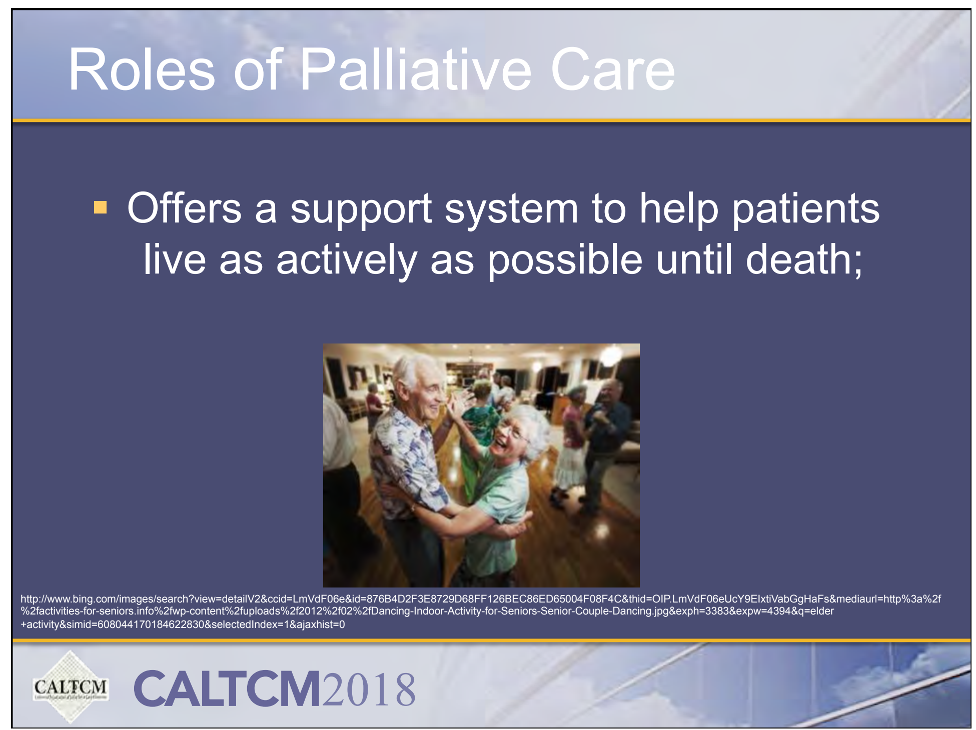
Roles of Palliative Care
Offers a support system to help patients live as actively as possible until death;
http://www.bing.com/images/search?view=detailV2&ccid=LmVdF06e&id=876B4D2F3E8729D68FF126BEC86ED65004F08F4C&thid=OIP.LmVdF06eUcY9ElxtiVabGgHaFs&mediaurl=http%3a%2f%2factivities-for-seniors.info%2fwp-content%2fuploads%2f2012%2f02%2fDancing-Indoor-Activity-for-Seniors-Senior-Couple-Dancing.jpg&exph=3383&expw=4394&q=elder+activity&simid=608044170184622830&selectedIndex=1&ajaxhist=0
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Roles of Palliative Care
Offers a support system to help the family cope during the patient's illness and in their own bereavement
http://www.bing.com/images/search?view=detailV2&ccid=qHQ2U%2beF&id=12FE0851625B7705A33C2AE2C0B98AC84DA9E4A7&thid=OIP.qHQ2U-eF1YcH_XkxXCrglwHaCy&mediaurl=https%3a%2f%2fdrlchristianduperouzel.files.wordpress.com%2f2017%2f03%2ffamily.jpg&exph=355&expw=945&q=family+support&simid=608045583209465987&selectedIndex=34&ajaxhist=0
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Roles of Palliative Care
Uses a team approach to address the needs of patients and their families
SOCIAL WORKER
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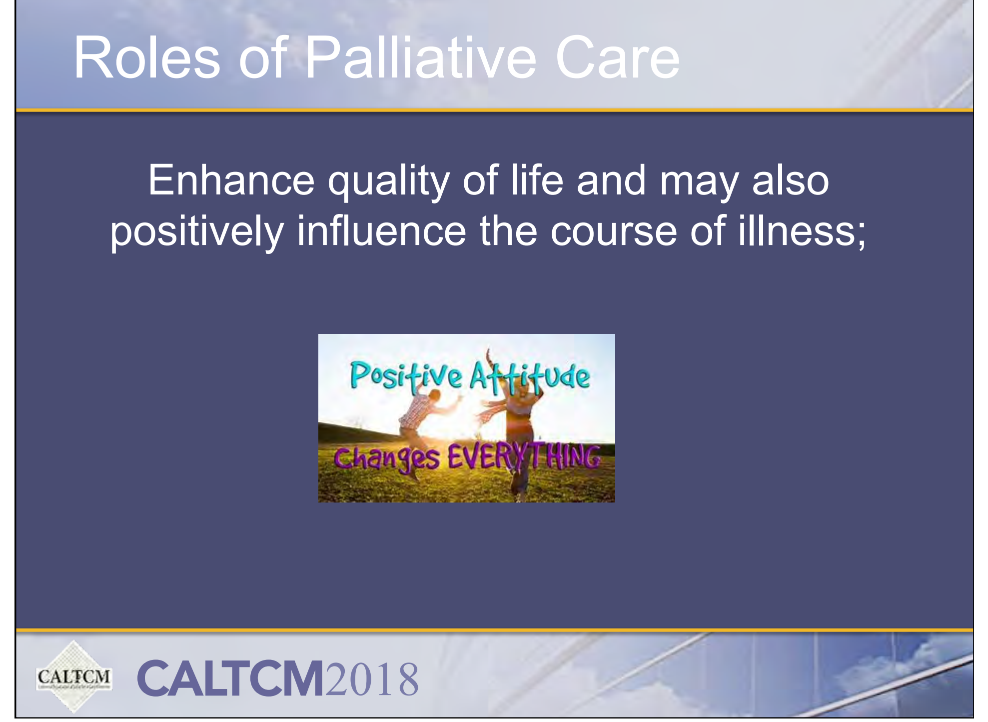
Roles of Palliative Care
Enhance quality of life and may also positively influence the course of illness;
Positive Attitude
Changes EVERYTHING
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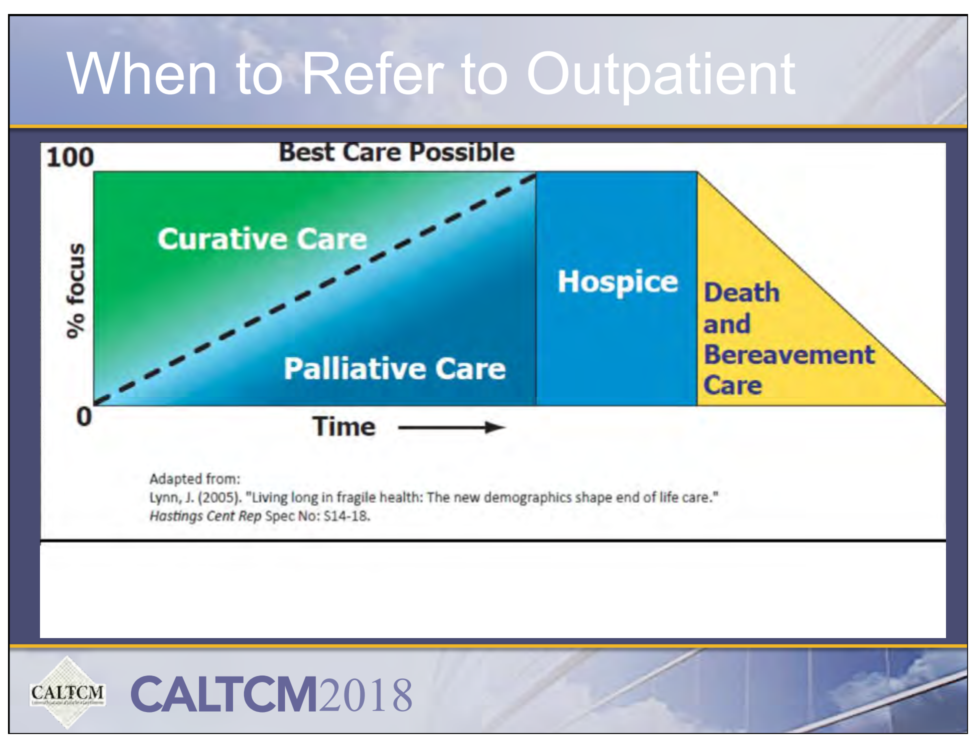
When to Refer to Outpatient



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Palliative Care - A Shifting Paradigm

The results of this study show that palliative care is appropriate and potentially beneficial when it is **introduced at the time of diagnosis of a serious or life-limiting illness** — at the same time as all other appropriate and beneficial medical therapies are initiated.

The fact that palliative care improved quality-of-life outcomes is consistent with the results of other studies of both nonhospice and hospice palliative care.

Amy S. Kelley, M.D., M.S.H.S., and Diane E. Meier, M.D.

N Engl J Med 2010; 363:781-782August 19, 2010DOI: 10.1056/NEJMe1004139

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Myths and Facts

Myth:

Palliative care is the same as hospice care.

Myths and Facts

- **Fact:** Although palliative and hospice care share the same principles of comfort and support.
- Palliative care begins at diagnosis and continues during treatment and beyond.
- Palliative care is NOT synonymous with end-of-life care

Myths and Facts

Myth*:*

If I accept palliative care, I won't get treatment

Myths and Facts

Fact:

Palliative care is given in addition to your prescribed treatment. It will continue to be provided to alleviate your symptoms and emotional issues throughout the course of your treatment.

Myths and Facts

Myth:

You have to give up your other physicians to receive palliative care.

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Myths and Facts

Fact:

- Palliative care specialists will make recommendations to your oncologist and other physicians about the management of your pain and other symptoms. You will continue to receive care from your other physicians.

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Myths and Facts

Myth:

Only patients can benefit from palliative care.

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Myths and Facts

Fact:

- Everyone involved can benefit, including family caregivers. Your doctors and nurses benefit, too, because they know they are meeting your needs by providing care that reduces suffering and improves quality of life.

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Myths and Facts

Myth:

Palliative care hastens death.

Myths and Facts

Fact:

Palliative care does not hasten death.

It provides comfort and the best quality of life from diagnosis of an advanced illness until end of life.

Myths and Facts

Myth:

Palliative care is only for people dying of cancer.

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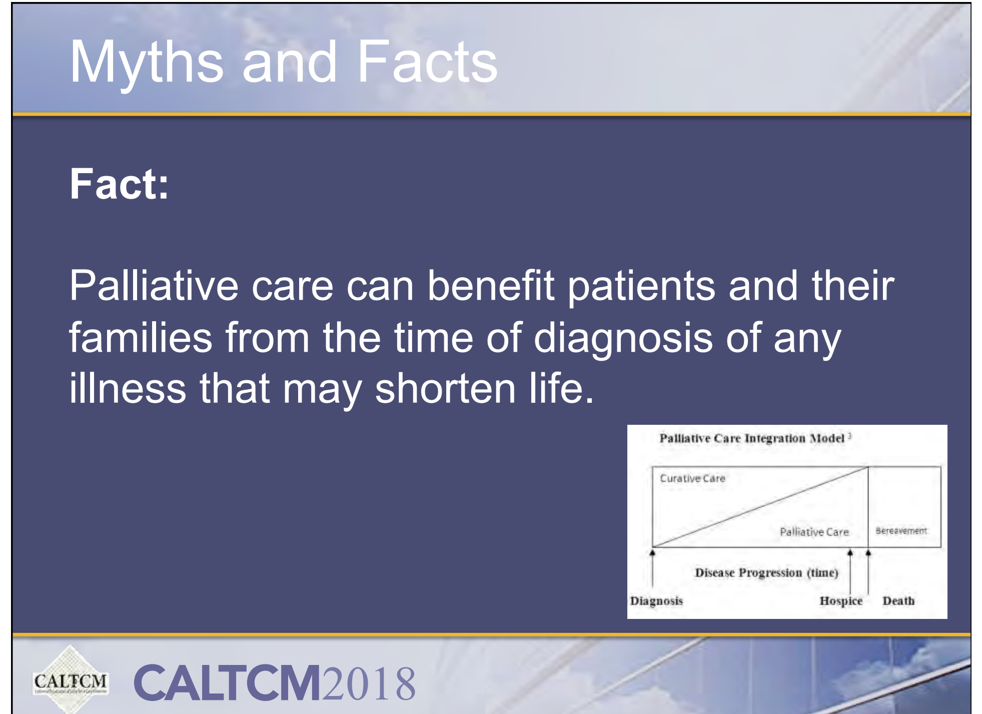

Myth

People in palliative care who stop eating die of starvation.

