CALTCM 2016

Quality Through Best Practices

Promoting quality patient care through medical leadership and education

April 29-30, 2016

Omni Los Angeles Hotel at California Plaza
Los Angeles, CA

Program Introduction

The 42nd Annual CALTCM meeting entitled ***Quality Through Best Practices*** is focused on person-centered care in the long-term care setting. Attendees will be challenged to find ways to integrate the latest knowledge into long-term care and post-acute care practices, recognizing models that reduce hospital readmissions. ***Quality Through Best Practices*** has been designed for practical training of all members of the interdisciplinary team, in areas where long-term care is presently focused to improve quality.

Quality Through Best Practices features several "cutting-edge" topics currently in your sight along with topics that will to take you into the future of healthcare. This annual meeting addresses several of the quality measures identified by the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO), Health Services Advisory Group (HSAG). Featured topics: Anti-psychotics, Informed Consent, the Young Psychiatric Patient, Diagnosing Infections, De-Prescribing, CKD, the OPTIMISTIC program, Palliative Care, POLST, Aid in Dying, GeriatricPain.org, Sex in the Nursing Home, Value-Based Purchasing, Bundled Payments, and Technology & Healthcare.

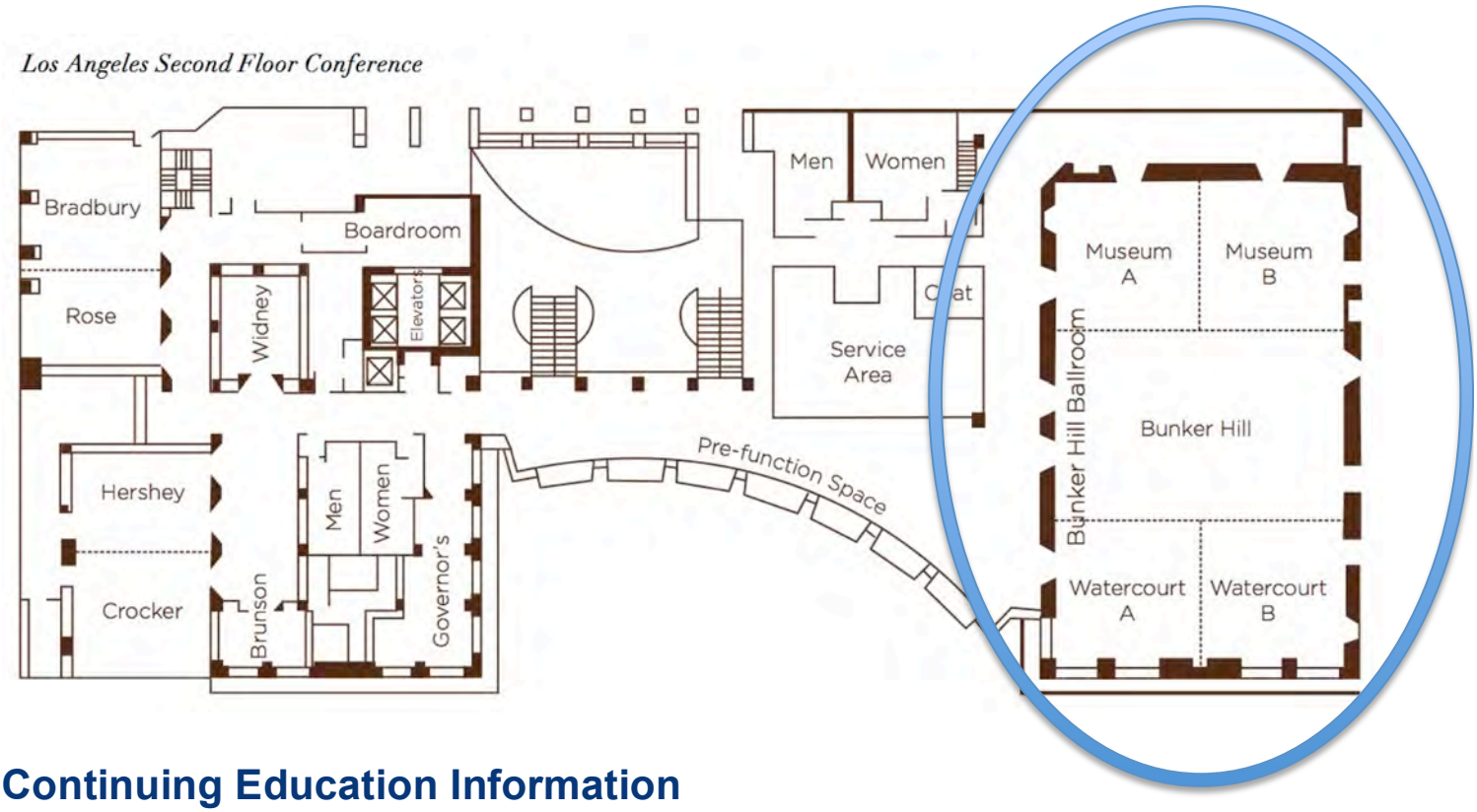
Learning Objectives

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

- Explain models and incentives for reducing hospital admissions and readmissions;
- Identify five best practices impacting the care of nursing home residents;
- Recognize the importance of appropriate medication prescribing, and understand the concept of “de-prescribing”;
- Implement changes necessary to effectively integrate advances in technology into their practice within the post-acute continuum;
- Identify and implement the use of informed consent related to the prescribing of antipsychotic medications;
- Identify four key components of an end-of-life discussion.

Meeting Information

The General Session of the Annual Meeting will be held on the second floor of the Omni Los Angeles Hotel at California Plaza, in the Bunker Hill/Museum Ballroom. Lunch and Dinner events will be held in Watercourt.



Continuing Education Information

Participants are required to sign in at the registration desk. The post event evaluations will be emailed to all participants. An evaluation MUST be completed to receive credit. The deadline for Continuing Education requests is September 1, 2016. If you prefer a hardcopy of the evaluation and credit request, please visit the registration desk to request a copy.

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.

CALTCM Annual Meeting 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 10 *AMA PRA Category 1 Credit(s)™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

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

American Academy of Family Physicians (AAFP)

This Live activity, CALTCM 42nd Annual Meeting: Quality Through Best Practices, with a beginning date of 04/29/2016, has been reviewed and is acceptable for up to 14.00 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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 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 actually 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 10 contact hours.

California Board of Behavioral Sciences (BBS)

Course meets the qualifications for 10.0 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences. SCAN Health Plan is a CAMFT-approved continuing education provider. Provider No. 127226.

Nursing Home Administrators Program (NHAP)

This activity has been approved by the Nursing Home Administrator Program for up to 10.0 hours of NHAP credit. Course approval number: 1797010-5427/P

Continuing Pharmacy Education

SCAN Health Plan® is accredited by the California Accreditation of Pharmacy Education (CAPE) as a provider of continuing pharmacy education. Pharmacists completing this course on 4/29/2016– 4/30/2016 will receive up to 10.0 hours of credit through SCAN Health Plan® (CAPE Provider #199).

The California State Board of Pharmacy recognizes CAPE accredited program units for pharmacist license renewal. If you hold a license from another state, please check with that state's board of pharmacy for eligibility of CAPE units.

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 Chair

Michael Wasserman, MD, CMD

Education Committee

Debra Bakerjian, PhD, RN, FNP

Diane Chau, MD

Heather D'Adamo, MD

Mary Ellen Dellefield, PhD

Rebecca Ferrini, MD, MPH, CMD

Timothy Gieseke, MD, CMD

Janice Hoffman, Pharm.D, CGP, FASCP

Ashkan Javaheri, MD, CMD

Jim Jensen, MHA, MA

Albert Kapstrom, MD

Albert Lam, MD

Vanessa Mandal

Renee McNally

KJ Page, RN, NHA, ND

Denise Rettenmaier, DO

Rajneet Sekhon, MD

Karl Steinberg, MD, CMD

Program Faculty

Patricia Bach, PsyD, RN
Clinical Gero/Neuropsychologist
President, Psychologists in Long Term Care

Debra Bakerjian, Ph.D., APRN, FAAN, FAANP
Senior Director for NP/PA Clinical Education and Practice; Associate Adjunct Professor, Betty Irene Moore School of Nursing, University of California, Davis

Alex Bardakh
Director, Public Policy at AMDA-The Society for Post-Acute and Long-Term Care Medicine

Flora Bessey, Pharm. D., CGP
Owner, Metro Rx Consulting and Hospital & Health Care Consultant

Kevin Broder, MD
Telehealth Director, Surgery Service - Section of Plastic Surgery, VA San Diego, Telemedicine and Wound Director - San Diego Geriatric Workforce Enhancement Project

Lynette Cederquist, MD
Clinical Professor at UC San Diego Health System

Diane Chau, MD
UCSD Health Sciences Clinical Associate Professor

Anthony Chicotel, Esq.
Staff Attorney, California Advocates for Nursing Home Reform (CANHR)

Joshua Chodosh, MD, MSHS, FACP
Michael L. Freedman Professor of Geriatric Research; Director, Freedman Research Program on Aging and Cognition; Division of Geriatric Medicine and Palliative Care NYU School of Medicine

Rebecca Ferrini, MD, MPH, CMD
Medical Director, Edgemoor DP SNF

George Fields, DO, SMO
CareMore Health Plan, Eastern Region

Program Faculty (continued)

Timothy Gieseke, MD, CMD
Multi-Facility Medical Director, Santa Rosa, CA; Associate Clinical Professor, University of California, San Francisco

Elizabeth Landsverk, MD
Adjunct Professor of Medicine, Stanford University

Vincent Nguyen, DO, CMD
Palliative Program Director HOAG Memorial Hospital

Thomas Osborne, MD
Director of Medical Informatics at Virtual Radiologic

Denise Rettenmaier, DO
Medical Director at Veterans' Home, State of California, Yountville

Jim Roxburgh, RN, MPA
Director, Dignity Health Telemedicine Network

Karl E. Steinberg, MD, CMD, HMDC
Medical Director, Kindred Village Square Transitional Care & Rehabilitation Center, San Marcos, CA; Medical Director, Life Care Center of Vista, Vista, CA; Editor-in-Chief, Caring for the Ages; Vice Chair, AMDA Public Policy Committee; Chair, Coalition for Compassionate Care of California; President, Stone Mountain Medical Associates, Inc.

Kathleen Unroe, MD
Assistant Professor of Medicine; Center Scientist, Indiana University Center for Aging Research; Investigator, Regenstrief Institute, Inc.

Michael R. Wasserman, MD, CMD
Director, Nursing Home, Health Services Advisory Group; CALTCM Education Committee Chair

Kerry Weiner, MD
Chief Medical Officer, IPC Healthcare, Inc.

Nancy Weintraub, MD
Director, VA/UCLA Geriatric Medicine Fellowship

Program Faculty Biographies

Patricia Bach, PsyD, RN

Dr. Patricia Bach is a clinical psychologist in Roseville, California, specializing in geriatrics and neuropsychology. She is an active member of AMDA and CALTCM, and focuses on issues including intimacy and sexuality, social media and interdisciplinary teams in long-term care settings. Dr. Bach heads a national psychology group "Psychologists in Long-Term Care", devoted to the psychosocial needs of patients, families, providers and staff in long-term care.

Debra Bakerjian PhD, APRN, FAAN, FAANP

Debra Bakerjian is Senior Director for Nurse Practitioner and Physician Assistant Clinical Education and Practice, as well as an associate adjunct professor, at the Betty Irene Moore School of Nursing at UC Davis. Dr. Bakerjian's research aims to maximize the role of advanced practice nursing within the interprofessional team and to improve the quality of care for aging populations. Her research focuses on the role of nurse practitioners; patient safety and quality improvement practices in long-term-care; comprehensive pain management in frail older adults; and in interprofessional education and practice.

Dr. Bakerjian and Co-PI Elena Siegel were recently awarded a $1.2 million CMS Civil Money Penalty grant to study the implementation of the MUSIC and MEMORY^{SM} program within a QAPI framework. This grant complements their study with collaborator California Association of Healthcare Facilities – this study will occur in almost 450 nursing homes in California.

Dr. Bakerjian earned a Doctor of Philosophy in Health Policy and Gerontology in 2006 and a Master in Science of Nursing in 1992, both from UC San Francisco School of Nursing. Her doctoral study, "Utilization of Nurse Practitioners in Nursing Homes: A Comparison with Physicians," received the 2006 Dissertation of the Year Award at UC San Francisco. Bakerjian earned a Family Nurse Practitioner and Physician Assistant certificate from the UC Davis School of Medicine in 1991.

Dr. Bakerjian is active in both state and national organizations associated with the care of older adults. She is the president of the California Association of Long Term Care Medicine and has been a member of CALTCM and AMDA since 2001. She has also served on the advisory committee for AMDA's Clinical Practice Guidelines. She was one of first nurses to serve on the steering committee for Advancing Excellence in American Nursing Homes' and is currently on the National Quality Forum's Common Formats standing committee. She has been on the Health Sciences Executive Committee of the Gerontological Society of America and served on the Quality Measures Committee for the American Geriatrics Society in the past. She is a past president of the Gerontological Advanced Practice Nurses Association and recently retired as chair of the

GAPNA Foundation. Dr. Bakerjian is a Fellow of both the American Association of Nurse Pract itioners and the American Academy in Nursing.

Program Faculty Biographies (continued)

Alex Bardakh, MPP, PLC

Mr. Bardakh serves as the Director of Public Policy at AMDA-The Society for Post-Acute and Long-Term Care Medicine (AMDA). In this role he is responsible for implementing the extensive legislative and regulatory policy agenda for the association. Mr. Bardakh previously spent three years at AMDA serving as the Health Policy Analyst working on physician payment, quality and care transitions issues. During that tenure, he developed resources on the Physician Quality Reporting Initiative and value-based purchasing program. He also served as the staff project lead for two AMDA white papers on care transitions. Prior to his return to AMDA, Mr. Bardakh spent two years as the Government Relations and Advocacy Coordinator for the American Urological Association where he managed the political action committee for organized urology, spearheaded urology's advocacy conference, and helped advance the association's policy goals in the areas of physician payment policy as well as prostate cancer treatment and urotrauma. Mr. Bardakh earned his undergraduate degree in Political Science and a Master of Public Policy with a concentration on health policy and legal policy from the University of Maryland Baltimore County.

Flora Bessey, Pharm D, CGP

Dr. Bessey received her Doctor of Pharmacy Degree from Midwestern University in 2000. In 2002 she attained certification as a geriatric pharmacist from the Commission for Certification of Geriatric Pharmacists. She currently works in the San Francisco Bay Area as a self-employed long-term care pharmacist consultant. Dr. Bessey is actively involved in the California Association of Long Term Care Medicine (CALTCM). Over the years, she has conducted presentations on regulatory changes in skilled nursing, psychotropic medication management, pain management, and Medicare Part D. Most recently, Dr. Bessey has spoken on behalf various organizations including CAHF on changes to the state operations manual.

Kevin Broder, MD

Telehealth Director, Surgery Service - Section of Plastic Surgery, VA San Diego Telemedicine and Wound Director - San Diego Geriatric Workforce Enhancement Project. Dr. Broder is a Plastic Surgeon that has worked for more than 20 years to improve the quality of healthcare and help revolutionize how healthcare is delivered through technology integration. Dr. Broder is a leader in Telemedicine program development within the largest integrated healthcare system in the United States. He has experience with mobile healthcare application design, medical device research, and utilizing innovative technology to provide healthcare education and improve access to care. He has a broad background in Plastic and Reconstructive Surgery, with specific training and expertise in Complex Wound Care and Telemedicine. He is a Board Certified Plastic Surgeon with subspecialty training in Craniofacial and Pediatric Plastic Surgery. He serves as the Surgery Department Telehealth Director, and Program Director of the VA San Diego Plastic Surgery/Spinal Cord Injury Telehealth Program where he has helped develop a number of innovative programs that incorporate technology to enhance patient care. These include Real Time Clinical Video Telehealth to provide specialty surgical evaluation of remote rural patients and a national SCAN-ECHO program which enables interdisciplinary consultation for rural patients with complex wounds utilizing tele-video communication as well as continuing medical education credit for participants. Dr. Broder is also the Telemedicine and Wound Director of the San Diego Geriatric Workforce Enhancement Project, dedicated to training our nation's future healthcare workforce in the use of advanced technology to augment healthcare education and complex wound care of the elderly. His research interests include the study of the Interdisciplinary Team Approach to Wound Care for improved outcomes, the use of novel wound therapies to improve the healing of complex wounds and pressure ulcers, and the benefits of Telemedicine as a tool to increase access to care, reduce cost and improve collaboration amongst patients, families and providers. As volunteer UCSD faculty, he is dedicated to the education of medical students, residents, fellows & nurses.

Program Faculty Biographies (continued)

Lynette Cederquist, MD

Dr. Lynette Cederquist is an internist who is also board certified in Hospice and Palliative Medicine. Her clinical practice has always had a focus on pain management, palliative care, and hospice care. She has been on faculty at the University of California, San Diego for over 20 years. She currently divides her time between her clinical practice, teaching, and her role as Director of Clinical Ethics Program. She is responsible for running the Ethics Consult service, and Chairing the Hospital Ethics Committee. She teaches in two of the medical school courses, supervises residents in clinic, and routinely gives lectures. In addition she works with the UCSD PACE program (Physician Assessment and Clinical Education) conducting physician assessments.

Diane Chau, MD

Diane Chau MD, is the Project Director of the University of California Geriatric Education Center/Geriatric Workforce Enhancement Project and the medical director of the Community Living Center at the Veteran Affairs in San Diego and an Associate Professor of Health Sciences Medicine at UCSD.

Dr. Chau graduated from Drexel University College of Medicine and completed a fellowship in geriatric medicine at the University of California, San Diego. He is board-certified by the American Board of Internal Medicine in Geriatric Medicine, Hospice and Palliative Medicine. She is has participated in many a national leadership development program for geriatric leaders and clinicians, and now serves on the multiple board of directors including the California Geriatrics Society and the California Long Term Care Association.

As a geriatric medicine specialist and researcher, Dr. Chau's work focuses on developing and implementing geriatric medicine services for older adults, their families and caregivers, and physicians who provide the patient's primary care. She has authored and co-authored numerous journal articles, book chapters, and abstracts and regularly gives presentations across the country.

Anthony (Tony) Chicotel, Esq.

Tony Chicotel is from Cleveland, Ohio and a graduate of The Ohio State University College of Law and the University of California School of Public Policy. For the first three years of his practice, he worked in Las Vegas representing people in mental health facilities. After moving to San Diego, Tony spent six years as a staff attorney for a program providing free legal services to San Diego County residents aged 60 and older. His primary role was as the lead attorney for the agency's Nursing Home Rights Enforcement Project. For the past nine years, Tony has worked as a staff attorney for California Advocates for Nursing Home Reform in San Francisco and teaches elder law and policy courses in various Bay Area universities. He has written a number of publications regarding the rights of long-term care consumers, conservatorships, and health care decision making. Favorite things include: sunshine, sleeping in, big hugs, and vigor. Unfavorite things include: intolerance, fences and locks, and vinegar.

Program Faculty Biographies (continued)

Joshua Chodosh, MD MSHS

Joshua Chodosh, MD, MSHS is the Michael L. Freedman Professor of Geriatric Research and is Professor of Medicine in the Division of Geriatric Medicine and Palliative Care in the Department of Medicine at NYU School of Medicine. He is also a core investigator in the VA HSR&D program at the Manhattan VA. He is a former Robert Wood Johnson Clinical Scholar and has extensive clinical and research expertise in dementia and related disorders. He has held a number of leadership roles on regional and national committees that influence healthcare policy impacting the quality of care for patients with chronic disease, particularly those with dementia. Dr. Chodosh served as Chair of the State of California Alzheimer's and related Dementias Advisory Committee and co-chaired a statewide effort leading to the California State Plan for Alzheimer's disease. The California Plan has provided a model for other state plans and the National Alzheimer's Project Act. He has published several peer-reviewed original health services research articles including quality of care for dementia and other chronic disease conditions and has led multiple implementation trials. Dr. Chodosh initiated a VA dementia assessment and care management program (V-CAMP) using clinical video-telehealth for rural-based Veterans with dementia. This program has been spread to 4 out of 22 VA national service regions and serves as a national model in geriatric tele-healthcare delivery. In addition to numerous commendations for his telehealth program, Dr. Chodosh has been recognized for his clinical and research accomplishments with a number of awards and was recruited to NYU this past year to establish the Freedman Center on Cognition and Aging. Most recently, Dr. Chodosh, along with Drs. Mittelman and Wisniewski, were awarded a $7.5 million State of NY Department of Health service grant to develop and coordinate caregiver services for family members of those with dementia living in all five boroughs of New York City.

Rebecca Ferrini, MD, MPH, CMD

Rebecca Ferrini, MD, MPH, CMD Medical Director, Edgemoor DP SNF. Dr. Ferrini holds Board certifications in General Preventive Medicine and Hospice and Palliative Medicine as well as a CMD. Rebecca L. Ferrini, MD, MPH, CMD is the full-time medical director of Edgemoor Hospital DP SNF in Santee, California, a government run 192-bed facility which cares for a younger long-term care population with extensive physical, psychosocial and psychiatric challenges. This facility was turned around from a run down building with poor quality indicators to a five star home honored as a top nursing home in US News and World report for the last three consecutive years. She was honored in 2009 as the AMDA Medical Director of the Year for her role in improving the quality of care at the facility. She was the lead author on the toolkit on managing younger adults in long term care for which she was awarded the 2013 AMDA Clinical Practice Committee Volunteer of the Year. Her facility has received the bronze and silver quality awards from the American Healthcare Association. She has special interest in consent and capacity, quality improvement and lean systems, risk mitigation, difficult patient populations, Huntington's Disease, and behavioral management.

Program Faculty Biographies (continued)

George E. Fields, D.O.
George Fields is a Board Certified Family Physician who has worked at CareMore Health Plan in Cerritos California since 2006. In his role at CareMore he was directly responsible for the Institutional Special Needs Plan, Duals Initiative and Palliative Care Programs. He is currently a Senior Medical Officer of CareMore, in charge of our Iowa, Ohio, Virginia and Tennessee markets. Dr. Fields has a keen focus on the redesign of health care and a desire to deliver better care to every patient.

Tim Gieseke
Dr. Gieseke graduated AOA from UCI in 1976 and then completed a straight Internal Medicine at UCD, Sacramento Medical Center. Since 1979, he has practiced internal medicine in Santa Rosa with an emphasis Post-Acute and Long Term Care Medicine as well as geriatrics and palliative care. He left his office practice in 2005 to focus full time on care of the frail elderly predominantly in the nursing home setting. He teaches geriatrics and palliative care at the Sonoma County UCSF affiliated Family Medicine Residency where he is an Associate Clinical Professor.

He was President of CALTCM (California Association of Long Term Care Medicine) July 2005-2007, and is the Chair of the Education committee again from May 2013 through April 2015. He was a member of AMDA Public Policy committee for 6 years ending in 2014. He is member of the Sonoma Co POLST Coalition and a member of the POLST Physician Leadership Council. He has presented at CALTCM and AMDA meetings and has been faculty for the INTERACT workshops. He is on the editorial board of the CALTCM WAVE and is a frequent contributor.

He is interested in International Medicine and has participated in medical projects in Equador (1990), Albania, and Kosovo.

Elizabeth Landsverk, MD
Elizabeth Landsverk, M.D. is a Geriatrician providing house calls for complicated patients in the San Francisco Bay area. She is an Adjunct Professor of Medicine at Stanford University. She has been a Hospice Medical Director and consulted for the San Francisco Elder Abuse Forensics Center, and is currently a Medical Director at a dementia only community in Belmont.

Dr. Landsverk founded ElderConsult Geriatric Medicine, a house calls practice, to address the challenging medical and behavioral issues facing older patients and their families. She has expanded to add an online community on her website to address the challenging care issues with elders.

Program Faculty Biographies (continued)

Vincent D. Nguyen, MD

Dr. Vincent D. Nguyen is a Board Certified Hospice and Palliative Care Specialist with Board Certifications in Geriatrics and Family Medicine. He earned his Medical Degree from Western University of Health Sciences in 1992. He is the Director of the HOAG CARES Program and in this role provides direct medical care as well as oversight of the inpatient and outpatient palliative clinical services at HOAG hospitals. Prior to his current role, he served as Medical Director of a national hospice agency in the Los Angeles and Orange County area for 12 years before joining MONARCH HealthCare as Medical Director of Geriatrics and Palliative Care Services for over 5 years. These fine places introduced him to new people, big ideas and global concepts that helped shape the person he is today. Over his career, he built a nationally recognized post-acute service in the Skilled Nursing Facility settings, and implemented Fellowship training programs for post-graduate and mid-career Physicians the art of Hospice and Palliative Medicine through UC Irvine. He has lectured, published in the Journal of Palliative Medicine and co-authored several chapters in 2 books on End-of Life issues published by the McGraw-Hill Companies.

In addition to being a volunteer Assistant Clinical Professor at UCI School of Medicine, he co-chairs the Orange County POLST Coalition since 2009 to inform and educate the public on the value of advance care planning. His passions outside of medicine include golf outings with his 3 daughters, yoga classes with his wife of 24 years, silent retreats and naps on weekends.

Thomas Osborne, MD

Dr. Osborne graduated from Dartmouth Medical School and completed his radiology residency at Harvard Medical School's Mount Auburn Hospital. He then went on to complete his Neuroradiology fellowship at Harvard Medical School's Massachusetts General Hospital.

In addition to his clinical work, Dr. Osborne is also the Director of Medical Informatics at Virtual Radiologic, which is the largest telemedicine company in the world. In this technology-leadership role, he and his multidisciplinary team have developed an innovative enterprise-wide communication, collaboration and efficiency platform to improve the practice of radiology.

Dr. Osborne was recently honored as the recipient of the "Top people to Watch in Radiology" award. This peer-nominated national award is presented to just one U.S. radiologist each year. In the words of the journal of Diagnostic Imaging, this contest honors clinicians that have proven to be "superstars in medical imaging."

Denise Rettenmaier, DO

Dr. Denise Rettenmaier is a graduate of the UCSF Internal Medicine residency at Highland General Hospital, a Stanford fellowship-trained Geriatrician and is also board-certified in Hospice and Palliative Care medicine. She remains on staff at the Veterans' Home of California at Yountville, and has spent most of her career there in Dementia Care, including serving as the Medical Director of the Memory Care Center. She continues as Assistant Clinical Professor on the Stanford Volunteer Clinical Faculty and as Geriatrics Rotation attending for the David Grant residents at Travis AFB.

Program Faculty Biographies (continued)

Jim Roxburgh, RN, MPA

Jim Roxburgh is the Director for the Dignity Health Telemedicine Network (DHTN). He is responsible for the leadership, development and coordination of the DHTN. In 4 years Jim advanced the DHTN from 4 Partner Site to more than 40 Partner Sites (Hospitals). The DHTN provides telehealth services in the acute, ambulatory and home setting. The DHTN provides more than 1,200 consults per month.

Jim's undergraduate degree is in Exercise Physiology. He also has degrees in Respiratory Therapy, Nursing and a Master Degree in Public Administration with an emphasis in Health Practice Management. He is currently licensed as a Respiratory Care Practitioner, Registered Nurse in California and Credentialed as an Exercise Technologist by the American College of Sports Medicine. Jim has worked in a variety of management and clinical areas that include: Cardiopulmonary, Neurodiagnostics, Cardiac Cath Lab, Electrophysiology Lab, Managed Care, Case Management and Disease Management Programs. Jim is a 5th Dan Tae Kwon Do Master and a Martial Art Instructor at Kang's United Martial Art College in Sacramento, CA.

Karl E. 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 medical director at Village Square, Life Care Center of Vista, Carlsbad by the Sea, and Hospice by the Sea. He got a 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 is on AMDA's Board of Directors and chairs their Public Policy Committee in addition to serving as editor-in-chief of their monthly periodical, Caring for the Ages. He also chairs 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. However, Dr. Steinberg is probably best known for taking his dogs on patient care rounds with him on most days.

Kathleen Unroe, MD, MHA

Unroe, MD, MHA, is an Assistant Professor of Medicine at Indiana University in Indianapolis. She is a nursing home physician – her research, clinical and policy interests are focused on improving quality of care, particularly access to palliative and end-of-life care, for long stay nursing home residents. Dr. Unroe was awarded a 2014 Paul B. Beeson K23 Career Development Award to examine hospice use in nursing homes. She is the co-project director of OPTIMISTIC, a 4 year $13.4 million CMS funded demonstration project aimed at improving quality of care and reducing avoidable hospitalizations in 19 Indiana nursing homes and is the Principal Investigator of a Hartford Foundation planning grant focused on OPTIMISTIC dissemination. She has also been funded by the National Palliative Care Research Center and was the American Academy of Hospice and Palliative Medicine 2014 Junior Investigator of the Year. She is Vice-Chair of the American Geriatrics Society Public Policy Committee. She was a 2009-2010 Health and Aging Policy Fellow and had a placement in Health and Human Services, ASPE Office of Disability, Aging, and Long Term Care Policy.

Program Faculty Biographies (continued)

Michael Wasserman, MD, CMD

Doctor Michael Wasserman is Director of Nursing Home Patient Safety for Health Services Advisory Group. He has devoted himself to serving the needs of seniors for the past thirty years. 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. 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 Glidepaths 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 developed a Consultative Geriatric Medical model. 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 Geriatric Society's Managed Care Task Force and presently serves on the Public Policy Committee. He was formerly a Public Commissioner for the Continuing Care Accreditation Commission.

Dr. Wasserman was a co-founder of MESA (Medicare 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 on its Board. He served on the Board of The Denver Hospice for fifteen years. He serves as a board member for the American Geriatric Society's Foundation for Health in Aging. He has spoken extensively and been published on a variety of topics involving geriatrics, healthy aging, Alzheimer's Disease, the business of health care, practice management and managed care.

Program Faculty Biographies (continued)

Kerry Weiner, M.D.

Kerry Weiner M.D. joined IPC in March 2011 as Chief Clinical Officer; in February 2013 he was promoted to Chief Medical Officer. Dr. Weiner leads the clinical functions of the Company and is charged with continuing the development of hospitalist leaders throughout IPC. Most recently, Dr. Weiner held the position of Chief Medical Officer for the Lakeside Medical Organization, a multispecialty group of 130 physicians and an IPA (Independent Practice Association) of approximately 2200 physicians. Dr. Weiner was one of the earliest proponents of hospitalists in Southern California, having utilized them at Lakeside since 1991. A co-founder of Lakeside Medical Group, Dr. Weiner served as president of the integrated medical group for 14 years. Dr. Weiner received his medical degree, masters in public health and bachelor's degree from the University of California, Los Angeles. Dr. Weiner is a member of the SHM Public Policy Committee and PAC Task Force for BOOST (National Program for Boosting Care Transitions).

Nancy Weintraub, MD

Nancy Weintraub, M.D. is Director of the Greater Los Angeles VA/UCLA Fellowship in Geriatric Medicine, a position she has held since July 1, 2008. She is also Director of the Greater LA VA Advanced Fellowship in Geriatrics. She is Health Sciences Professor of Medicine at the David Geffen School of Medicine at UCLA and staff physician at the Greater Los Angeles Veterans Affairs Medical Center.

Dr. Weintraub graduated from NYU Medical School in 1981, completed her Internal Medicine Residency at Jacobi Hospital/Albert Einstein College of Medicine in 1984, and completed her Geriatric Medicine fellowship at New Your University/Bellevue Medical Center in 1986. She was faculty at NYU School of Medicine and on staff at those institutions and at the Manhattan VA until relocating to Los Angeles in 1992. She joined the faculty at UCLA at that time, and she joined the medical staff at the GLA VA in 2001.

Faculty and Planner Disclosures

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

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Tom Osborne, MD	Faculty	Medical Director Neuro-radologist and Director of Medical Informatics	HealthVerge/ Salary Virtual Radiologic / Salary
Dan Osterweil, MD	Faculty Planner	None	
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Denise Rettenmaier, DO	Faculty / Planner	None	
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Rajneet Sekhon, MD	Planner	None	
Karl Steinberg, MD, CMD, HMDC	Faculty / Planner	Non-Branded Speakers Bureau / Honoraria Advisory Board / Honorarium	Boehringer Ingelheim Sunovion
Kathleen Unroe, MD	Faculty	None	
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Nancy Weintraub, MD	Faculty	None	

2016 CALTCM Leadership Award

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

CALTCM is proud to present the 2016 CALTCM Leadership Award to:

Karl E. Steinberg, MD, CMD, HMDC

Dr. Karl Steinberg has been a long-term care geriatrician and palliative medicine physician for 25 years in the San Diego area. He got a bachelor's in biochemistry from Harvard, then taught high school in New York City for 3 years. He then studied medicine at The Ohio State University College of Medicine and did his residency in Family Medicine at UCSD. He has continued his passion for education by serving as adjunct faculty for Case Western Reserve University and affiliate faculty for the California State University's Institute for Palliative Care, and volunteer faculty for numerous other institutions. Dr. Steinberg is very active in AMDA, serving on their Board of Directors and chairing their Public Policy Committee in addition to serving as editor-in-chief of Caring for the Ages. He also chairs the Coalition for Compassionate Care of California and is on the Board of the San Diego County Medical Society. However, Dr. Steinberg feels his true claim to fame is his dogs, who accompany him on patient care rounds with him on most days.

Special Acknowledgements

CALTCM would like to extend our gratitude to all our sponsors

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Special Acknowledgements (continued)

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Program Agenda

Friday, April 29, 2016

11:00 a.m.	Registration/Exhibits Open
11:45 a.m.	Industry Supported Lunch
1:00 p.m.	Welcome & Introductions
1:10 p.m.	Opening Comments
1:15 p.m.	Pharmacist's on the Front Line
1:35 p.m.	"Let's Be Careful Out There": Informed Consent
2:10 p.m.	A Geriatrician's View
2:30 p.m.	The Younger Psychiatric Patient in Long-Term Care
2:50 p.m.	Break/Exhibits
3:20 p.m.	It's not always a UTI: Diagnosing Infections in the Nursing Home
3:40 p.m.	"De-Prescribing": Identify and Reduce Potentially Inappropriate Medications (PIM's)
4:00 p.m.	An Update on CKD in Long-Term Care
4:20 p.m.	Be OPTIMISTIC
5:00 p.m.	Q&A Panel Discussion
5:30 p.m.	CALTCM Update: What's New in PA/LTC?
6:00 p.m.	CALTCM Poster Session & Reception
6:00 p.m.	Exhibits Close
7:00 p.m.	Industry Sponsored Dinner

Program Agenda

Saturday, April 30, 2016

6:45 a.m.	Exhibits Open / Breakfast
8:00 a.m.	Welcome
8:05 a.m.	Presentation of 2016 CALTCM Leadership Award
8:15 a.m.	Best Practices in Palliative Care
8:35 a.m.	The Pulse (POLST) of California: Relevant Updates from the Coalition for Compassionate Care of California
8:55 a.m.	Having "The Talk"
9:30 a.m.	Break/Exhibits
10:00 a.m.	Aid in Dying: Our New Reality
10:30 a.m.	GeriatricPain.org
10:50 a.m.	Intimacy, Sexuality and Patient Autonomy
11:10 a.m.	A Clinician's Decisions About Sex
11:30 a.m.	Q&A Panel Discussion
12:00 p.m.	Break/Exhibits/ Industry Supported Lunch
1:05 p.m.	CALTCM Awards
1:30 p.m.	Value Based Purchasing, SNF's and SNFist's
1:45 p.m.	Bundled Payment Models
2:05 p.m.	Review of Telehealth and Telemedicine in Geriatrics
2:35 p.m.	Avoiding Technology Through Technology: Reducing Admissions
2:55 p.m.	Break/Exhibits
3:25 p.m.	Sensing the Future Through Health Monitoring
3:50 p.m.	Access to Care: The Use of Telemedicine Across the Healthcare Continuum
4:15 p.m.	Real World Challenges for Telehealth
4:35 p.m.	Q&A Panel Discussion
5:10 p.m.	Closing Comments/Evaluations/Adjourn


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California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Pharmacists on the Front Line
Flora Y. Bessey, PHARM.D., CGP
CALTCM 2016

Notes:

Disclosure

I receive compensation for speaking at Forest Pharmaceutical programs. My spouse works for Eli Lilly as a pharmaceutical salesman.