Fact

Fact:

People with advanced illnesses don't experience hunger or thirst as healthy people do. People who stop eating die of their illness, not starvation.

Myth

Myth:

Palliative care is only provided in a hospital.

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Fact

Fact:

Palliative care can be provided wherever the patient lives – home, long-term care facility, hospice or hospital.

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Myth

Myth:

Palliative care means my doctor has given up and there is no hope for me.

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Fact

Fact:

Palliative care ensures the best quality of life for those who have been diagnosed with an advanced illness.

Hope becomes less about cure and more about living life as fully as possible.

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Myth

Myth:

***It is a place for people to live their final days and die*.**

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Fact

Fact:

Doctors making the referrals of terminally-ill patients to the palliative care ward often fail to explain to the patients what will happen to them there.

Patients can be distressed by the lack of information provided to them, especially if they already have their own negative perception of palliative care. This is probably why people tend to misunderstand this term so often.

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Myth

Myth:

It is catered only for the old and dying patients with end-stage diseases without further treatment.

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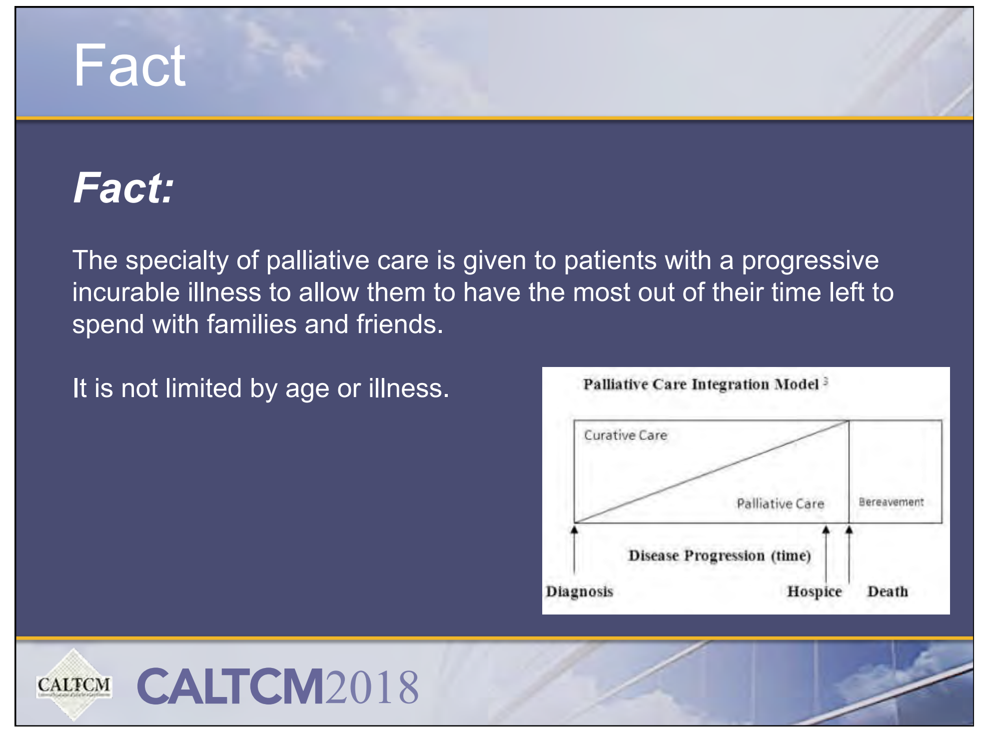

RESOURCES:

2009 May 1;115(9):2013-21. doi: 10.1002/cncr.24206.

- **Supportive versus palliative care: what's in a name?: a survey of medical oncologists and midlevel providers at a comprehensive cancer center.**
- Fadul N[1], Elsayem A, Palmer JL, Del Fabbro E, Swint K, Li Z, Poulter V, Bruera E.
- N Engl J Med 2010; 363:781-782August 19, 2010DOI: 10.1056/NEJMe1004139
- http://www.who.int/cancer/palliative/definition/en/
- https://health.ucsd.edu/specialties/cancer/programs/palliative/facts/Pages/default.aspx

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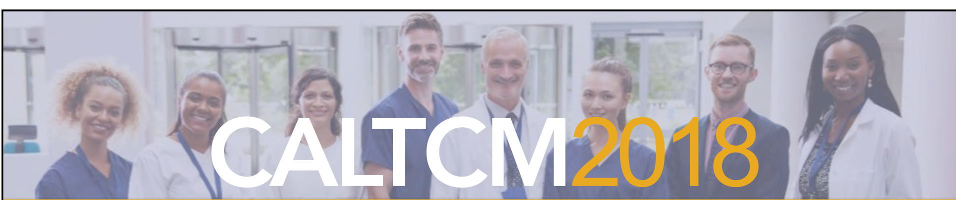

An Approach to Assessing Capacity at the End of Life

Paul Schneider, MD FACP; Clinical Professor of Medicine, UCLA; Chairman, Southern California Bioethics Committee Consortium

Disclosures

- Paul Schneider, MD FACP, has no relevant financial relationships with commercial interests to disclose

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Case

The patient is a 57 year old man with untreated schizophrenia and squamous cell carcinoma of the anus. He has had the disease for 2 years and has received courses of radiation and chemotherapy at several hospitals. He has received care at over 35 different VA hospitals in different states over the past decade. Recently, he has left several hospitals against medical advice for unclear reasons. He was just diagnosed with recurrence of his cancer in the genital area, which is severe and unresectable due to its size. He currently declines further anticancer treatment but would like nursing care for pain, nausea and incontinence. His MOCA is 29/30 and although somewhat detached and guarded, he shows no signs of psychosis or depression currently. Is he a hospice candidate?

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Why do we even assess capacity anyway?

- Capacity ≈ Competence.
- Sending every determination to court would paralyze care.
- Informed consent is required in virtually all medical encounters – what changes is the degree of documentation.
- Informed consent in the absence of capacity is invalid and may lead to allegations of wrongdoing.
- Capacity assessments uncover diagnoses that were not considered. Yet, incapacity requires no specific diagnosis.
- In incapacity, surrogate decision-making may help protect the patient’s rights and autonomy.

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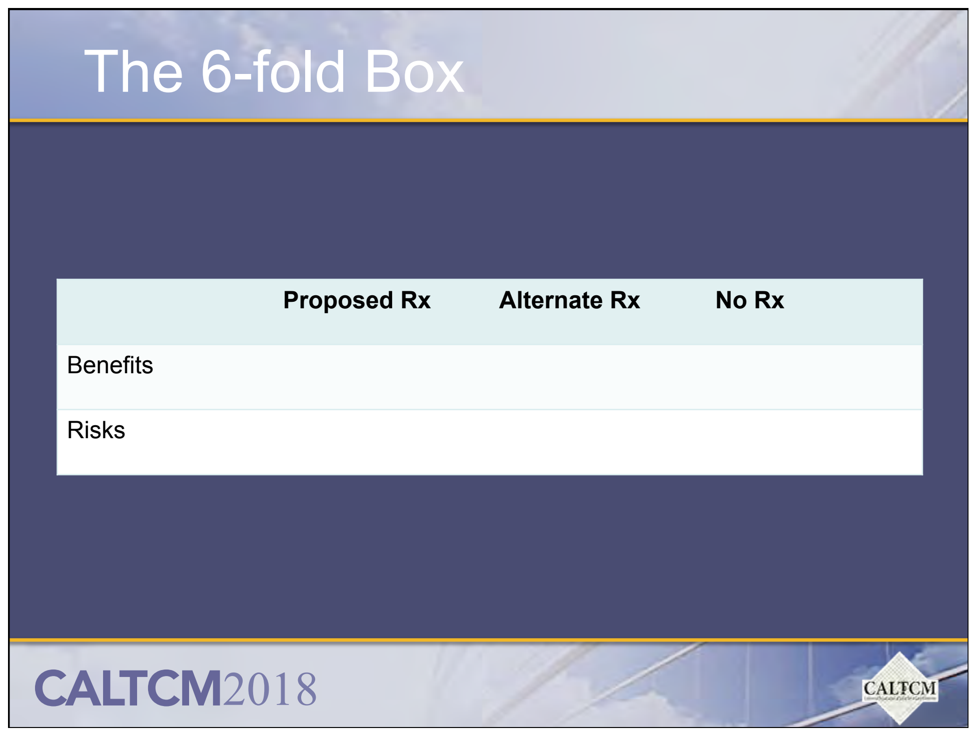
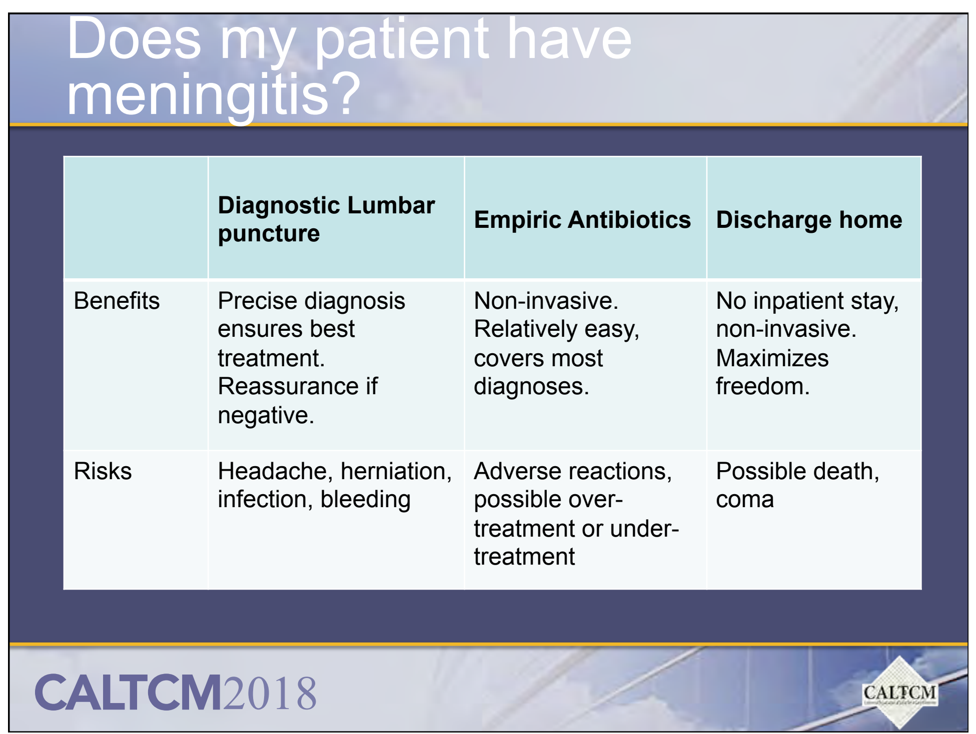


	Proposed Rx	Alternate Rx	No Rx
Benefits			
Risks			



	Diagnostic Lumbar puncture	Empiric Antibiotics	Discharge home
Benefits	Precise diagnosis ensures best treatment. Reassurance if negative.	Non-invasive. Relatively easy, covers most diagnoses.	No inpatient stay, non-invasive. Maximizes freedom.
Risks	Headache, herniation, infection, bleeding	Adverse reactions, possible over-treatment or under-treatment	Possible death, coma

Action Verbs!

- **Understand** the situation and its consequences
- **Understand** the relevant information
- **Reason** about treatment options
- **Communicate** a choice.

Applebaum, Paul. Assessment of Patients' Competence to Consent to Treatment. NEJM 2007;357:1834-40.

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How Common is Incapacity?

- 302 consecutive acute medical inpatients were assessed with a standardized competence tool over 18 months at a British hospital.
  - 72 (24%) severely cognitively impaired or unconscious, non-communicative. Obviously incapacitated.
  - 71 (24%) refused to participate or spoke no English. Excluded.
  - Remainder of 159 patients interviewed. Of these, 31% lacked capacity.
  - Of the total sample, 40% lacked capacity.
  - Clinical teams successfully identified only about one quarter.

Raymont et al. Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. Lancet vol 364, No. 9443

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What about in Nursing Facilities?

- Goodwin et al. Decision-making incapacity among nursing home residents: results from the 1987 NMES survey. Behav Sci Law. 1995 Summer;13(3):405-14.
- Pruchno et al. Competence of long-term care residents to participate in decisions about their medical care: a brief, objective assessment. Gerontologist. 1995 Oct;35(5):622-9.

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What is the inter-rate reliability of a capacity assessment?

- 29 patients with mild Alzheimer disease and 16 normal older controls were assessed for capacity using a standardized interview and videotaped. 5 academic physicians with experience assessing capacity of dementia patients were recruited from Gero-psychiatry, Geriatric medicine and Neurology and were blinded to diagnoses.
- Physicians were 98% in agreement about controls.
- Physicians were 56% in agreement about AD pts. ($p = 0.44$)

Marson et al. Consistency of physician judgments of capacity to consent in mild Alzheimer's disease. JAGS 1997;45:453-7

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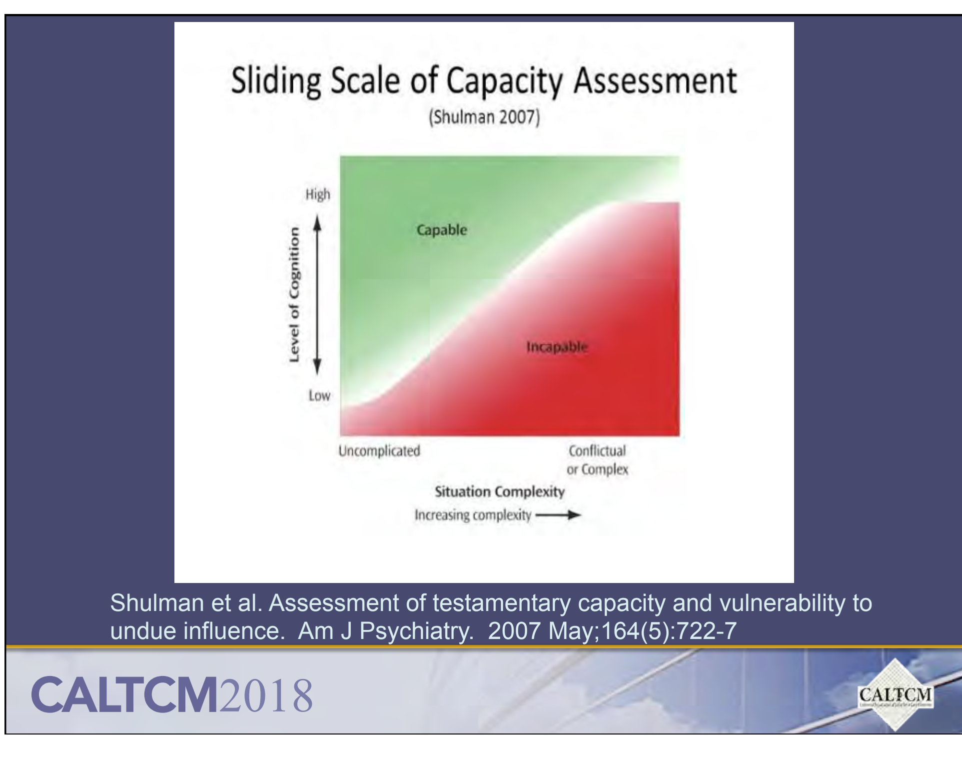

Shulman et al. Assessment of testamentary capacity and vulnerability to undue influence. Am J Psychiatry. 2007 May;164(5):722-7

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Is the MMSE useful in capacity determination?

- 100 consecutive inpatients who either refused a major Rx or did not seem to have capacity were given a capacity evaluation via a formalized instrument by clinician and a MMSE by a research nurse.
- These patients then had two independent expert assessments of capacity, which were videotaped.
- If the experts disagreed, videos were sent to an adjudicator panel.
- Conclusion: Capacity assessments by treating clinician and MMSE scores agree closely with results of expert assessments.

Etchells et al. Assessment of patient capacity to consent to treatment. JGIM 1999 Jan;14(1):27-34

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The Capacity to Execute a DPAHC

- Can patient reliably indicate that one person is trusted to act in his/her behalf?
- Can patient reliably understand executing this will undo any previous documents or arrangements?
- Does patient understand what that person will do as a result?
- Does patient understand the purpose of the form and when it might be put to use?

Moye et al. Evaluation of the capacity to appoint a healthcare proxy. Am J Geriatr Psychiatry. 2013 April;21(4):326-336

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The Capacity to Consent to Hospice

	Hospice Rx	**Nursing home s hospice**	**Return home**
Benefits	Tender-loving care, multidisciplinary. More comfort. Family's needs met. May live longer. A medicare benefit.	Care needs met. Can continue 911 and ED visits.	More independence. Comfort of home.
Risks	May live shorter. Give up 911, most ED visits.	Less attention to comfort and to family's needs. More financial risks.	Care needs may go unmet. Life may be significantly shortened.

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The Big Questions

- In assessing capacity regarding end of life care, do we come with assumptions about which course is right?
- If we do come with assumptions, do we allow them to influence our evaluation of capacity?
- If we do allow them to influence our evaluation, is this wrong? Can it be right?

Case

The patient is a 57 year old man with untreated schizophrenia and squamous cell carcinoma of the anus. He has had the disease for 2 years and has received courses of radiation and chemotherapy at several hospitals. He has received care at over 35 different VA hospitals in different states over the past decade. Recently, he has left several hospitals against medical advice for unclear reasons. He was just diagnosed with recurrence of his cancer in the genital area, which is severe and unresectable due to its size. He currently declines further anticancer treatment but would like nursing care for pain, nausea and incontinence. His MOCA is 29/30 and although somewhat detached and guarded, he shows no signs of psychosis or depression currently. Is he a hospice candidate?

Paul Schneider, MD FACP
Paul.Schneider@va.gov
Clinical Professor of Medicine, UCLA
Chairman, Southern California Bioethics Committee Consortium

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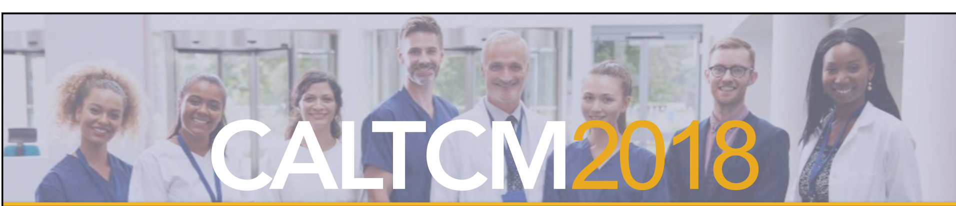

Perspective from a Palliative Care Nurse Practitioner

Leah C. Morris, MPH, MS, NP
CALTCM 2018

Disclosures

- Leah Morris, MPH, MS, NP has no relevant financial relationships with commercial interests to disclose

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How did a Nurse Practitioner Get Involved?

Background on me:

- 2013 graduate of the UC Davis Nurse Practitioner program
- Previously, 25 + years in managed care and health care consulting focused on program planning and development
  - Commercial – national Preferred Provider Organization
  - Medi-Cal – statewide health maintenance organization
- During NP school – Senior Clinical Consultant for development of California's Health Benefit Exchange – *Covered California*

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How did a Community Hospice Get Involved?

Background on the program:

- Small, not-for-profit northern California hospice program, daily census of approximately 70 home based hospice patients
- SB 1004 of 2015 – directs Medi-Cal managed care plans to provide Community Based Palliative Care (CBPC)
- Partnership HealthPlan of California and the California Health Care Foundation join forces to launch innovation

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Is it Hospice or is it Palliative Care?

Hospice Program

- Patient has 6 month life expectancy
- Patient no longer seeking disease directed treatment
- Hospice program provides all support for hospice diagnosis, including medications & DME; medical care is often directed by the hospice MD and/or NP

CBPC Program

- Patient may have no limitation on life expectancy
- Patient may be very engaged in disease directed treatment
- Referring providers maintain responsibility for directing medical care including medications, treatments, DME, etc. CBPC team serves in a consultative role

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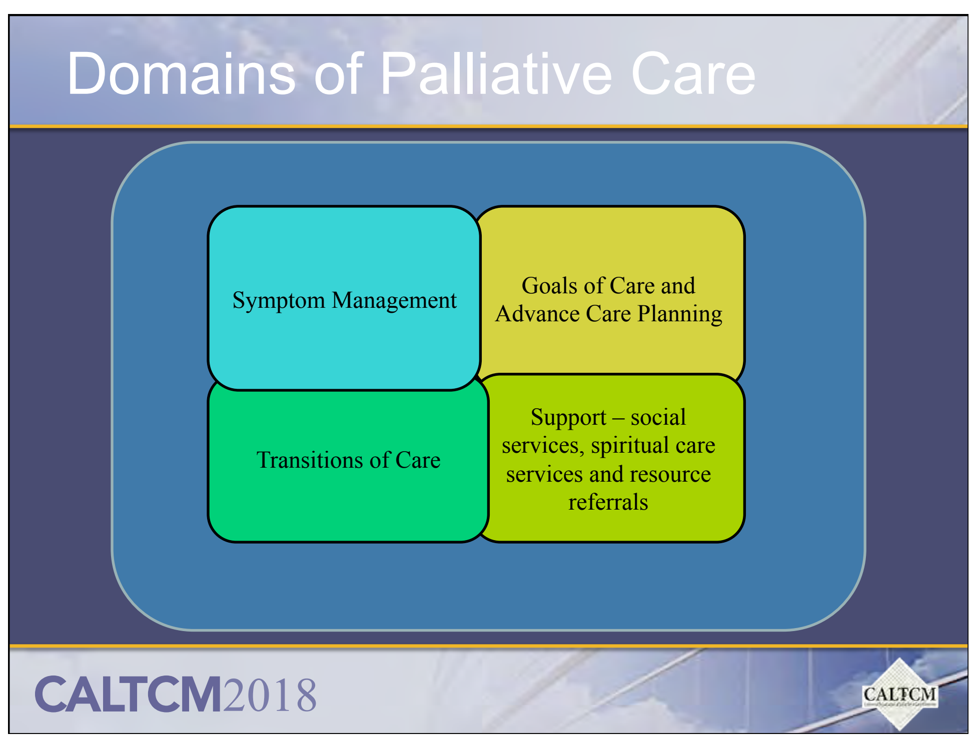

What happened?

- Fall 2016 CBPC pilot program launched and served 7- 10 Partnership HealthPlan* patients in six months
  - *Cancer * CHF
  - *COPD * Cirrhosis
- May 2017 opened to additional (non-Partnership) referrals
- Census today approx 50 patients
- >90% Philanthanthropic funded
- Provisionally approved for Joint Commission Accreditation

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Lessons and Challenges

- Plan, plan, plan
- Use resources (CAPC, etc.)
- Do a Needs Assessment
- Engage community providers who would refer patients
- Build a strong clinical team who understands palliative care
- Have executive support

- Reimbursement for CBPC is very new
- Some payor patient requirements are still difficult to meet
- Expect confusion in the medical community
- Think about what your goals are and how you will measure impact

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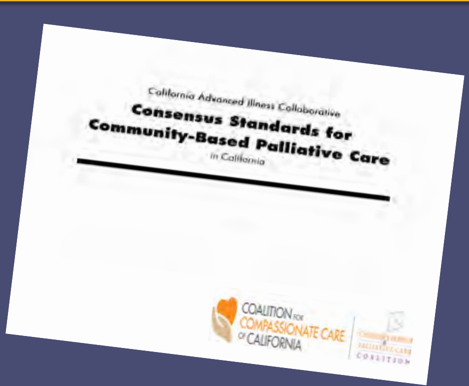
Thank You and Resources

1. California Health Care Foundation
2. Center to Advance Palliative Care (CAPC)
3. Coalition for Compassionate Care of California (CCCC)



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The Hospice Team & Hospice Medicare Benefit

Cindy Keenan: Area Director of Operations

Disclosures

Ms. Cindy Keenan has disclosed that she is currently:

- Owner and managing member of Sojourn Hospice Care in Sacramento, CA.