Notes:

Objectives

At the conclusion of this activity, attendees should have the ability to:

- Utilize methods to monitor adverse drug reactions with antipsychotics
- Specific responsibilities of the consultant pharmacist with regards to antipsychotic use
- High risk medications

Notes:

Antipsychotic Survey Tool

- https://www.dropbox.com/s/ysg3yeusayyts0s/FP1B_CDPH%20LC%20Antipsychotic%20Survey%20Tool%202014%20Revision-2.pdf?dl=0
- Created by CMS to help surveyors identify deficiencies
- Specific with regards to:
  - Diagnosis, appropriate behavior, consent, risk-benefit assessment, dose reduction attempts, etc.
- Supplemental guide provided to help with tool use
  - https://www.dropbox.com/s/vac9ovd9xtho57d/FP1A_Antipsychotic%20Use%20Survey%20Tool%20Supplemental%20Guidance%202014%20Revision-2.pdf?dl=0
  - Each section of the tool has ftags specified if the facility is deficient

Notes:

Adverse Drug Reaction Monitoring

- As identified by table 1, medications of particular relevance.
  - http://www.health.state.mn.us/divs/fpc/cww/D01_Transmittal22ExcerptTableI.pdf
  - Identifies specific monitoring for each class of drugs
- Antipsychotics:
  - Anticholingeric effects, akathesia, nms, arrhythmias, increased risk for death in the elderly, falls, lethargy, lipids, a1c/fasting glucose, orthostatic hypotension, td, cv events, sedation

Notes:

Role Of A Pharmacist

- Appropriateness of orders
  - Dose, indication, behavior monitoring
- Review orders for monitoring
  - Ekg, fasting lipids, a1c
- Request dose reductions
  - 2 separate quarters with one month in between
- Providing risks and benefits is the role of the prescriber
  - Not the pharmacist. No standardized tool to help make this process faster or easier.

Notes:

High Risk Regimens

- Multiple Antipsychotics
- Antidepressants, Antipsychotics, Serotonin Syndrome
- Additive Effects:
  - Celexa >20mg Per Day-increased Risk For Qtc Interval Prolongation
  - Pain Meds, Psych Meds, Increased Risk For Sedation

Notes:

Best Practices

- IDT approach to initiation of antipsychotic meds
- Review all new admission meds within 72 hours
- Establish a comprehensive plan for obtaining informed consents
- Prescribers must be aware of risk benefit documentation
- Pharmacist must be part of monthly IDT to review psych meds, best when done based on MDs schedule
- Request meaningful dose reductions timely
- Use available resources, http://www.dementiacareresourceca.org/#!nursing-home-staff/c1qou

Notes:


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Quality Through Best Practices
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Promoting quality patient care through medical leadership and education
Let's Be Careful Out There.
Legal Elements of Informed Consent
Anthony Chicotel
Staff Attorney, California Advocates for Nursing Home Reform
CALTCM 2016

Notes:

Disclosure Statement

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

Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Identify the legal risks associated with the use of psychotropics
- Recognize the elements of informed consent in prescribing antipsychotics and other psychotropics
- Implement tools for obtaining and documenting informed consent
- Identify ways to mitigate risk in the use of antipsychotics

Notes:

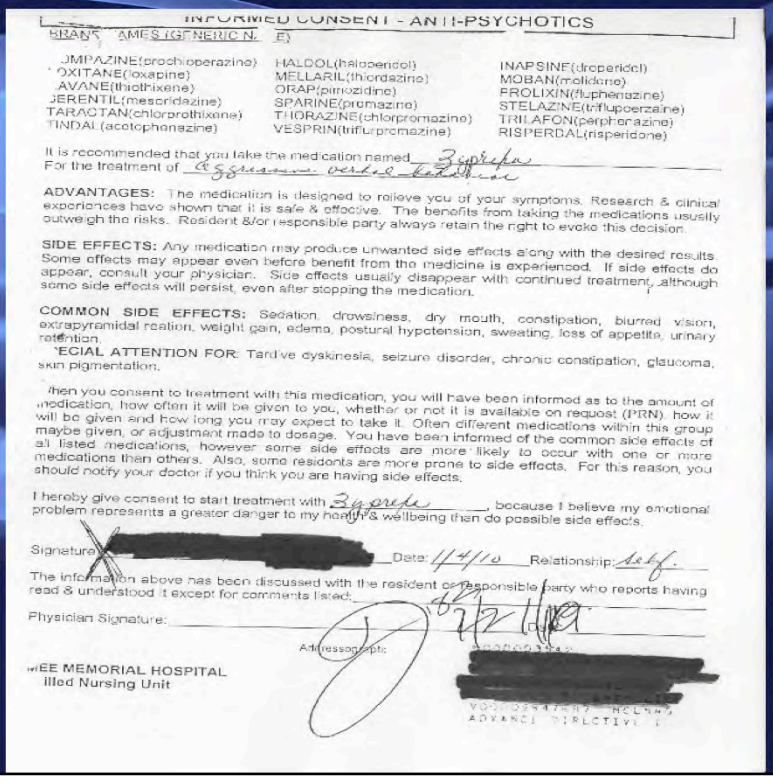
Notes:

What Is Informed Consent?

1. Informed
   - Communicating proposed treatment, risks, benefits, and alternatives in a way that can best be understood by the patient
   - Conversation is key
2. Consent
   - Acceptance
   - What about acquiescence?

Notes:

Informed Consent?



INFORMED CONSENT - ANTI-PSYCHOTICS

BRAND NAMES (GENERIC NAME)

UMPAZINE(prochloperazine)	HALDOL(haloperidol)	INAPSINE(droperidol)
OXITANE(loxapine)	MELLARIL(thioridazine)	MOBAN(molidone)
AVANE(thiothixene)	ORAP(pimozidine)	PROLIXIN(fluphenazine)
JERENTIL(mesoridazine)	SPARINE(promazine)	STELAZINE(trifluoperzaine)
TARACTAN(chlorprothixene)	THORAZINE(chlorpromazine)	TRILAFON(perphenazine)
TINDAL (acetophenazine)	VESPRIN(triflurpromazine)	RISPERDAL(risperidone)

It is recommended that you take the medication named Zyprexa
For the treatment of aggressive, verbal behavior

ADVANTAGES: The medication is designed to relieve you of your symptoms. Research & clinical experiences have shown that it is safe & effective. The benefits from taking the medications usually outweigh the risks. Resident &/or responsible party always retain the right to evoke this decision.

SIDE EFFECTS: Any medication may produce unwanted side effects along with the desired results. Some effects may appear even before benefit from the medicine is experienced. If side effects do appear, consult your physician. Side effects usually disappear with continued treatment, although some side effects will persist, even after stopping the medication.

COMMON SIDE EFFECTS: Sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal reation, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention.

SPECIAL ATTENTION FOR: Tardive dyskinesia, seizure disorder, chronic constipation, glaucoma, skin pigmentation.

When you consent to treatment with this medication, you will have been informed as to the amount of medication, how often it will be given to you, whether or not it is available on request (PRN), how it will be given and how long you may expect to take it. Often different medications within this group maybe given, or adjustment made to dosage. You have been informed of the common side effects of all listed medications, however some side effects are more likely to occur with one or more medications than others. Also, some residents are more prone to side effects. For this reason, you should notify your doctor if you think you are having side effects.

I hereby give consent to start treatment with Zyprexa, because I believe my emotional problem represents a greater danger to my health & wellbeing than do possible side effects.

Signature: [redacted] Date: 1/4/10 Relationship: Self

The information above has been discussed with the resident or responsible party who reports having read & understood it except for comments listed:

Physician Signature:

Addressograph:

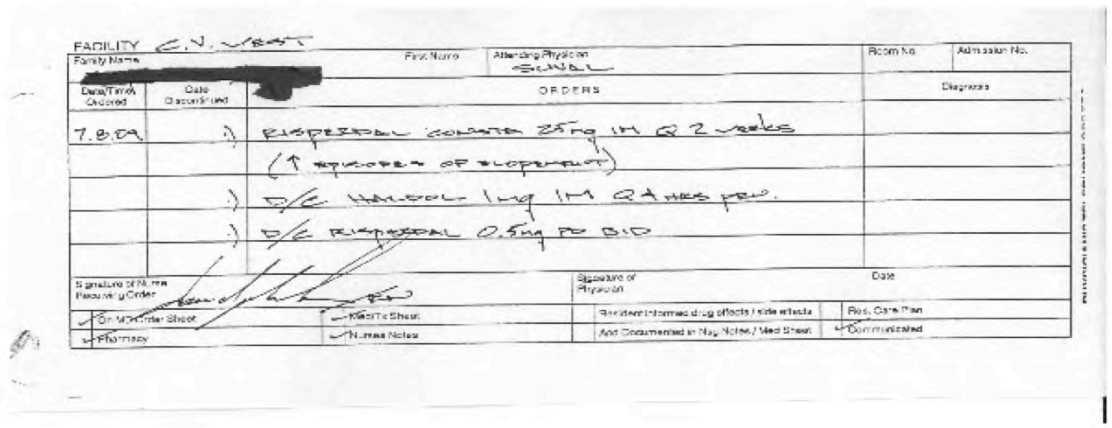
[redacted]

[illegible] MEMORIAL HOSPITAL
[illegible] Nursing Unit

[illegible] HEALTH
ADVANCE DIRECTIVE

Notes:

Informed Consent?



FACILITY C.V. VBAT

Family Name	First Name	Attending Physician	Room No.	Admission No.
[redacted]		SUNIL		

Date/Time Ordered	Date Discontinued	ORDERS	Diagnosis
7.8.09		1) RISPERIDAL CONSTA 25mg IM Q 2 weeks	
		(1 injection of risperidal)	
		2) D/C HALDOL 1mg IM Q 4 hrs prn.	
		3) D/C RISPERDAL 0.5mg PO BID	

Signature of Name Receiving Order | Signature of Physician | Date

Dr. MD Order Sheet | Med Tx Sheet | Resident Informed drug effects / side effects | Res. Care Plan

Pharmacy | Nurses Notes | Add Documented in Nsg. Notes / Med Sheet | Communicated

Notes:

Why Informed Consent?

- 100+ years of common law, California's key case is *Cobbs v. Grant*
- Autonomy – failure to honor is battery
- Consent not effective unless informed – failure to honor is negligence
- Expectation of best patient-physician practices

Notes:

California Informed Consent

- There is no blanket statute
- Common law + piecemeal specifications for special treatments

Notes:

Informed Consent in Long-Term Care

- 22 Cal. Code Regulations Sec. 72528: prescriber ("health care practitioner") tasked with obtaining i.c. for psych drug or physical restraint
- Nursing home tasked with verifying
- How about RCFEs?

Notes:

Who Can Give Consent?

- Patient (unless no capacity)
- Patient Surrogate – conservator, POA agent, family, others(?)

- Regardless of patient capacity or presence of surrogate, patient always retains right to refuse

Notes:

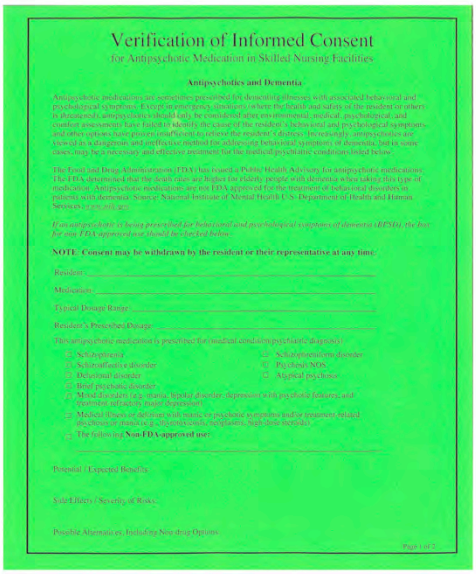
A Note on Hlth. & Safety Code Sec. 1418.8

Notes:

Getting Informed Consent

1. Have the conversation
2. Document it:

www.dementiacareresourceca.org/#!informed-consent/bh3x3



Verification of Informed Consent

for Antipsychotic Medication in Skilled Nursing Facilities

Antipsychotics and Dementia

NOTE: Consent may be withdrawn by the resident or their representative at any time.

Notes:

Being Careful Out There

1. Risks: Black Box warning labels, off-label use, Beers criteria, etc.
2. Alternatives: Your chance to avoid unnecessary use and better assure positive clinical outcomes.

Notes:

Comfort Care

- Stop medicalizing healthy responses
- “Behaviors” are rarely symptoms of dementia - they are the natural response to distress and unmet needs.
- People who feel good do not hit.

Notes:

A crying baby

What do you do?

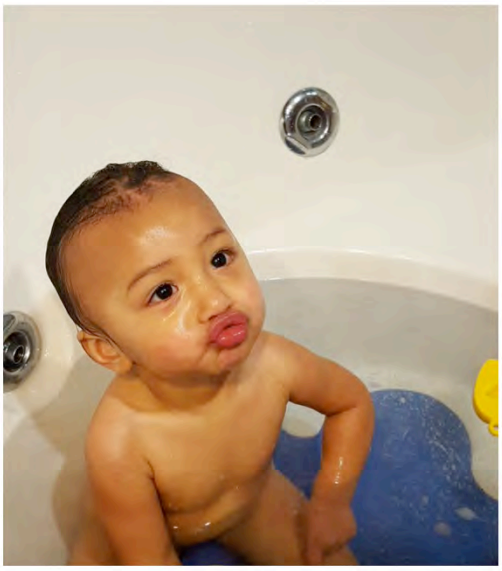
a) Give them drugs

or

b) Tend to their needs and comfort them?

Notes:

Thank You for this Incredible Opportun



CALTCM 2016 Quality Through Best Practices

Notes: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Contact Anthony Chicotel
Staff Attorney
California Advocates for Nursing Home Reform
tony@canhr.org
CALTCM 2016
Quality Through Best Practices

Notes:

Agitation

Elizabeth Landsverk, MD

Education lead for the California Coalition for Culture Change

Notes:

Disclosure Statement

- I have no relevant financial relationships to disclose.

Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Recognize the clinical indications for the use of antipsychotics in LTC residents.
- Discern methods to determine necessity for chronic verus episodic use
- Identify non-pharmacologic approaches to addressing behavioral and psychiatric symptoms of dementia (BPSD)

Notes:

Views of a Geriatrician

- Remove the offending medications
  - Avoid sleeping pills, Benzodiazepines
  - Avoid anticholinergic medications
  - Be ware of Parkinson's medications
- Treat pain adequately
  - Standing Acetaminophen, may need narcotics
  - NSAIDs have many complications

Notes:

Views of a Geriatrician

- Engage, Exercise, Repeat
- Evaluate for Infection
- Judicious use of Psychoactive Medications
  Model of Palliative Care
- Antipsychotics should be thought of as chemotherapy, to improve quality of life with serious risks

Notes:

Remove Offending Medications

- Xanax/Alprazolam is the Crack of Benzos
- Benzodiazepines are not gentler in dementia mostly lead to over-sedation or agitation after a few months, think of like shots of vodka
- Parkinson's Medications
- Keppra (Levitriciam)
- Anticholinergics -TylenolPM/Diphenydramine, Detrol/Tolterodine

Notes:

Treat Pain Adequately

- Reposition every 2 hours, keep walking
- NSAIDS do not treat nerve pain
- Increase risk of GI bleed, HTN, Renal failure
- Standing dose long acting Tylenol 650mg
- Tramadol – possible sedation, confusion
- Hydrocodone/mapap 5/325mg, low dose ½ tab several times a day
- Methadone, low dose ¼ tab at night
- Always give bowel meds, senna…

Notes:

Engage, Exercise, Repeat

- The cornerstone to any successful dementia care program
- Programs to keep elders walking are crucial,
  - less staff time in transfers and care
  - less staff injuries from transfers
- Avoiding daytime sleeping will decrease Insomnia (limit naps to 1 hour)

Notes:

Medications

- 78 yo s/p urosepsis with a foley catheter
  Carbi/Levodopa 25/100 1.5 tabs 3 x a day
  Olanzapine 5 mg a day
  Valproic Acid 500 mg twice a day
  Lorazepam 1 mg 3 x a day
  Sleeping a lot of the day, restless at night

Notes:

Medications

85 yo frail woman with vaginal itching, irritable, yelling and hitting out.

- Naproxen 500 2 x a day
- Zolpidem 10 mg qhs
- Alprazolam 0.25 q 4h prn
- Estrogen cream

Notes:

Medications

82 yo woman had been independent with HTN, hypercholesterolemia worsening memory

- Conserved, lawyer advise no psych meds
- Pulled a knife on caregiver
- 5150 to hospital Ativan 1 mg 3 x a day
- Quetiapine 50 mg 3 x a day
- Transferred stuporous to SNF

Notes:

Medications

- Sedated elders MUST always have sedating medications decreased/held and alert MD
- NEVER label obtunded elder end stage unless OFF offending medications
- Pain meds come first

  Do not treat pain with Lorazepam or Quetiapine

Notes:

A Geriatricians View

- Remove the offending medications
- Treat the pain adequately
- Engage, Exercise, Repeat
- Judicious Psychoactive medication
  DementiaCareResourcesCA.org
  ElderConsult.com/medications

Notes:

A Geriatricians View

- Questions? Comments?
  Community Chat at ElderConsult.com

Elizabeth Landsverk MD
ElderConsult Geriatric Medicine
Adjunct Professor at Stanford University

Notes:


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Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
The Younger Psychiatric Patient in LTC
Rebecca Ferrini, M.D., MPH, CMD
CALTCM 2016

Notes:

Disclosure Statement

- Dr Ferrini has no conflicts of interests or relative disclosures.
- Dr. Ferrini is not a psychiatrist, but she has been forced to learn psychiatry caring for psychiatrically impaired residents for the last 15 years with no deficiencies.....
- Some discussion about the use of psychotropic medications may involve off-label uses, based on experience.

Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Recognize appropriate diagnostic categories for the use of antipsychotics in the younger LTC population
- Understand the concept of considering gradual dose reduction as this population ages
- Identify alternative approaches to treatment of psychiatric illness in younger LTC residents

Notes:

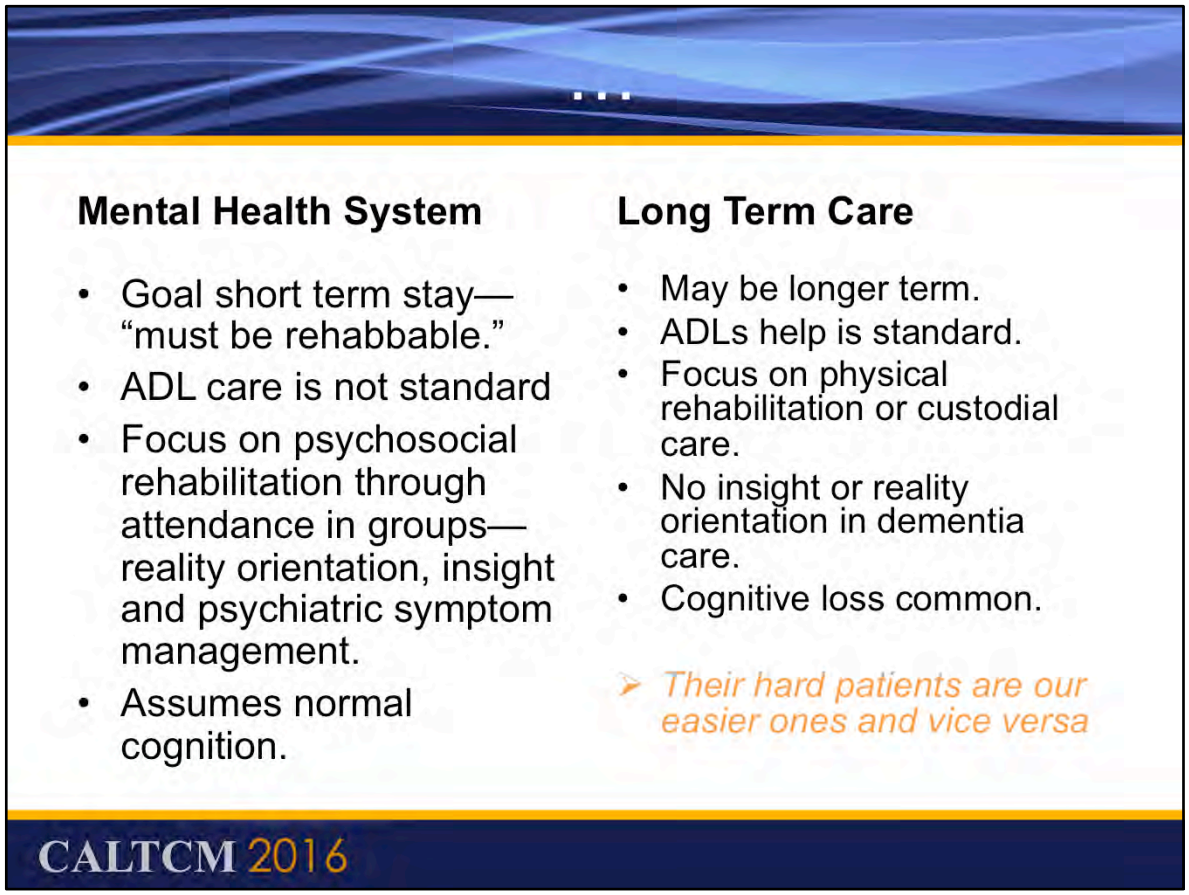
- Increasingly, those with mental illness are entering the LTC environment.
  - Shorter life expectancy
  - Comorbidities
  - Lack of psychosocial support and community options
  - Cognitive decline/dementia— “no longer have rehab potential”
  - “old before their time.”

Notes:

Frankie

- Frankie has had schizophrenia> 30 yrs has had protracted periods of homelessness. She isolates herself, can lash out, is irritable, mumbles, plays music loudly. She wears pajamas all day, has occasional incontinence, and refuses assessments. When she recovers from her fracture, you find you cannot find a placement for her.

Notes:


. . .
Mental Health System
• Goal short term stay—"must be rehabbable."
• ADL care is not standard
• Focus on psychosocial rehabilitation through attendance in groups—reality orientation, insight and psychiatric symptom management.
• Assumes normal cognition.
Long Term Care
• May be longer term.
• ADLs help is standard.
• Focus on physical rehabilitation or custodial care.
• No insight or reality orientation in dementia care.
• Cognitive loss common.
➢ Their hard patients are our easier ones and vice versa
CALTCM 2016

Notes:

- Consider dementia/cognitive loss, even in young people:
  - Head injury
  - Drug/alcohol
  - Neurodegenerative
  - Anoxia
  - Effects of drugs/medication
  - Effects of long-term mental illness
  - Other atypical dementias
- Any may be a consequence of behaviors and injuries, or “what got them here.”

Notes:

- Because of the combination of mental illness, dementia, physical impairments and being younger, neither mental health nor LTC want, or are necessarily well prepared to care for these residents.

- Most will be long-stay residents, often with few or no discharge options.

Notes:

Milton

- Milton is 58, admitted after a methamphetamine-induced CVA. His history refers to substance abuse, head trauma in jail, and a variety of diagnoses (bipolar, antisocial, schizophrenia, impulse control disorder)—unfortunately, there is no one to tell you the whole story.

Notes:

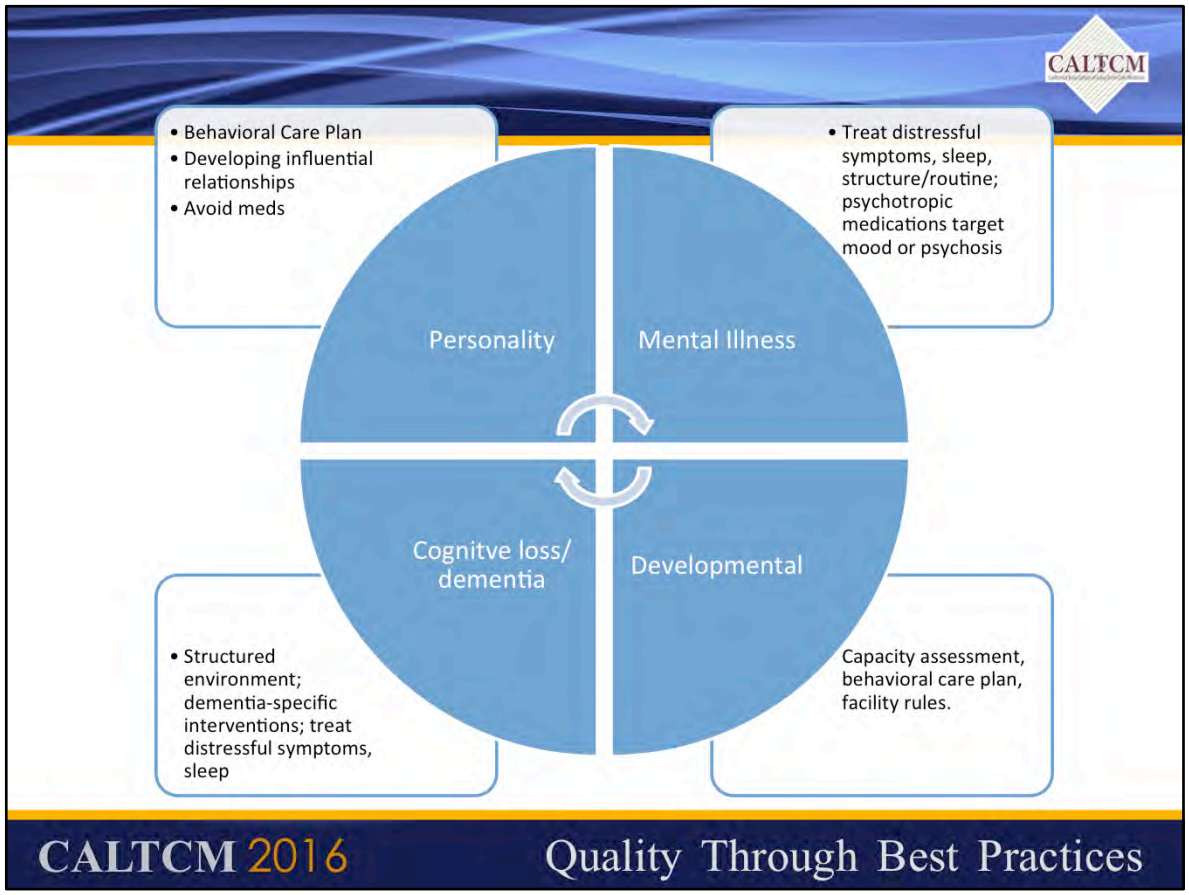
- Behaviors may be tangled combination of true mental illness, brain injury, effects of substance use, adjustment to physical and/or cognitive losses and developmental stage disruptions.

Notes:

Approach

- Identify ALL Behaviors
- Categorize them by cause:
  - Personality
  - Cognitive/Dementia
  - Developmental
  - Mental illness (mood, psychosis, other..)
- Select agent which, at least theoretically, makes sense.

Notes:


CALTCM
• Behavioral Care Plan
• Developing influential relationships
• Avoid meds
• Treat distressful symptoms, sleep, structure/routine; psychotropic medications target mood or psychosis
Personality
Mental Illness
Cognitve loss/ dementia
Developmental
• Structured environment; dementia-specific interventions; treat distressful symptoms, sleep
Capacity assessment, behavioral care plan, facility rules.
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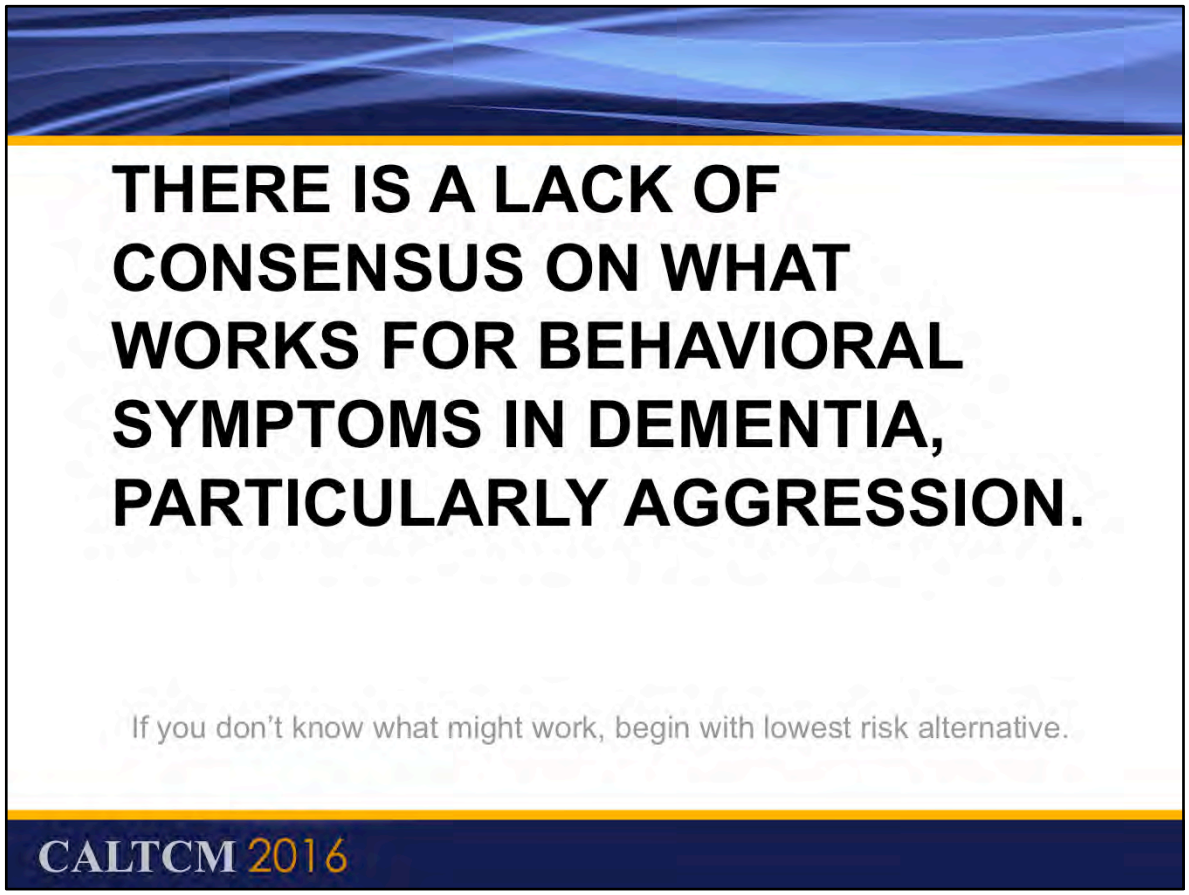
Quality Through Best Practices

Notes:


THERE IS A LACK OF CONSENSUS ON WHAT WORKS FOR BEHAVIORAL SYMPTOMS IN DEMENTIA, PARTICULARLY AGGRESSION.
If you don't know what might work, begin with lowest risk alternative.
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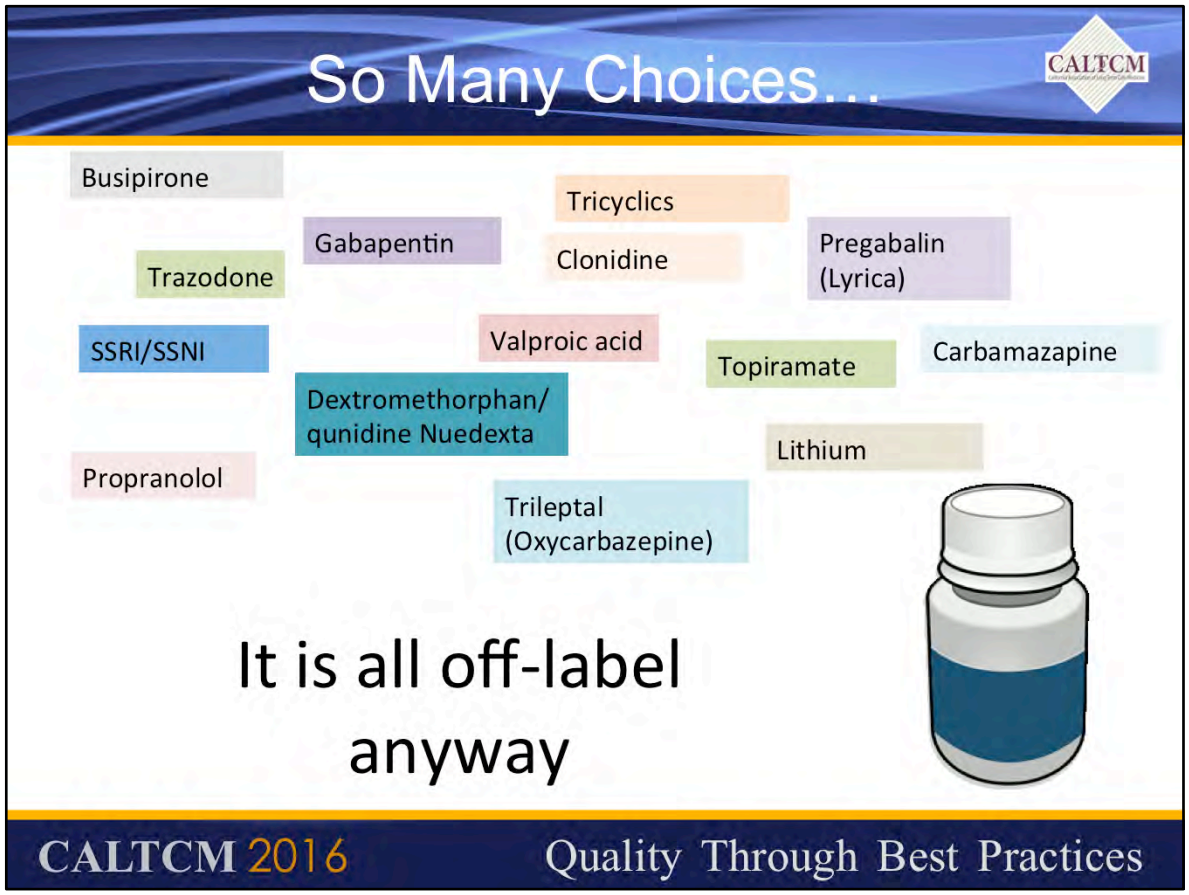
Notes:


So Many Choices…
CALTCM
Busipirone
Tricyclics
Gabapentin
Clonidine
Pregabalin (Lyrica)
Trazodone
SSRI/SSNI
Valproic acid
Topiramate
Carbamazapine
Dextromethorphan/ qunidine Nuedexta
Lithium
Propranolol
Trileptal (Oxycarbazepine)
It is all off-label anyway
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Notes:

What is the flavor of the aggression?

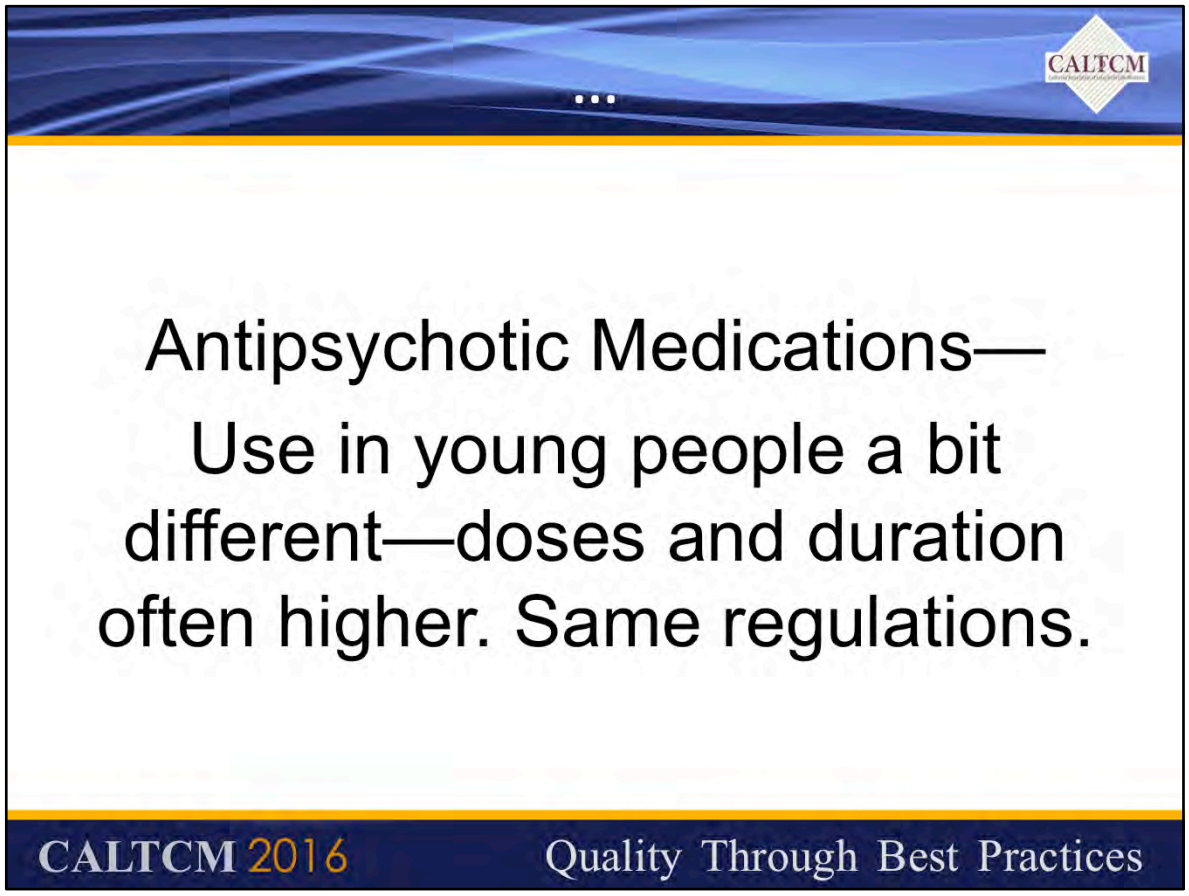
Excessive fixation on routine with intolerance of changes—OCD---SSRI (high dose)

Brought on with mood changes, irritability, an overreaction---consider mood stabilizers, SSRI

"The voices are telling me to hurt him"--antipsychotic

Resisting care/ Dementia—use behavioral approaches first, medications later.