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- The Hospice mission should be to affirm the life of the individual who is terminally ill by providing a full continuum of clinical, spiritual, and emotional support, allowing that individual and their loved ones the ability to cope with the final stages of their life with comfort and dignity.

Hospice Care Team Includes:

- Primary Care Physician
- Hospice Medical Director
- Registered and Licensed Vocational Nurses
- Hospice Aide
- Medical Social Worker
- Chaplain or Spiritual Advisor
- Physical Therapist
- Occupational Therapist
- Speech and Language Pathologist
- Volunteers
- Bereavement Counselor

Primary Care Physician

- The physician will have the overall responsibility for the medical care of the patient and will ensure palliation and medical management of the terminal illness in accordance with the plan of care.

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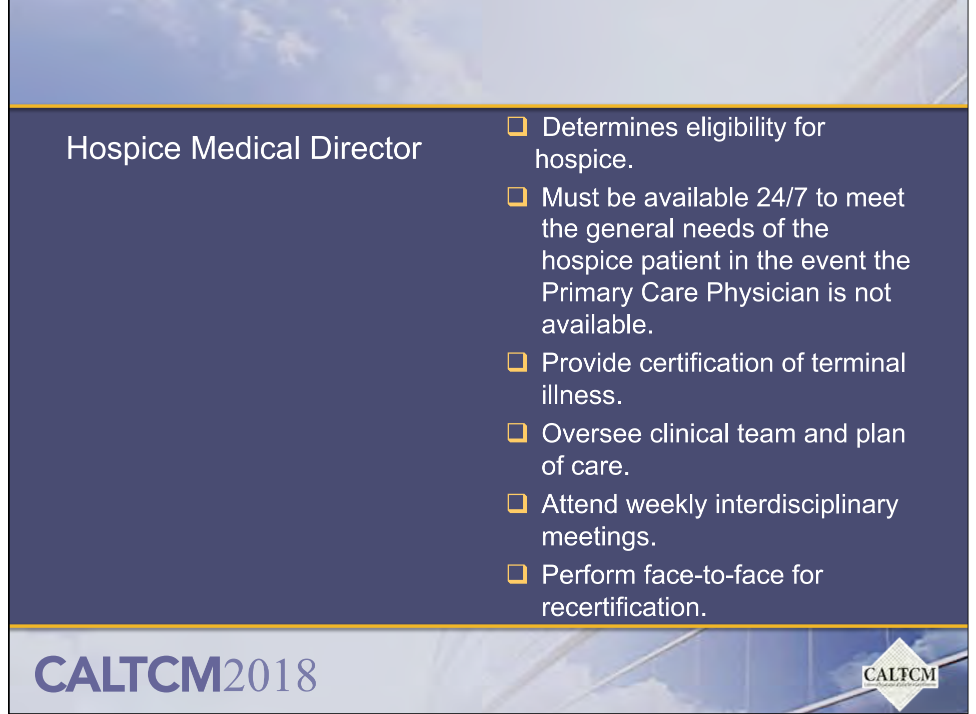
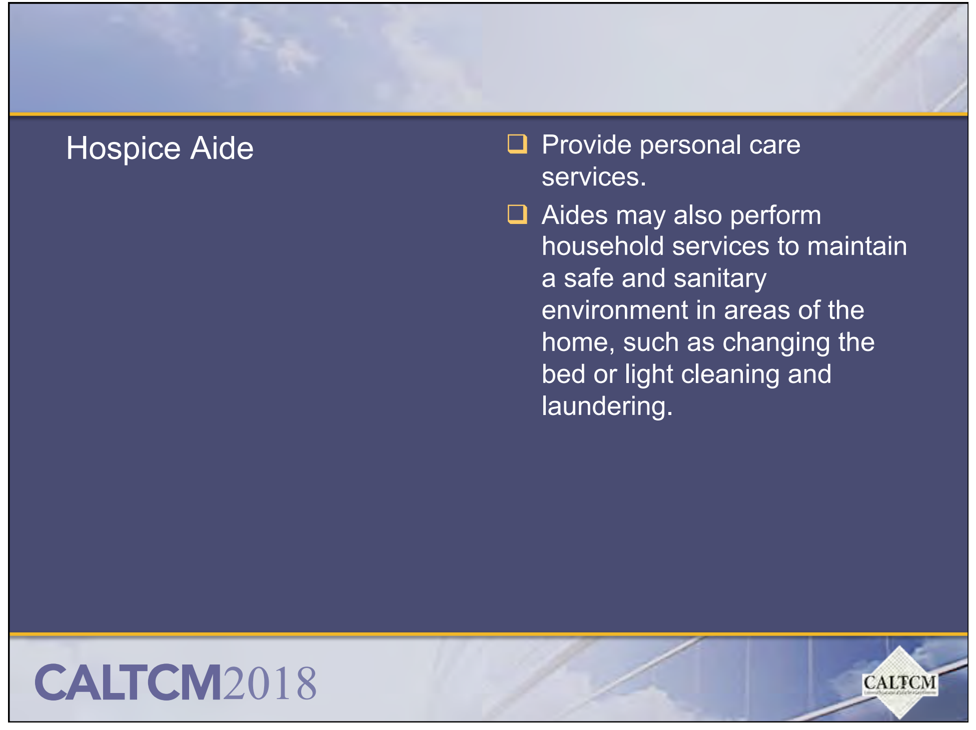


Registered and Licensed Vocational Nurses

- Registered Nurse performs/ establishes initial and ongoing plan of care, impact of terminal diagnosis.
- Effectiveness of plan of care.
- Coordinates with all disciplines of the interdisciplinary team.
- Registered Nurse to supervise the LVN and Hospice Aide.
- LVN assists Registered Nurse in providing services consistent with plan of care



Medical Social Worker

- Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment.
- Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources, and availability of the community resources.
- Counseling services.

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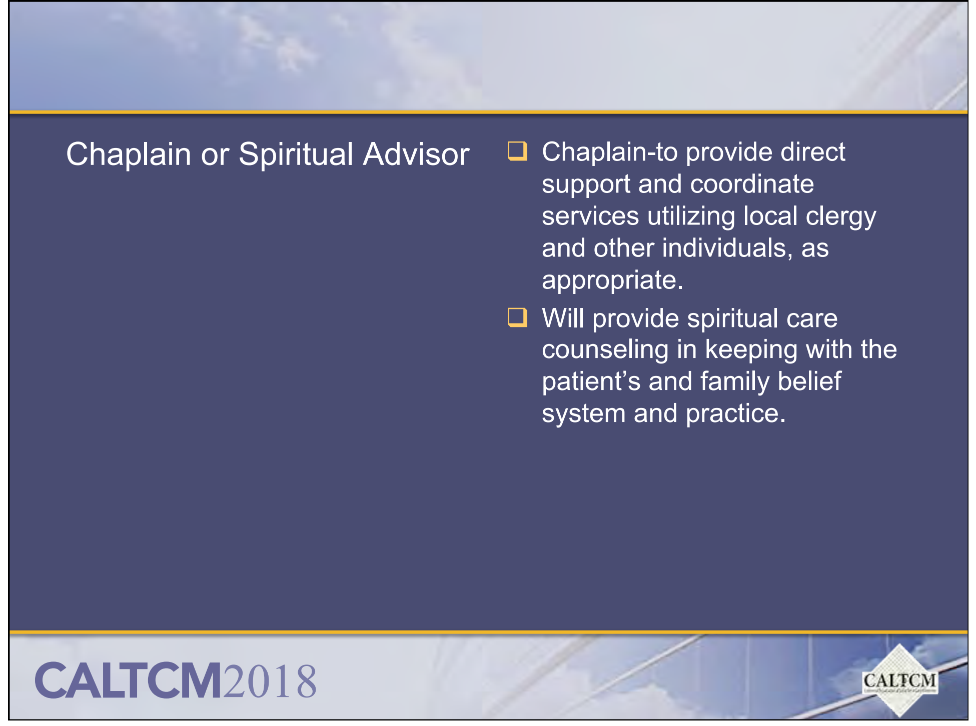

Physical and Occupational Therapy, Speech and Language Pathologist
The Rehabilitation professional will develop, implement, and revise, in collaboration with the interdisciplinary group, the plan of care with the patient and family/caregiver.
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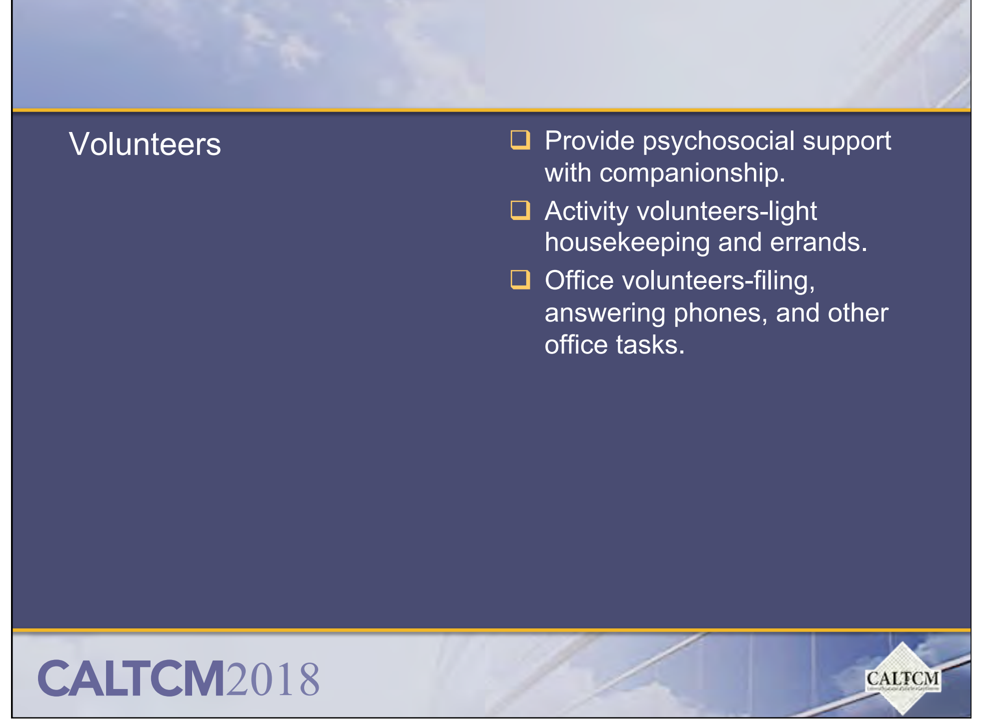
Volunteers
Provide psychosocial support with companionship.
Activity volunteers-light housekeeping and errands.
Office volunteers-filing, answering phones, and other office tasks.
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Bereavement Counselor

- Will provide bereavement services to the family/ caregivers of the hospice patients, before and after the patient’s death, in accordance with the plan of care.
- The purpose of these services will be to facilitate a normal grieving process and identify those persons who may be experiencing pathological grief reactions that may interfere with the eventual resolution and integration of their losses.

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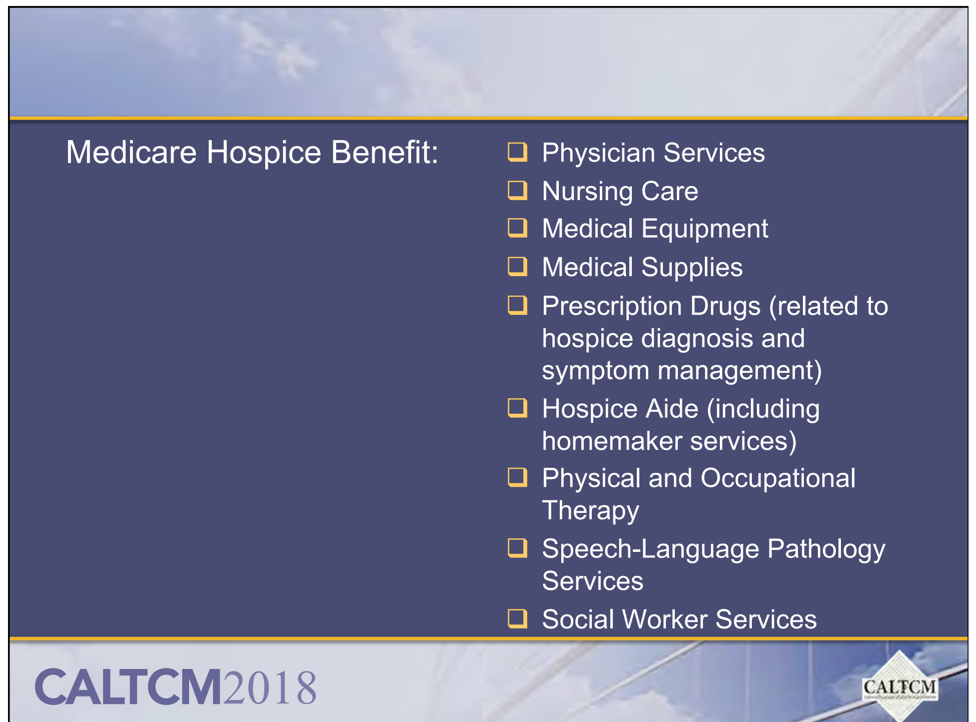

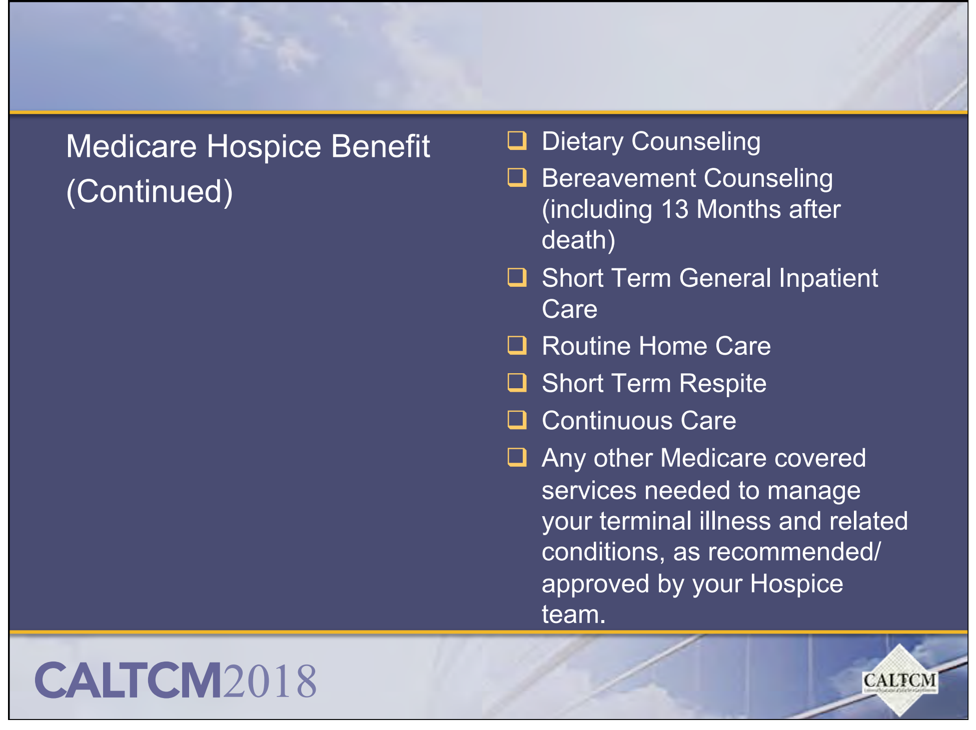

References

- JCAHO: Joint Commission Accreditation of Healthcare Organizations
- CMS: Centers for Medicare and Medicaid Services

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Parsing the POLST: Palliative Conversations
Vanessa J. Mandal M.D.,CMD,MS
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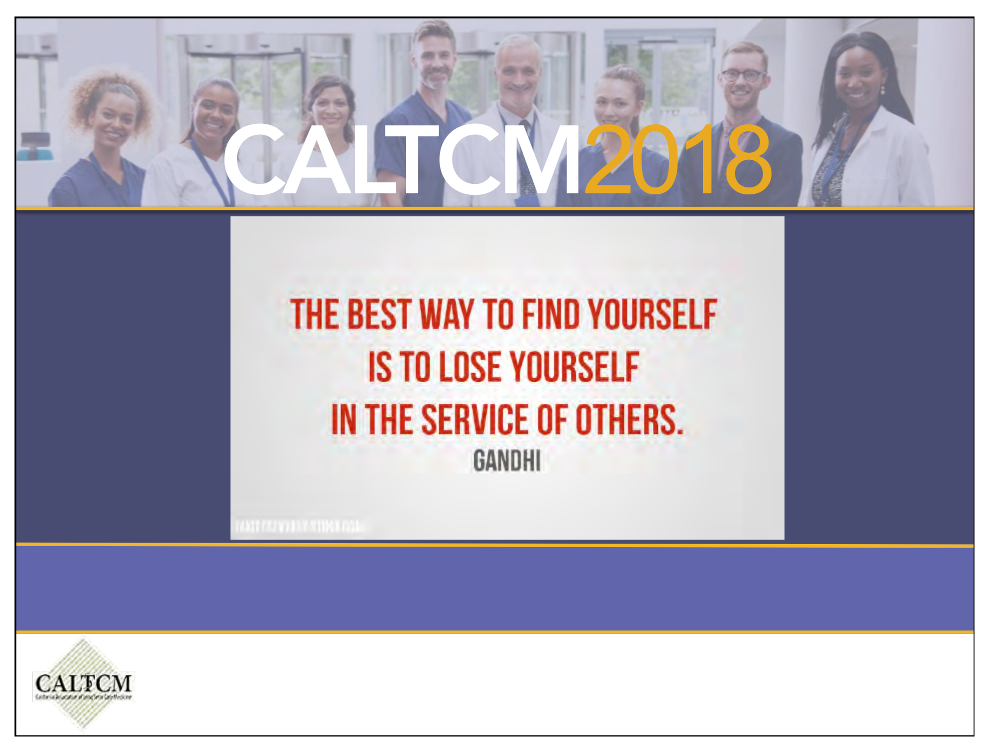
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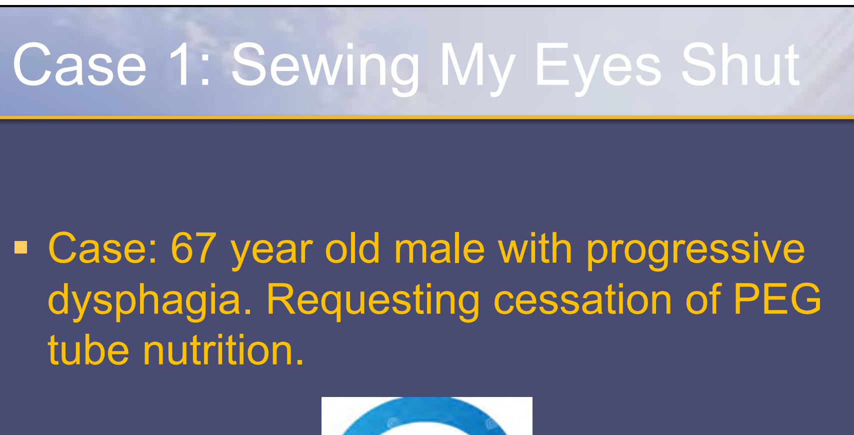
THE BEST WAY TO FIND YOURSELF
IS TO LOSE YOURSELF
IN THE SERVICE OF OTHERS.
GANDHI
CALTCM

Disclosures

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

Objective: Discuss POLST in context of palliative care.



Case 1: Sewing My Eyes Shut

- Case: 67 year old male with progressive dysphagia. Requesting cessation of PEG tube nutrition.

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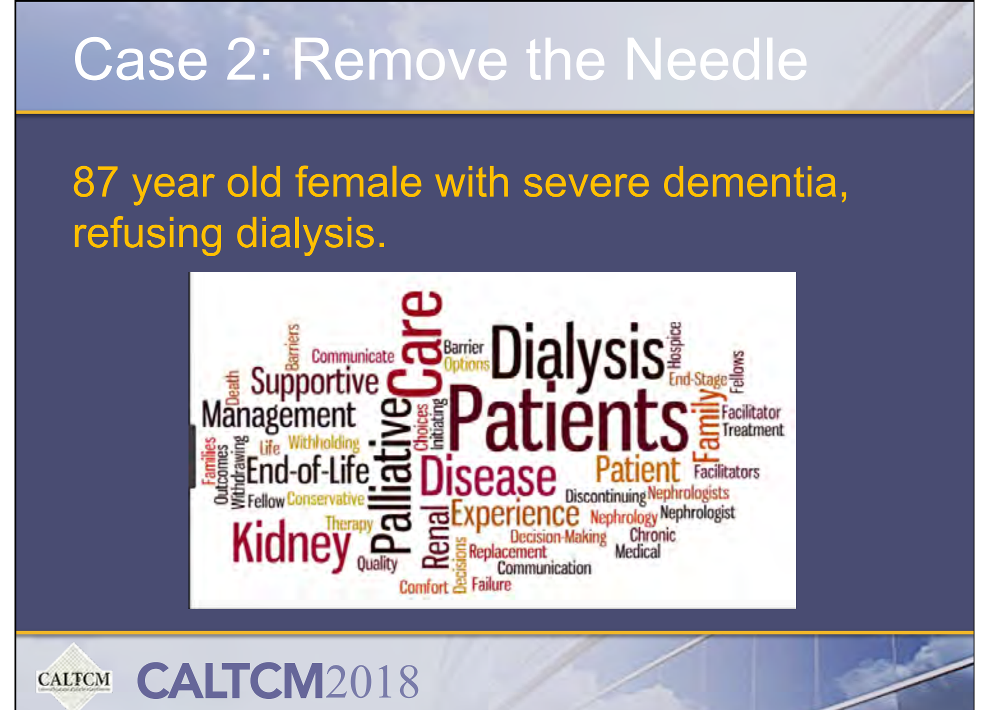

Case 2: Remove the Needle

87 year old female with severe dementia, refusing dialysis.

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CMS Palliative Care Definition

- Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering."

- https://www.cms.gov/Medicare/Provider...and.../Survey-and-Cert-Letter-12-48.pdf

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Palliative Care Spectrum

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Holistic Approach

- Caring begins at any stage of an acute or chronic illness from the day of diagnosis to the end of life.

- National Consensus Project Clinical Guidelines for Quality Palliative Care, Third Edition (2013), National Coalition for Hospice and Palliative Care

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Patient Centered Philosophy

Address physical, intellectual, emotional, social, and spiritual needs

- https://csupalliativecare.instructure.com/courses/469/pages/1-usual-care-palliative-care-and-hospice-care?