Notes: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Antipsychotic Medications—
Use in young people a bit different—doses and duration often higher. Same regulations.
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Notes:

- Appropriate diagnostic categories for use of antipsychotics
  - Schizophrenia*
  - Schizoaffective
  - Bipolar
  - Mood d/o/depression with psychosis
  - Delusional disorder
  - Huntington's Disease
  - Psychosis NOS (often associated with brain injury)

  (of note, only schizophrenia, HD and Tourette's is "acceptable" in MDS 3.0)

Notes:

F 329 Evaluating Need for Antipsychotic Medication

Examines:

- Whether other causes for the symptoms (including behavioral distress that could mimic a psychiatric disorder) have been ruled out;
- Whether the signs, symptoms, or related causes are persistent or clinically significant enough (e.g., causing functional decline) to warrant the initiation or continuation of medication therapy;
- Whether non-pharmacological interventions are considered;
- Whether a particular medication is clinically indicated to manage the symptom or condition; and
- Whether the intended or actual benefit is sufficient to justify the potential risk(s) or adverse consequences associated with the selected medication, dose, and duration.

Notes:

No need to treat happy delusions!

Do the reality distortions, delusions, or hallucinations cause distress to the resident, risk of harm to self or others?

Notes:

F 329 Specific to Antipsychotics

Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated.

- After the first year, a GDR must be attempted annually, unless clinically contraindicated.

Notes:

F 329 Specific to Antipsychotics

- Diagnosis of primary psychosis avoids need for ongoing gradual dose reductions if antipsychotics can be documented as necessary for ongoing treatment of the disorder.
- Must have acceptable diagnosis and rationale.

Notes:

F 329 Unnecessary Drugs

For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if:

- The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or
- The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

Notes:

- If psychotic symptoms are related to brain injury/dementia, then gradual dose reductions may be required absent more robust documentation showing psychosis involving:
  - Distress to resident when GDR attempted
  - Danger to others when GDR attempted
  - Danger to self when GDR attempted

Notes:

F 329 Unnecessary Drugs

For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if:

- The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and
- The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.

Notes:

- Antipsychotics must not be used for chemical restraint or “purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.” (F 222).
  - Be careful to clearly document relationship of antipsychotic to appropriate **medical** symptoms
  - E.g., yelling, irritating behavior, wandering, non-adherence, aggression may not be a medical symptom, but may elicit staff requests for medication

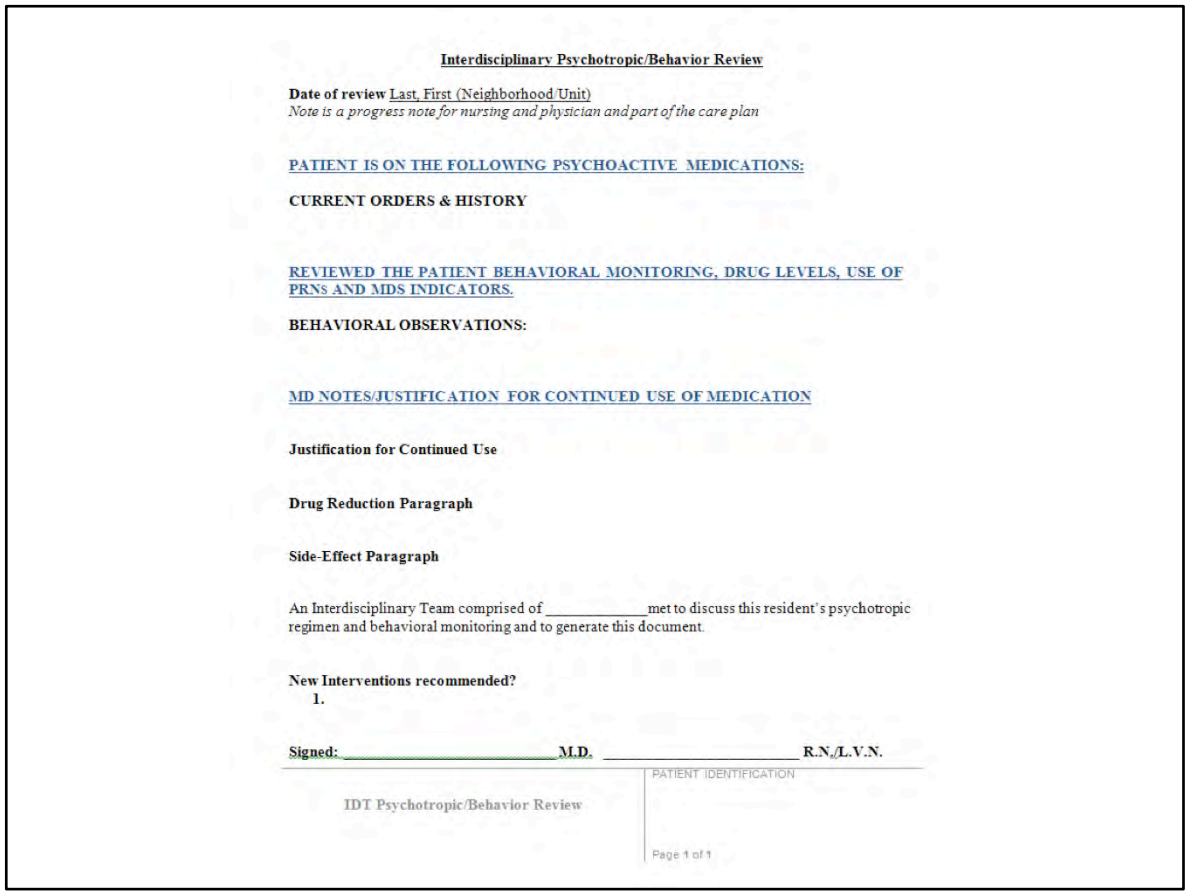
Notes:

Psychotropic Review Process: a solution

- Quarterly review by IDT including MD, RN, SW, TR, Pharmacist and, if you have one, Psychologist
- Review of risks, benefits, alternatives, potential for gradual dose reductions and side-effects

Note: This is a clinical review for all residents on psychotropics in addition to the monthly medication regimen review by the pharmacist.

Notes:



Interdisciplinary Psychotropic/Behavior Review

Date of review Last, First (Neighborhood/Unit)
Note is a progress note for nursing and physician and part of the care plan

PATIENT IS ON THE FOLLOWING PSYCHOACTIVE MEDICATIONS:

CURRENT ORDERS & HISTORY

REVIEWED THE PATIENT BEHAVIORAL MONITORING, DRUG LEVELS, USE OF PRNS AND MDS INDICATORS.

BEHAVIORAL OBSERVATIONS:

MD NOTES/JUSTIFICATION FOR CONTINUED USE OF MEDICATION

Justification for Continued Use

Drug Reduction Paragraph

Side-Effect Paragraph

An Interdisciplinary Team comprised of _____met to discuss this resident's psychotropic regimen and behavioral monitoring and to generate this document.

New Interventions recommended?
1.

Signed: _____M.D. _____ R.N./L.V.N.

IDT Psychotropic/Behavior Review

PATIENT IDENTIFICATION

Page 1 of 1

Notes:

Standard GDR Paragraph

The pharmacist reminds the team of the CMS guidelines in terms of recommended doses for geriatric patients and those with dementia, warnings against use of duplicative therapy, black box warnings and other side effects of psychoactive medications (known and unknown, short and long-term), FDA indications and mandated consideration of medication reductions in drugs in various categories. Mandated dosing requirements and drug reductions are not applicable to medications prescribed for schizophrenia, bipolar, schizoaffective and psychosis NOS, Huntington's Disease or static cognitive decline suffered from brain injurious events associated with aberrant mood or behavior. However, medication reductions are always considered both within this review and at the time of recapitulation and resident visit with the effort to achieve the lowest possible pharmacological burden (minimize unnecessary therapy and reduce ADRs) while maximizing quality of life, functional status, and pro-social behaviors.

Notes:

Side Effects Paragraph

All drugs have side effects. These are monitored by the physician and nursing staff through observation, records of lab tests, impact of drug or dose change on symptoms, examination, and self- report as well as consideration of other health conditions and their impact. However, there are currently no known side effects or adverse effects clinically significant enough to impact the decision about medication dosing. Concern about side effects (short and long term, known and unknown) is balanced against the physician assessment of the benefit of the medication on target symptoms and frequent observations by interdisciplinary staff about the quality of life of the resident and control of behavioral symptoms posing a danger to the resident or others.

Notes:

Alternative Treatments

- Medications are only partially effective.
- Structured environment, consistent staff, caring approach, relationship building, age-appropriate activities, sleep and routine

Notes:

- Medications don't work for:
  - Homelessness (hoarding, avoiding peers, refusing to be touched)
  - Dementia—apathy, abulia, wandering, perseveration, confusion
  - Personality—antisocial, whining, demanding
  - Developmental—"I don't belong with these old people. I like to stay up late and sleep all day"

Notes:

- "Developmental attunement" – Erikson's stages
  - "Typical" LTC resident likely engaged in reflection on life (Ego integrity vs. despair)
  - Younger LTC resident may be engaged in earlier stages, e.g.,
    - Identity vs. role confusion (identity development)
    - Intimacy vs. isolation (relationships)
    - Generativity vs. Stagnation (work/parenthood)
  - With brain injury, may regress to even earlier stages.

Notes:

- Issues of identity, intimacy, and generativity may lead to behaviors not seen as usual LTC concerns
  - Acting out
  - Boundary violations
  - Visitors
  - Leaving grounds
  - Substance abuse
  - Reckless behavior
  - Adjustment reactions to derailment of appropriate development and losses
- Medications not usually targeting these behaviors.

Notes:

- Key issues in dealing with younger psychiatric and brain injured patients revolve around:
  - Capacity assessment—ability to assume risks
  - Our duty to protect: risk mitigation
  - Relationship building

Notes: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SAN DIEGO
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Notes:


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Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Nursing Homes, Diagnosing the Elderly:
It's NOT Always a UTI!
Michael R. Wasserman, MD, CMD
Director, Nursing Home
Health Services Advisory Group (HSAG)
CALTCM 2016

Notes:

Disclosure

Michael R. Wasserman, MD receives honorarium for his role as a member of the Editorial Board for The Merck Manual

All conflicts of interest have been resolved in accordance with the ACCME's Standards for Commercial Support.

Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Determine appropriate diagnosis of urinary tract infection (UTI) in nursing home (NH) residents
- Identify the importance of the white blood cell count and percentage of bands in diagnosing bacterial infection in the elderly
- Define fever
- Understand that asymptomatic bacteriuria is not a UTI
- Recognize how the use of probiotics can be useful in preventing antibiotic associated diarrhea

Notes:

Diagnosing UTIs in the NH: Flipping a Coin

Notes:

Create a Baseline: Assess Your Patients

- What is their activity level?
- Are they fatigued?
- What is their temperature?
- What is their cognitive status?
- Are they having pain?
- Has anything changed?

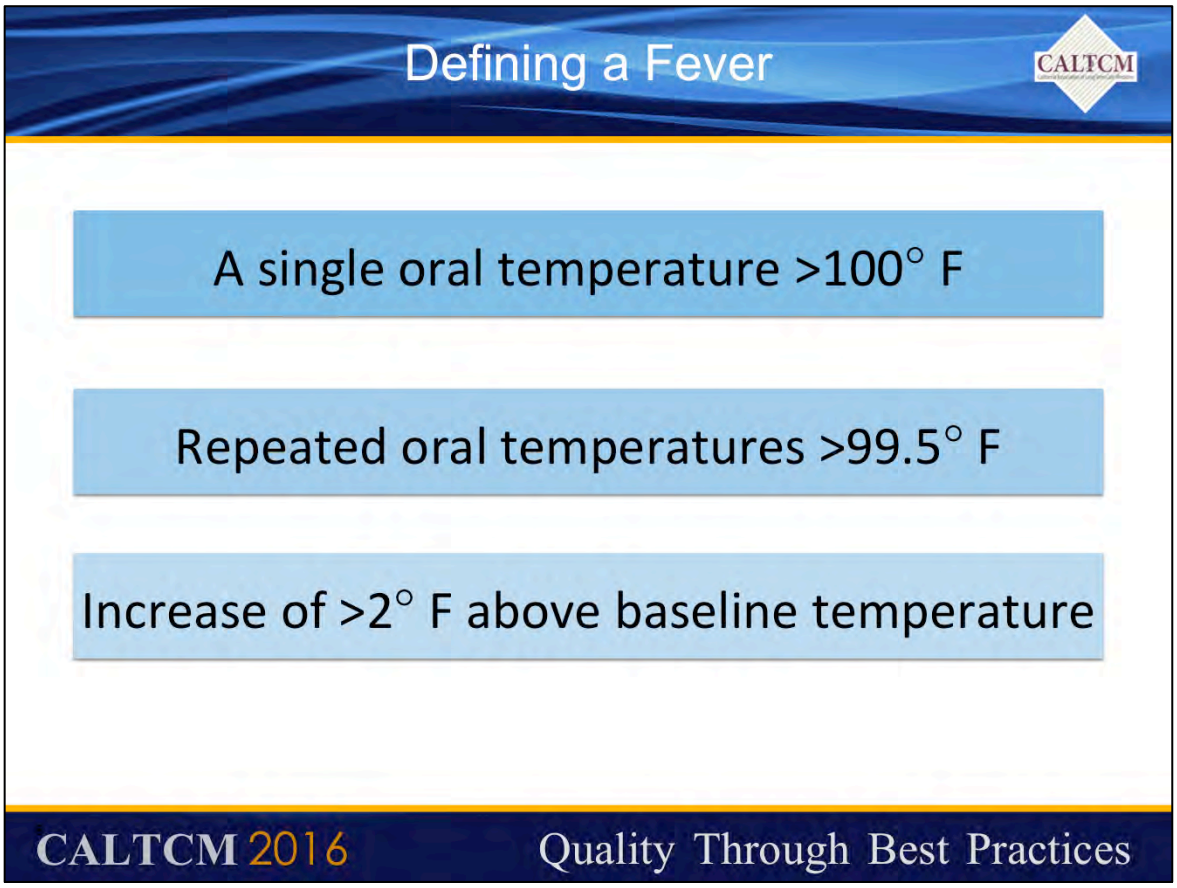
Notes:

Detecting an Infection: Change in Condition

- New or increased confusion
- Incontinence
- Falls
- Deteriorating mobility
- Reduced food intake
- Failure to cooperate with staff

Notes:

Notes:


Defining a Fever
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A single oral temperature >100° F
Repeated oral temperatures >99.5° F
Increase of >2° F above baseline temperature
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Notes:

Most Useful Diagnostic Labs to Identify Infection

- An elevated white blood count (WBC) count of >14K.
- A left shift >6 percent is indicative of a bacterial infection.
- The higher the WBC count and/or the higher the bandemia (bands), the greater the likelihood of a bacterial infection.

Wasserman M, et al. J Am Geriatr Soc. 1989, Utility of fever, white blood cells, and differential count in predicting bacterial infections in the elderly.

Notes:

Notes:

"Pyuria Among Chronically Incontinent but Otherwise Asymptomatic NH Residents"

Design: Prospective, descriptive case series

Setting: Six NHs

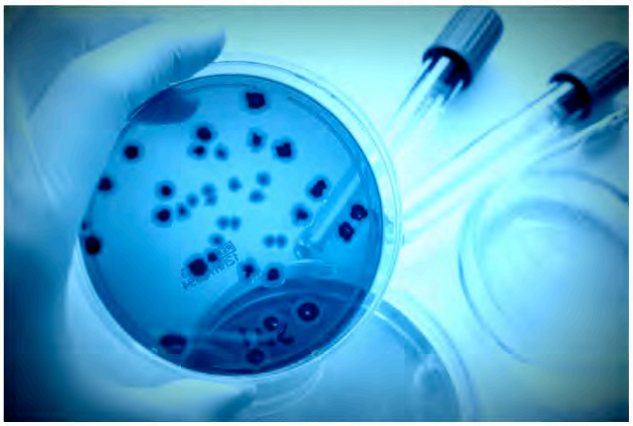
Participants: 214 chronically incontinent, but otherwise asymptomatic, NH residents who were enrolled in a clinical intervention trial for urinary incontinence

J Am Geriatr Soc. 1996 Apr; 44(4):420-3, Ouslander JG, Schapira M, Schenelle JF, Fingold S, Pyuria among chronically incontinent but otherwise asymptomatic nursing home residents, http://www.ncbi.nlm.nih.gov/pubmed/8636589 Accessed on: March 15, 2016

Notes:

Objective

To determine the prevalence of pyuria and its relationship to bacteriuria in a representative sample of chronically incontinent NH residents



J Am Geriatr Soc. 1996 Apr; 44(4):420-3, Ouslander JG, Schapira M, Schenelle JF, Fingold S, Pyuria among chronically incontinent but otherwise asymptomatic nursing home residents, http://www.ncbi.nlm.nih.gov/pubmed/8636589 Accessed on: March 15, 2016

Notes:

Measures

214 urine specimens were collected by a validated, clean-catch technique. Each specimen underwent dipstick testing for leukocyte esterase, microscopic urinalysis to determine the number of WBCs per high-power field of centrifuged urine, and quantitative urine culture using standard laboratory techniques.

J Am Geriatr Soc. 1996 Apr; 44(4):420-3, Ouslander JG, Schapira M, Schenelle JF, Fingold S, Pyuria among chronically incontinent but otherwise asymptomatic nursing home residents, http://www.ncbi.nlm.nih.gov/pubmed/8636589 Accessed on: March 15, 2016

Notes:

Results

- **Prevalence of pyuria:** 45 percent, (> 10 WBC/ high power field [HPF])
- **Prevalence of bacteriuria:** 43 percent, (>100,000 colony forming units [CFUs])
- **Bacteriuria:** 59 percent with pyuria
- **No bacteriuria:** 34 percent with pyuria
- **Pyuria:** 56 percent had bacteriuria
- **No pyuria:** 31 percent had bacteriuria
- **Leukocyte esterase positive:** sensitivity of 83 percent and a specificity of 52 percent for pyuria on microscopic urinalysis

J Am Geriatr Soc. 1996 Apr; 44(4):420-3, Ouslander JG, Schapira M, Schenelle JF, Fingold S, Pyuria among chronically incontinent but otherwise asymptomatic nursing home residents, http://www.ncbi.nlm.nih.gov/pubmed/8636589 Accessed on: March 15, 2016

Notes:

Conclusions

- Pyuria common among incontinent NH residents
- Must be cautious in interpreting pyuria
- Using pyuria can result in unnecessary use of antibiotics
- Bacteriuria has similar issues

J Am Geriatr Soc. 1996 Apr; 44(4):420-3, Ouslander JG, Schapira M, Schenelle JF, Fingold S, Pyuria among chronically incontinent but otherwise asymptomatic nursing home residents, http://www.ncbi.nlm.nih.gov/pubmed/8636589 Accessed on: March 15, 2016

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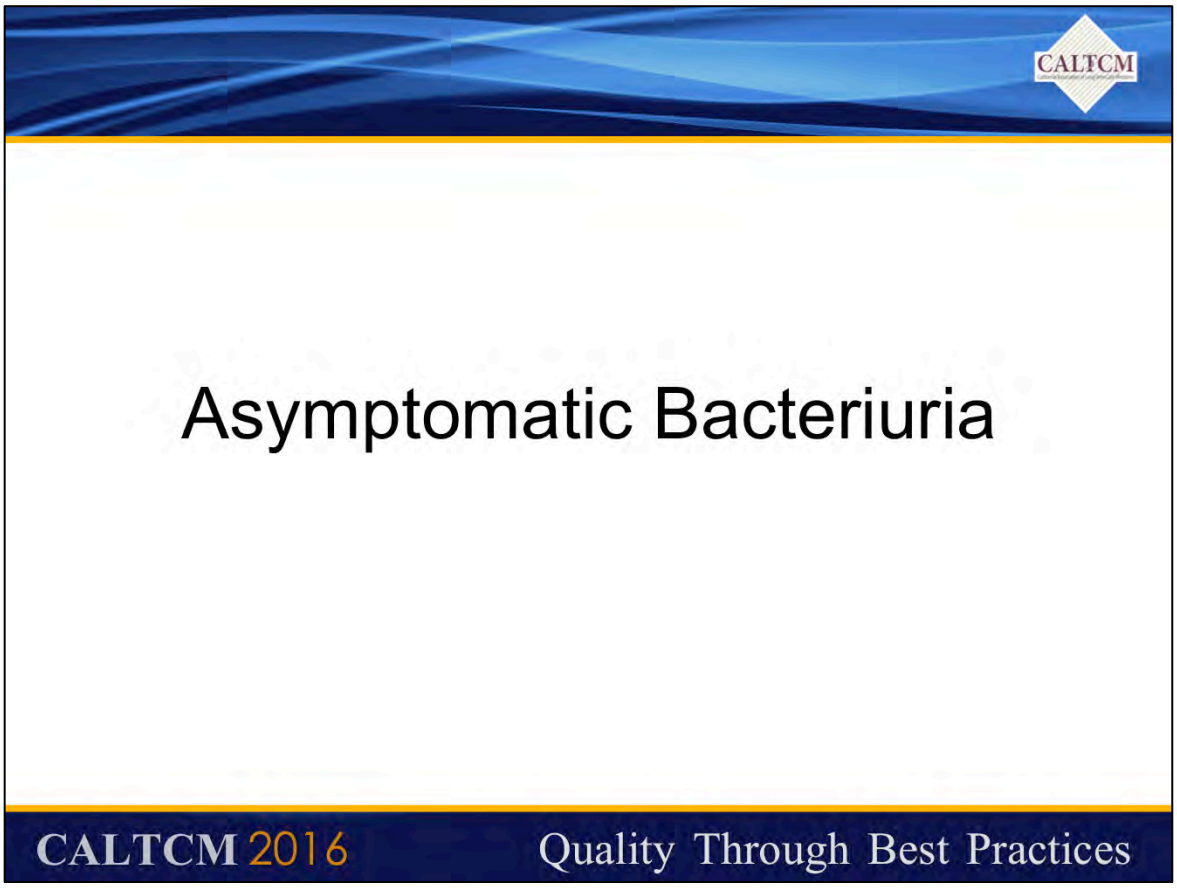
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Asymptomatic Bacteriuria
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Notes:

Definition of Asymptomatic Bacteriuria

A positive urine culture does not prove that a patient has a urinary tract infection (UTI). The term *asymptomatic bacteriuria* (ASB) is used to suggest that a patient has bacteria in the urine, but not a true infection; a true UTI is bacteriuria in association with specific symptoms arising from the urinary tract.

Timothy J. Benton, MD, Rodney B. Young, MD, and Stephanie C. Leeper, MD, FACP, Asymptomatic Bacteriuria in the Nursing Home
http://www.annalsoflongtermcare.com/article/5962 Accessed on: March 15, 2016

Notes:

Results

ASB does not always equal UTI!

Physicians must be thorough in their testing and diagnosis

The elderly, especially those residing in N Hs,
have a higher incidence of ASB than other populations

Timothy J. Benton, MD, Rodney B. Young, MD, and Stephanie C. Leeper, MD, FACP, Asymptomatic Bacteriuria in the Nursing Home
http://www.annalsoflongtermcare.com/article/5962 Accessed on: March 15, 2016

Notes:

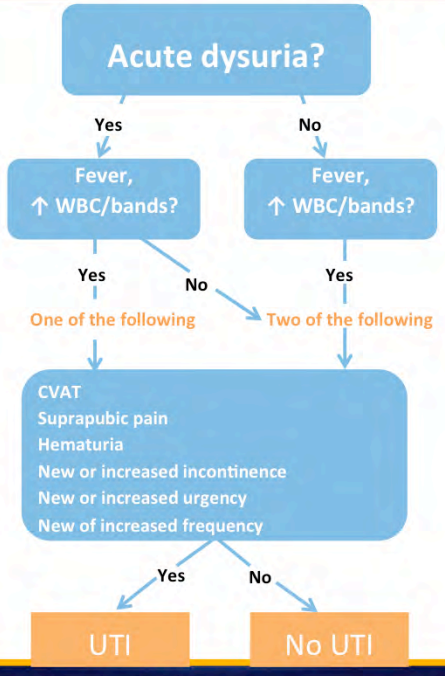
Conclusions

- If antimicrobial therapy is continued as a regular and often unnecessary course of treatment, residents will become ABX resistant.
- The prevention of ASB is unnecessary if treatment is not needed.
- Good perineal hygiene and frequent bladder emptying is important.
- Little data exists on effective prevention of UTIs in the NH setting.

Timothy J. Benton, MD, Rodney B. Young, MD, and Stephanie C. Leeper, MD, FACP, Asymptomatic Bacteriuria in the Nursing Home http://www.annalsoflongtermcare.com/article/5962 Accessed on: March 15, 2016

Notes:

Is Urine the Answer? What to Look for…



Notes:


Warning!
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Never
Assume
Anything
21
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Notes:

Other Infectious Etiologies That May Cause Fever and Elevated WBC

- Pneumonia: hypoxemia or tachypnea; abnormal chest x-ray
- Viral respiratory infection
- Skin or soft tissue infection
- Gastrointestinal infection

Notes:


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Case Example
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Notes:

Case Example: Background

- Sadie Smith, 106 year-old woman
- Resides in Shady Acres Nursing Home
- Ambulates with use of a walker, but recently started demonstrating cognitive impairment
- Incontinent of urine, wears adult diapers
- Responded well to toileting program
- Not on medications
- Suffers from macular degeneration and is hard of hearing

Notes:

Case Example: Change in Condition

- Two days ago, Sadie complained of feeling tired and achy.
- Temperature 97.5° F and blood pressure 180/60
- Urinalysis and complete blood count (CBC) were ordered.

Notes:

Case Example: Lab Results

Urinalysis
25–50 WBCs
and bacteria

CBC
WBCs: 6.5K
50% neutrophils
0% bands

Notes:

Case Example: Treatment

Scenario 1:

Over the next few days, Sadie was monitored and began feeling better.

Scenario 2:

Sadie was started on Amoxicillin 500mg POx7 days. Two weeks later, she began developing watery stools, four times daily.

Notes:

Antibiograms

An antibiogram is the result of an antibiotic sensitivity test, a laboratory test for the sensitivity of an isolated bacterial strain to different ABX. It is by definition an in vitro sensitivity, but the correlation of in vitro to in vivo sensitivity is often high enough for the test to be clinically useful.

Notes:

Antibiogram

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Antibiogram for dd/mm/yyyy to dd/mm/yyyy

Your Nursing Home Name / Clinical Lab Name

	Gram Negative				Gram Positive			
Antibiotic Tested	Escherichia coli	Klebsiella pneumoniae	Proteus mirabilis	Pseudomonas aeruginosa	Staphylococcus aureus non-MRSA ‡	Staphylococcus aureus MRSA +	Staphylococcus coag. Neg	Enterococcus sp
# of Isolates:	165	75	39	33	10*	35	18	68
Oral or Oral Equivalent					Oral or Oral Equivalent			
Ampicillin	46%	0%	62%		50%	0%	50%	96%
Amox / Clav	77%	96%	100%					
Cefazolin	70%	93%	88%		100%	0%	50%	
Cefoxitin	82%	100%	100%					
Ceftriaxone	85%	79%	92%					
Ciprofloxacin	58%	79%	62%	56%		0%	0%	47%
Levofloxacin	59%	79%	62%	57%	33%	20%	0%	64%
Nitrofurantoin	100%	0%	0%		100%	100%	100%	100%
TMP / SMX	64%	79%	54%		67%	100%	100%	
Tetracycline	64%	60%	0%		100%	100%	80%	38%
Oxacillin					100%	0%	50%	
Clindamycin					50%	50%	100%	
Erythromycin					50%	0%	0%	
Linezolid					100%	100%		100%
IV Only					IV Only			
Pip / Taz	98%	96%	100%	100%				
Cefepime	89%	95%	92%	91%				
Ceftazidime				91%				
Gentamicin	85%	83%	92%	91%	100%	100%	67%	
Imipenem	100%	100%	100%	71%				
Vancomycin					100%	100%	100%	100%

* Organisms with fewer than 30 isolates should be interpreted with caution, as small numbers may bias the group susceptibilities

† MRSA = Methicillin-resistant Staph aureus, represents a subset of all Staph aureus isolates

‡ N= pooled isolates by species from urine, wound, sputum and blood specimens

Abbreviations: PIP/TAZ = Pipercillin/Tazobactam; TMP/SMX= Trimethoprim/sulfamethoxazole ;Amox/Clav = Amoxicillin/Clavunate

Please direct questions to: insert program champion name, phone, e-mail

http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/nh-aspguide/module2/index.html
Accessed on: March 15, 2016

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Notes:

Risk of *Clostridium difficile*

- One of the largest risks for inappropriate ABX
- Significant morbidity and mortality in NHs
- Endemic pathogen in NHs
- Prevention and treatment evolving
  - Appropriate ABX treatment
  - Use of probiotics
  - Infection control precautions
  - Fecal transplantation

Notes:

Probiotics as Prevention and Treatment of *C. diff*

- Evidence is mixed
- Core common benefits
- Prevention during antibiotic treatment
  - Saccharomyces boullardii
- Treatment after antibiotics
  - Lactobacillus should be okay
- Monitor for side effects, e.g. constipation
- Benefits seem to outweigh risks

Notes:


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Conclusion
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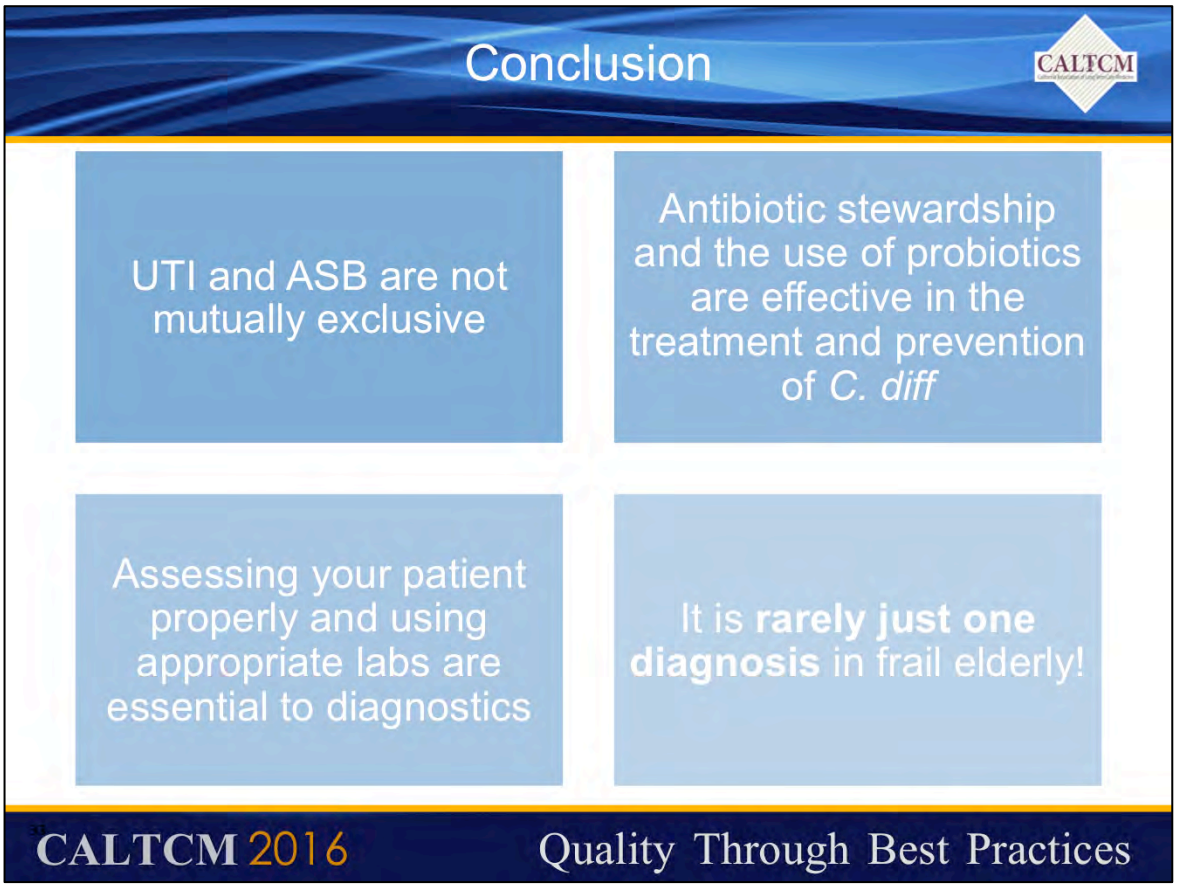
Notes:


Conclusion
CALTCM
UTI and ASB are not mutually exclusive
Antibiotic stewardship and the use of probiotics are effective in the treatment and prevention of C. diff
Assessing your patient properly and using appropriate labs are essential to diagnostics
It is rarely just one diagnosis in frail elderly!
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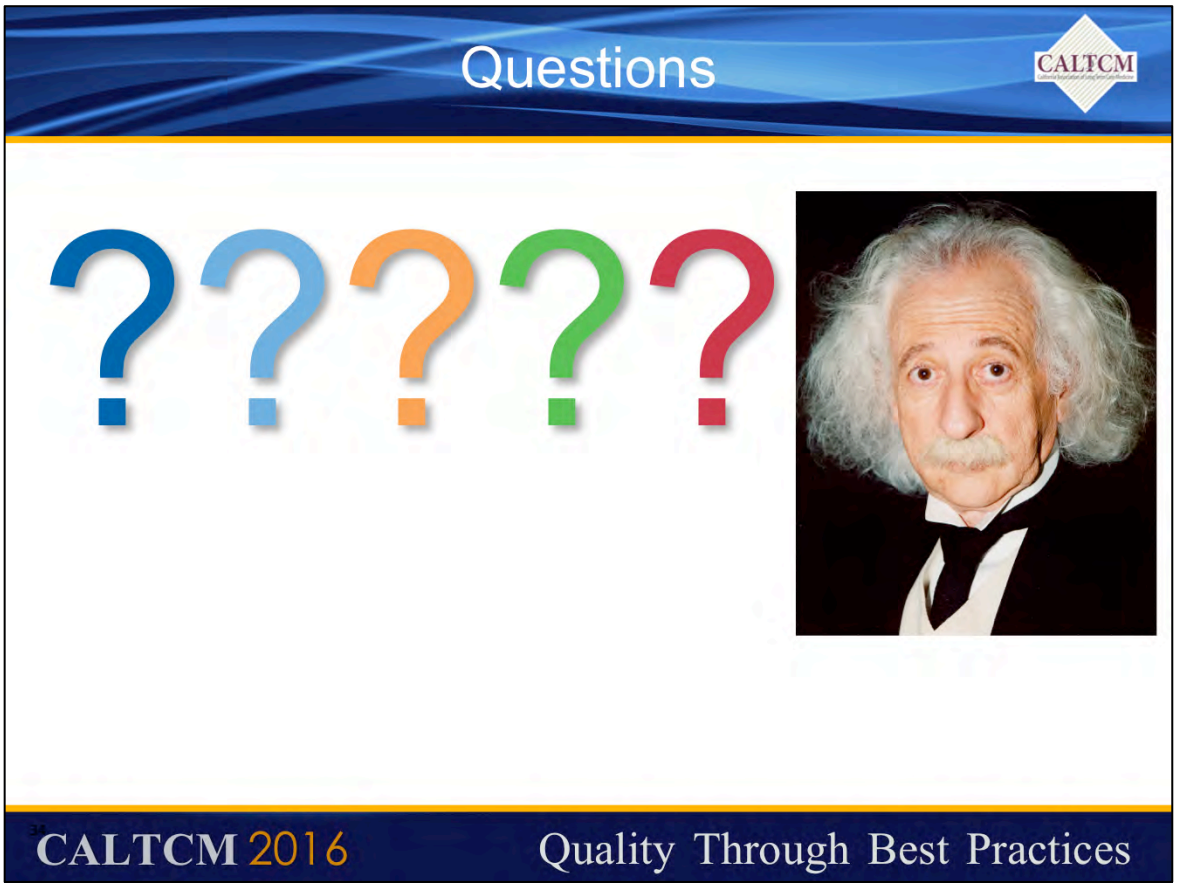
Notes:


Questions
CALTCM
CALTCM 2016
Quality Through Best Practices

Notes:

Thank you!