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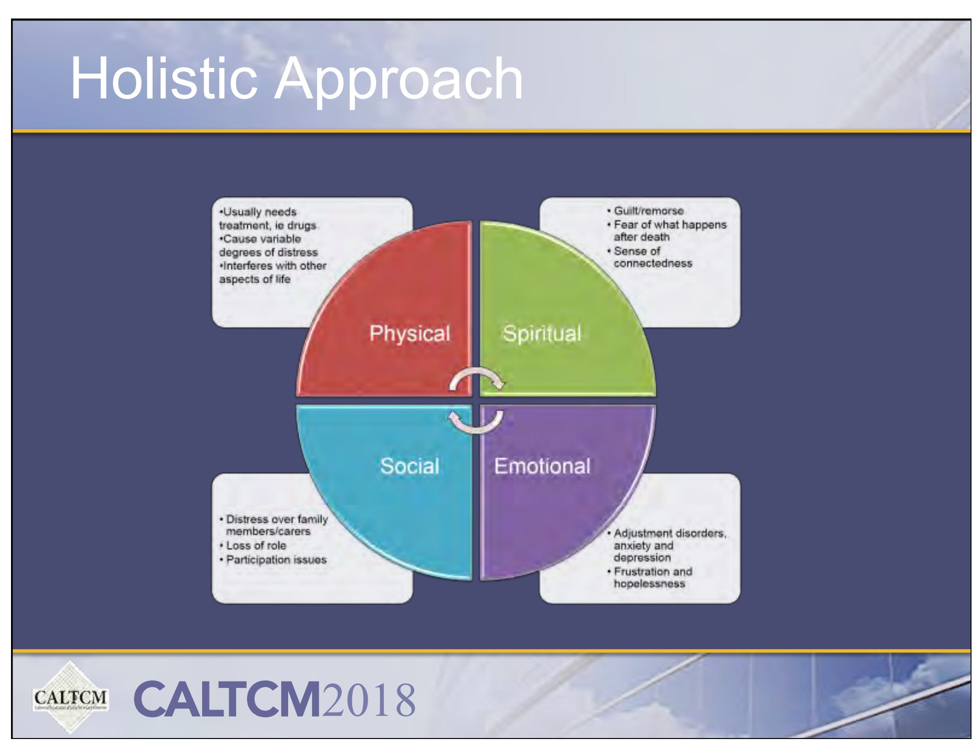
Holistic Approach
•Usually needs treatment, ie drugs
•Cause variable degrees of distress
•Interferes with other aspects of life
• Guilt/remorse
• Fear of what happens after death
• Sense of connectedness
Physical
Spiritual
Social
Emotional
• Distress over family members/carers
• Loss of role
• Participation issues
• Adjustment disorders, anxiety and depression
• Frustration and hopelessness
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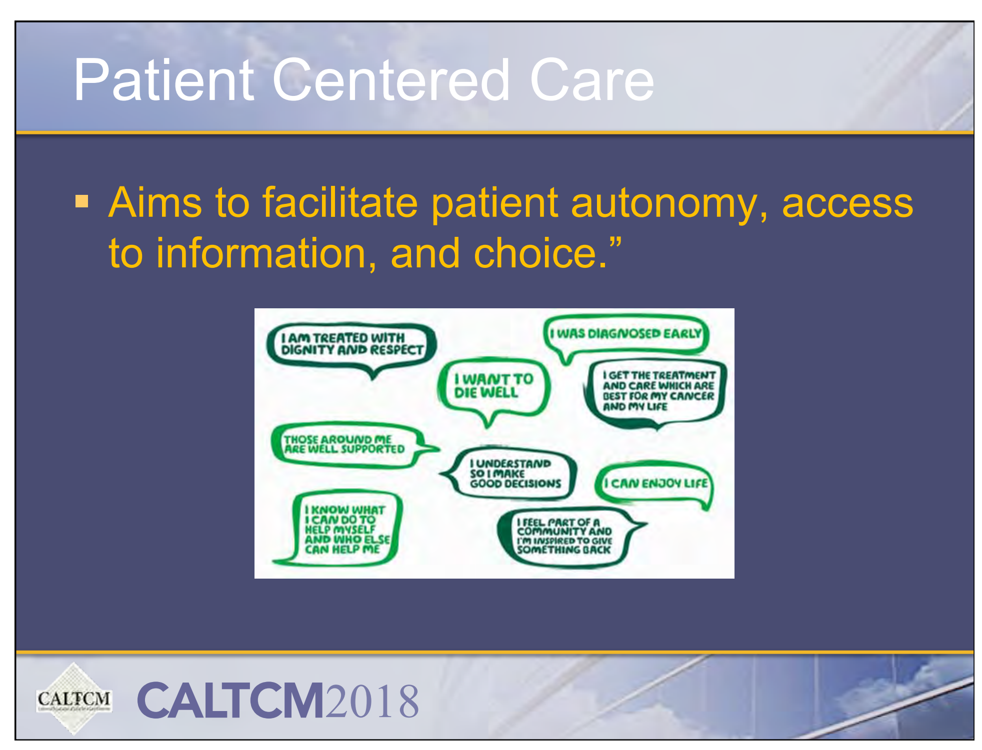
Patient Centered Care
▪ Aims to facilitate patient autonomy, access to information, and choice."
I AM TREATED WITH DIGNITY AND RESPECT
I WAS DIAGNOSED EARLY
I WANT TO DIE WELL
I GET THE TREATMENT AND CARE WHICH ARE BEST FOR MY CANCER AND MY LIFE
THOSE AROUND ME ARE WELL SUPPORTED
I UNDERSTAND SO I MAKE GOOD DECISIONS
I CAN ENJOY LIFE
I KNOW WHAT I CAN DO TO HELP MYSELF AND WHO ELSE CAN HELP ME
I FEEL PART OF A COMMUNITY AND I'M INSPIRED TO GIVE SOMETHING BACK
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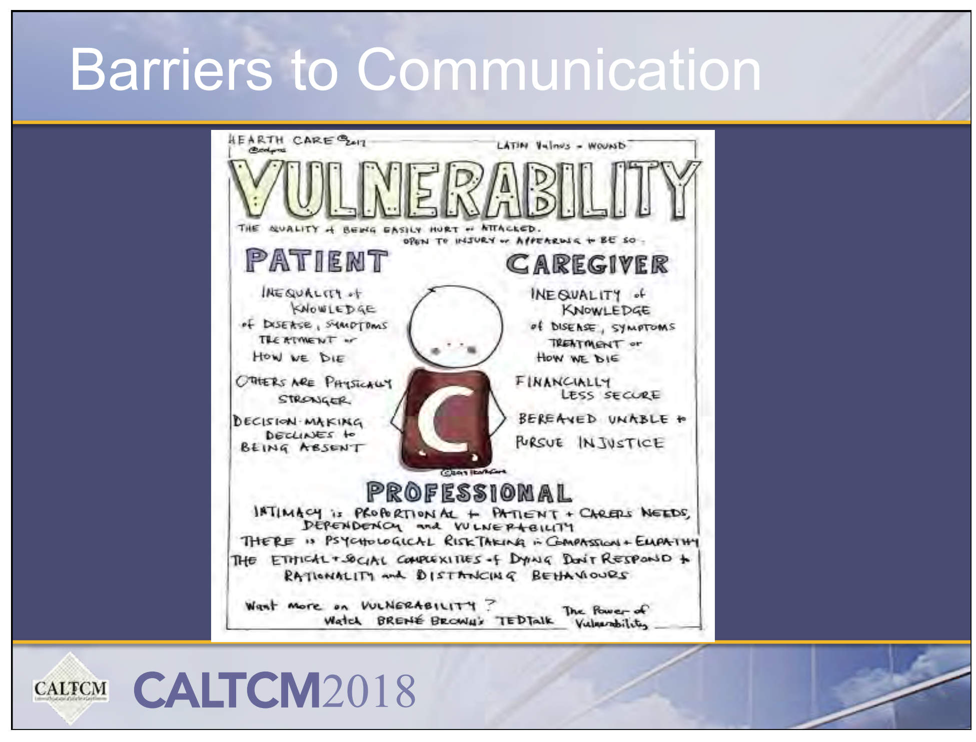

Barriers to Communication

- Reluctance- to explore death and dying
- Fragmented health care system- some else’s problem.

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Barriers to Communication

- Poor-quality communication in crisis situations
- Inadequate structural supports for advance care planning, clinician training, reimbursement, and POLST portability.

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Elements of Good Conversation

- Conveying Prognosis
- Handling Emotions
- Nurturing Hope
- Addressing spirituality and religion

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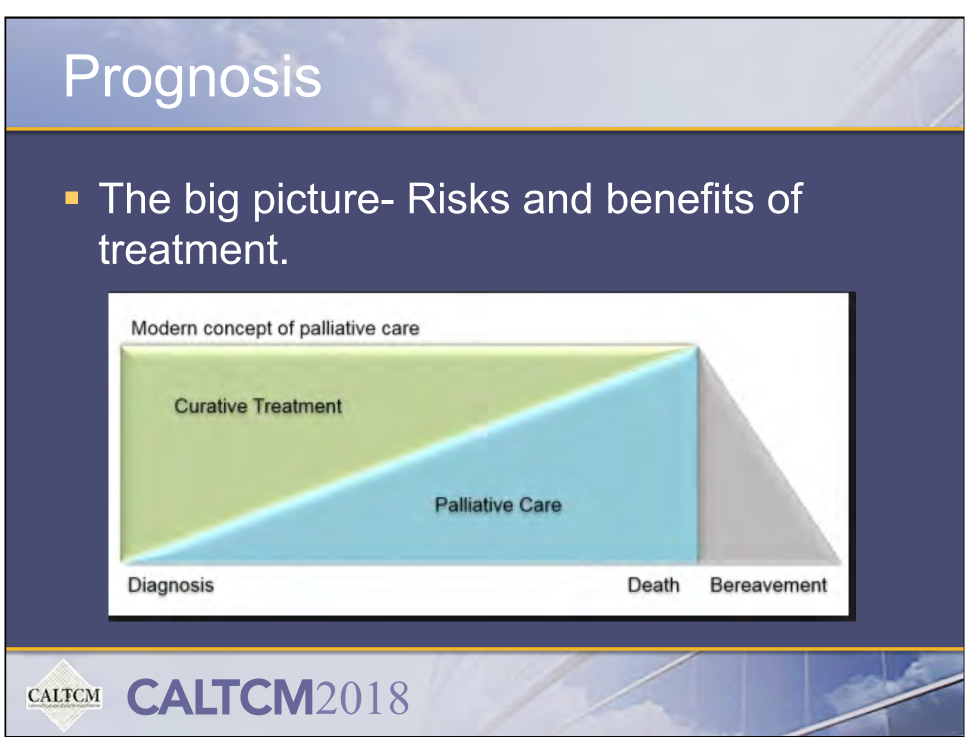
Prognosis
The big picture- Risks and benefits of treatment.
Modern concept of palliative care
Curative Treatment
Palliative Care
Diagnosis
Death
Bereavement
CALTCM
CALTCM2018

Handling Emotions
Response to symptoms, diagnosis, treatment, social issues, healthcare system, and death and dying.
R Recognizing
U Understanding
L Labeling
E Expressing
R Regulating
EMOTION
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Nurture Hope

- Hope for the best, have a plan for decline
- Explore realistic goals of care
- Address priorities for day to day living

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Patient and Family Centered Care

- Who I am ?
- What I need?

- https://csupalliativecare.org/programs/advance-care-planning/power-of-words-ebook/

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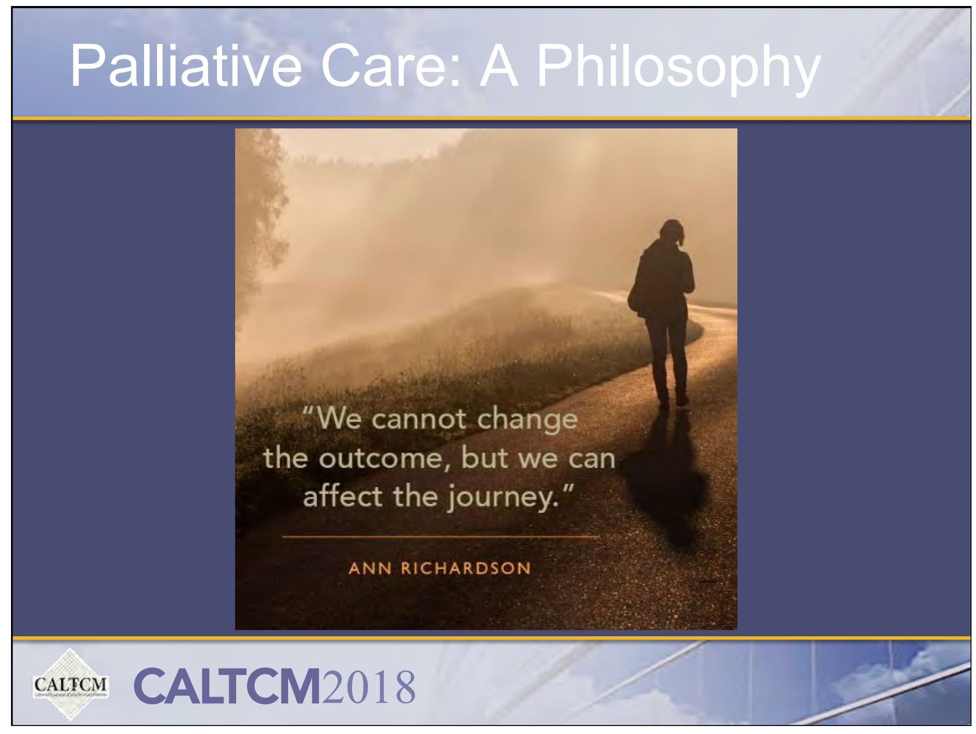

References:

- Benson, WF; Aldrich N. (2012) Advance care planning: ensuring your wishes are known and honored if you are unable to speak for yourself. Critical Issue Brief, Centers for Disease Control and Prevention. 2012. https://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf
- National Consensus Project Clinical Guidelines for Quality Palliative Care, Third Edition (2013), National Coalition for Hospice and Palliative Care
- http://www.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx
- https://csupalliativecare.org/

SAMPLE POLICY ON TRAUMA FOCUSED CARE

POLICY: FACILITY strives to utilize a trauma-informed approach as part of cultural awareness to improve our understanding of ourselves and others. This includes:

- Recognition of the individual impact of trauma (as victim, witness or perpetrator)
- Understanding triggers
- Supporting recovery
- Integrating knowledge about trauma into policies, procedures, and practices and every interaction

II. RESPONSIBLE PARTY(IES) The trauma-informed approach applies to all residents, family members, staff and community members. The Quality of Life Committee, a subcommittee of the Quality Council, oversees this program.

III. PROCEDURES

A. All Facility staff will be educated through the lens of Trauma Informed systems and encouraged to use these concepts in their daily interactions with others.

B. During the initial Psychosocial Assessment, the SW will observe for signs of trauma and concerns will be transmitted to the primary care team through the care planning process

C. Complaints from residents, families or staff will be reviewed by the Quality of Life Committee and Senior leaders with consideration of potential impact of trauma to prompt a more trauma informed review of policies, procedures, and practices.

D. Policies, procedures, guidelines, educational materials will be reviewed and updated with attention to the impact of trauma and the concepts of trauma informed systems.

E. Relationship development and management is a primary method to enhancing a trauma informed approach. Methods by which FACILITY promotes the development of relationships include, but are not limited to:

- consistent assignments,
- limited transfers of residents from one area to another,
- Encouragement of and supervision by supervisors for staff to engage in reconciliation with residents and each other with help from licensed staff,
- utilizing clinical staff such as SW, MD or psychologist to assist as needed.
- Attendance of primary CNA staff at RCC
- Staff training and initiatives.
- Use of universal approach to promote dignity, empathy, and choice.

SAMPLE ONE PAGE EDUCATIONAL HANDOUT: AN INTRODUCTION TO TRAUMA INFORMED SYSTEMS

Research suggests that trauma from childhood or adulthood can result in permanent changes in how our brains work and how we react to the environment and other people. What are some examples of trauma? Maybe losing a parent, witnessing violence, being neglected, or suffering verbal or physical abuse. Trauma can happen once or many times. Many of our residents and staff have suffered much

before they have come to us. The changes can lead to medical problems (diabetes, high blood pressure, high levels of stress, hormones, cognitive loss) and psychological problems (nervousness, depression, being very vigilant, difficulty getting close to people, trouble trusting others, difficulty sleeping, angry outbursts, panic, fear, negativity, violence, antisocial behavior, mental illness, crime, addiction to substances, family problems). People who have suffered trauma may not know how to ask for or receive help; they may lack social skills or self-awareness. They may not even be aware that the trauma has affected them so much. They may not know another way to live or react. Behavior can be a way for a person to communicate a feeling. Trauma Informed Systems asks us to look at behavior and try to figure out what it means. If we notice a person withdraw or acting angrily or reacting negatively, we need to check it out and change our behavior so we don't add to their trauma and sense of hopelessness. Understanding their perspective and making an environment that feels safe will help to heal them. Trauma informed systems look at the world through the perspective of other people. How does the building or the neighborhood feel to you? Do you feel welcomed? Are we respectful and kind? We are looking for your input in this process. We can be a place where everyone can be safe to learn and grow together by maintaining boundaries and sensitivity and showing each other how to treat each other without violence, with respect and with constant kindness. You may notice changes as we look at ways to improve.

What we ask you to do:

1. Watch how you speak to and about others. Try to avoid negative labels or referring to people by their diagnoses.

2. Look at behavior as a sign that the person has something to say to you—be attentive to the fact that it may reflect a traumatic experience from the past.

3. Treat every interaction with care and kindness.

4. Look at others not as manipulative or bad on purpose, but instead more positively as lacking the skills to deal with something. Teach, mentor, support and collaborate rather than trying to blame, shame, or punish.

5. Recognize you may hurt others without intending to. Choose your words and actions carefully. Be aware of your actions/interactions and be alert of your impact upon others and be willing to change and apologize.

6. Look at the world through the eyes of the other person—see if there are things you can do or the facility could do to make the experience better for all those we serve. If you have suggestions on how to improve the way we care for people here, please feel free to contact anyone in leadership or use a suggestion box!

TRAUMA INFORMED RESOURCES

Advancing Trauma-Informed Care is a multi-site demonstration project to better understand how to implement trauma-informed approaches to health care delivery. Supported by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies, this national initiative is developing and enhancing trauma-informed approaches to care and sharing emerging best practices. For more information, visit

www.chcs.org. Whitepaper is at
http://www.chcs.org/media/ATC_whitepaper_040616.pdf

https://www.cdc.gov/violenceprevention/acestudy/index.html

https://nursing.ceconnection.com/files/TraumaInformedCareIstheBestClinicalPracticein-1520206899164.pdf;jsessionid=F06D5901E79205B54D72B2610A20C977

https://www.ncbi.nlm.nih.gov/books/NBK207188/

https://alamedacountytraumainformedcare.org/caregivers-and-providers/assessment-tools/

https://www.cdc.gov/violenceprevention/acestudy/index.html

Search YouTube—so many short and longer videos on the topic.

V.J. Felitti, R.F. Anda, D. Nordenberg, D.F. Williamson, A.M. Spitz, V. Edwards, et al. “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study.” American Journal of Preventive Medicine, 14, no. 4 (1998): 245-258.

J. P. Shonkoff, A. S. Garner, and the Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; and Section on Developmental and Behavioral Pediatrics. “The Lifelong Effects of Early Childhood Adversity and Toxic Stress.” Pediatrics, 129, (2012b): 232–246.

Public Health Management Corporation (2013). Findings from the Philadelphia Urban ACE Survey. Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407836.

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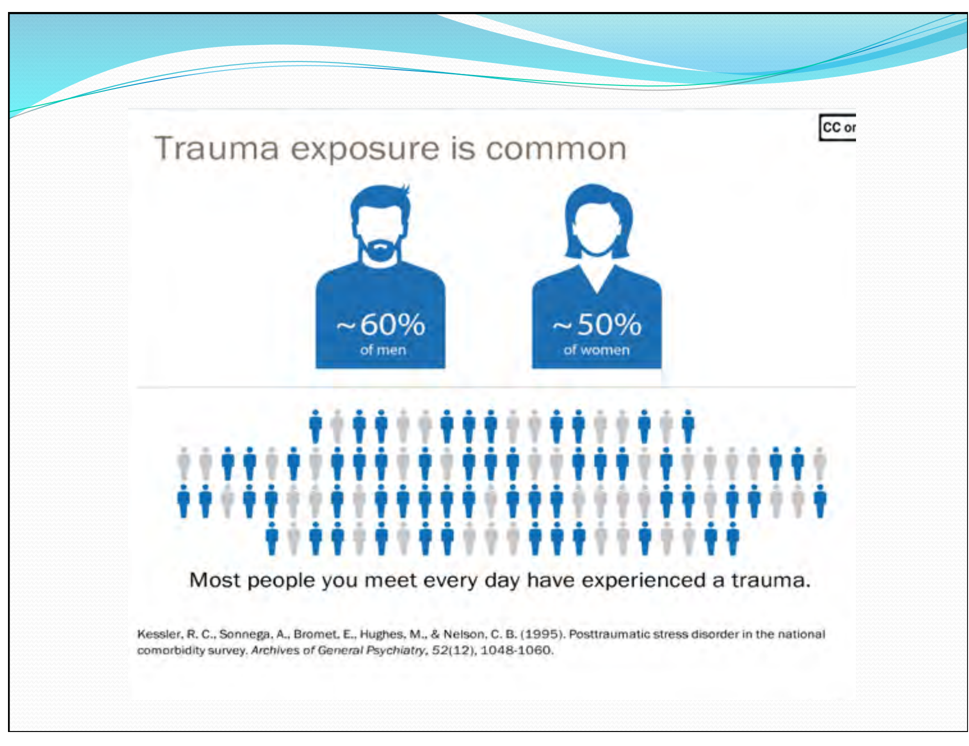
Public Health Management Corporation (2013). Findings from the Philadelphia Urban ACE Survey. Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407836.

Trauma Informed Care

Rebecca Ferrini MD
Robert Gibson PHD

What is Trauma?

Something that happened to someone, often as a child, that was experienced as physically and/or emotionally harmful or threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual wellbeing



A history of physical or psychological trauma can impact many parts of life

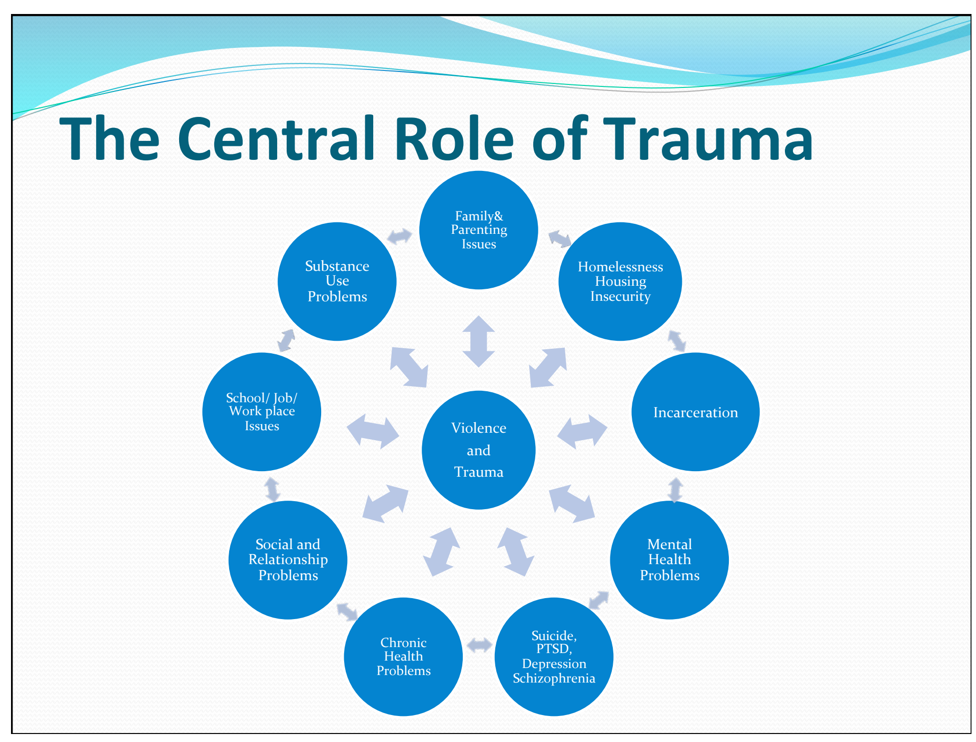
How the person acts…

How they react…

How they cope…

How they relate…

How they feel…



Trauma effects include

- Changes in the brain
- Problems with social and emotional skills
- Making bad decisions
- More likely harming self with eating disorders, smoking, substance abuse, violence, promiscuity or cognitive impairment
- Severe and persistent behavioral health, physical health and social problems leading to early death.
  - *Felliti et al 1998*

How Violence & Trauma Affect Your Residents

An experience of violence and trauma can affect engagement in health care.

- Refusal of care
- Over-reaction to things
- Chronic pain, depression or anxiety
- Failure to form relationships
- Doing things that harm the relationships or themselves

Ways Medical Care Can Re-Traumatize

- Invasive procedures
- Removal of clothing
- Physical touch
- Personal questions that may be embarrassing/distressing
- Power dynamics of relationship
- Gender of healthcare provider
- Vulnerable physical position
- Loss of and lack of privacy

Abuse Complaint

Since admission, "Sally" yells at and hits staff when they are providing care. "Sally" needs nearly total assistance with ADL's, and two staff have been assigned to her due to risk of aggression and "false accusations." She has moderate dementia, and most of the time, she appears happy, but she says she is being abused and a report is made.