- Michael R. Wasserman, MD, CMD
- mwasserman@hsag.com

Notes:

CMS Disclaimer

- This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for California, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. CA-11SOW-C.2-0315206-04

Notes: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42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
De-prescribing in Long Term Care
Nancy Weintraub, MD
GLA VA GRECC
Professor of Medicine, UCLA
Director, UCLA Geriatric Medicine Fellowship
CALTCM 2016

Notes:

Disclosure Statement

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

Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Utilize Start and Stop and the new Beers criteria
- Identify approaches to identifying and reducing PIM's
- Explain the concept of de-prescribing
- Describe the process of simplifying medications and person-centered prescribing

Notes:

ABIM Foundation Choosing Wisely Program

- 5-10 recommendations of best practices from each medical specialty
- AGS provided 10
- 7 of 10 were recommendations about avoiding medications

Notes:

AGS Choosing Wisely

- Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.
- Don't use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.

Notes:

More Choosing Wisely

- Don't prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.
- Don't use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia.

Notes:

More Choosing Wisely

- Avoid using prescription appetite stimulants or high-calorie supplements for treatment of anorexia or cachexia in older adults; instead, optimize social supports, provide feeding assistance, and clarify patient goals and expectations.
- Avoid using medications to achieve hemoglobin A1c <7.5% in most adults age 65 and older; moderate control is generally better.
- Don't prescribe a medication without conducting a drug regimen review.

Notes:

Adverse Drug Events

- Result in 5-28% of acute hospitalizations in geriatric populations
- Most commonly: cardiovascular drugs, diuretics, NSAIDs, hypoglycemics, anticoagulants and medications with a narrow margin of safety

Notes:

Risk Factors for ADEs

- 6 or more concurrent chronic conditions
- 12 or more doses of drugs/day
- 9 or more medications
- Prior adverse drug event
- Low body weight or low BMI
- Age 85 or older
- Estimated CrCl < 50 mL/min

Notes:

Risk for ADE

- 13% for people taking 2 medications
- 58% for people taking 5 medications
- 82% for people taking 7 or more medications

Notes:

BEERS CRITERIA

- From AGS
- Revised 2015
- Lists Potentially Inappropriate Medications PIMs) for use in older people
- Provides explanations and suggests alternatives
- Lists Drug-drug and Drug-disease Interactions to avoid

Notes:

Steinman et al, JAGS 2015

Table 1. Key Principles to Guide Optimal Use of the American Geriatrics Society (AGS) 2015 Beers Criteria

1	Medications in the AGS 2015 Beers Criteria are potentially inappropriate, not definitely inappropriate.
2	Read the rationale and recommendations statements for each criterion. The caveats and guidance listed there are important.
3	Understand why medications are included in the AGS 2015 Beers Criteria and adjust your approach to those medications accordingly.
4	Optimal application of the AGS 2015 Beers Criteria involves identifying potentially inappropriate medications and where appropriate offering safer nonpharmacological and pharmacological therapies.
5	The AGS 2015 Beers Criteria should be a starting point for a comprehensive process of identifying and improving medication appropriateness and safety.
6	Access to medications included in the AGS 2015 Beers Criteria should not be excessively restricted by prior authorization and/or health plan coverage policies.
7	The AGS 2015 Beers Criteria are not equally applicable to all countries.

Notes:

Beers Example PIM

Therapeutic Category/Drug(s)	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation
Alpha1 blockers Doxazosin Prazosin Terazosin	High risk of orthostatic hypotension; not recommended as routine treatment for hypertension; alternative agents have superior risk–benefit profile.	Avoid use as an antihypertensive.	Moderate	Strong

Notes:

Beers Drug-Disease Interaction

DISEASE OR SYNDROME	DRUG	RATIONALE	RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
SYNCOPE	AChEIs	Increases risk of Orthostatic Hypotension or Bradycardia	AVOID	MODERATE	STRONG

Notes:

Beers PIM Use with Caution

Drug(s)	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation
Aspirin for primary prevention of cardiac events	Lack of evidence of benefit versus risk in adults aged ≥80	Use with caution in adults aged ≥80	Low	Strong

Notes:

Other Beers Tables

- Drug-Drug Interactions
- Drugs requiring dose adjustment in renal insufficiency
- Drugs with strong anticholinergic properties

Notes:

How to Use Beers Criteria

- Warning light
- Assess for potentially subtle adverse effects
- Do not automatically defer to consultants
- Taper drugs slowly if withdrawal is a concern
- Use your healthcare team:
  - Pharmacy
  - Nursing

Notes:

STOPP Criteria

- Similar to Beers but less detailed
- Developed in Europe
- Shorter list
- Organized primarily by organ system
- List of 5 drug categories to avoid in patients who fall
- 3 general recommendations about opiate use
- 1 recommendation to avoid duplicate drugs in the same class

Notes:

Use of drugs from Beers and STOPP correlate with increased ER visits and hospital admissions in older people

Notes:

Adverse Drug Events in Nursing Homes

- For each $1.00 spend on medications, $1.33 is spent as a consequence of adverse drug events

Notes:

OBRA Requirements

- Monthly medication review by pharmacist
- Periodic medication review by physician
- No unnecessary drugs:
  - Too much
  - Too long
  - No monitoring
  - No indication
  - In spite of adverse events due to the drug

Notes:

More OBRA

Psychoactive drugs must have trials of dose reductions, unless there are documented contraindications

Notes:

Case

- 92 year old man admitted after a fall
  - Baseline cognition: some memory deficit
  - Baseline gait: unsteady, uses walker
- Pertinent PE:
  - Sleepy but arousable
  - Confused about events leading to admission
  - Unable to stand independently
  - Having involuntary muscle jerks

Notes:

Case continued

- Pertinent labs:
  - CBC at baseline
  - Renal insufficiency, at baseline
  - Head CT w/o bleeding or new lesions

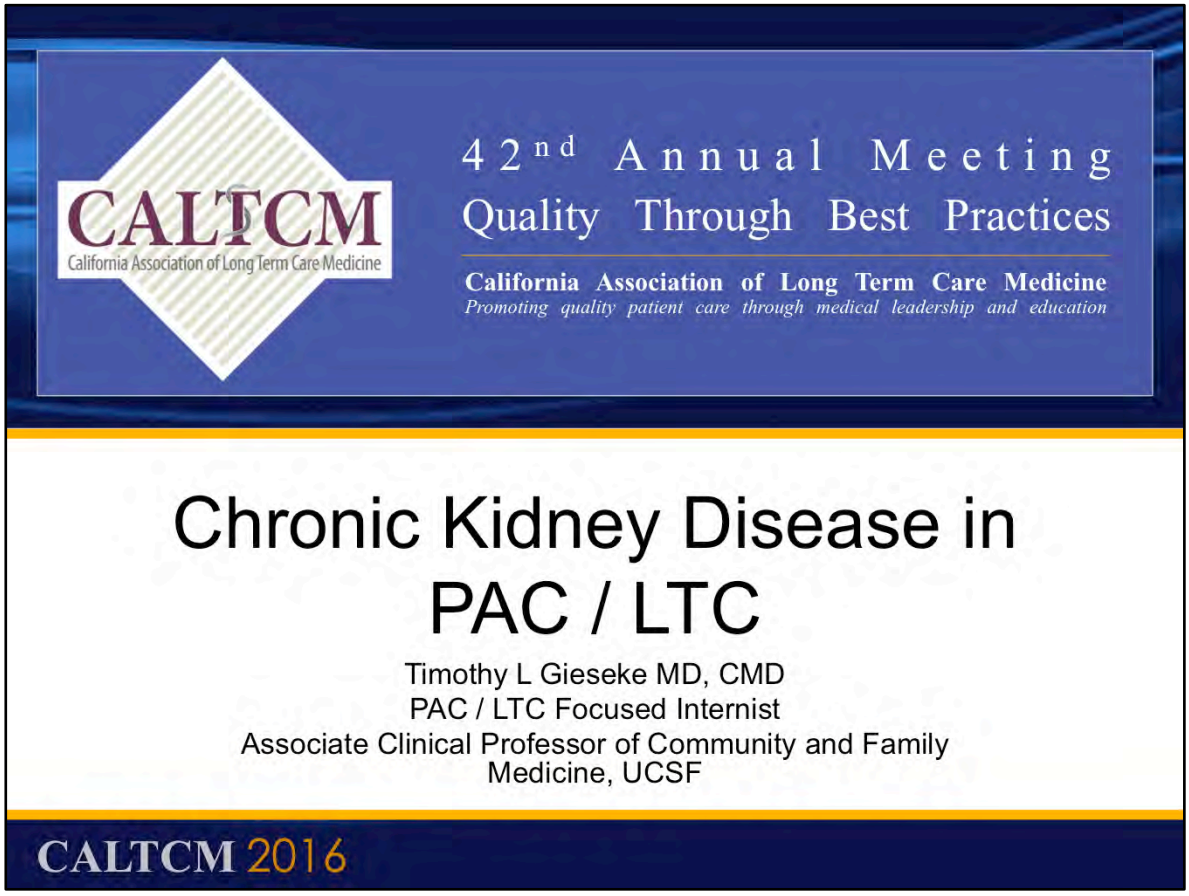
Notes:

Case continued

- Meds:
  - Amlodopine 10 qd
  - ASA 81 qd
  - Citalopram 20 qd
  - Long acting morphine 30 mg q 8h
  - Tramadol 50 mg q 6h prn
  - Trazodone 25 HS

Notes:

Notes:


CALTCM
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Chronic Kidney Disease in PAC / LTC
Timothy L Gieseke MD, CMD
PAC / LTC Focused Internist
Associate Clinical Professor of Community and Family Medicine, UCSF
CALTCM 2016

Notes:

Speaker Disclosures

- I have no relevant financial relationships
- Please remember to write down questions for our later panel discussion time.

Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Recognize the hallmarks of CKD in LTC
- Implement the appropriate management approach that may reduce the rate of progression of CKD
- Implement appropriate management to reduce the burdens of care while improving QOL
- Utilize advance care planning to reduce iatrogenic complications and help patients and families to individualize care

Notes:

New Admission to your Facility

- 74 y/o black male hospitalized with pneumococcal pneumonia with septic shock who had complicating AKI, delirium, malnutrition, and unstageable sacral decubitus. He has co-morbid: HBP, Rt. Lacunar CVA (mild Lt. apraxia), Type 2 IDDM, Stage 3b CKD (eGFR 38), chronic LBP, and chronic anemia. He needs assistance with transfers, ambulation, toileting and dressing. He becomes restless and confused in the evenings.

Notes:

New Admission to You and Your Facility

- Knowing that he has CKD and the above problems, what would be prudent to do or avoid:
  A. Change the diet order from CCD, NAS, to a Renal Failure CCD diet.
  B. Adjust dose of Metformin and Antibiotics on basis of Crockcroff–Gault Formula
  C. Avoid discussing advance illness management since that would likely be too upsetting to a patient this sick
  D. Tight glycemic control plan to minimize further infection risk

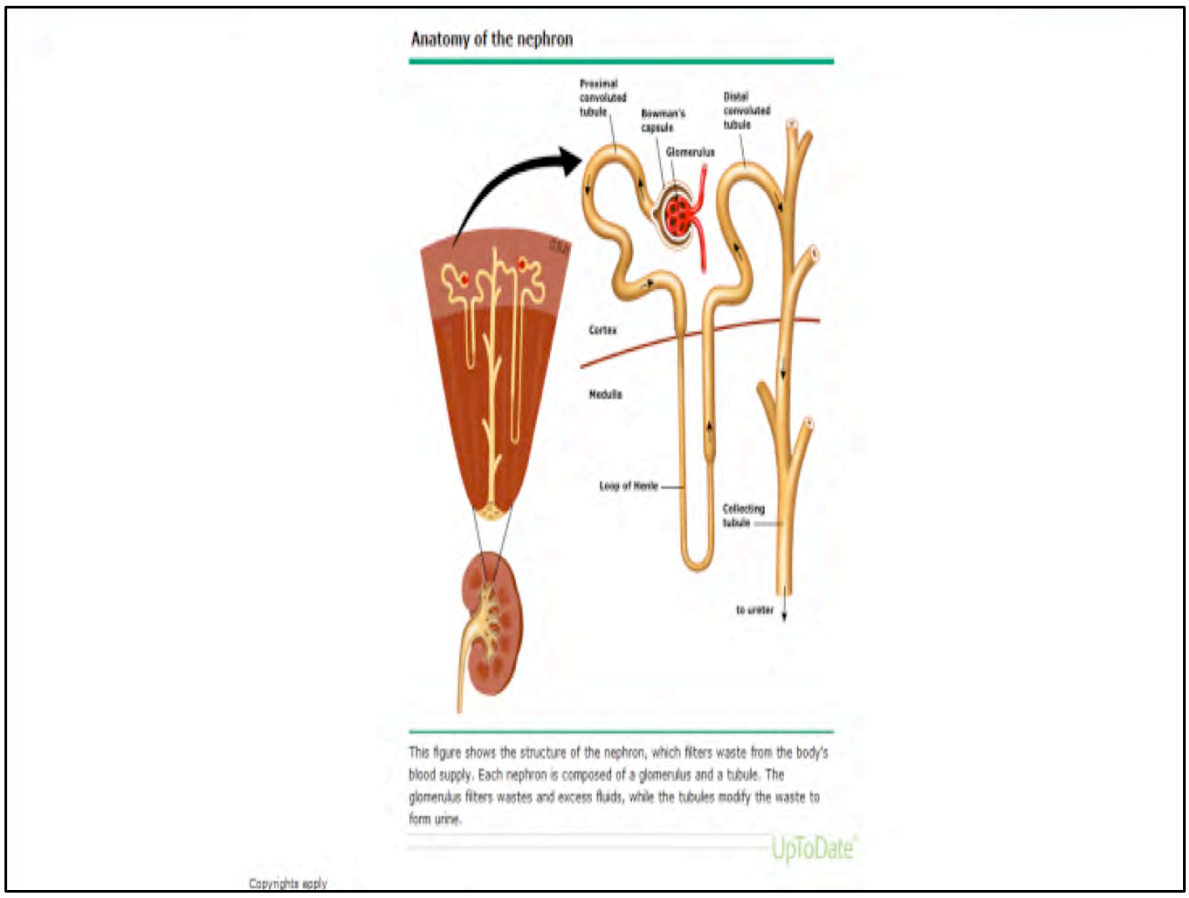
Notes:

New Admission to You and Your Facility

- Knowing that he has CKD and the above problems, what would be prudent to do or avoid:

  B. Adjust dose of Metformin and Antibiotics on basis of Crockcroff–Gault Formula

Notes:


Anatomy of the nephron
Proximal convoluted tubule
Bowman's capsule
Glomerulus
Distal convoluted tubule
Cortex
Medulla
Loop of Henle
Collecting tubule
to ureter
This figure shows the structure of the nephron, which filters waste from the body's blood supply. Each nephron is composed of a glomerulus and a tubule. The glomerulus filters wastes and excess fluids, while the tubules modify the waste to form urine.
UpToDate
Copyrights apply

Notes:

Major functions of nephron segments

Nephron segment	Major functions
Glomerulus	Forms an ultrafiltrate of plasma
Proximal tubule	Reabsorbs isosmotically 60 to 65 percent of the filtered NaCl and H2O
	Reabsorbs 90 percent of the filtered HCO3-
	Major site of ammonia production in the nephron
	Reabsorbs almost all of filtered glucose and amino acids
	Reabsorbs K+, phosphate, calcium, magnesium, urea, and uric acid
	Secretes organic anions (such as urate) and cations (such as creatine); this pathway is also used for excretion of protein-bound drugs and toxins
Loop of Henle	Reabsorbs 25 to 35 percent of filtered NaCl
	Countercurrent multiplier as NaCl reabsorbed in excess of water
	Major site of active regulation of magnesium excretion
Distal tubule	Reabsorbs about 5 percent of filtered NaCl but almost no water
	Major site, with connecting segment, of active regulation of calcium excretion
Connecting segment and cortical collecting tubule	Principal cells reabsorb Na+ and Cl- and secrete K+ under the influence of aldosterone
	Intercalated cells secrete H+, reabsorb K+, and, in metabolic alkalosis, secrete HCO3-
	Reabsorb water in the presence of antidiuretic hormone
Medullary collecting tubule	Site of final modification of the urine
	Reabsorb NaCl, the concentration of which can be reduced to less than 1 meq/L
	Reabsorb water and urea relative to the amount of antidiuretic hormone present, allowing a concentrated or dilute urine to be excreted
	Secrete H+ and NH3; urine pH can be reduced to as low as 4.5 to 5.0
	Can contribute to potassium balance by reabsorption or secretion of K+

Contribution of the different nephron segments to solute and water homeostasis.

Notes:

Assessing Kidney Function

- Creatinine works well in healthy younger patients and is proportional to muscle mass which varies by sex (men > women) and race (Blacks > Caucasians > Asians).
- Creatinine is less reliable with aging due to normal loss of muscle mass, adaptive hyper-filtration by remaining nephrons, and increasing creatinine secretion by the proximal tubules.
- Creatinine Clearance is more reliable, but has accuracy limits depending on how its calculated. App for IPad / IPhone from NKI: **eGFR Calculator**
  - Cockcroft-Gault Formula – the basis for dosing recommendations for most meds, but overestimates CrCl in advanced stages CKD
  - MDRD Study Equation – more accurate in advanced disease, but less studied in > 70 y/o.
  - CKD-EPI Creatinine Equation – more accurate in early stages CKD

Notes:

Normal Aging

- Start out life with 700,000 -1.8 million nephrons
- CrCL declines .8 ml/yr over the age of 40
- Adaptive Hyper-filtration / Focal Segmental Glomerulosclerosis /Cortical Atrophy / Reduced long tubule nephrons / Reduced sensitivity to Arginine Vasopressin /Reduced medullary osmotic gradients
- **Physiologic Consequences**
  - More susceptible to AKI (acute kidney injury) if hypotensive
  - Reduced capacity for Conserving/Excreting Na+, K+, H+, water, wastes, and drugs

Notes:

Physiologic Consequences

- Reduced filtration of wastes / drugs – (normally 70-80 liters blood filtered/day)
- Dehydration and Volume Depletion (reduced Na+ conservation) occurs early in changes of condition.
- Hypernatremia (reduced H20 conservation)
- Nocturia & polyuria (less Na+ excreted during day & more H20 excreted at night d/t less ADH sensitivity)
- Heart Failure more challenging (less excretion of Na+)
- Metabolic acidosis (reduced acid and ammonium secretion) may accelerate CKD

Notes:

CKD is More than a decline in Creatinine Clearance

- Ongoing injury to the kidney
- Reflected by excessive Albumin secretion > 3 months
- Staged by CrCl and degree of protein excretion.
  - > protein excretion > greater risk CKD progression.
- Ethnic groups > susceptible to CKD & > risk progression to ESRD
  - Black men and women > 2x more susceptible than Caucasians

Notes:

Revised chronic kidney disease classification based upon upon glomerular filtration rate and albuminuria

GFR stages	GFR (mL/min/1.73 m^2)	Terms
G1	>90	Normal or high
G2	60 to 89	Mildly decreased
G3a	45 to 59	Mildly to moderately decreased
G3b	30 to 44	Moderately to severely decreased
G4	15 to 29	Severely decreased
G5	<15	Kidney failure (add D if treated by dialysis)
Albuminuria stages	**AER (mg/day)**	**Terms**
A1	<30	Normal to mildly increased (may be subdivided for risk prediction)
A2	30 to 300	Moderately increased
A3	>300	Severely increased (may be subdivided into nephrotic and non-nephrotic for differential diagnosis, management, and risk prediction)

The cause of CKD is also included in the KDIGO revised classification but is not included in this table.

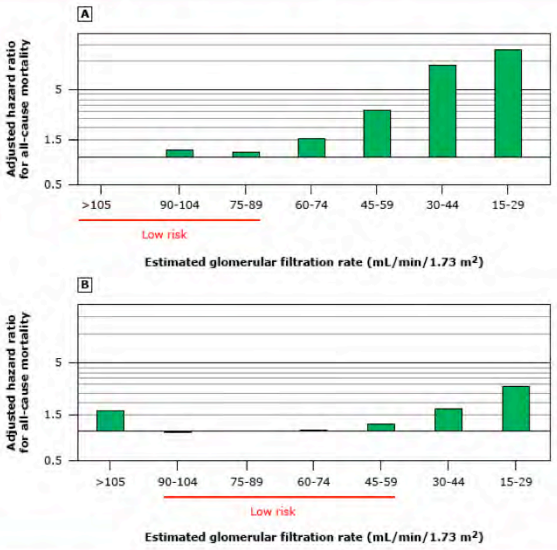
GFR: glomerular filtration rate; AER: albumin excretion rate; CKD: chronic kidney disease; KDIGO: Kidney Disease Improving Global Outcomes.

Data from:

1. *KDIGO. Summary of recommendation statements. Kidney Int 2013; 3 (Suppl):5.*
2. *National Kidney Foundation. K/DOQI clinical practice guidelines for chronic kidney disease: evaluation, classification, and stratification. Am J Kidney Dis 2002; 39 (Suppl 1):S1.*

Notes:

Adjusted hazard ratio for all-cause mortality



(A) Association of estimated GFR with all-cause mortality among individuals aged 18 to 54 years (reference group: >105 mL/min/1.73 m^2).
(B) Association of estimated GFR with all-cause mortality among individuals 75 years and older (reference group: 75 to 89 mL/min/1.73 m^2).
Adjusted hazard ratios for all-cause mortality in individuals without albuminuria based on pooled estimates from 33 general population cohorts. Low risk is a serum creatinine-based estimated GFR of >75 mL/min/1.73 m^2 in younger adults (18 to 54 years, top panel) and an estimated GFR of 45 to 104 mL/min/1.73 m^2 in older adults (>75 years, bottom panel).

Data from: Hallan SI, Matsushita K, Sang Y, et al. Age and association of kidney measures with mortality and end-stage renal disease. JAMA 2012; 308:2349.

Notes:

CKD is Expensive
(Data from 2009)

- ~ Annual cost per ESRD = $88,000/yr
- Medicare spent $29 Billion for ESRD or ~6% of Medicare budget
- Managing costs will be an issue for ACOs.
- Annual cost increases as CKD progresses.
  - Stage 2 = $1,700
  - Stage 3 = $3,500
  - Stage 4 = $12,700

Notes:

Managed Care by Health Care Partners in Massachusetts – NEJM January 2016

- A large highly integrated care system like KP
- High risk care management directed towards the costliest 1%.
  - 20% of spending for Post-Acute Care
  - High cost patients had co-occurring chronic conditions (average of 5 – CKD common)
  - 25% had serious mental disorders
- Optimal CKD management may reduce costs.

Notes:

Selected Utilization and Health Status Information for the Costliest 1% of Patients Whose Care Is Managed by Partners HealthCare, According to Payer Type.

Selected Utilization and Health Status Information for the Costliest 1% of Patients Whose Care Is Managed by Partners HealthCare, According to Payer Type.*

Variable	Medicare	Medicaid	Commercial
Average annual spending for high-cost patients ($)	146,584	85,347	101,359
Proportion of overall spending accounted for by high-cost patients (%)	14	17	22
Average no. of co-occurring chronic conditions in high-cost patients	8.1	5.1	4.4
Most prevalent chronic conditions (% of high-cost patients)	Hypertension (88) Chronic kidney disease (67) Ischemic heart disease (64) Congestive heart failure (61) Hyperlipidemia (60)	Depression (24) Anxiety (23) Hypertension (20) Bipolar disorder (15) Asthma or COPD (14)	Hypertension (55) Hyperlipidemia (43) Depression (25) Arthritis (25) Chronic kidney disease (25)

* Populations represent the costliest 1% of patients in each payer category, according to 2014 health care spending. Spending for Medicare and Medicaid patients represent total medical expenses. Spending for commercially insured patients was cost standardized across payers. Chronic conditions were identified using the Center for Medicare and Medicaid Services chronic condition grouper. Data are from an internal analysis of 2014 claims data from Partners HealthCare. COPD denotes chronic obstructive pulmonary disease.

Powers BW, Chaguturu SK. N Engl J Med 2016;374:203-205.

The NEW ENGLAND JOURNAL of MEDICINE

Notes:

Epidemiology in USA

- 20 million Adults have CKD
- Most never progress to ESRD (<2% risk)
- Over 40 y/o, risk increases 10%/decade
- Risk of CKD: Blacks (males > females) > Hispanics > Native Americans > Caucasians

Notes:

Common Causes of CKD

- **Diabetes** is the leading cause of ESRD
  - ~45% of new cases in > 75 y/o are DM related.
- **HBP** increases with age and with onset of CKD.
  - second leading cause of ESRD
- Metabolic Syndrome
- Healthy **Obesity** Associated with CKD Development
  - Annals IM February 9, 2016
- Shock in elderly may result in CKD and ESRD
- Daily **NSAIDS** > risk CKD & ESRD
- Cigarettes > risk CKD

Notes:

Stage 3b CKD - Potential Complications

- **Anemia** d/t
  - low grade GI Bleed (platelet dysfunction)
  - iron deficiency a role in ~ 50% of anemias.
  - Erythropoetin deficiency possible.
- **HBP** may worsen (Na+ retention)
- **CHF** may worsen
- Metabolic non-anion gap acidosis
  - **HCO3** < 20 (may accelerate progression CKD)

Notes:

Potential Complications

- **Hyperphosphatemia**
  - d/t failure to excrete it
  - CaP04 deposition may accelerate ASVDz
- **Secondary Hyperparathyroidism**
  - compensates for hyperphosphatemia
  - renal osteodystrophy
- Functional **Vitamin D** deficiency
  - Failure to convert 25 hydroxy vit. D to active form (25 Hydroxy Vit D = Calcitriol)

Notes:

Potential Complications

- **Malnutrition** (Palatable issues)
  - Restricted diet w/ protein .8 mg/kg + restricted K+ and Na+ & Phosphate binders with meals.
  - Restricted fluids
- **Depression** is common
  - responds to Sertraline or Citalopram
- **Fatigue/Reduced strength**
  - significant fall risk

Notes:

Potential Complications

- **CAD** events & **Strokes**
  - Common cause of morbidity & mortality
- **Infection**
  - Influenza, Pneumonia, UTIs, Cellulitis
    - > risk Sepsis
    - Sicker & slower recovery
  - If Stage 5D, AV Fistula and line sepsis
  - C. Diff
    - common, severe, prolonged, and recurrent
  - Immunizations:
    - Influenza, Pneumovac, **Prevnar 13**, Shingles, Tdap, Hep B (Stage4)

Notes:

Medication Issues: (stage 3b or worse)

- **CrCl calculated** if lab eGFR< 45
  - use NKI calculator app
- **Metformin**
  - Reduce dose in 3b to 500 mg bid
  - Closely monitor renal function
  - Avoid if CrCl < 30 (fatal lactic acidosis)
- **NSAIDS**
  - Use briefly if at all
  - Risk: AKI, Hyperkalemia, CHF, & UGI bleed
- **Bactrim DS**
  - Risk: Reduced renal function & serious hyperkalemia
  - > risk in diabetics

Notes:

Medication Issues

- **Insulin**
  - Lower dosage since less insulin is catabolized by failing kidneys
  - > risk of serious hypoglycemia
    - Avoid sliding scale insulin at bedtime
  - In ACCORD trial of tight glycemic control, > mortality mainly in those with CKD.
- **When CrCl < 30**:
  - Many **drugs to avoid**: egs.
    - Bisphosphonates for osteoporosis
    - DOAC's (Dabigatrin, Rivaroxaban) & Lovenox
  - **Reduce dose** most meds

Notes:

Managing CKD Risks

- When changes of condition develop, prompt assessment with aggressive fluid replacement and antibiotics when indicated.
- Monitor renal function closely, particularly during COCs and medication changes
- Closely monitor diabetics on hypoglycemic agents
- Alert Consulting pharmacist when Stage 3b or 4, to request med review

Notes:

Managing CKD Risks:

Check:

Phosphate, PTH, Mg+, Ferritin, and % iron Saturation (goal > 20%) when stage 4 and consider when stage 3B

Dieticians

Develop palatable diet that's ethnically appropriate, effective, & sustainable

Infections:

- Expect C. Diff to reoccur.
- Immunizations: Review and update

Notes:

Managing Risk:

- **Control HBP**
  - < 130/80 (may take 3-4 diff meds to achieve goal)
  - Use **ACE or ARBs**
    - If proteinuria (Albumen > 30 mg/day).
    - Creatinine rise ~.9 initially due to reduced glomerular pressures
- **Hyperlipidemias**:
  - High dose **Statin Drugs** for high CAD risk
  - Lower dose in ESRD, where outcomes not proven
- **Cigarette cessation** reduces progression of CKD
- **Phosphate binders**
  - Initiate when Phos > 5.5.
  - May reduce rate of CVDz progression.

Notes:

Managing Risk:

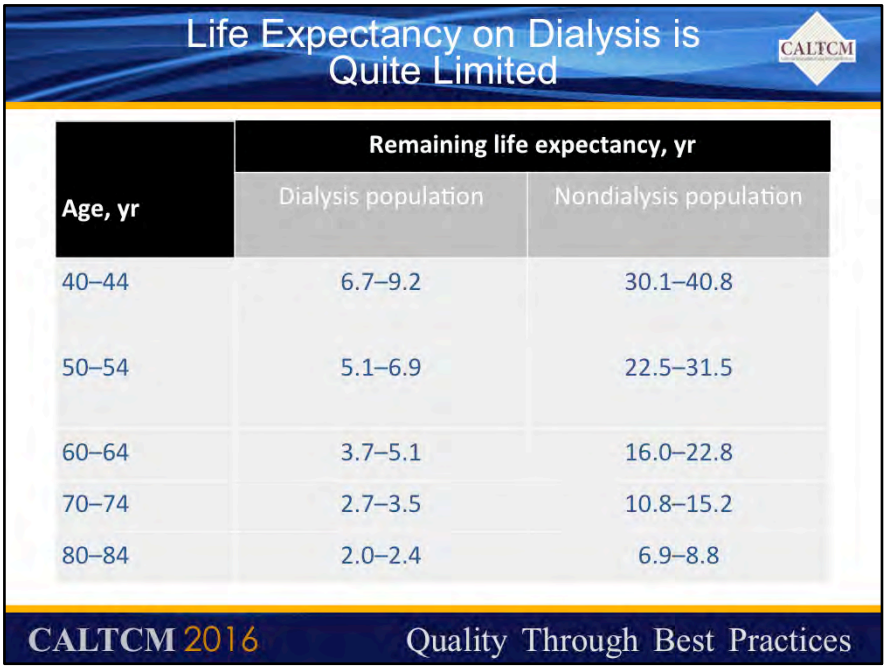
- **Bicarbonate** p.o. if non-anion gap acidosis
- **Anemia**
  - **Replace Iron first** to keep % Transferrin saturation > 20 prior to starting Erythropoetin
- **Depression**
  - Common, impairs QOL, function, and adherence to care plans
  - Good response to treatment
- **Bladder scanners**
  - Helpful for identifying reduced function d/t obstruction
- **Nephrologist** consultation when Stage 4 or 5:
  - Co-manage the many potential complications
  - Drug dosing and safety (NSAIDS, IV contrast agents, Gentamycin, Vancomycin, etc.)
  - Patient education
  - Advance Care Planning (ACP)

Notes:

Renal Replacement Therapy

- Generally offered when **CrCl < 10** or earlier if uremic symptoms
- > 55% of ESRD patients are > 60 y/o
- Renal transplant list
  - ~ 5 years with age discrimination likely
  - Much better QOL & Life Expectancy than PD or Hemodialysis patients
- Peritoneal Dialysis
  - More physiologic and better QOL
  - Risk of peritonitis – much education, training, and support needed
- Hemodialysis
  - Life revolves around dialysis
  - AV fistulas and Mechanical access devices are challenging
  - Sepsis is a common complication

Notes:


Life Expectancy on Dialysis is Quite Limited
CALTCM
Age, yr
Remaining life expectancy, yr
Dialysis population
Nondialysis population
40–44
6.7–9.2
30.1–40.8
50–54
5.1–6.9
22.5–31.5
60–64
3.7–5.1
16.0–22.8
70–74
2.7–3.5
10.8–15.2
80–84
2.0–2.4
6.9–8.8
CALTCM 2016
Quality Through Best Practices

Notes:

Advance Care Planning Needed

- Given poor prognosis and challenging QOL on dialysis, frank ACP discussions are important.
- **Coordinating ACP** with Patient, Family, Nephrologist and Dialysis center.
  - Is **DNAR** an option on the outpatient dialysis units in your community?
- **Palliative care consultations** are becoming common in the acute hospital settings.
  - How well are those conversations documented and conveyed?
  - Most common reason for cessation of dialysis (in > 65 y/o) is poor QOL.
  - **ACP** discussions ideally should occur **prior to decisions for** renal replacement therapy.
    - This a long term commitment that may be burdensome w/ greatly reduced life expectancy & at times may become low value care
- **ACP** is now **billable** for physicians and NPs/PAs. Requires at least 16 min FTF for 99497.

Notes:

Remember

- Kidney function is seldom normal in seniors. They warrant careful and early monitoring of volume and electrolyte status when sick or changing meds.
- CKD is a common, burdensome, and expensive.
- Facilities can expect to see more patients with CKD in the future, since these are the patients who become functionally impaired for prolonged times when acutely ill.
- Using a team QAPI approach, facilities can identify opportunities to better serve this high risk population and meet partnership goals for improved patient outcomes.

Notes: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42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Be OPTIMISTIC!
Initiative to Reduce Avoidable Hospitalizations of Long Stay Nursing Home Residents
Kathleen Unroe MD, MHA
CALTCM 2016

Notes:

Disclosure

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

Notes:

Objectives

At the conclusion of this activity, attendees should have the ability to:

- Describe a CMS Innovations Center multi-site demonstration project
- Identify evidence-based components of the OPTIMISTIC model
- Discuss implementation strategies for initiating and sustaining a multi-year quality improvement program in a nursing facility network
- Describe the Phase 2 financial payment demonstration to incentivize nursing facilities and providers to provide acute care in place

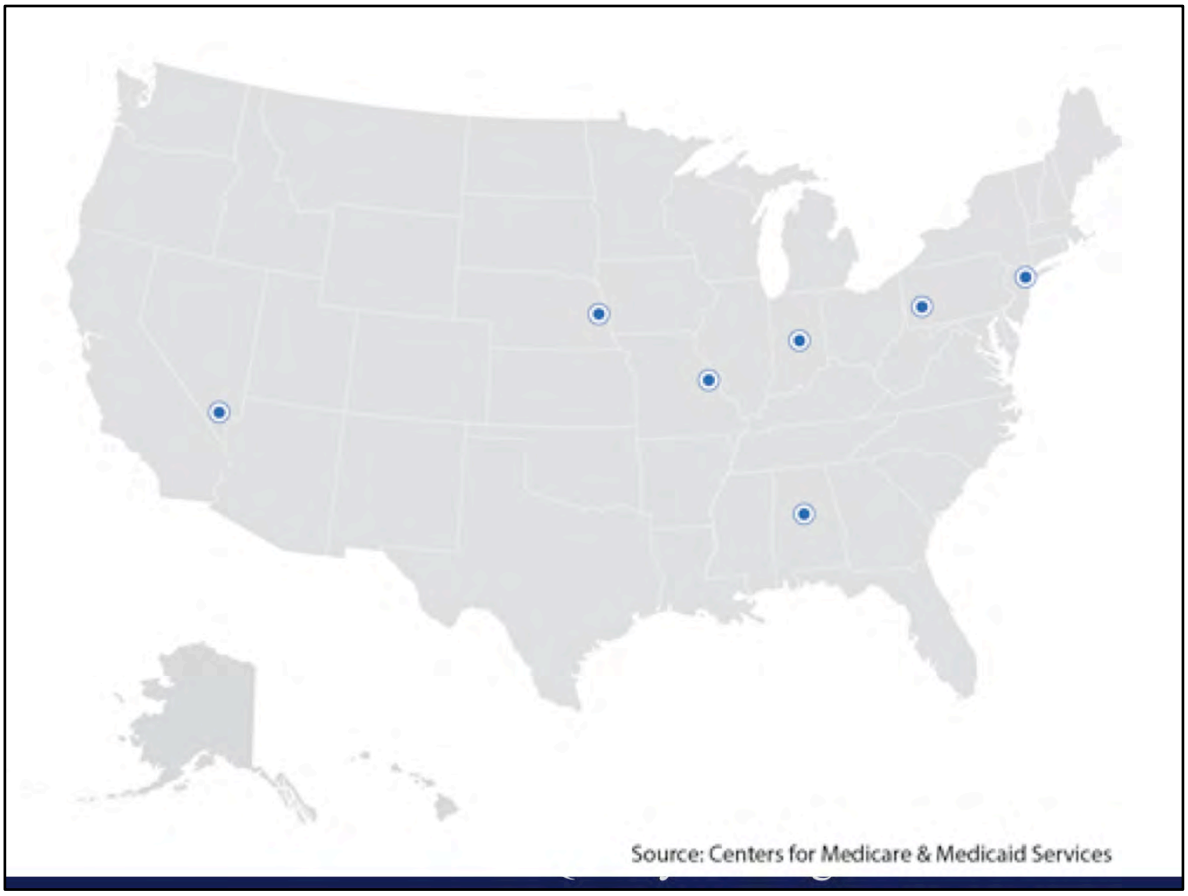
Notes:

Centers for Medicare and Medicaid Innovations Center Demonstration

Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

- 4 year initiative (2012-2016)
- 15 partner facilities required, with average census >100 residents
- Focus on long stay, dual eligible residents
- Approximately $100 million for 7 sites

Notes:



Notes:

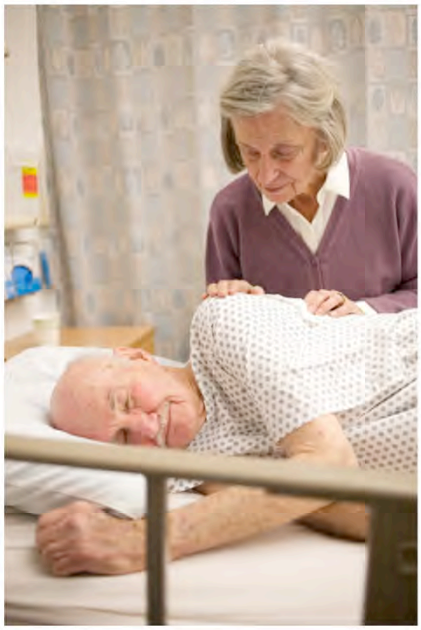
Why Focus on Hospitalizations

- In 2005, $2.6 billion spent by Medicare and Medicaid on *potentially avoidable* nursing home hospitalizations – about 40% of hospital transfers considered avoidable
- Research demonstrates that 30-67% of all hospitalizations of nursing home residents are "potentially avoidable"

Notes:

Transfers are Burdensome and Costly

- Impact on residents and their families
  - Disruption of care
  - Risk of complications and infections
  - Likelihood of reduced functioning on return
- Burden on nursing facility staff to ensure safe transitions out of and back into facility



Notes:

But what does "avoidability" mean?