As we learn more about Sally, we find out that she was subject to physical and sexual abuse as a child. We also know that she is anxious, and when she reacts during care, she seems to panic and does not appear to understand what is happening.

How might trauma be affecting her behavior? What can we do?

How might trauma be affecting Sally?

- Her yelling and hitting happen only during care when staff must touch her, including changing and dressing.
- She suffers from moderate dementia and seems to panic.
- She cannot understand what is happening and only sees people taking off her clothes and touching her "where they shouldn't."

Another Abuse Complaint

"Jerry" is "high functioning" but does makes frequent complaints of abuse. He says staff make mean or inappropriate comments about him and handle him roughly. This results in an abuse complaint. He is known to have a past drug history that contributed to him being here after a stroke, and he often complains of severe pain and requests pain medication, though he is active and does not show signs of pain otherwise. "Jerry" denies past trauma saying his past life was "perfect" though his family won't talk to him and he has no known contacts.

How might trauma be affecting his behavior? What can we do?

How might trauma be affecting Jerry?

- While Jerry presents as "high functioning," his reactions and perceptions don't fit.
- He shows a bias to interpret communications and actions as people intending to harm him.
- Past drug abuse and "drug-seeking" behavior may suggest that substances were a way he has tried to cope with something.
- While most people have difficulties in life, he reports his past as "perfect" and denies any trauma. This prevents discussion of what might be bothering him or ways to help.

We need to be trauma-informed

Realizes	• Think about trauma and take "universal precautions" (treat everyone as if they might have been traumatized)
Recognizes	• Recognizes how trauma affects all individuals involved with the program, organization, or system, including its own workforce
Responds	• Respond by putting this knowledge into practice
Resists	• Resist being the CAUSE of trauma

Focus is not on "what's wrong with you," but instead, "what happened to you?"

From Vicky Kelly

Trauma informed language uses less labeling and more understanding

- She is needy and demanding.
- He is verbally aggressive and excessively reactive

- She lacks experience in getting her needs met in a positive way.
- His fear based on prior trauma causes him to overreact to staff comments, especially when told what to do.

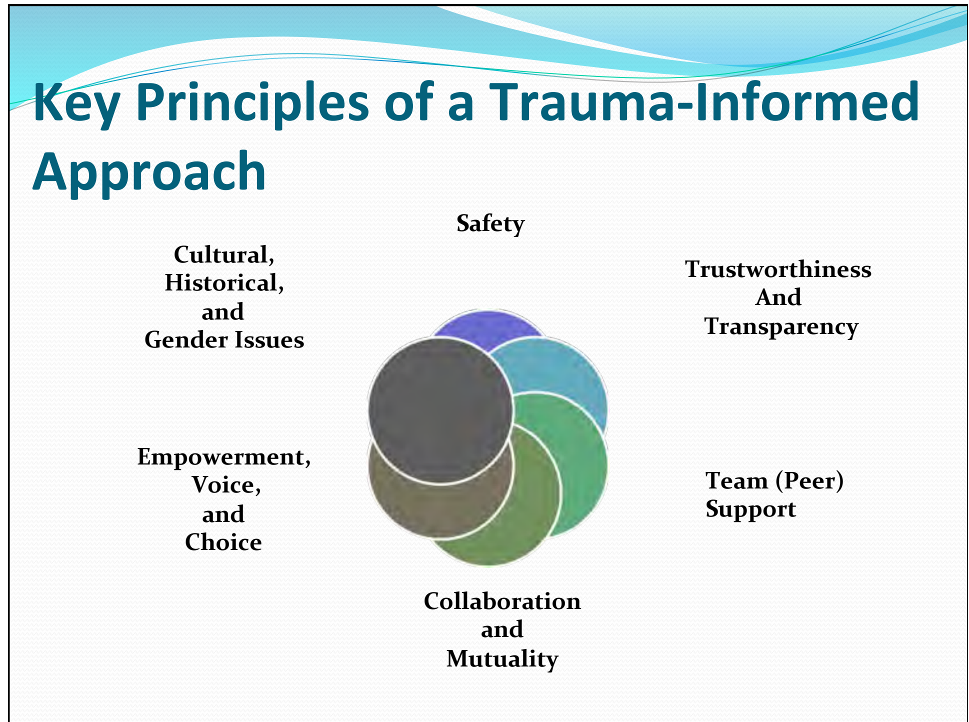
Universal Precautions

What we say

- Ask permission to enter, approach, touch
- Use language that is sensitive
- "You are safe here"
- Explain what and why on what we are doing
- Ask about trauma

What we do

- Move slowly and observe signs of resistance or fear
- Avoid blaming statements
- Pay attention to the emotional needs even when doing mundane tasks like changing a brief
- Use soothing voice, constant quiet explanations



Safety

- Throughout the organization, staff and the people they serve feel physically and psychologically safe;
- The physical setting is safe
- Interpersonal interactions promote a sense of safety.

Promoting Safety

- Since Sally suffers from dementia and known trauma:
  - Develop a positive relationship
  - Always introduce yourself and discuss the help she needs and explain how you will help
  - Remind her of this as you provide care to lessen the chance of her panicking and/or losing awareness of what is actually happening, e.g., "I'm going to help you turn…" "I'm going to clean you now" etc.
  - If she escalates, stop, and see if you can re-focus her on the care
  - May need two staff due to risk of allegations

Promoting Safety

- In approaching Jerry, do so with the idea of "universal precautions" regarding possible trauma.
- Likely reasonable hypothesis that trauma is relevant due to misperceptions and drug history.
- As always, try to develop a positive connection.
- May be beneficial to have a second person present as a witness.
- Be very mindful of tone and body language.
- If Jerry shows a change in presentation, e.g., getting quiet or irritable, see if he can describe what he is feeling – if he's feeling "mistreated," maybe this can be corrected.

Trustworthiness and transparency

- We run the organization in a way that it is transparent —decisions and why these are made are clear
- The whole organization is based on trust—we do what we should do

---

- With both Sally and Jerry, consistency and clear explanations are needed
- Consistent assignment is important to develop trust
- IDT needs to communicate closely with each other and the resident to avoid splitting, where team members are told different things by the resident which causes confusion
- If there is tension, or if things seem to be getting worse, involve other IDT members

Team (Peer) support

- While general trauma informed approaches involve peer support, our staff provides the majority of support
- We set up a therapeutic environment where the staff work with the residents to establish safety, build trust, enhance collaboration, and maximize a sense of empowerment, e.g.,
  - Consistent assignments
  - Focus on informal complaint resolution at the lowest level
  - RCC/IDT
  - Person centered approach

Collaboration and mutuality:

- Healing happens in relationships and in the meaningful sharing of power and decision-making.
- Everyone has a role to play in a trauma-informed approach; "one does not have to be a therapist to be therapeutic."

- Sally may not remember us or the plan or routine. We move slowly, especially with touch, and explain. We treat her with a high degree of respect and perhaps even formality. . We remember her sensitivity in each interaction, even with people she knows well.
- For Sally, reminders and permission will be important
- We try not to feel hurt by Jerry's blaming and instead see him as a person who was likely hurt and doesn't know how to react and form relationships. His behaviors can be seen as symptoms, rather than intentional efforts to harm us.
- Greater collaboration and problem solving on the neighborhood may help build a better relationship and reduce his negative views.

Empowerment, Voice and Choice:

- Individuals' strengths and experiences are recognized and built upon;
- We respect and acknowledge their voice and choices to help them heal (though we may not always agree or do what they ask).
- We believe in resilience and in the ability of individuals, to heal and promote recovery from trauma;
- We build on strengths and not just addressing perceived deficits.

- Though Sally's choices may be limited, we encourage as much participation as possible.
- Sally may be able to make some choices and should be supported in doing so whenever she can to increase her sense of control.

- Jerry presents with strengths, such as greater cognitive function. We should try to engage him in positive problem-solving and in his care as much as possible.
- While Jerry most often presents with a negative or even paranoid view of others, we need to listen. Not doing so will increase his negativity and we may wind up dismissing real issues.

Nonviolent Communication

- Marshall Rosenberg founded a type of communication that works for conflicted situations, is simple to learn and helps you as well as those you care for.
- We may not think of our words as violent, but they can cause or aggravate hurt or pain both in ourselves and others.
- Nonviolent communication is about empathy—to ourselves and others for our feelings and needs and being clear about what we want.

Nonviolent Communication

- The concrete actions we observe that affect our well being
- How we feel in relation to what we observe
- The needs, value and desires that create our feelings
- The concrete actions we request in order to enrich our lives.

Empathy—seeing people's behaviors, words and actions as their feelings and needs.

- Behaviors and Expressions of Emotion such as anger, frustration and irritability are all signs of FEELINGS and NEEDS.
- Helping THEM identify their feeling and need builds empathy.
- Your identifying your own feelings and needs improves the chance you will be effective.

Observation without judging or applying meaning (drone-view)

People feel criticized and unhappy if we combine observations with judgements (what it means)

Observing without Evaluating

Evaluating

- He is intentionally annoying his peers. It has to stop!
- She constantly complains.
- You seldom do what I want
- Henry is aggressive

Observing

- He stands near people when they are talking on the phone which inhibits their privacy.
- The last three times I spoke with her, she focused on what she doesn't like about other people.
- When I asked for help yesterday twice, you did not help.
- In the last month, Henry has hit staff twice.

Identifying Feelings (without blame)

- Our feelings are our business—they are normal and from within and come from our needs. They may be triggered by others, but are not CAUSED by others.
- Our culture does not like a lot of focus on feelings so sometimes we try to hide them or justify them.
- Empathy is achieved when we help ourselves and others get in touch with feelings and relate them to needs.
- Feelings may be frustration, hostility, sadness, loneliness, hopelessness, fear, jealousy, shame.

Which are feelings?

Feelings: I feel

- Frustrated
- Afraid
- Disgusted
- Anxious
- Annoyed
- Overwhelmed
- Disappointed
- Concerned

NOT feelings: I feel

- As if you should know better
- My resident is being manipulative
- Like hitting you
- I am constantly being pulled
- Inadequate as a nurse
- Unappreciated
- Attacked
- Manipulated
- Misunderstood

Feelings are due to unmet needs

- Needs can be food, clothing, shelter, water
- Needs can be emotional: empathy, order, control, connection, trust, emotional security, safety, authenticity, autonomy….
- We are not used to talking about our needs in our culture.
- We often need practice to see that our feelings come from our needs not from the other person!
- E.g. *When you talk so much to me before you let me care for you, I feel frustrated as a I have a need for timeliness for my work.*

strong feelings—try empathy towards yourself and them.

- What others do is a trigger for feelings, but not the cause
- If we hear negative messages we have four options: blame ourselves, blame them or give them or us empathy. Let's choose the last two!
- Connect the feeling with a need
- NOT: When you are mean to me, I am hurt
- TRY: I hear a lot of anger and I wonder if you are feeling a need for more control?
- I feel angry when you say that because I am wanting respect and I hear your words as an insult.

Making requests in a nonviolent way

- Positive—tell them what you want them to do, not what you Don't want them to do
- Be clear and specific
- *Example: "Stop kicking me!" versus "Hold your leg still while I put on your sock. "*
- *"Show me some respect" versus "speak kindly to me when I am providing care."*
- Make sure you are not mixing in feelings, needs or judgements in your request.
- *"You should do this because it makes sense" or "you are taking too much time" versus I would like to change your brief and be out of here within 5 minutes to meet my next appointment.*
- They can say no to requests. Honor the no.

Cultural, historical, and gender issues

- Edgemoor staff is sensitive to differences based on culture.
- We take people's histories into account and give them grace in interpreting their behavior understanding that they may have been through much more than we can ever know.

- We know or suspect both Sally and Jerry have suffered trauma and a lifetime of events, both good and bad, that we will never know.
- These experiences will impact how they relate to us and others.
- It may help us if we assume they are doing the best they can, in light of what they've been through.
- This may help us to understand why they act as the do and also help us better relate with and care for them.

References

Substance Abuse and Mental Health Service Administration

SAMHSA