- "based on **preventability**, identifying ambulatory and primary care-sensitive conditions where emergency admissions can be prevented through **intervention in primary care**."
- "admissions that follow acute flare-ups of clinical conditions that could have been avoided if appropriate preventive care in the nursing home had been provided, including admissions for conditions that can be safely and effectively managed in the nursing home"

Walsh EG, et al. J Am Geriatr Soc. 2012;60:821–829
O'Cathain A et al. 2013;126(4): 110-118

Notes:

Case

- Mrs. P, an 84 yo long stay nursing home resident, is found to be in respiratory distress when the CNA comes into her room to help her to bed.
- The nurse assesses her - her RR is 30, O2 sats are 82%, pulse 110, BP 86/50.
- She calls the physician covering that evening who agrees with the plan to transfer to the ER.

Notes:

Case

- The following day, the Director of Nursing asks the care nurse who sent the patient out – “could this transfer have been avoided?”
- She answers – obviously not! The patient was unstable!

Notes:

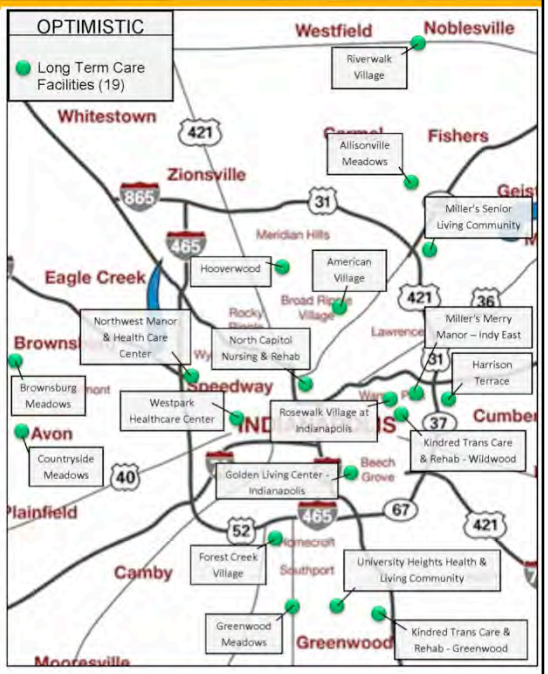
Kathleen Unroe
kunroe@iupui.edu

OPTIMISTIC

Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms:

Transforming Institutional Care

- 19 facilities in central Indiana
- About 2000 long stay residents at any point in time
- $13.4 million over 4 years



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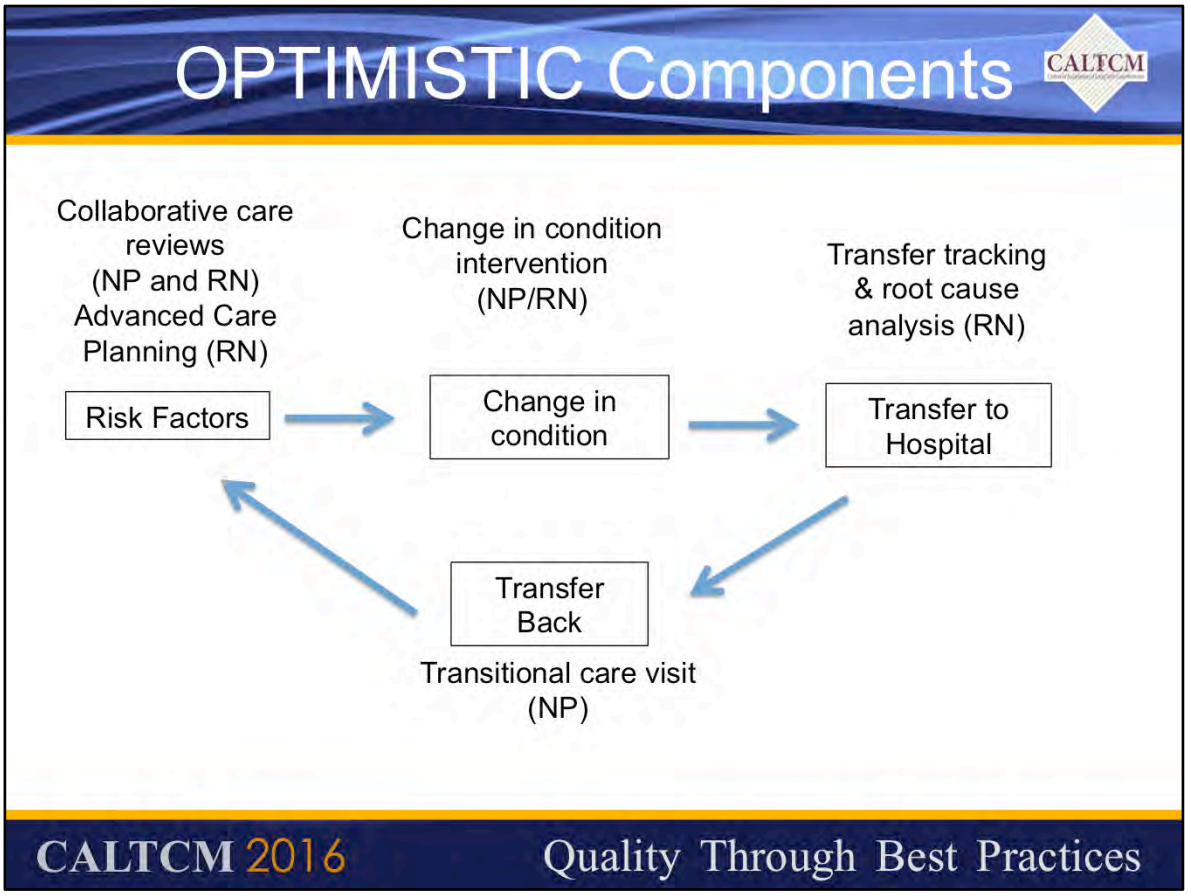
Notes:


OPTIMISTIC Components
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Collaborative care reviews (NP and RN) Advanced Care Planning (RN)
Change in condition intervention (NP/RN)
Transfer tracking & root cause analysis (RN)
Risk Factors
Change in condition
Transfer to Hospital
Transfer Back
Transitional care visit (NP)
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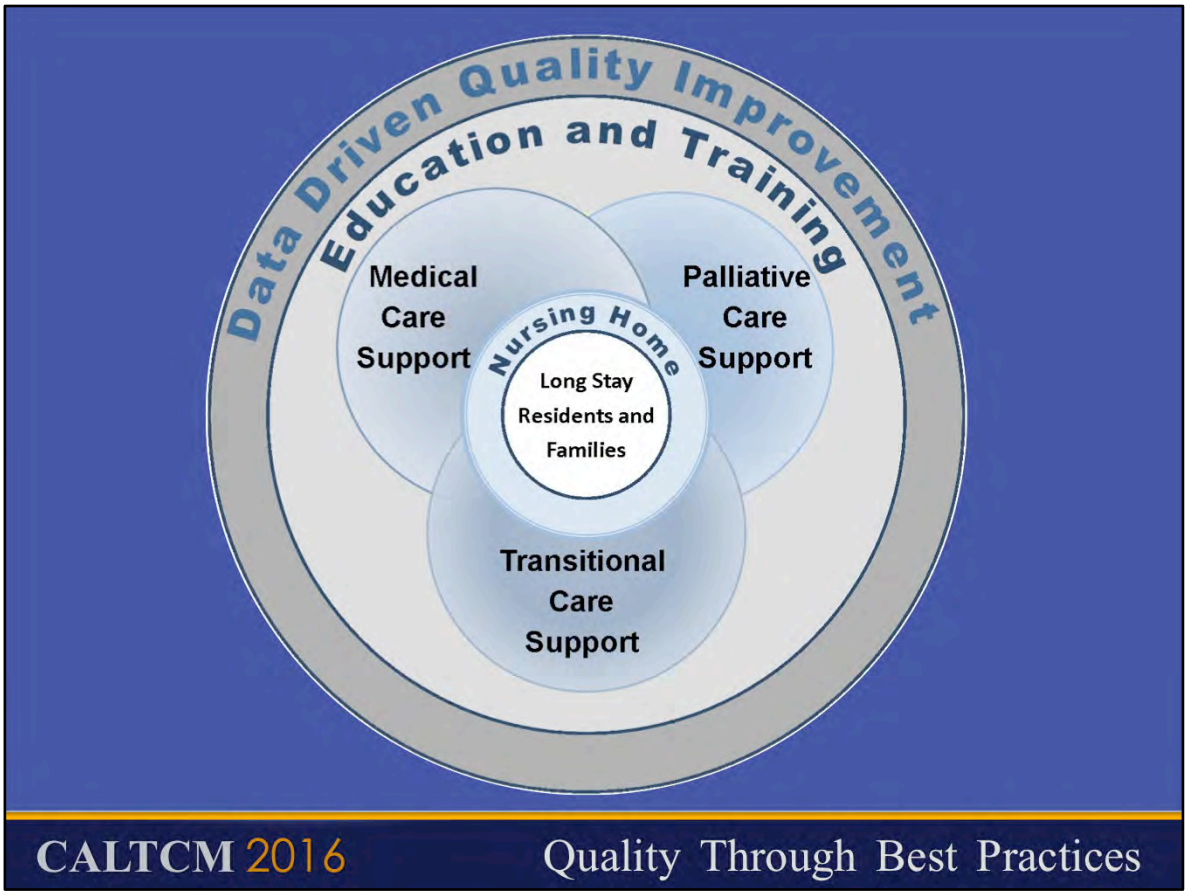
Quality Through Best Practices


Data Driven Quality Improvement
Education and Training
Medical Care Support
Palliative Care Support
Nursing Home
Long Stay Residents and Families
Transitional Care Support
CALTCM 2016
Quality Through Best Practices

Notes:

OPTIMISTIC Staff Roles

OPTIMISTIC RN Duties

- **Acute Change in Condition**– INTERACT implementation; mentoring and coaching
- **NP Liaision** – identify patients; communication
- **Advance Care Planning** – 10 residents/month
- **Collaborative Care Reviews** – gather information
- **Quality Improvement** – transfer root cause analyses; integrate into facility QI efforts

OPTIMISTIC NP Duties

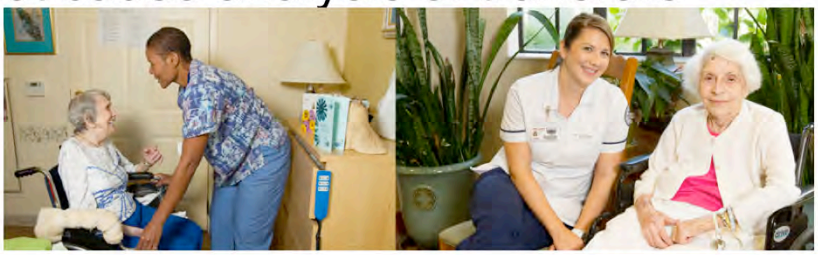
- **Acute Change in Condition**
- **Transition Visits**
- **Collaborative Care Reviews**
- **Support RNs** in education efforts

Notes:

Notes:

INTERACT

- Communication tools
  - SBAR
  - Stop and Watch
- Care Pathways
- Root cause analysis of transfers



Notes:

Advance Care Planning

Physician Orders for Life Sustaining Treatment (POLST)

- Supports patient-centered care by expanding beyond DNR/full code orders[1,2,3]
- More effective than traditional approaches at ensuring treatment preferences are documented as orders[4]
- Orders change the kinds of treatments patients receive[4] and treatments provided are largely consistent with POST orders[3]
- Viewed as helpful by clinicians including EMTs and hospice personnel [3,5]

[1]Hammes et al., 2012; [2]Hickman et al., 2004; [3] Hickman et al., 2009
[4]Hickman et al., 2010; [5]Schmidt et al., 2004

Notes:

Transition Visits

- Key role for NPs – focusing on high risk window for communication breakdowns and errors
- Goal – improve patient safety and care, prevent re-hospitalizations
- Jan-July 2015 NPs completed 515 transition visits
- Each NP averaged 27 transition visits/ month, average 102 minutes long

Notes:

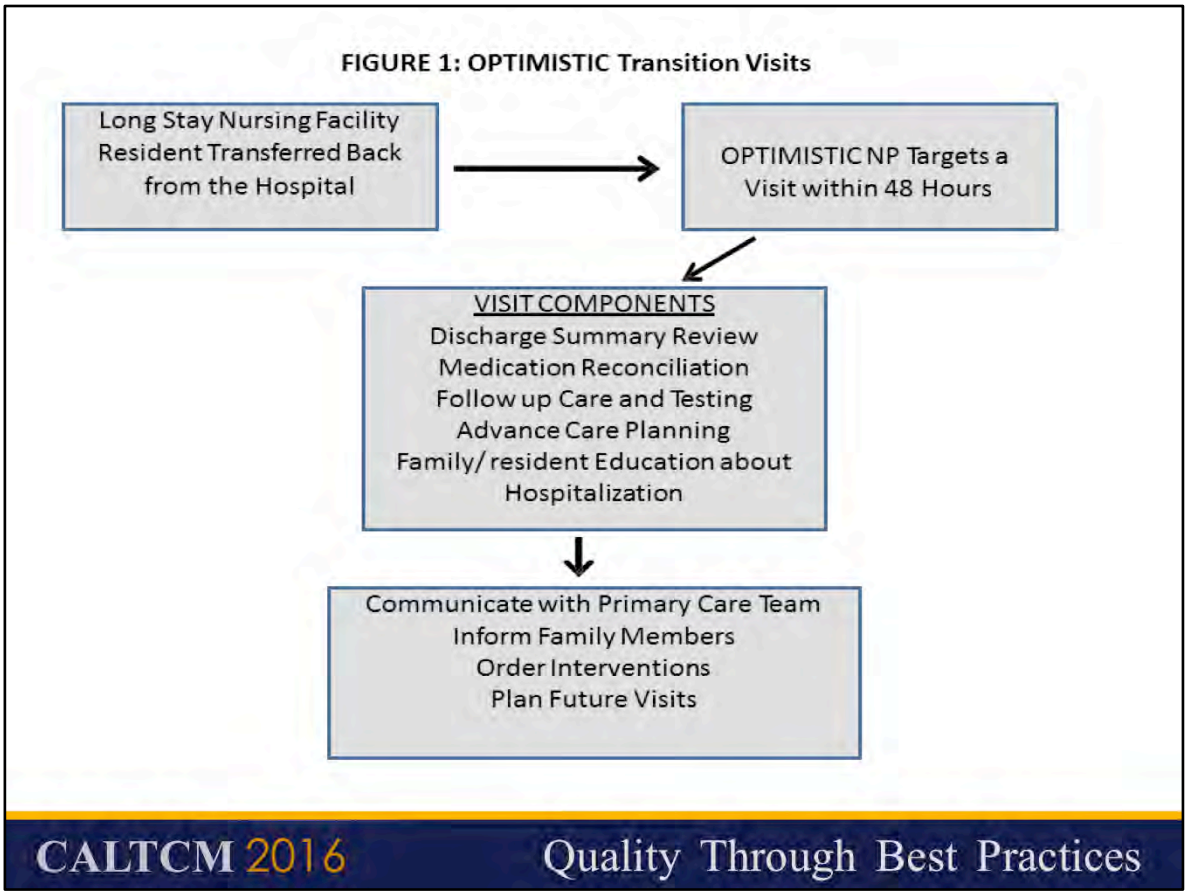


FIGURE 1: OPTIMISTIC Transition Visits
Long Stay Nursing Facility Resident Transferred Back from the Hospital
OPTIMISTIC NP Targets a Visit within 48 Hours
VISIT COMPONENTS
Discharge Summary Review
Medication Reconciliation
Follow up Care and Testing
Advance Care Planning
Family/ resident Education about Hospitalization
Communicate with Primary Care Team
Inform Family Members
Order Interventions
Plan Future Visits
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Notes:

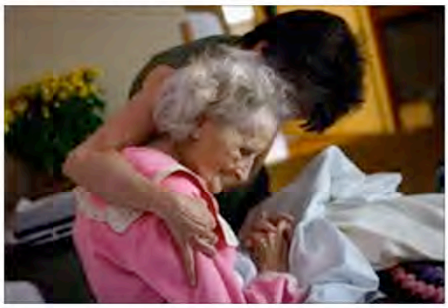
Implementation Challenges

- Integration of RNs/NPs into facility
  - New role, 3rd party
- Educational needs of our staff and facility staff
- Facility engagement
- Provider engagement
- Maintaining momentum

Notes:

Implementation Strategies

- Integration/acceptance by facility staff
  - Corporate/leadership support
  - Same uniform, badge
  - Sought ways to be helpful, found win-wins
  - Patience



Notes:

Implementation Strategies

- Education and training for our staff
  - Need to invest – principles of geriatrics and palliative care, management of chronic and acute conditions, facilitating ACP conversations
  - quality improvement methodology, training in delivering effective education
- Training offered to facility staff
  - Training courses offered centrally and at facility

Notes:

Implementation Strategies

- Facility and provider engagement
  - Early and repeated contacts
  - In person meetings
  - Ask for feedback and approval to protocols
  - Have a plan to deal with turnover
  - Cultivate strong corporate/physician group leadership relationships when possible

Notes:

Implementation Strategies

- Create and maintain momentum
  - Create and utilize regional community stakeholder group
  - Regular contacts/meetings, ie-newsletter
  - Monitor level of engagement regularly and respond
  - Be ready to “re-set” when needed, creating facility specific action plan

Notes:

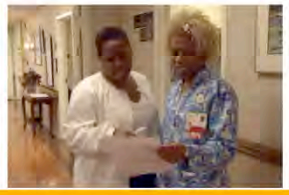
Next steps

- Phase 2 of CMS demonstration project
- Planning for dissemination

Notes:

Phase 2: Payment Reform

- A 4 year extension and expansion of OPTIMISTIC
- Renew agreements with 19 original facilities – who keep their OPTIMISTIC clinical resources
- Recruit 25 new facilities in Indiana – who are currently high performing and will not receive RNs or NPs
- ALL participating facilities and providers will be able to bill Medicare under 3 new payment codes



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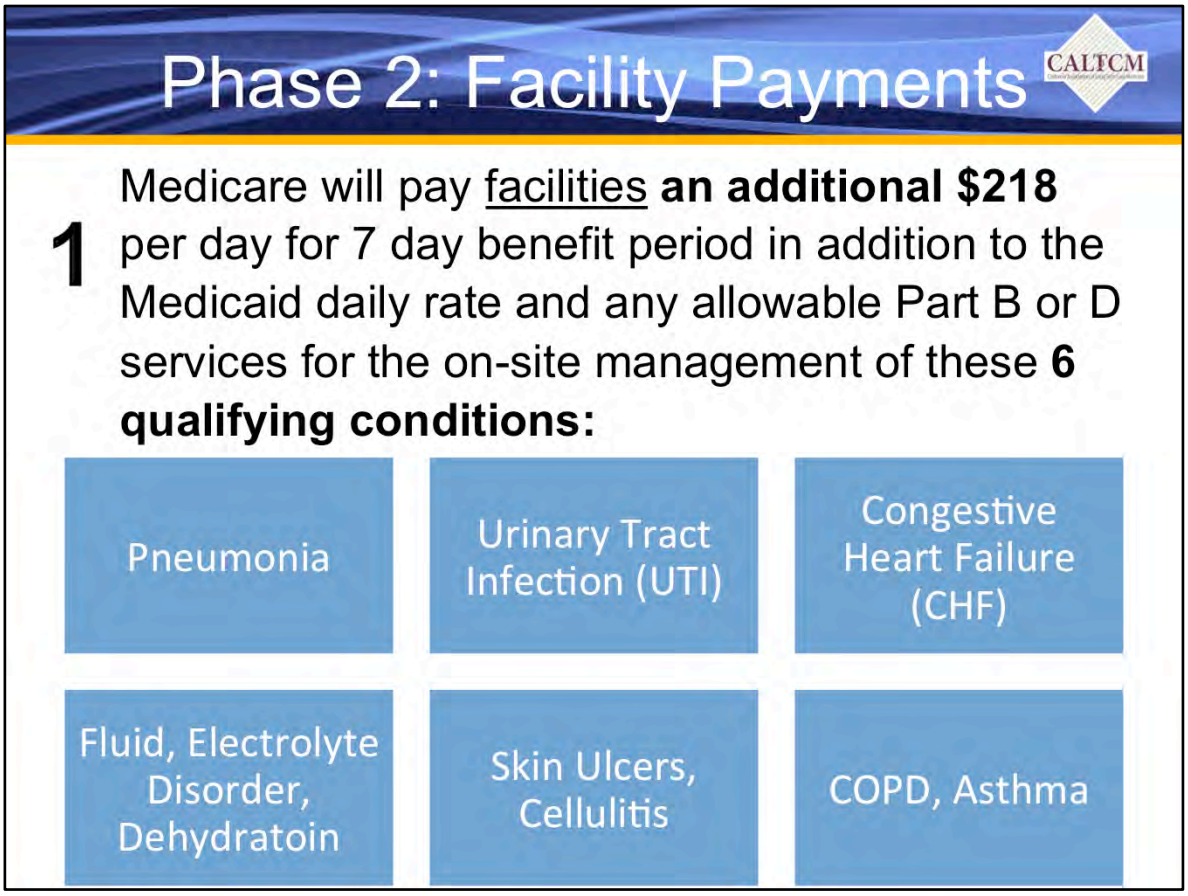
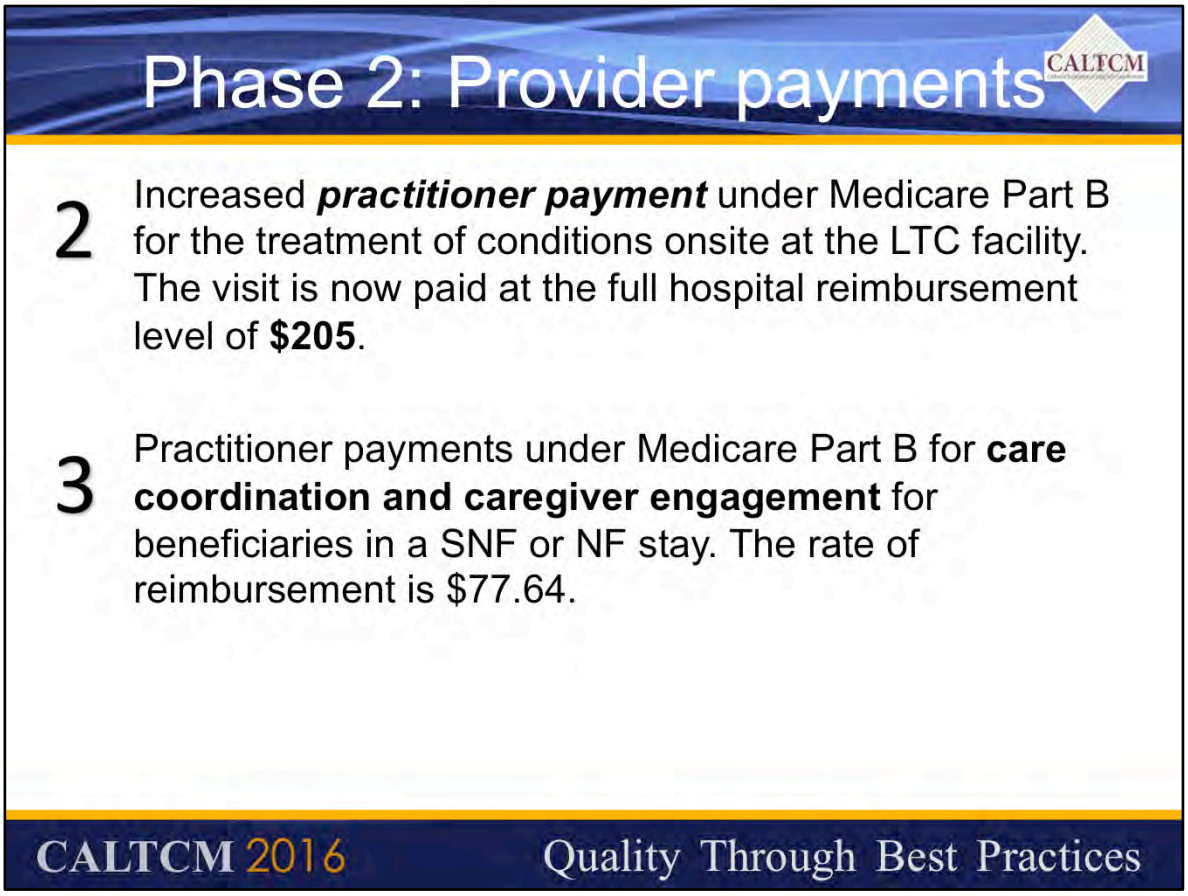
Notes:


Phase 2: Facility Payments
CALTCM
1
Medicare will pay facilities an additional $218 per day for 7 day benefit period in addition to the Medicaid daily rate and any allowable Part B or D services for the on-site management of these 6 qualifying conditions:
Pneumonia
Urinary Tract Infection (UTI)
Congestive Heart Failure (CHF)
Fluid, Electrolyte Disorder, Dehydratoin
Skin Ulcers, Cellulitis
COPD, Asthma

Notes:


Phase 2: Provider payments
CALTCM
2
Increased ***practitioner payment*** under Medicare Part B for the treatment of conditions onsite at the LTC facility. The visit is now paid at the full hospital reimbursement level of **$205**.
3
Practitioner payments under Medicare Part B for **care coordination and caregiver engagement** for beneficiaries in a SNF or NF stay. The rate of reimbursement is $77.64.
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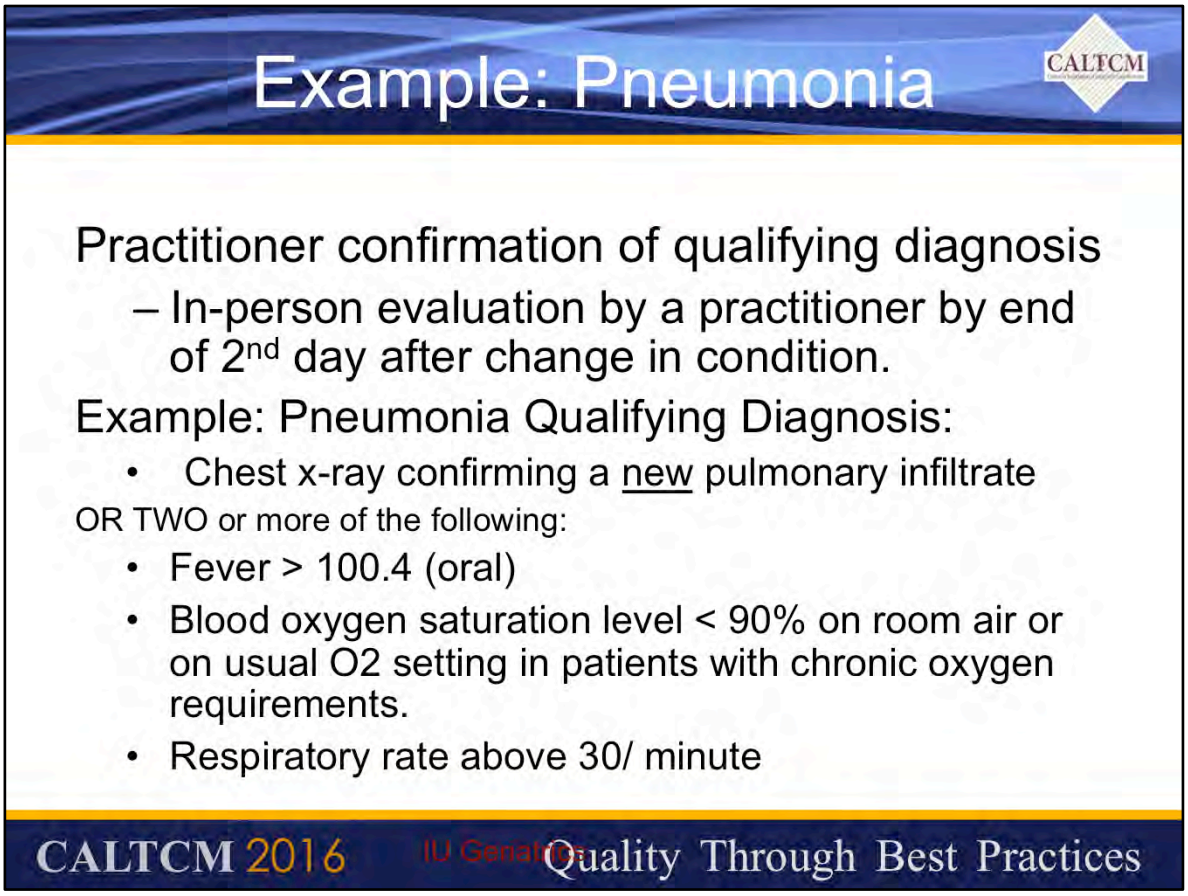
Notes:


Example: Pneumonia
CALTCM
Practitioner confirmation of qualifying diagnosis
– In-person evaluation by a practitioner by end of 2nd day after change in condition.
Example: Pneumonia Qualifying Diagnosis:
• Chest x-ray confirming a new pulmonary infiltrate
OR TWO or more of the following:
• Fever > 100.4 (oral)
• Blood oxygen saturation level < 90% on room air or on usual O2 setting in patients with chronic oxygen requirements.
• Respiratory rate above 30/ minute
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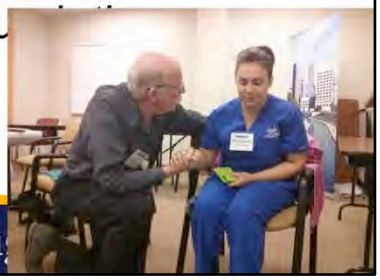
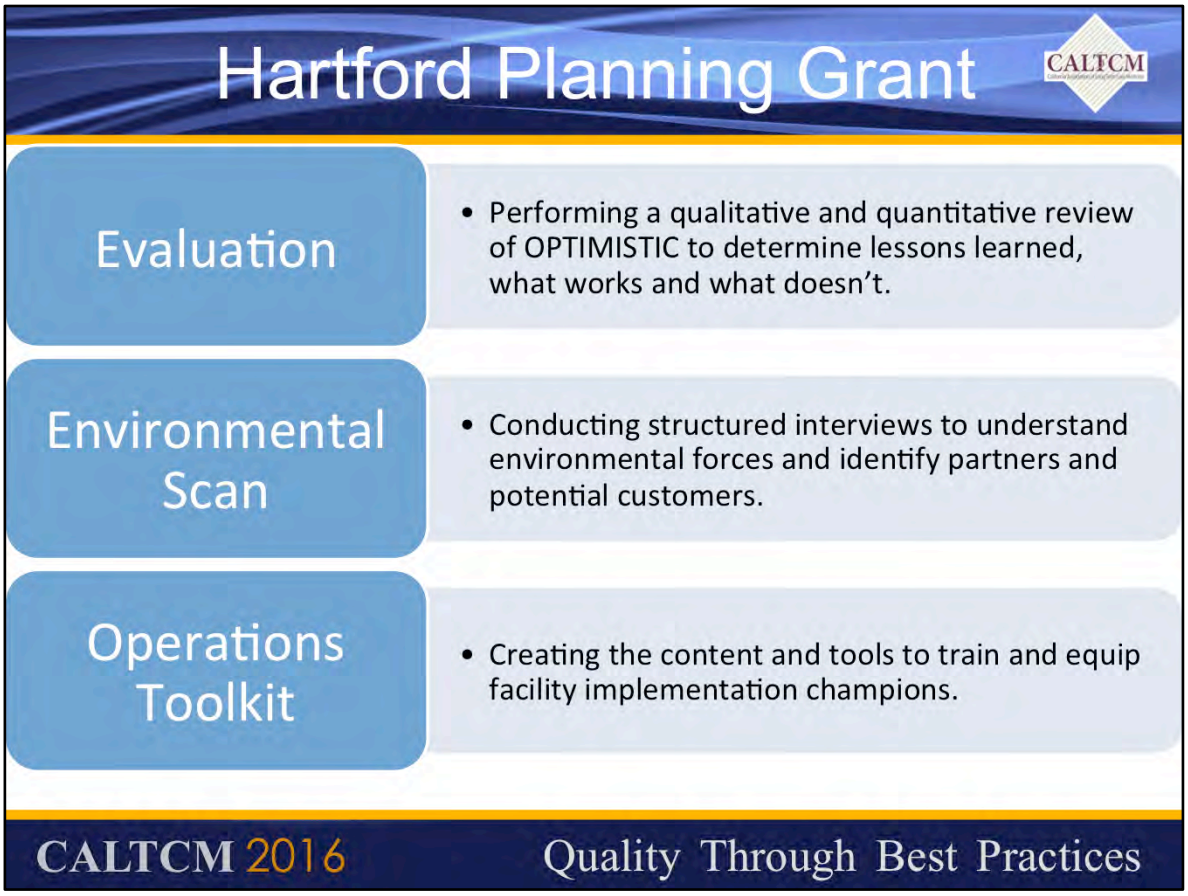
Notes:

Dissemination Planning Grant

- Goal: Develop an OPTIMISTIC Resource Center
  - Define and develop a scalable model
  - Roadmap for a self-sustaining, national center
  - Identify and collaborate with key national partners
  - Funded by John A. Hartford Fou



Notes:


Hartford Planning Grant
CALTCM
Evaluation
• Performing a qualitative and quantitative review of OPTIMISTIC to determine lessons learned, what works and what doesn't.
Environmental Scan
• Conducting structured interviews to understand environmental forces and identify partners and potential customers.
Operations Toolkit
• Creating the content and tools to train and equip facility implementation champions.
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Notes:

Mrs. P. – was her transfer avoidable?

- In talking with the CNA, she said that it had been harder to get her shoes on her the past few days due to swelling…
- The Medical Director has been talking with the DoN about starting a heart failure care pathway protocol but it hadn't been instituted yet…
- In the hospital, the palliative care team sat down with the daughter who stated that due to her mother's advanced dementia and other medical problems, she would want care only focused on comfort…

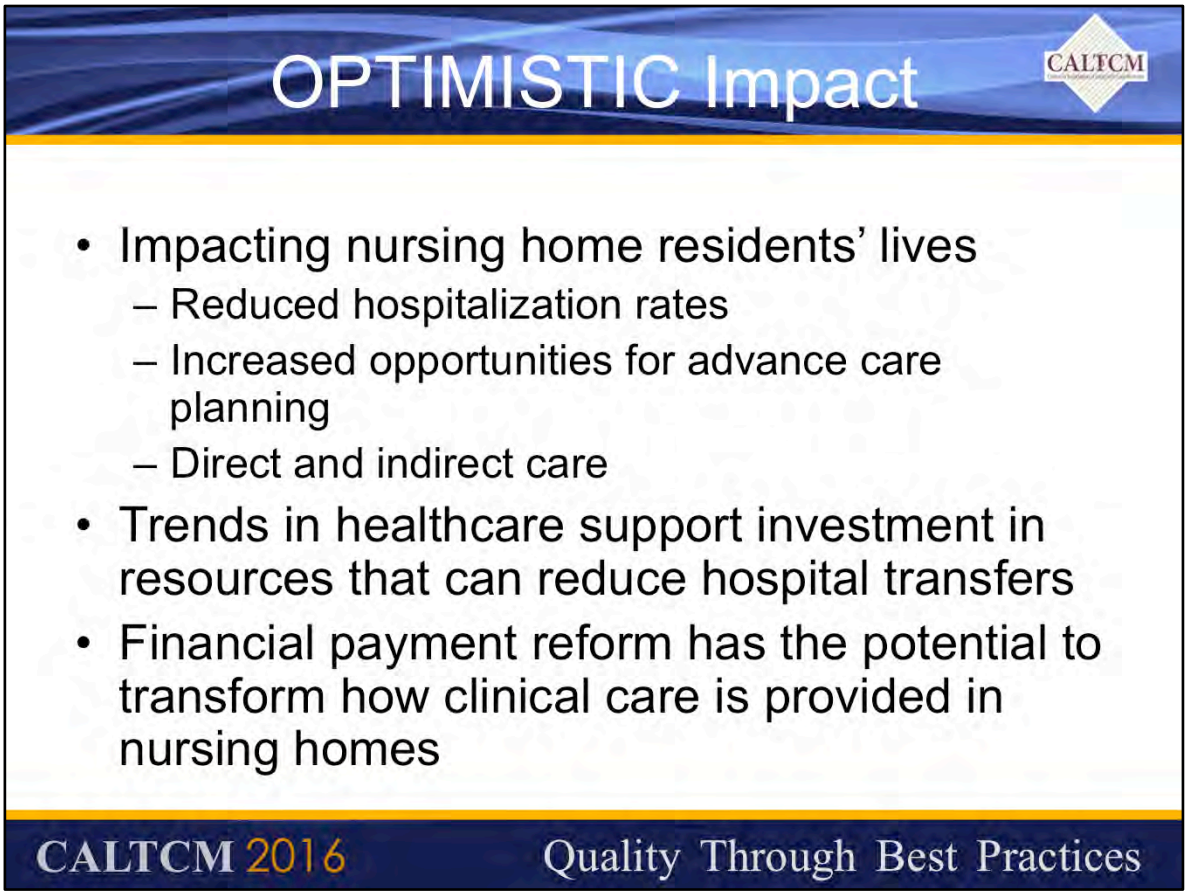
Notes:

Mrs. P – an OPTIMISTIC approach

- CNAs trained for early warning signs and empowered to communicate changes in condition
- Skills and resources to care for common conditions in house
- Proactive conversations about prognosis and goals of care

Notes:

Kathleen Unroe
kunroe@iupui.edu



Notes:

The OPTIMISTIC Team!

Ellen Miller Tom Haithcoat
Ashley Gulley Nicole Fowler
Laura Holtz Anne Thomas Shannon Effler
Russell Evans Kathleen Unroe
Greg Gramelspacher Monica Tegeler
Brittany Bernard Bryce Buente Kevin Howard
Susan Hickman Lidia Dubicki
Greg Sachs Arif Nazir
John Price Mary Ersek
Samuel Gurevitz
Steve Counsell Kathy Frank
Greg Arling Ravan Carter
Melanie Parks Katie Rukes

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Notes:


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Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Best Practices in Palliative Care
George Fields, DO
CALTCM 2016

Notes:

Disclosure Statement

I receive stock for my role as an employee for Anthem.

All conflicts of interest have been resolved in accordance with the ACCME's Standards for Commercial Support.

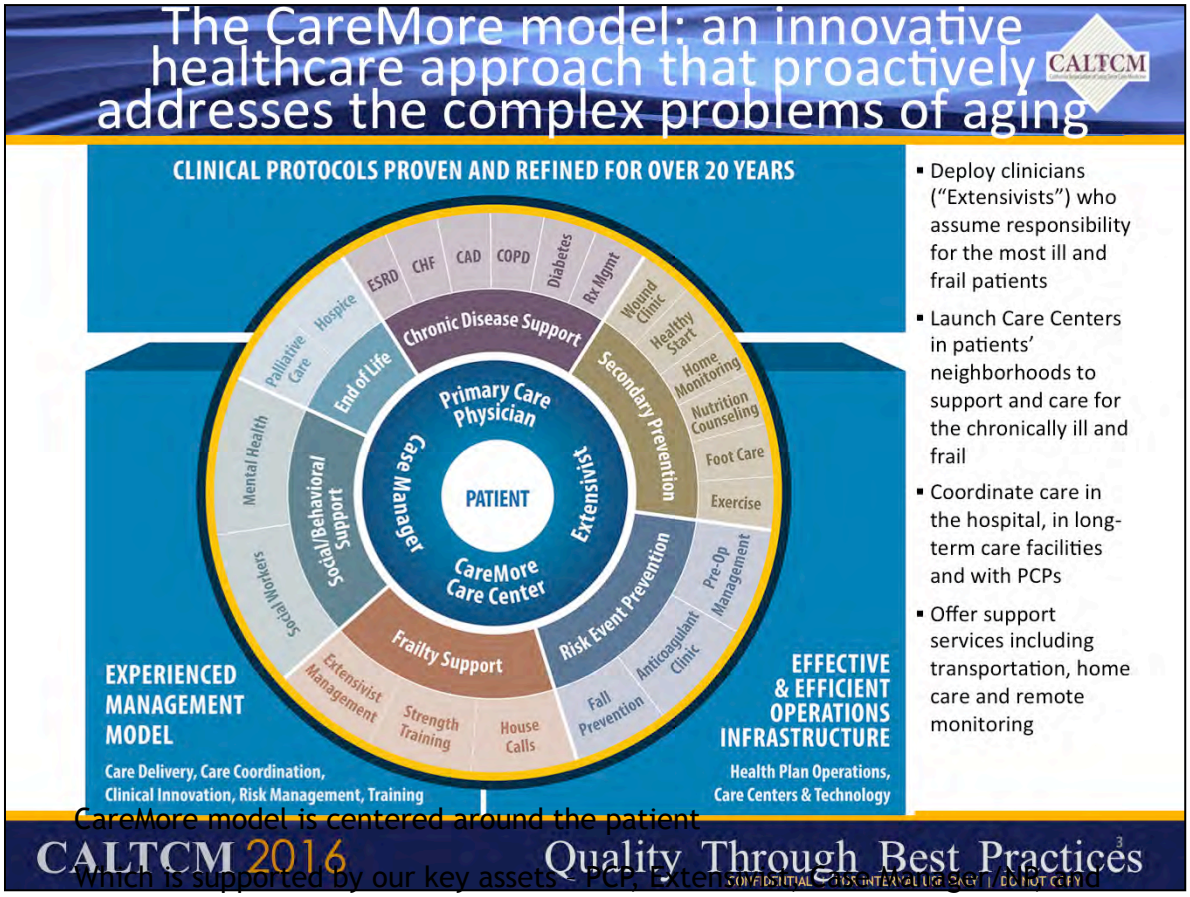
Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Provide a simple, effective definition of Palliative Care
- List the 3 Essential components of Palliative Care
- Explain the Role of the Clinician in a Palliative Care Team

Notes:



CareMore model is centered around the patient

Which is supported by our key assets - PCP, Extensivist, Case Manager and CCC

CareMore clinical experts engage in activities that manage the chronically ill and frail – chronic disease support, secondary prevention, frailty support, social/behavior support, and end of life care

This model is enabled by a robust IT platform / engine

Notes: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42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Coalition for Compassionate Care of California
Karl Steinberg, MD, CMD
Collaborative of thought leaders representing healthcare providers, systems, consumers and government agencies Committed to improving end-of-life care, and foster change in the areas of system, professional and cultural readiness
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Notes:

Disclosures

- Boehringer Ingelheim (non-branded Speakers Bureau for Transitions of Care talk)
- Sunovion (Scientific Advisory Board)

- *Thanks to Drs. Jim Mittelberger & Bob Arnold for content assistance*

Notes:

Objectives

- Identify the updated CARE recommendations from the 4 C's.
- Understand the status of Medicare reimbursement for end of life discussions
- Recongize Advanced Care planning codes

Notes:

Coalition for Compassionate Care of California

- Brought **POLST** to California in 2008
- Helped NP/PAs be able to sign **POLST** in 2016
- Many other accomplishments including:
  - Faith communities
  - Developmentally disabled
  - Cross-cultural ACP and PC initiatives
  - Awardee for ACP project with UCLA Health

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Notes:

Legislative Update

- Lots of things are happening in the legislative and regulatory arena!

Notes:

National Developments

- SGR Repealed! MACRA, move toward value
- ACP Codes now reimbursed
- SNF/NF Regulations 42 CFR 483 (Requirements of Participation) being revised, first time since OBRA—probably final rule late this summer
- Medicare Care Choices pilot (hospice alongside curative care) expanded
- Care Planning Act of 2015 (S.1529) Expands Access to Advanced Illness Management, Advance Care Planning, more pilots/innovation
- ICD-10

Notes:

State Legislative Developments

- AB 2139 (2014)—Requires disclosure to patient when they have a terminal prognosis (1 year) and discussion of end-of-life treatment choices
- AB 639 (2015)—NP/PAs can sign POLST as of January 1, 2016—new forms already in use (old forms still valid, but NP/PAs signing forms should only use new ones)
  - Expand access to quality POLST conversations/forms
- SB 19 (2015)—POLST Registry Pilots (unfunded)—currently looking at multiple RFPs

Notes:

State Legislative Developments

- AB X2-15—End-of-Life Options Act effective June 9, 2016
  - Physician Aid in Dying
  - Many safeguards, but still very controversial
  - Nobody is obligated to participate or even refer
  - A whole 'nother talk!
- SB 1004 (2014)—Requires access to Palliative Care for adult Medi-Cal recipients
  - Unfortunately, like POLST Registry, it's unfunded
  - Starting out with metastatic cancer patients
  - Now expanding to COPD/CHF

Notes:

State Judicial Developments

- HSC 1418.8, Epple Bill, allows SNF interdisciplinary team to make decisions for incapacitated/unbefriended pts.
- *CANHR v. Chapman*, attempt to invalidate Epple Act, successful ruling that the 1418.8 process is unconstitutional
  - Lacking in due process as to giving notice to the resident that s/he has been deemed incapacitated by the physician
  - Final writ in January, prohibited use of Epple for antipsychotics or for "withdrawing or withholding life-sustaining treatment"
  - Also said it could be used for hospice (???)
- CALTCM, CCCC, CMA, CAHF, CHA and others requested that CDPH appeal the decision—in late March, CDPH appealed. Ruling stayed.
- For now, Epple is still valid, but should be used prudently as always

Notes:

Look How Granular ICD-10 Is!

- W 55.21 – Bitten by a Cow
- V 00.01 – Pedestrian Struck by Roller Skater
- Y 92.146 – Injury Sustained at Prison Swimming Pool
- Y 93.81 – Knitting or Crocheting Injury
- V 94.810 – Accident Between Civilian Watercraft and Military Watercraft
- V 96.00 – Unspecified Balloon Accident Injuring Occupant

http://medicaleconomics.modernmedicine.com/medical-economics/news/20-bizarre-new-icd-10-codes

Notes:

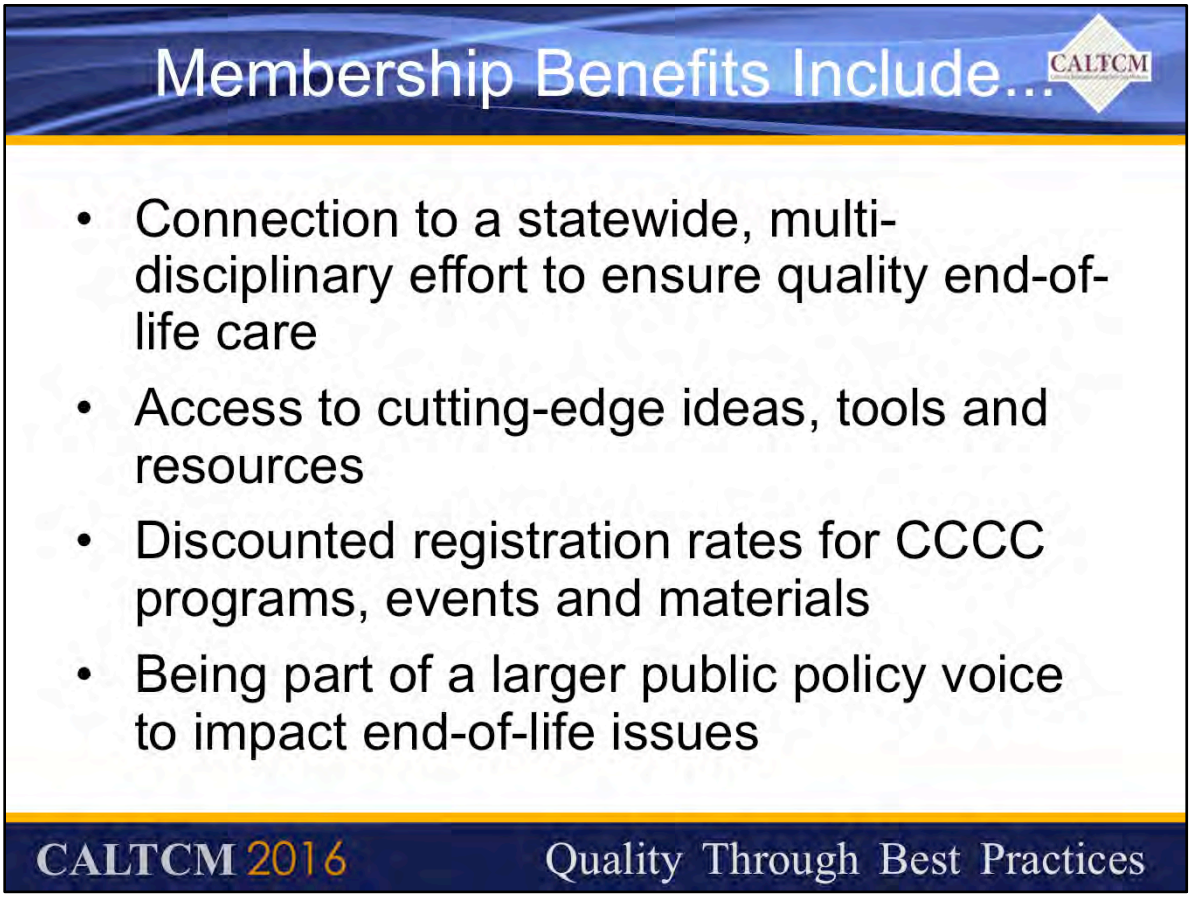
Membership

- **Join us as a member today!**

- **Membership Categories:**
- Individual: $50/year
- Community Coalition: $100/year
- Organization: $250-750, based on budget

- CoalitionCCC.org/**membership**

Notes:


Membership Benefits Include...
CALTCM
• Connection to a statewide, multi-disciplinary effort to ensure quality end-of-life care
• Access to cutting-edge ideas, tools and resources
• Discounted registration rates for CCCC programs, events and materials
• Being part of a larger public policy voice to impact end-of-life issues
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Notes:


Expert Resources on Advance Care Planning & Palliative Care
CALTCM
Advance care planning promotes compliance with patients' wishes and improves satisfaction
Home-based palliative care increases satisfaction and reduces symptoms
Timely hospice care reduces pain and discomfort for patients and increases family satisfaction
Inpatient palliative care improves care quality and family satisfaction
Clinic-based palliative care decreases symptoms and improves patient satisfaction
THINKING AHEAD
My Way, My Choice, My Life at the End
TRUST
CHOICE
DIGNITY
PEACE
THINKING AHEAD MATTERS
Supporting and Improving Healthcare Decision-Making and End-Of-Life Planning for People with Intellectual and Developmental Disabilities
August 2014
CARE RECOMMENDATIONS
Compassion and Respect Toward the End of Life
CoalitionCCC.org
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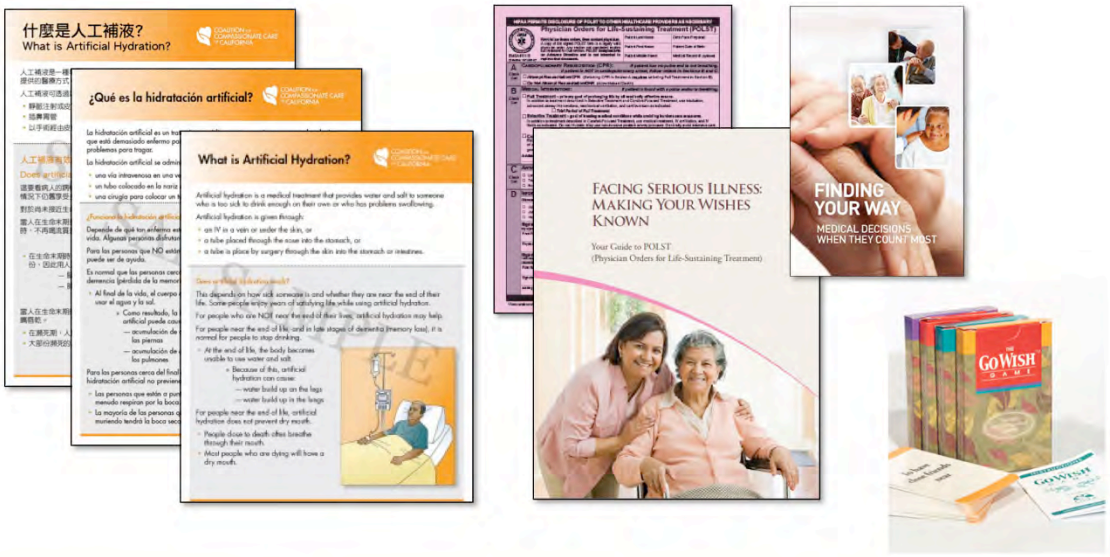
Notes:

Online Store



CoalitionCCC.org/store

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Notes:

Other Upcoming Educational Opportunities

- **May 12-13, 2016, Newport Beach**
- **8th Annual Palliative Care Summit**
- **July 14-15, 2016, San Francisco**
- **POLST: It Starts with a Conversation**
- See our website for complete details – www.coalitionccc.org

CoalitionCCC.org/training

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Notes:


8th Annual Summit
IGNITE. INSPIRE. INNOVATE.
TAKING PALLIATIVE CARE TO THE NEXT LEVEL
MAY 12-13, 2016
NEWPORT BEACH, CALIFORNIA
CCCCSUMMIT.ORG
COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

Notes:

Notes:


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COALITION FOR COMPASSIONATE CARE OF CALIFORNIA
CoalitionCCC.org
(916) 489-2222 // info@coalitionccc.org
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Notes:

Thank You! For All You Do!

Notes:


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California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Having "The Talk": Strategies for Productive Advance Care Planning Conversations
Karl Steinberg, MD, CMD
CALTCM 2016

Notes:

Disclosures

- Boehringer Ingelheim (non-branded Speakers Bureau for Transitions of Care talk)
- Sunovion (Scientific Advisory Board)

- *Thanks to Drs. Jim Mittelberger & Bob Arnold for content assistance*

Notes:

Objectives

- Recognize the importance and value of discussing prognosis and advance care planning
- Be familiar with some techniques for exploring values and treatment preferences with patients and their families
- Consider resources for determining prognosis in geriatric patients
- Access tools for patient education around treatment preferences, benefits, risks and harms

Notes:

What is Advance Care Planning?

- **Collaborative process between healthcare providers, patients and family (loved ones) to make decisions about future health care concerns, even through periods of incapacity**
  - Thinking through one's values and preferences.
  - Discussing one's values and preferences in the context of his or her specific condition(s) & prognosis
  - Documenting the values and sharing the information.
    - Made "in **advance**"—not "advanced"

Notes:

Why is Advance Care Planning Important?

- Helps avoid unwanted and unpleasant medical interventions and "medicalization" of death
- Allows loved ones/decisionmakers to feel comfortable when directing treatment
  - Nothing completely eliminates guilt, but ACP conversations and documents definitely help
- Makes healthcare professionals more comfortable with providing or withholding/withdrawing treatment
- Usually enhances patient-clinician relationship and trust

  ** Works in both directions*

Notes:

Why is Advance Care Planning Important?

- Avoids making decisions in a crisis situation
- Creates realistic expectations of medical interventions and predicted functional status
- Helps us provide truly person-centered care
- Allows family members to become closer through these important discussions among themselves
  - *But: Cannot envision every possible scenario*
  - *And: Remember, people change their minds*

Notes:

Why is Advance Care Planning Important?

- May reduce healthcare costs in addition to reducing suffering
- Can designate a specific surrogate (agent/ proxy)—important, especially when there is discord among family members
- Can grant leeway to decision-makers (or not)
- Allows for actual medical orders (e.g., POLST) to be written and honored when appropriate

Notes:

Medicalization of Death

Half of older Americans visited ED in last month of life, and 75% in their last 6 months

- Death is a human experience, not a medical experience
- People want to die at home
- For our custodial residents, our facilities (homes) are home!

Smith AK et al. Health Affairs 2012;31:1277-85.

Notes:

Aggressive, Non-beneficial* EOL Care

- 65% of Medicare patients with poor-prognosis cancers are hospitalized and 25% use the ICU in the last month of life
- High intensity EOL care has *not* been shown to improve survival in advanced cancer, and is associated with *worse* QOL and perceptions of worse EOL care

-Morden et al. *Health Affairs* 2012
-Brooks et al, *J Nat Cancer Inst* 2013
-Zhang et al, *Arch Int Med* 2012
-Wright et al., *JAMA* 2016

*Synonymous with "futile" and sometimes called "medically ineffective" treatment

Notes:

Why Serious Illness Communication as a focus?

1. Patients and families want and expect advance care planning
2. End of life communication is the right thing to do
3. The serious illness communication gap is a recognized critical care gap
4. Clearest clinical benefit is for those patients facing serious illness
5. Physician practice is the largest source of variation
6. Patients with end of life conversations have better outcomes and lower cost

Notes:

Serious Illness Communication: Standard of Care

- Kaiser Family Foundation Poll 2015
  - 90% polled believe:
    - Physicians should "talk with their patients about end of life issues"
  - 17% had had such discussions
- Previous CHCF Study (2012) demonstrated similar results
- Medicare pays for ACP Conversations as of 1/1/2016
  - ~$ 80 for first 30 minutes (1.5 RVU) in SNF (99497)
    - Realistically, 16 minutes or more
  - ~$75 for additional 30-min. increments (99498 add-on code)
  - Can bill alongside regular SNF codes (99306-99318)
  - No set limits on number of times code can be billed

Kaiser Family Foundation Health Tracking Poll, September 30, 2015 National random telephonic survey

Notes:

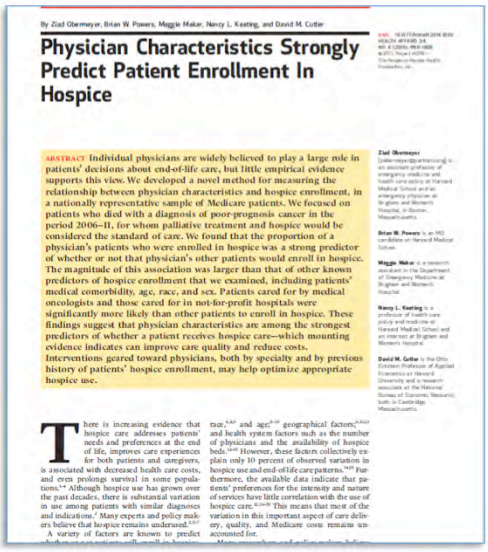
Serious Illness Communication: Standard of Care

- American College of Physicians
  - Communication about goals of care for patients with serious illness is one of five most important low-cost, high-value interventions
- Value of conversation greatest when patient facing serious illness, but not at time of catastrophic hospitalization—communicate at the right time in the right way for greatest impact
- Nursing home residents in general are not a healthy cohort—they deserve to receive accurate information in an empathetic way:
  - Create realistic expectations
  - Allow them to make individualized, informed decisions

American College of Physicians Advice on High Value Care 2014

Notes:

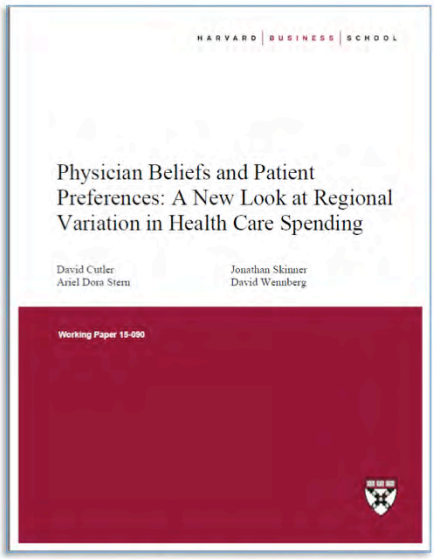
Physician characteristics are by far the most important predictor of end-of-life costs and hospice enrollment



By Ziad Obermeyer, Brian W. Powers, Maggie Makar, Nancy L. Keating, and David M. Cutler

Physician Characteristics Strongly Predict Patient Enrollment In Hospice

ABSTRACT Individual physicians are widely believed to play a large role in patients' decisions about end-of-life care, but little empirical evidence supports this view. We developed a novel method for measuring the relationship between physician characteristics and hospice enrollment, in a nationally representative sample of Medicare patients. We focused on patients who died with a diagnosis of poor-prognosis cancer in the period 2006–11, for whom palliative treatment and hospice would be considered the standard of care. We found that the proportion of a physician's patients who were enrolled in hospice was a strong predictor of whether or not that physician's other patients would enroll in hospice. The magnitude of this association was larger than that of other known predictors of hospice enrollment that we examined, including patients' medical comorbidity, age, race, and sex. Patients cared for by medical oncologists and those cared for in not-for-profit hospitals were significantly more likely than other patients to enroll in hospice. These findings suggest that physician characteristics are among the strongest predictors of whether a patient receives hospice care—which mounting evidence indicates can improve care quality and reduce costs. Interventions geared toward physicians, both by specialty and by previous history of patients' hospice enrollment, may help optimize appropriate hospice use.



HARVARD | BUSINESS | SCHOOL

Physician Beliefs and Patient Preferences: A New Look at Regional Variation in Health Care Spending

David Cutler
Ariel Dora Stern

Jonathan Skinner
David Wennberg

Working Paper 15-090

We should take a look at our own values—and as medical directors, try to ensure that all practitioners in our facilities are respecting patient preferences

Notes:

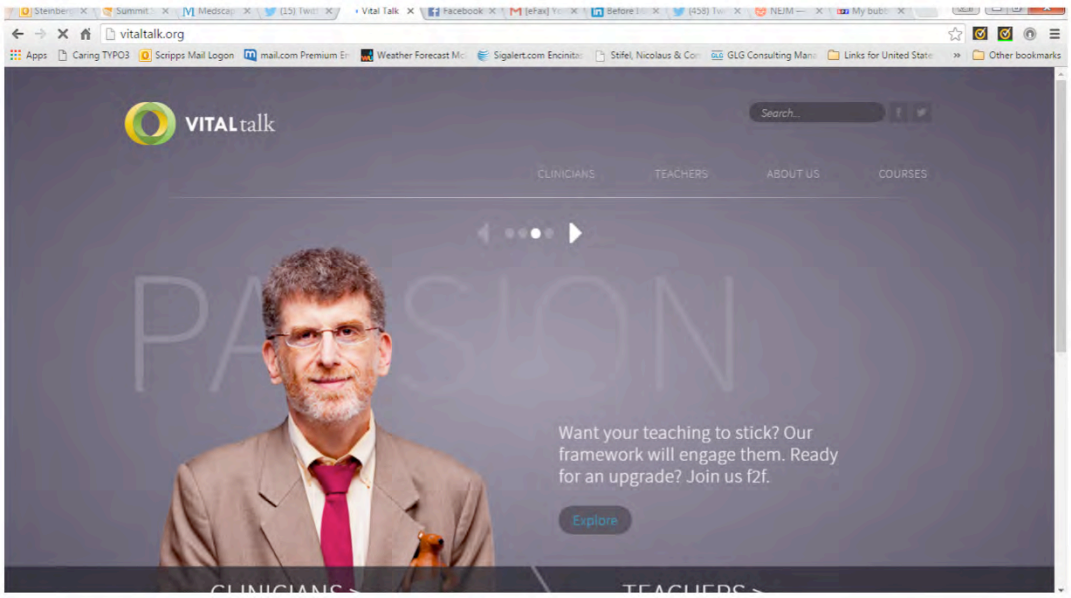
Healthcare providers may voice these attitudes:

- This daughter just does not "get it."
- Why on earth did they put a feeding tube in their profoundly demented, nonverbal mom?
- How unrealistic can a husband be? Does he really think she is going to make it to her 100th birthday?
- It is so obvious that he is dying, how can his family not see that?

- ***It's our duty to help create realistic expectations and prepare patients/families for bad outcomes, without taking away hope***

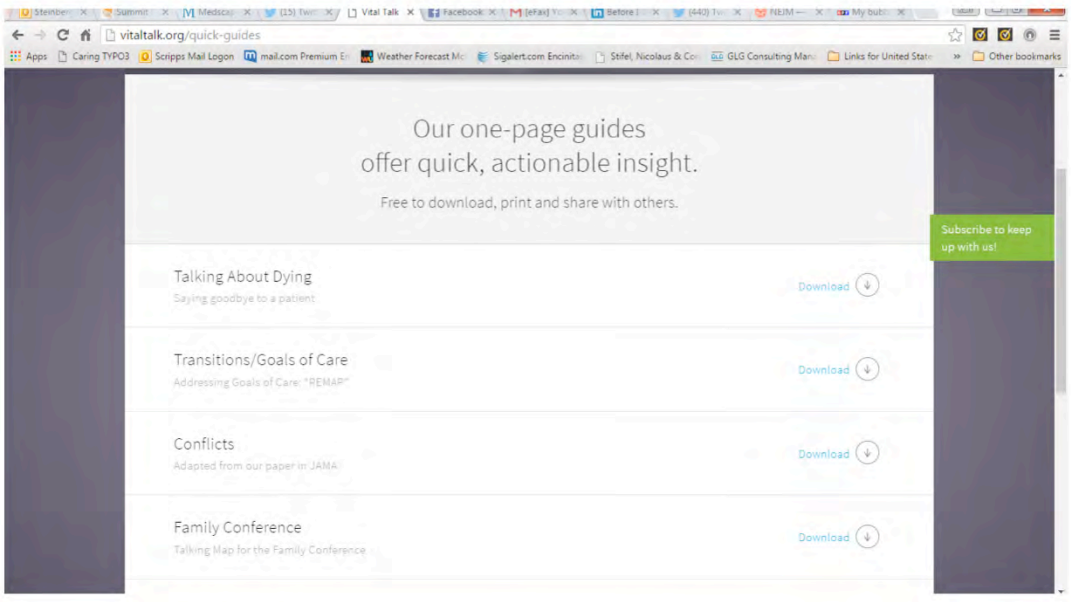
Notes:

VitalTalk



Notes:

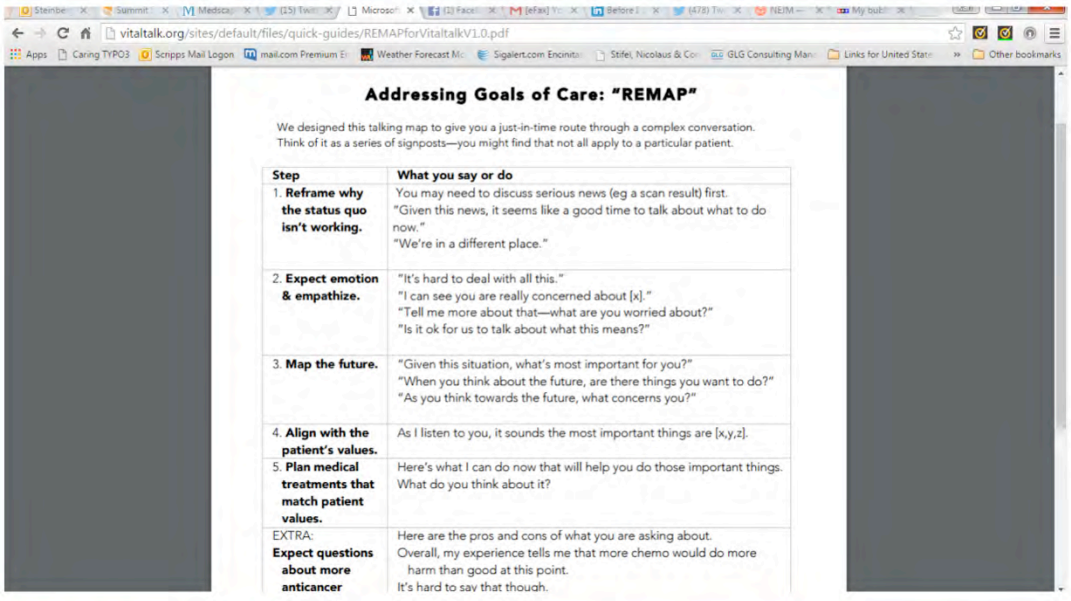
VitalTalk



CALTCM 2016 Quality Through Best Practices

Notes:

VitalTalk



vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf

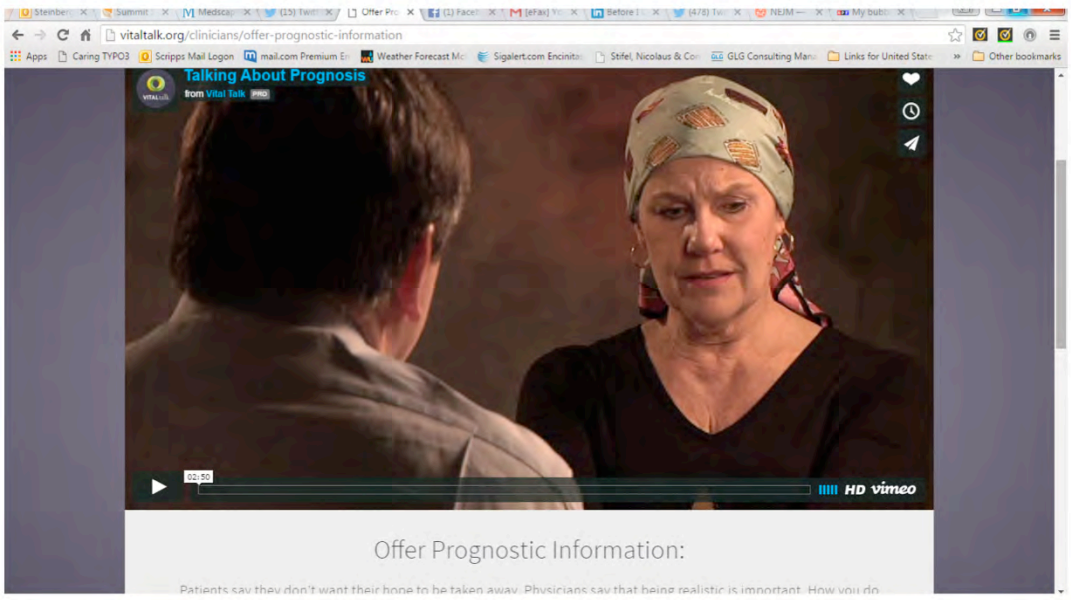
Addressing Goals of Care: "REMAP"

We designed this talking map to give you a just-in-time route through a complex conversation.
Think of it as a series of signposts—you might find that not all apply to a particular patient.

Step	What you say or do
1. **Reframe why the status quo isn't working.**	You may need to discuss serious news (eg a scan result) first. "Given this news, it seems like a good time to talk about what to do now." "We're in a different place."
2. **Expect emotion & empathize.**	"It's hard to deal with all this." "I can see you are really concerned about [x]." "Tell me more about that—what are you worried about?" "Is it ok for us to talk about what this means?"
3. **Map the future.**	"Given this situation, what's most important for you?" "When you think about the future, are there things you want to do?" "As you think towards the future, what concerns you?"
4. **Align with the patient's values.**	As I listen to you, it sounds the most important things are [x,y,z].
5. **Plan medical treatments that match patient values.**	Here's what I can do now that will help you do those important things. What do you think about it?
EXTRA: **Expect questions about more anticancer**	Here are the pros and cons of what you are asking about. Overall, my experience tells me that more chemo would do more harm than good at this point. It's hard to say that though.

Notes:

VitalTalk



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Notes:

Establish Rapport

- Start with the patient's agenda
- Track the emotional data as well as the cognitive data
- Move the conversation forward one step at a time
- Make your empathy visible (and audible)
- Clarify what you ***can*** do first--**before** you talk about what you ***can't*** do
- Agree on 'big picture' goals before specific medical interventions
- Give your complete, undivided attention to your patient for key moments

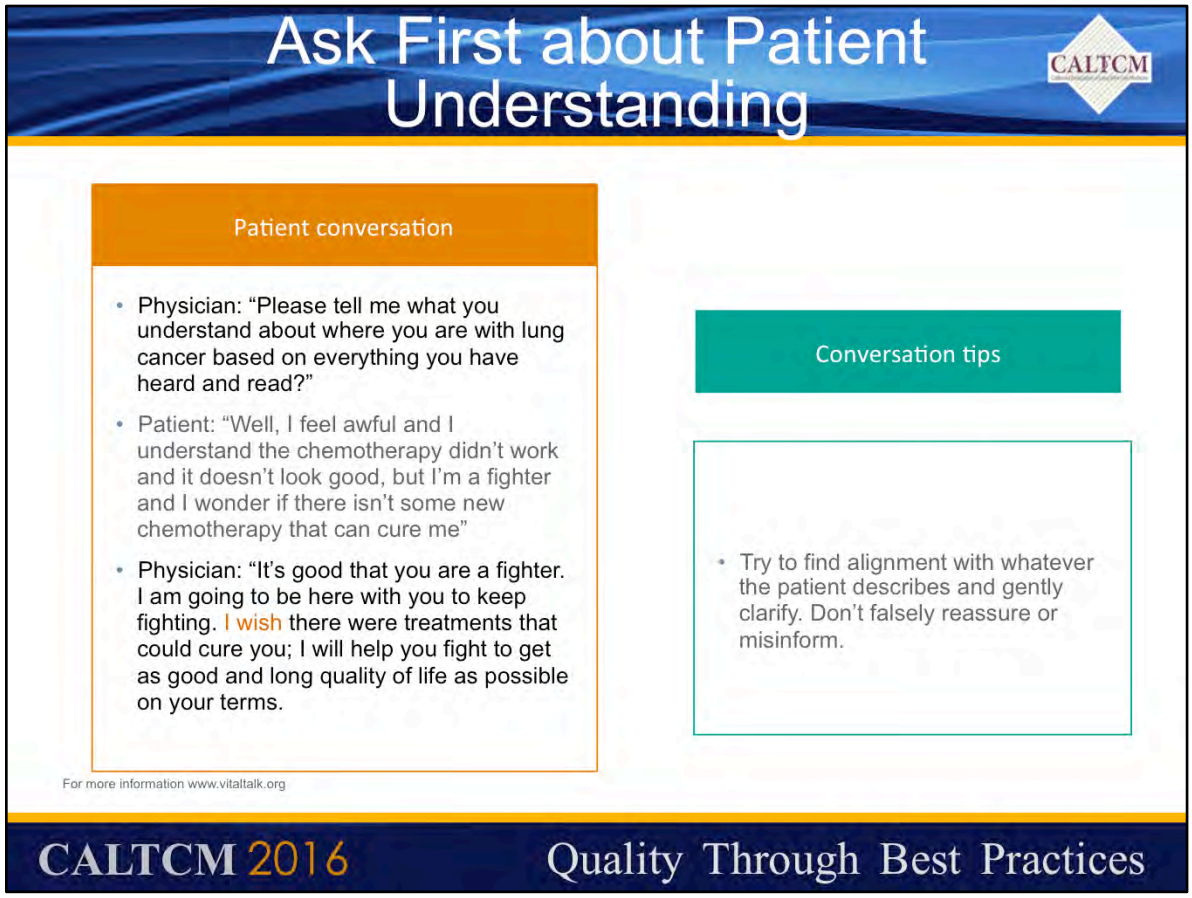
Notes:

Prepare for the Conversation

- Facing "serious illness"
- Plan for the timing and setting
- Eye level and eye contact
- Sit down
- *We are used to doing this in SNF*

"I think it is important now for us to take stock of where you are with your disease and plan for the future. Is it OK with you if we discuss this now, or would you prefer to wait?"	Asking permission gives the patient more control and reduces anxiety. Make sure patient is receptive to the topic of conversation.
"Would you like to bring your husband for that conversation?"	

Notes:


Ask First about Patient Understanding
CALTCM
Patient conversation
Physician: "Please tell me what you understand about where you are with lung cancer based on everything you have heard and read?"
Patient: "Well, I feel awful and I understand the chemotherapy didn't work and it doesn't look good, but I'm a fighter and I wonder if there isn't some new chemotherapy that can cure me"
Physician: "It's good that you are a fighter. I am going to be here with you to keep fighting. I wish there were treatments that could cure you; I will help you fight to get as good and long quality of life as possible on your terms.
Conversation tips
Try to find alignment with whatever the patient describes and gently clarify. Don't falsely reassure or misinform.
For more information www.vitaltalk.org
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Notes:

Recognize Emotion – Express Empathy

- A touch and a nod
- Genuine empathic statements
- Pause -- silence
- *(We are not good at this)*

"NURSE"
- **N**aming
- **U**nderstanding
- **R**especting
- **S**upporting
- **E**xploring

"I don't know how I will tell my children!"

"This is very hard." (pause)

" I just want them to know how much I love them and spend some more time with them."

Notes:

Frame the Conversation Positively

Does this mean you want me to give up hope?	No, we won't give up hope. I want to be sure we are fighting for the right things. If we can't wipe out the cancer, we can do lots of things to help you live your best possible life here and now no matter what happens.
What is the point of talking about this?	Talking about this we can be sure you and your family are doing all the right things now and also reduce the chance that your family will need to guess if something happens in the future and you can't speak for yourself.

Notes:

Central Focus: The Patient!

- Substituted judgment vs. best interests for decision-making
- Often helpful when discussing with families at bedside: "If your mom could be with us now, seeing this situation she is in, and she was back in her 'right mind,' what would she tell us to do?"
- Always bring it back to the patient. "This must be very hard for you. Our job here is to do the right thing for her."

Notes:

Discussing EOL: It's the Law!

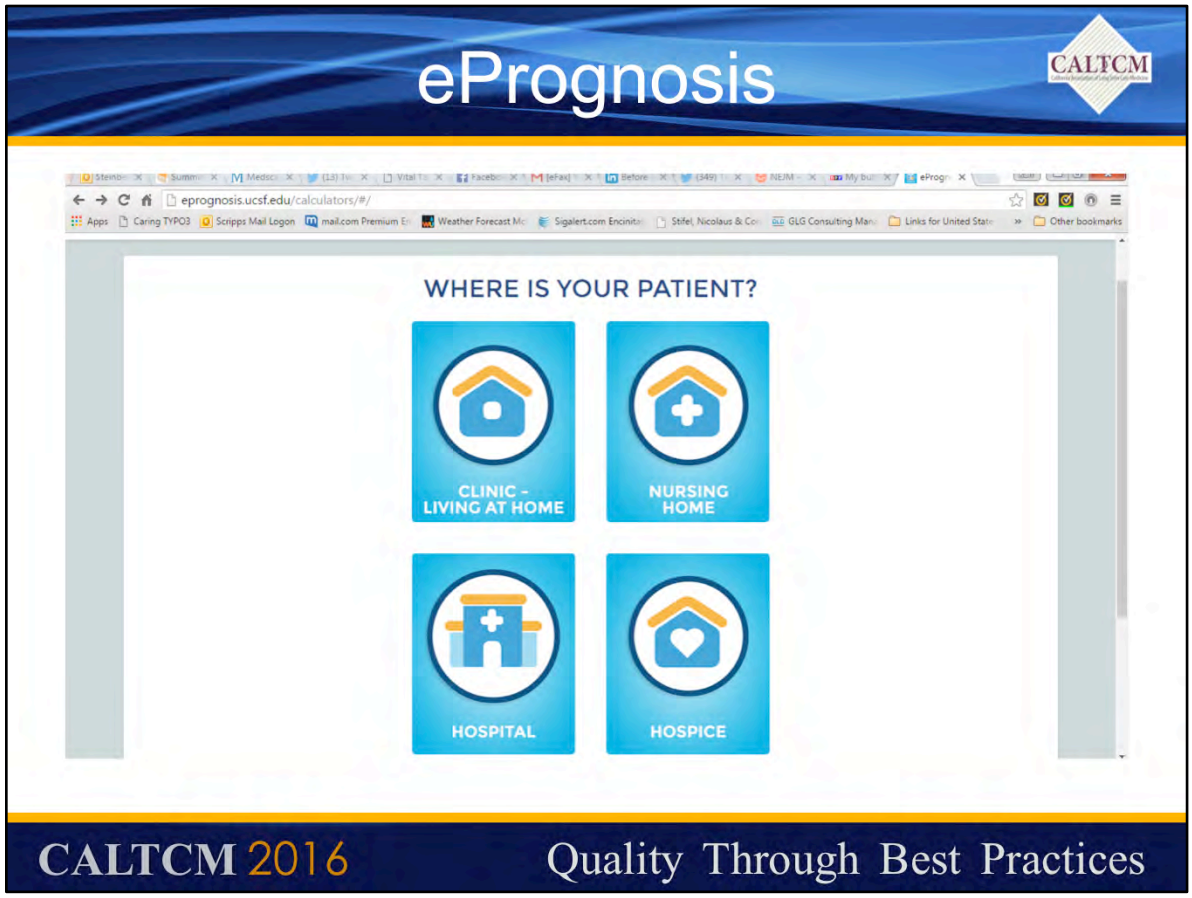
- AB 2139 (Eggman, 2014)
  - When a health care provider, as defined, makes a diagnosis that a patient has a **terminal illness**, existing law requires the health care provider to provide the patient, upon the patient's request, with **comprehensive information and counseling regarding legal end-of-life options**, as specified, and provide for the referral or transfer of a patient, as provided, if the patient's health care provider does not wish to comply with the patient's request for information on end-of-life options.
  - "Terminal illness" means <1 year life expectancy
  - Exception: Under AB X2-15 (EOLOA), not mandatory to provide any info on physician-assisted dying

Notes:

How to Prognosticate?

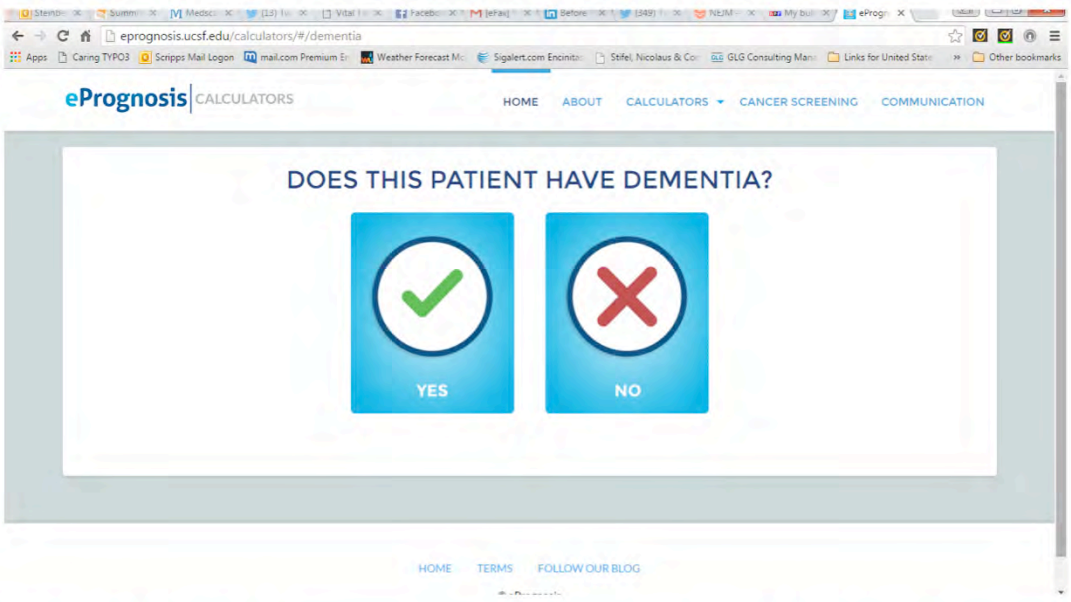
- "Surprise" Question (Would you be surprised if this person died in the next 12 months?)
- For malignancies, advanced liver disease, some other specific conditions, there are better data
- www.ePrognosis.org can help
  - Has SNF-specific calculators (Porock, Mitchell, Flacker)
  - Basically mortality predictors, but can definitely help create realistic expectations (e.g., out of 100 nursing home residents with similar characteristics, 28 will die in the next year)

Notes:


ePrognosis
CALTCM
eprognosis.ucsf.edu/calculators/#/
WHERE IS YOUR PATIENT?
CLINIC - LIVING AT HOME
NURSING HOME
HOSPITAL
HOSPICE
CALTCM 2016
Quality Through Best Practices

Notes:

ePrognosis



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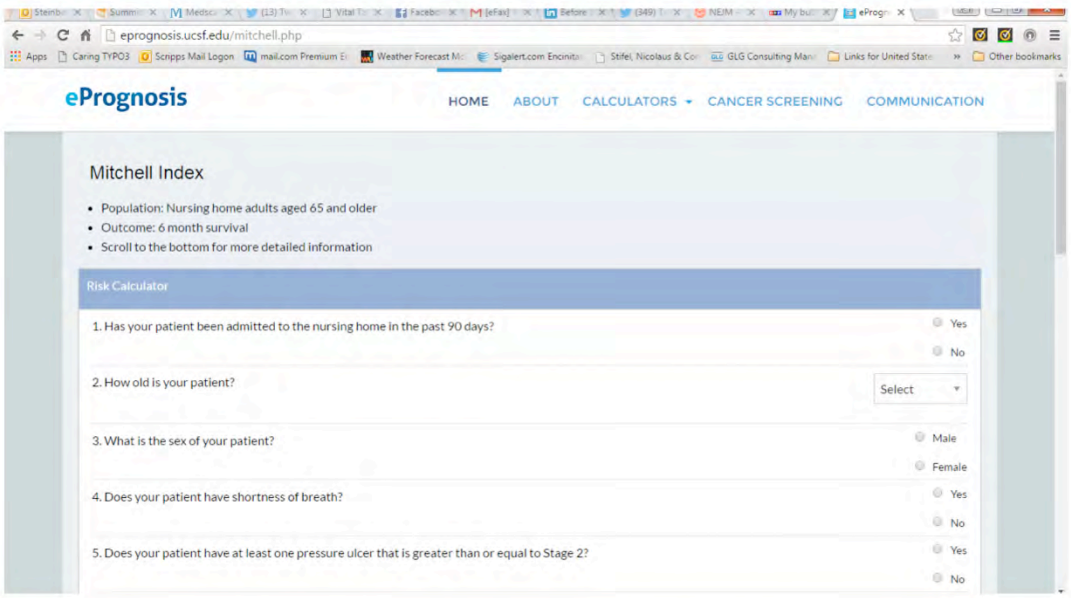

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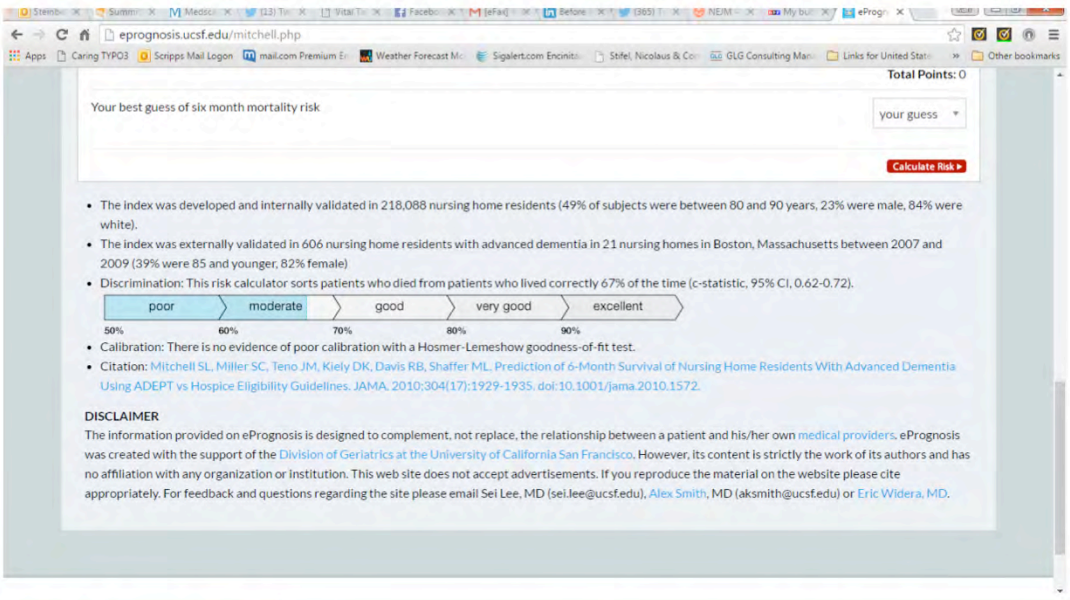
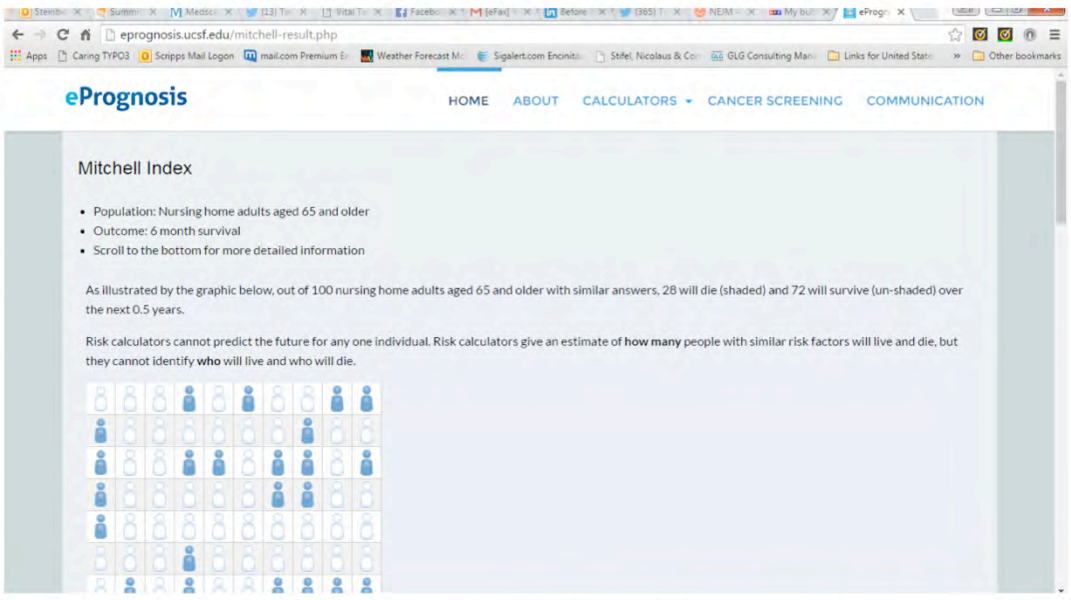
Notes:

ePrognosis



Notes:

ePrognosis



Notes:

How to Prognosticate?

- Functional dependence correlates with shorter life expectancy
- Delirium carries a poor prognosis, no matter the cause
  - Longer it lasts, worse the prognosis
  - Consider carefully any elective surgery in our population
- Weight loss, malnutrition, inflammatory factors, pressure ulcers (low albumin level correlates with these)
- Sarcopenia/Frailty Scales, correlate to poor prognosis and increased mortality

Notes:

Frailty

7
8
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Depression
Osteoarthritis
Osteoporosis

Table 1
A Scale to Identify Frailty in the Nursing Home: The FRAIL-NH Scale
We are investigating 2 versions of the FRAIL-NH Scale. In version 1, the "I" stands for Incontinence. In version 2, the "I" stands for Illness
F = Fatigue, No, Yes, Depressed based on PHQ-9 of ≥10
R = Resistance, Can patient transfer, Independently, Help with set up only, or Physical assistance
A = Ambulation, Independent, With assistive device, Not able
I = Incontinence, None, Urinary incontinence, Bowel incontinence
OR
I = Illness, measured by number of medications: ≤5, 5–9, ≥10
L = Loss of weight, None, ≥5% in 3 months, ≥10% in the past 6 months
N = Nutritional approach, Regular diet, Mechanically altered diet, Feeding tube
H = Help with dressing, Independent, Help with set up only, Physical help

	0	1	2
Fatigue	No	Yes	PHQ-9 ≥10
Resistance	Independent transfer	Set up	Physical help
Ambulation	Independent	Assistive device	Not able
Incontinence	None	Bladder	Bowel
OR			
Illness	≤5	5–9	≥10
Loss of weight	None	≥5% in 3 mo	≥10% in 6 mo
Nutritional approach	Regular diet	Mechanically altered	Feeding tube
Help with dressing	Independent	Set up	Physical help
Total/Version 1			0–14
Total/Version 2			0–14

If the patient meets both criteria, he or she will be assigned 2 points. For example, if a patient is incontinent of bladder and bowel he or she will be assigned 2 points for that category. This applies to the categories of fatigue and weight loss as well.

http://www.jamda.com/article/S1525-8610(15)00137-1/abstract

http://www.jamda.com/article/S1525-8610(14)00797-X/abstract

Notes:

Give Honest Prognostic Information

(…to those who want it)

How long do I have?	"I wish I had a better answer… In your situation, the prognosis for most people is from a few months to a year, sometimes longer." • Use I wish statements • Give a range
What can we do?	"Let's make sure we address what is most important – what are the most important goals for you in your life right now?"… then listen. • Help patients focus on *their* goals

Notes:

Be Willing to Discuss Specific Interventions

- Important: "DN(A)R/AND" on **POLST** does not mean "just let me die"—it ONLY applies when no pulse and no resps.
- CPR is vanishingly unlikely to succeed in a frail nursing home patient, if success is a return to baseline
- CPR is a procedure and an act of violence with its own set of significant risks (but we don't require consent for it!)
- Feeding tubes are CONTRAINDICATED in advanced dementia
  - Increased risk of pressure ulcer, aspiration pneumonia, delirium, and actual tube complications
  - Comfort feeding has better outcomes, even with dysphagia

Notes:

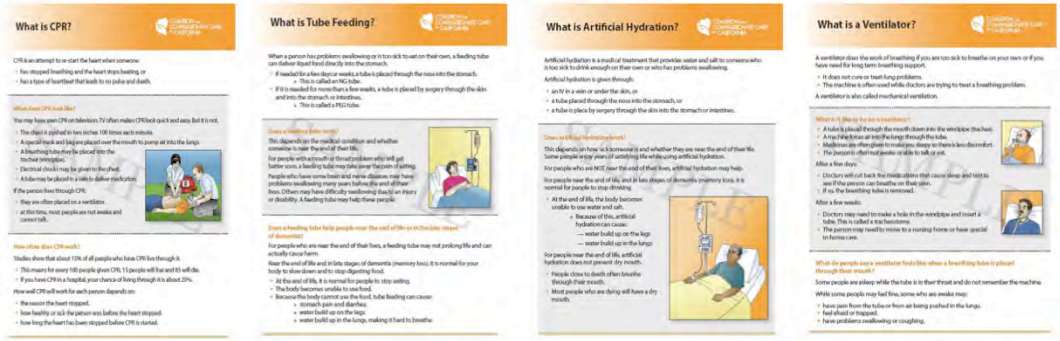
Be Willing to Discuss Interventions and Death

- Intravenous hydration may be reasonable short-term, but is generally contraindicated at end of life
  - Fluid overload, third spacing, pulmonary edema
- Dying from dehydration is generally a pretty benign exit
  - BP drops, brain perfusion drops, ketosis may produce mild euphoria, patient drifts off to sleep, eventually hypovolemia
  - Usually takes 7-14 days—but that is with NO FLUIDS
  - More peaceful than most forms of death
- Voluntary refusal of food and fluids (VRFF) also called Voluntary stopping of eating and drinking (VSED) always an option for patients with decisional capacity

Notes:

Decision Guides from CCCC

CPR • Tube Feeding • Hydration •Ventilation



http://coalitionccc.org/tools-resources/decision-guides/

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Notes:

More Aggressive EOL Measures

- Palliative sedation to unconsciousness—intravenous drip
- Normally done in hospital, but can be done in SNF on hospice
- A last resort when other measures have failed to stop unbearable suffering

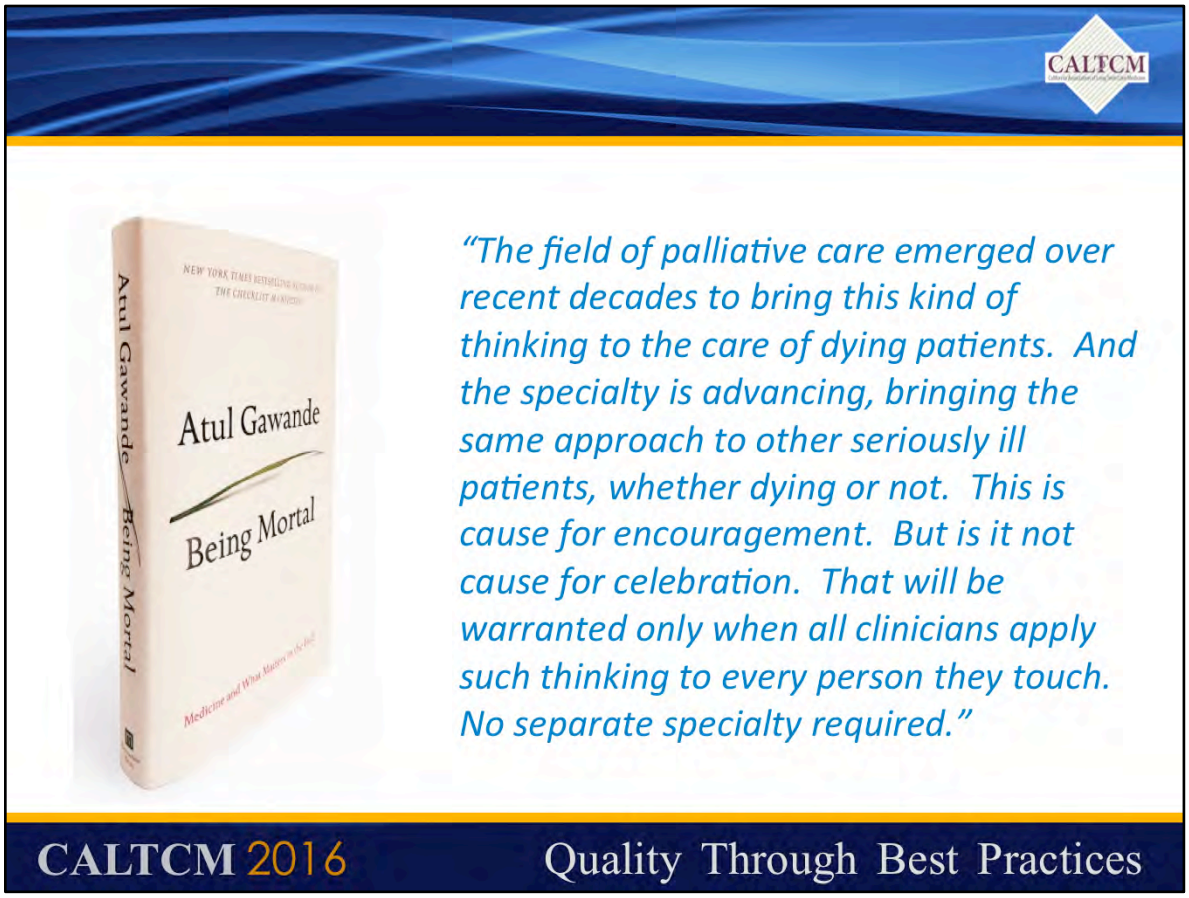
- AB X2-15 (End of Life Option Act) becomes a reality on June 9, 2016: Physician-Assisted Death
- In other states, a rarity in SNFs, but should have policies
- No healthcare worker who objects to it has to participate

Notes:

Palliative Care

- Team-based, patient and family, maximize quality of life (not primarily quantity), symptom control, person-centered
- *Hey! This is what we have been doing in SNF for decades*
- Huge workforce shortage of certified Hospice & Palliative Medicine docs (<1000 in CA), and other certified personnel (chaplains, nurses, social workers)
  - If interested, get certified! (e.g. www.csupalliativecare.org)
- Need to deputize every healthcare worker to have expertise in palliative care, call in specialists for more complex cases

Notes: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Atul Gawande
Being Mortal
"The field of palliative care emerged over recent decades to bring this kind of thinking to the care of dying patients. And the specialty is advancing, bringing the same approach to other seriously ill patients, whether dying or not. This is cause for encouragement. But is it not cause for celebration. That will be warranted only when all clinicians apply such thinking to every person they touch. No separate specialty required."
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Quality Through Best Practices

Notes:

Take-Home Messages

- Advance Care Planning is important!
- Conversations may require 5 minutes or >5 hours
- Person-centered care—individualize discussions
- People change their minds in both directions
- Concept of Leeway in decision-making
- We are not required to provide medically ineffective tx.
- A little self-disclosure can go a long way—we are human, we have feelings and experiences, and hugs and tears happen sometimes—"professionality" notwithstanding

- *Our job is to help people make informed decisions and honor the decisions they make—our only agenda*

Notes:

Take-Home Messages

- DNR does not mean “just let me die”
- It’s better to have discussions in non-crisis times
- Good advance care planning helps get people the treatment they want, and avoid the treatment they don’t want (or that won’t help them)
- Dying of dehydration is generally a peaceful death
- We need to make these conversations normal, and encourage everyone to be comfortable with them

Notes:

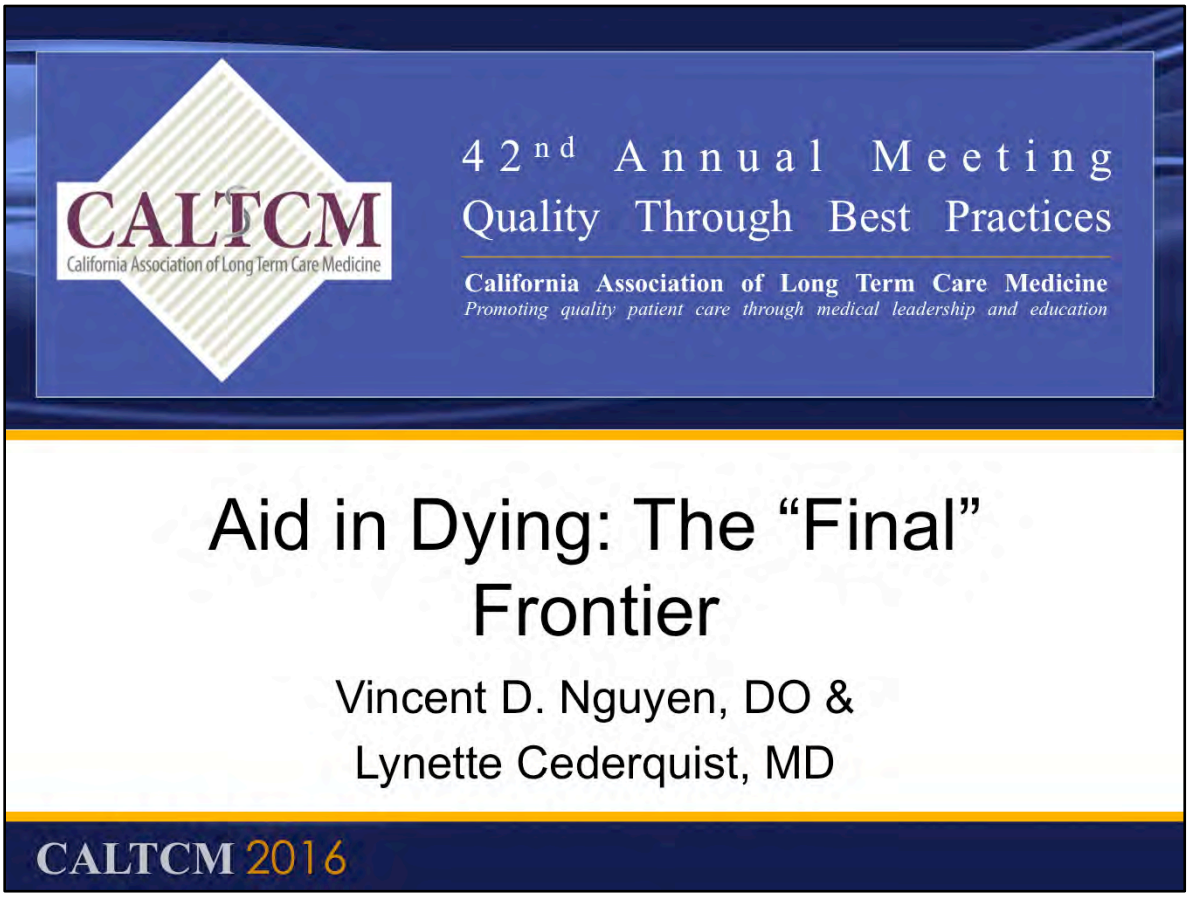
Take-Home Messages

- It can help to have a script to have these difficult discussions
  - But we must be culturally and individually sensitive
  - Must be adaptable and nimble
  - Practice doesn't make perfect, but we do get better at it
- At the base of all our interactions should be our compassion and empathy for the patient and his or her loved ones

Notes:

Thank You!

Notes: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California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Aid in Dying: The "Final" Frontier
Vincent D. Nguyen, DO &
Lynette Cederquist, MD
CALTCM 2016

Notes:

Disclosure Statements

Dr. Cederquist has no relevant financial relationships with commercial interests to disclose.

Dr. Nguyen received consulting fees from Gale and Insys for being on their Speakers Bureau, and received stock from Acology for participating on their Advisory Board.

All conflicts of interest have been resolved in accordance with the ACCME's Standards for Commercial Support.

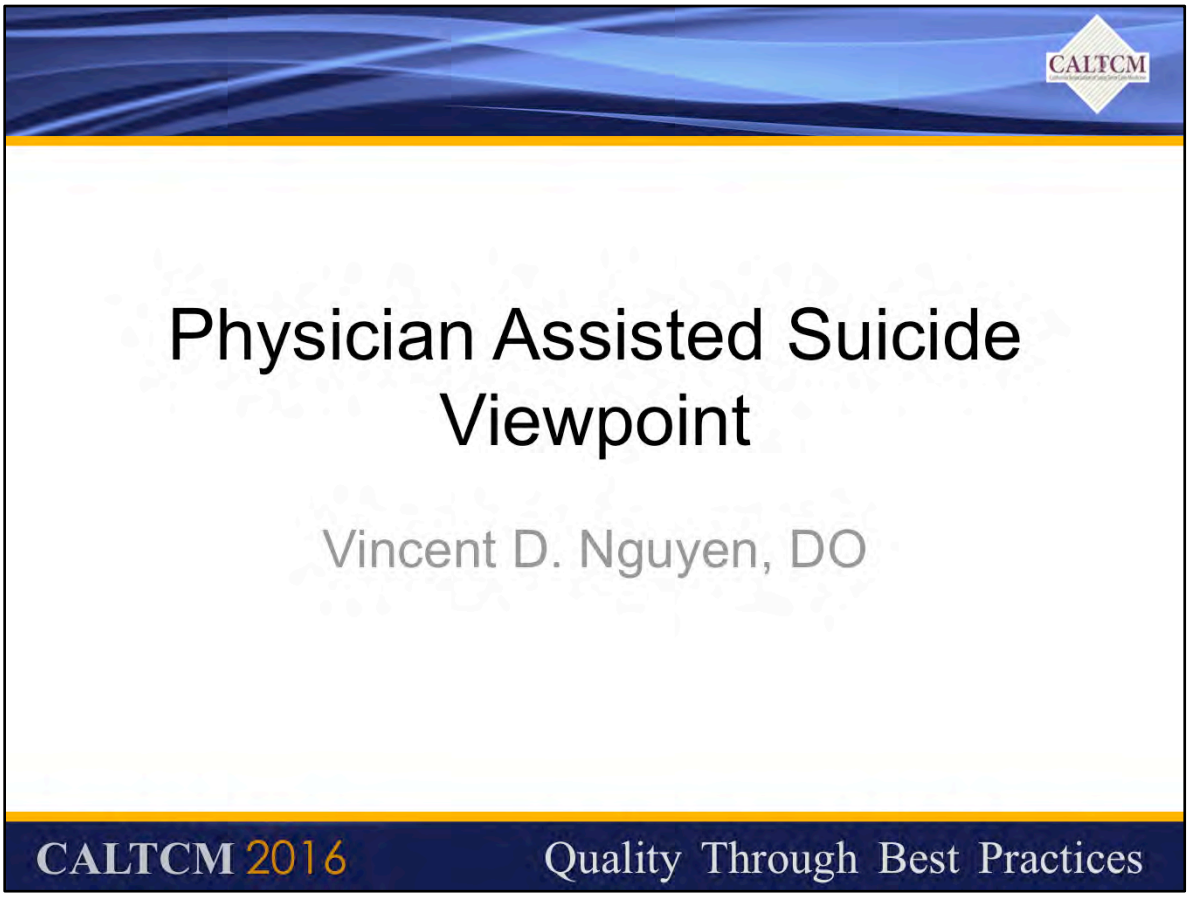
Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Describe the new Aid in Dying law
- Identify implications in LTC based on the new law
- Discuss possible approaches to implementing the new law in the LTC setting

Notes:


CALTCM
Physician Assisted Suicide Viewpoint
Vincent D. Nguyen, DO
CALTCM 2016
Quality Through Best Practices

Notes:

Physician Assisted Suicide is NEVER Justifiable

"Physician Assisted Suicide is fundamentally ***inconsistent*** with the physician's professional role."

American Medical Association

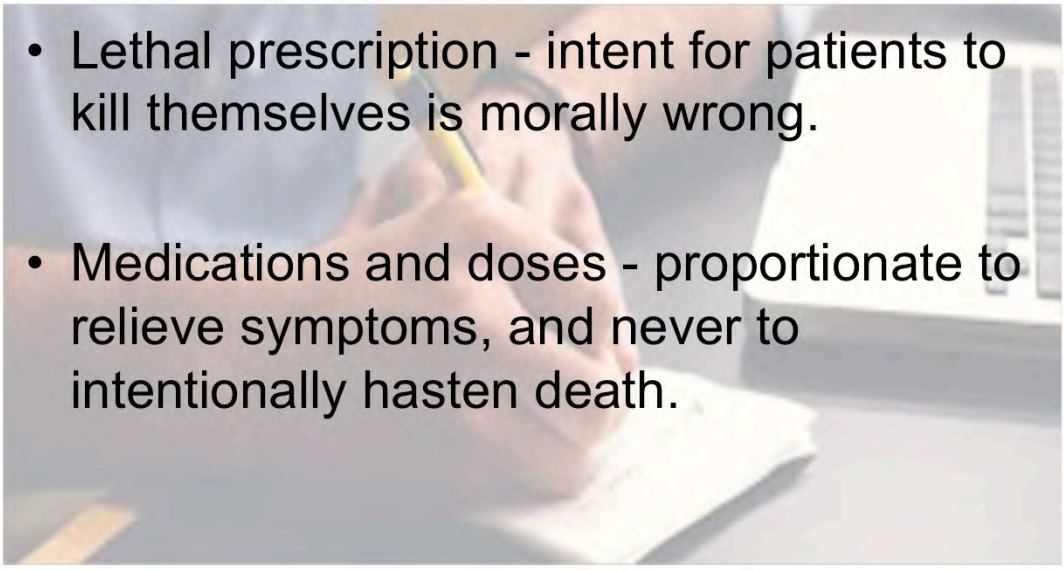
Notes:

Duty of the Physician

- Safeguard human life
- Benefit the sick
- Alleviate suffering
- Unburden fear

Notes:

Do NOT Kill!



- Lethal prescription - intent for patients to kill themselves is morally wrong.
- Medications and doses - proportionate to relieve symptoms, and never to intentionally hasten death.

Notes:

Patients have the rights to…

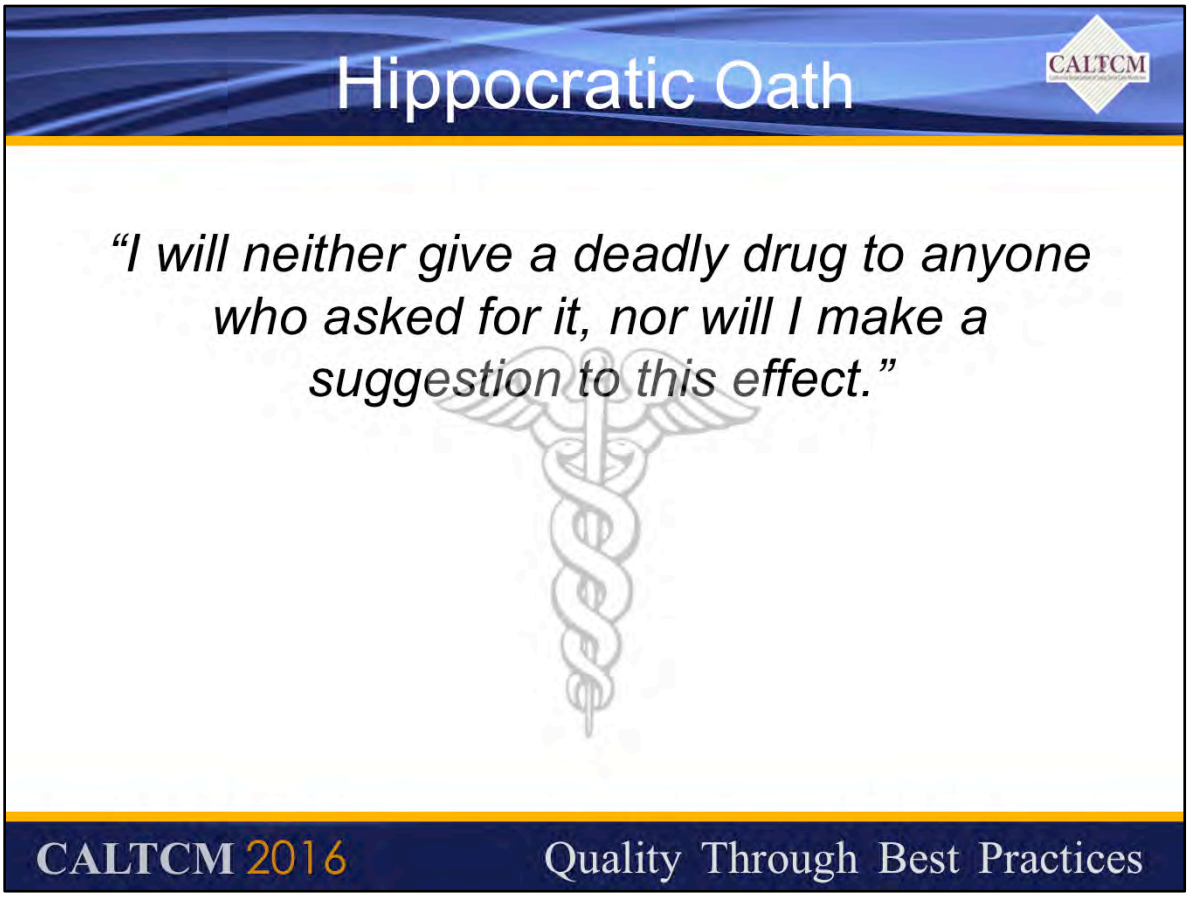
- Refuse life-sustaining treatments
- Forgo burdensome treatments at the end of life
- Proportionate palliation, even if death is hastened as a side effect
- Voluntarily stop eating and drinking
- End their lives by all manners of methods that do NOT involve physicians.

Notes:

"Right to Die"

- "Right to have a physician help me kill myself."

Notes:


Hippocratic Oath
CALTCM
"I will neither give a deadly drug to anyone who asked for it, nor will I make a suggestion to this effect."
CALTCM 2016
Quality Through Best Practices

Notes:

Displaces Public Trust

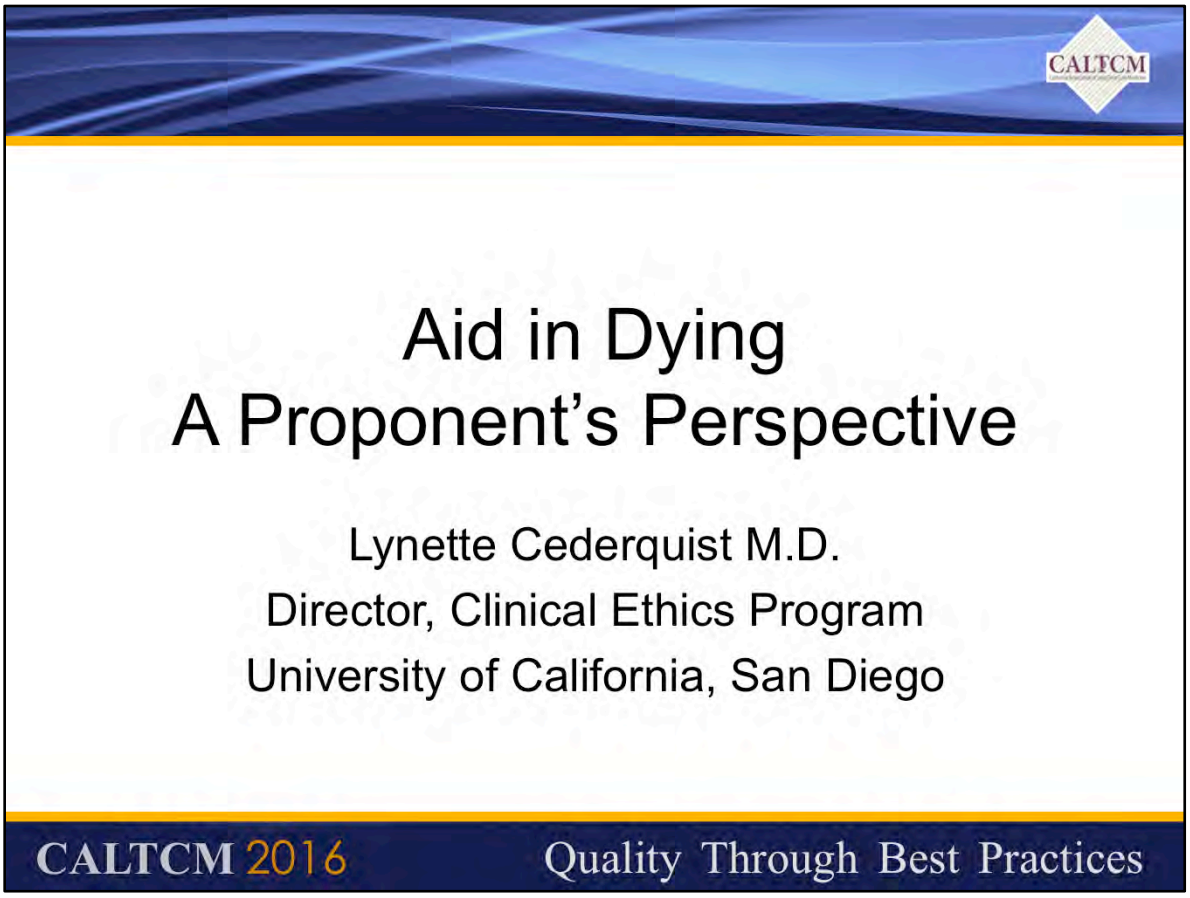
- There can be no practice of medicine if patients do not trust physicians to care for them when they can not care for themselves.

Notes:

PAS is Never Justifiable

- Violates the injunction of not to kill
- Unjustly patronizes the desires of the few
- Contradicts the physician's professional role and solidarity with the vulnerable
- Medicine is a healing profession

Notes:


CALTCM
Aid in Dying
A Proponent's Perspective
Lynette Cederquist M.D.
Director, Clinical Ethics Program
University of California, San Diego
CALTCM 2016
Quality Through Best Practices

Notes:

Is PAD Ethically/Morally Justifiable?

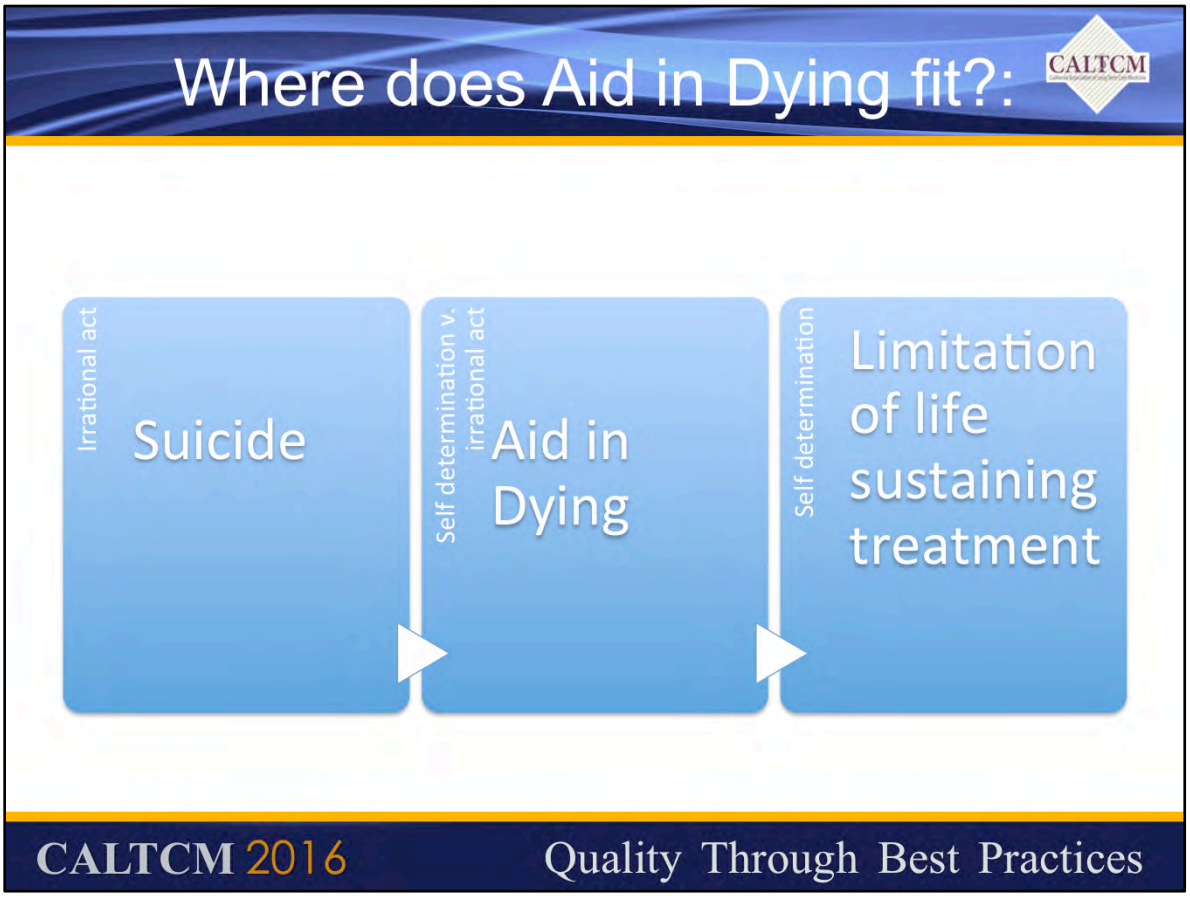
- Autonomy:Those in support believe that individuals should be allowed the right to choose PAD - right to self determination
- Justice: Patients have the right to refuse treatment which might prolong their life. For patients who are terminally ill but not dependent on life support, refusing treatment will not result in death. To treat these patients in an equitable manner, they should be allowed the choice of PAD to hasten death
- Compassion: PAD may be a compassionate response to unremitting suffering

Notes:

…Arguments in favor of PAD:

- Individual liberty vs. State interest: Though society has a strong interest in preserving life, that interest lessons when a person is terminally ill and has a strong desire to end their life. A complete prohibition against PAD excessively limits personal liberty
- Honesty and transparency: Some acknowledge that aid in dying already occurs in a secretive manner.
  - via physicians surreptitiously
  - via organizations such as Hemlock Society

Notes:


Where does Aid in Dying fit?:
CALTCM
Irrational act
Suicide
Self determination v. irrational act
Aid in Dying
Self determination
Limitation of life sustaining treatment
CALTCM 2016
Quality Through Best Practices

Notes:

90 year old man residing in a SNF in Australia:

- "It is my firm opinion that enforced prolonged life when quality of life is lost is a fate far worse than death. I fear degeneration far more than I fear death. It is inhumane to leave those who have lost quality of life, whether it be degeneration or terminal illness that leaves them confined in a nursing home indefinitely suffering from dementia, Alzheimer's, incontinence and the like."
- "Times have changed. In my grandparents day there were no nursing homes. My parents cared for my grandparents at home. The family doctor every other week would check on them. When they lost quality of life, he asked for a family conference and was given permission to ease them out with analgesics. It was not called euthanasia but rather compassion."

Notes:


CALTCM
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
geriatricpain.org
Debra Bakerjian PhD, APRN, FAAN, FAANP
President, CALTCM
Associate Adjunct Professor
Betty Irene Moore School of Nursing
University of CA, Davis
CALTCM 2016

Notes:

Financial Disclosures

- I am a founding member of the team that created geriatricpain.org
- I have no actual or potential conflict of interest in relation to this program

Notes:

Objectives

1. Describe a web-based resource on pain management available free of charge to nursing homes

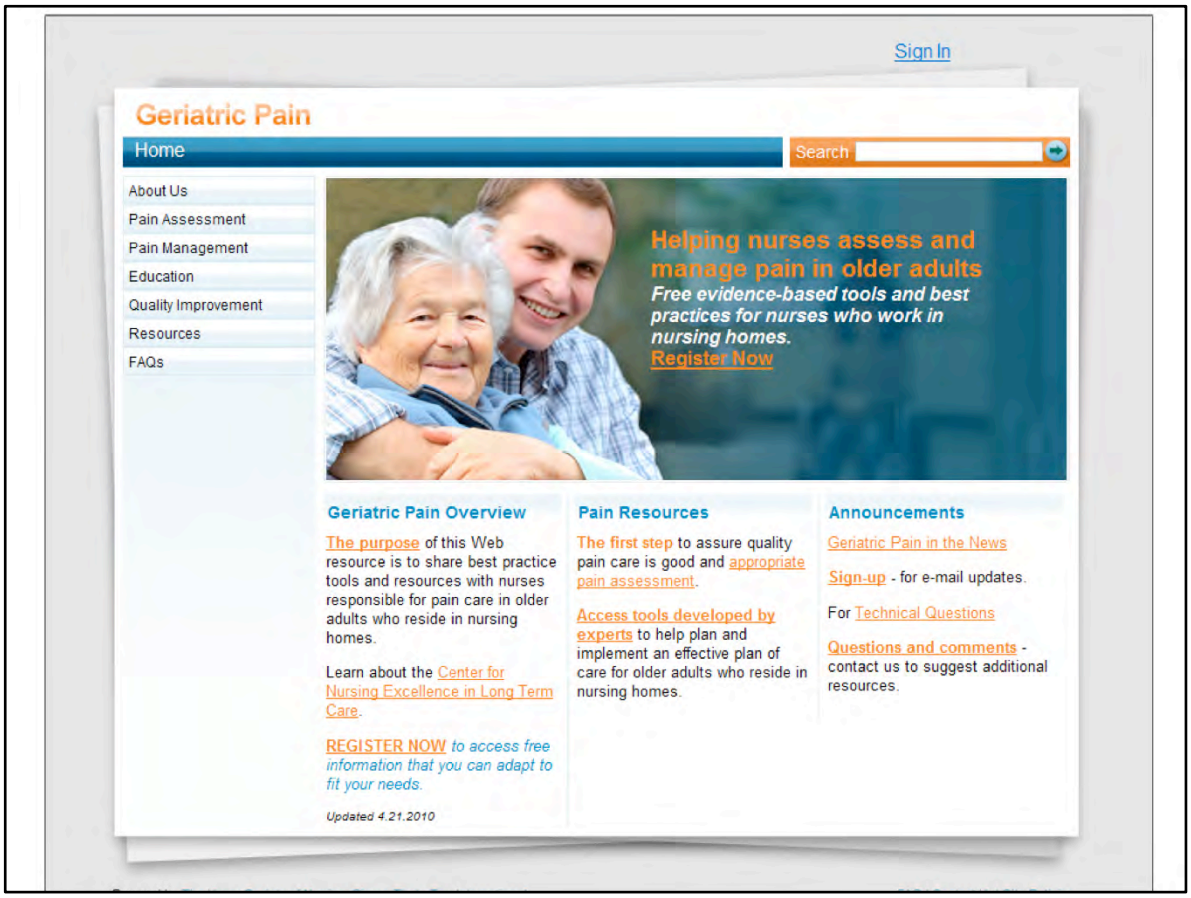
2. Demonstrate how nursing homes can access the information

Notes:

geriatricpain.org

- Website specifically designed for NH staff
- Resources are evidence based
- Resources are free
- Go to www.geriatricpain.org
- Registration is required but takes about 2 minutes

Notes:


Sign In
Geriatric Pain
Home
Search
About Us
Pain Assessment
Pain Management
Education
Quality Improvement
Resources
FAQs
Helping nurses assess and manage pain in older adults
Free evidence-based tools and best practices for nurses who work in nursing homes.
Register Now
Geriatric Pain Overview
The purpose of this Web resource is to share best practice tools and resources with nurses responsible for pain care in older adults who reside in nursing homes.
Learn about the Center for Nursing Excellence in Long Term Care.
REGISTER NOW to access free information that you can adapt to fit your needs.
Updated 4.21.2010
Pain Resources
The first step to assure quality pain care is good and appropriate pain assessment.
Access tools developed by experts to help plan and implement an effective plan of care for older adults who reside in nursing homes.
Announcements
Geriatric Pain in the News
Sign-up - for e-mail updates.
For Technical Questions
Questions and comments - contact us to suggest additional resources.

Notes:

Contents

- Pain Assessment
- Pain Management
- Education on Pain for staff
- Quality Improvement
- Resources
- FAQs
- MDS 3.0

CALTCM 2016 Quality Through Best Practices

Notes:

Pain Assessment

- Core Principles of Pain Assessment
- Pain terminology- glossary of terms
- Pain communication tools
- Comprehensive Pain Assessment forms
  - Cognitively Intact
  - Cognitively Impaired

Notes:

Assessment Cognitively Intact

Comprehensive Pain Assessment Form
Cognitively Intact

Resident Name _____ **ID #** _____ **Room #** ____
Assessment Date _____ **Time** _____ **Physician** _____

Residents Pain Control Goal	Residents Pain Intensity Goal
☐ Sleep comfortably ☐ Comfort at rest ☐ Comfort with movement ☐ Total pain control ☐ Stay alert ☐ Perform desired activities ☐ Other:_____	0 1 2 3 4 5 6 7 8 9 10 ☐☐☐☐☐☐☐☐☐☐☐ (Check the correct rating)

Current Pain-related Diagnosis(es):_____

Reason for Assessment: ☐MDS Admission ☐MDS Significant Change ☐MDS Readmission ☐MDS Quarterly ☐ MDS Annual ☐New Condition ☐Routine Monitoring

Type of Pain: ☐ Nociceptive (Joint/bone/soft tissue) ☐ Neuropathic ☐ Mixed

Depression (yes/no): ____ Depression Scale and Score: _____ Date: _____

Intensity of Pain: Scale Used

☐**Numerical 0-10** (circle the correct rating)

0 1 2 3 4 5 6 7 8 9 10
↑ No Pain ↑ Moderate Pain ↑ Worst Possible Pain

☐**Faces Pain Scale-Revised**

Used with permission from IASP; this figure may not be used or modified without express written consent from IASP

Score the chosen face as 0, 2, 4, 6, 8 or 10, counting left to right with 0= "no pain" and 10 "worst pain possible".

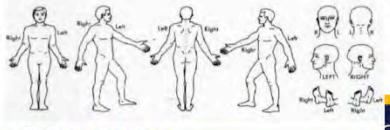
☐**Verbal Descriptor Scale**

Circle the words that best represent the intensity of your pain now:

No pain Mild pain Moderate pain Severe pain Extreme pain Pain as bad as could be

Location: (Resident or nurse mark drawing) Mark on the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with all the symbols that apply. Make sure you show all affected areas.

O Aching
/ Burning
Cramping
≡ Crushing
◆ Dull
* Numbness
+ Pins/needles
● Sharp
↓ Stabbing
↑ Throbbing



History of Pain

Onset of Pain: ☐New (within the last 7 days) ☐Recent (within the last 3 mos.) ☐More distant (> 3 mos.) ☐Unknown

Frequency of Pain: ☐Constant ☐Frequent ☐Infrequent ☐ Unknown

Description of Pain: ☐Aching ☐Burning ☐Cramping ☐Crushing ☐Dull ☐Numbness ☐Pins & Needles ☐Sharp ☐Shooting ☐Throbbing ☐Other, describe:_____

Change in Pattern of Pain: Has the pain changed in description or intensity the last 7 days? ☐ Yes ☐No ☐Unknown If yes, describe the change: _____

Causes/Increases in Pain: ☐Movement ☐Coughing ☐Cold ☐Heat ☐Fatigue ☐Anxiety ☐Other, describe: _____

What Relieves the Pain: ☐Cold ☐Heat ☐Exercise ☐Eating ☐Opioids ☐Non-Opioid Meds ☐Massage ☐Relaxation ☐Rest ☐Repositioning ☐Distraction ☐Other, describe:_____

Effects of Pain: Using the following scale, rate how the pain has had an effect in each area in the past 24 hours: **0** (no effect) **2** (mild effect) **5** (moderate effect) **10** (severe effect)

Accompanying Symptoms (e.g., nausea) ____ Sleep Disturbance ____ Appetite Change ____
Physical Activity Change____ Mood/Behavior ____Concentration ____
Relationship with Others ____ Other (describe): _____

Worst Pain in 24 Hours: 0 1 2 3 4 5 6 7 8 9 10
↑ No Pain ↑ Moderate Pain ↑ Worst Possible Pain

In the past 24 hours, how much have the medications or treatments eased your pain?
0 No relief **2** Mild relief **5** Moderate relief **8** Relief **10** Complete relief

Plan for Addressing Pain: ☐Initiate pain management flow sheet ☐Call Prescriber ☐Refer to pain team ☐Rehab referral (PT, OT, ST) ☐Non-med intervention ☐Medications prescribed ☐Spiritual counseling ☐Staff education/communication

Comments:_____

Signature/Title of person completing assessment: _____ Date: _____

CALTCM 2016 Quality Through Best Practices

Notes:

Assessment Cognitively Impaired

Comprehensive Pain Assessment Form
Cognitively Impaired

Name _____ **ID #**_____ **Room #**_____
Assessment Date_____ **Time** _____ **Physician**_____

Resident's/Family's Pain Control Goals	Resident's/Family's Pain Behavior Goal
☐ Sleep comfortably ☐ Comfort at rest ☐ Comfort with movement ☐ Total pain control ☐ Stay alert ☐ Perform activities ☐ Other:_____	0 1 2 3 4 5 6 7 8 9 10 ☐☐☐ ☐☐☐☐☐☐ ☐☐ ☐ (Check the correct rating)

Current Pain-related Diagnosis(es): _____

Reason for Assessment: ☐MDS Admission ☐MDS Significant Change ☐MDS Readmission ☐MDS Quarterly ☐ MDS Annual ☐New Condition ☐Routine Monitoring

Type of Pain: ☐ Nociceptive ☐ Neuropathic ☐ Mixed ☐ Unknown

Verbal Self-report Attempted (Yes/No):_____ Resident's Response:_____

Verbal Report Matches behavioral indicators (yes/no):_____

Depression (yes/no):_____ Depression Scale and Score:_____ Date:_____

PAINAD (Pain Assessment in Advanced Dementia) (See page 3 for instructions and item definitions)

	0	1	2	Score
Breathing Independent of Vocalizations	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.	
Negative Vocalizations	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial Expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure.	
Total Points				

Additional Pain Behaviors--(from MDS, Section J)

Nonverbal Sounds	Vocal Complaints	Facial Expression	Protective Body Movements
☐Whining ☐Gasping	☐"Ouch" ☐"That hurts"	☐Winces ☐Wrinkled forehead ☐Furrowed brow ☐Clenched jaw	☐Bracing ☐Guarding ☐Rubbing body part/area ☐Clutching/holding body part/area during movement

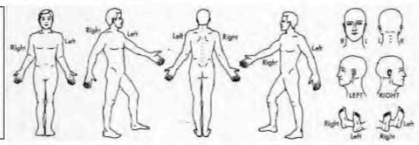
Other Behaviors_____

Effects of Pain: Check each area below that is affected by pain:

☐Accompanying Symptoms (e.g., nausea) ☐Sleep Disturbance ☐Appetite Change ☐Physical Activity Change ☐Mood/Behavior ☐Concentration ☐Relationship with Others ☐Unknown ☐Other (describe) _____

Location: Mark the areas of known pain.

O Aching
/ Burning
Cramping
= Crushing
◆ Dull
* Numbness
+ Pins/needles
● Sharp
↓ Stabbing
↑ Throbbing



History of Pain

Onset of Pain: ☐New (within the last 7 days) ☐Recent (within the last 3 mos.) ☐More distant (> 3 mos.) ☐Unknown

Frequency of Pain: ☐Constant ☐Frequent ☐Infrequent ☐ Unknown

Change in Pattern of Pain: Has the pain changed in description or intensity the last 7 days? ☐Yes ☐No ☐Unknown If yes, describe the change:_____

What Relieves the Pain: ☐Opioids ☐Non-Opioid meds ☐Cold ☐Heat ☐Exercise ☐Eating ☐Massage ☐Relaxation ☐Rest ☐Repositioning ☐Distraction ☐Unknown ☐Other, describe:_____

Family Report about Pain/Pain History:

_____

_____

Plan for Addressing Pain: ☐Initiate pain management flow sheet ☐Call prescriber ☐Refer to pain team ☐Rehab referral (PT, OT, ST) ☐Non-med intervention ☐Medications ☐Spiritual counseling ☐Staff education/communication

Comments:_____

Signature/Title of person completing assessment: _____ Date: _____

Notes:

Pain Management

- Core principles of Pain Treatment
- Pain Mangement Terminology
- Pain Management Interventions
  - WHO Ladder
  - Side-Effects Management
  - Serial Trial Intervention
  - Non-pharmacological Pain Management Interventions
- Pain Communication tools
- Principles of Pain Management: Adult Guide

Notes:

Serial Trial Intervention

- Systematic process used to assess and proactively treat pain in moderately to severely cognitively impaired adults
- Individuals with dementia use behaviors instead of specific verbal complaints to express pain
- If basic care (feeding, toileting, or positioning) doesn't resolve behaviors trial of analgesia may be helpful
- Protocol has 5 steps to guide the intervention

Non-pharmacological Pain Management Interventions

- Overview Topics
  - Heat, cold, massage, positioning
  - Distraction
  - Music
  - Relaxation; controlled breathing and guided imagery
- Each Topic
  - Definition
  - Techniques
  - What you can do in NH

Notes:

Education- Clinician

- Clinicians resources
  - 5 modules – How To
  - Pain assessment, communication
- End of Live Nursing Education Consortium (ELNEC) modules
- Pain myths
- Barriers to effective pain management with suggested approaches
- Pain Jeopardy Game
- Pain management in patients with Addictive Disease

Notes:

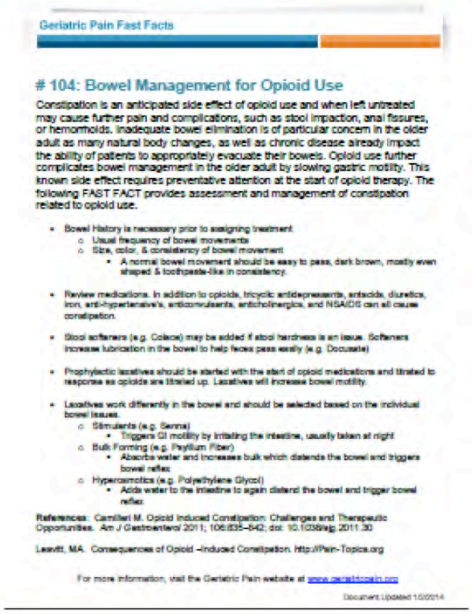
Education for Residents and Families

- Hand out Brochure from AGS
- Persistent Pain – Patient Education
- Hand-out on 10 Meds to be Avoided or used with caution

Notes:

Education – Clinical Staff

- 16 “Fast Facts” – perfect for short education sessions
- Great to hang up as reminders



Geriatric Pain Fast Facts

 # 104: Bowel Management for Opioid Use

Constipation is an anticipated side effect of opioid use and when left untreated may cause further pain and complications, such as stool impaction, anal fissures, or hemorrhoids. Inadequate bowel elimination is of particular concern in the older adult as many natural body changes, as well as chronic disease already impact the ability of patients to appropriately evacuate their bowels. Opioid use further complicates bowel management in the older adult by slowing gastric motility. This known side effect requires preventative attention at the start of opioid therapy. The following FAST FACT provides assessment and management of constipation related to opioid use.

- Bowel History is necessary prior to assigning treatment
  - Usual frequency of bowel movements
  - Size, color, & consistency of bowel movement
    - A normal bowel movement should be easy to pass, dark brown, mostly even shaped & toothpaste-like in consistency.
- Review medications. In addition to opioids, tricyclic antidepressants, antacids, diuretics, iron, anti-hypertensive's, anticonvulsants, anticholinergics, and NSAIDS can all cause constipation.
- Stool softeners (e.g. Colace) may be added if stool hardness is an issue. Softeners increase lubrication in the bowel to help feces pass easily (e.g. Docusate)
- Prophylactic laxatives should be started with the start of opioid medications and titrated to response as opioids are titrated up. Laxatives will increase bowel motility.
- Laxatives work differently in the bowel and should be selected based on the individual bowel issues.
  - Stimulants (e.g. Senna)
    - Triggers GI motility by irritating the intestine, usually taken at night
  - Bulk Forming (e.g. Psyllium Fiber)
    - Absorbs water and increases bulk which distends the bowel and triggers bowel reflex
  - Hyperosmotics (e.g. Polyethylene Glycol)
    - Adds water to the intestine to again distend the bowel and trigger bowel reflex

References. Camilleri M. Opioid-Induced Constipation: Challenges and Therapeutic Opportunities. *Am J Gastroenterol* 2011; 106:835–842; doi: 10.1038/ajg.2011.30

Leavitt, MA. Consequences of Opioid –Induced Constipation. http://Pain-Topics.org

For more information, visit the Geriatric Pain website at www.geriatricpain.org

Document Updated 1/2/2014

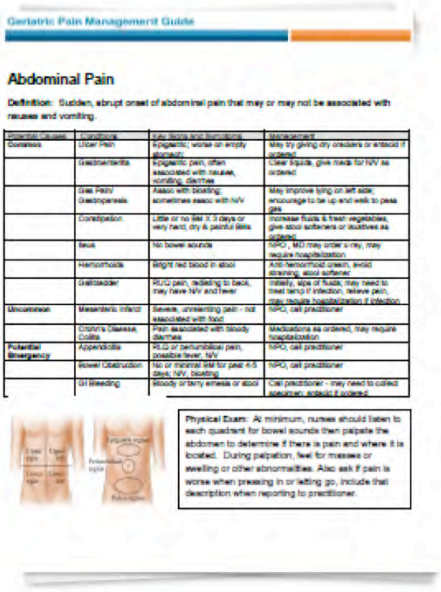
Notes:

Management Guides

- More comprehensive information
- Appropriate for licensed nurses
- Foundation of an inservice

Notes:

Abdominal Pain



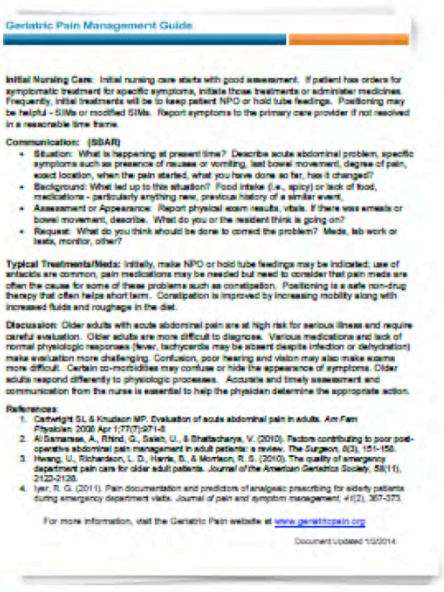
Geriatric Pain Management Guide

Abdominal Pain

Definition: Sudden, abrupt onset of abdominal pain that may or may not be associated with nausea and vomiting.

Potential Causes	Conditions	Key Signs and Symptoms	Management
Common	Ulcer Pain	Epigastric; worse on empty stomach	May try giving dry crackers or antacid if ordered
	Gastroenteritis	Epigastric pain, often associated with nausea, vomiting, diarrhea	Clear liquids, give meds for N/V as ordered
	Gas Pain/ Gastroparesis	Associ with bloating; sometimes assoc with N/V	May improve lying on left side; encourage to be up and walk to pass gas
	Constipation	Little or no BM X 3 days or very hard, dry & painful BMs	Increase fluids & fresh vegetables, give stool softeners or laxatives as ordered
	Ileus	No bowel sounds	NPO, MD may order x-ray, may require hospitalization
	Hemorrhoids	Bright red blood in stool	Anti-hemorrhoid cream, avoid straining, stool softener
	Gallbladder	RUQ pain, radiating to back, may have N/V and fever	Initially, sips of fluids; may need to treat temp if infection, relieve pain; may require hospitalization if infection
Uncommon	Mesenteric infarct	Severe, unrelenting pain - not associated with food	NPO, call practitioner
	Crohn's Disease, Colitis	Pain associated with bloody diarrhea	Medications as ordered, may require hospitalization
Potential Emergency	Appendicitis	RLQ or periumbilical pain, possible fever, N/V	NPO, call practitioner
	Bowel Obstruction	No or minimal BM for past 4-5 days; N/V, bloating	NPO, call practitioner
	GI bleeding	Bloody or tarry emesis or stool	Call practitioner - may need to collect specimen; scope if ordered

Physical Exam: At minimum, nurses should listen to each quadrant for bowel sounds then palpate the abdomen to determine if there is pain and where it is located. During palpation, feel for masses or swelling or other abnormalities. Also ask if pain is worse when pressing in or letting go; include that description when reporting to practitioner.



Geriatric Pain Management Guide

Initial Nursing Care: Initial nursing care starts with good assessment. If patient has orders for symptomatic treatment for specific symptoms, initiate those treatments or administer medicines. Frequently, initial treatments will be to keep patient NPO or hold tube feedings. Positioning may be helpful - SIMs or modified SIMs. Report symptoms to the primary care provider if not resolved in a reasonable time frame.

Communication: (SBAR)

- **Situation:** What is happening at present time? Describe acute abdominal problem, specific symptoms such as presence of nausea or vomiting, last bowel movement, degree of pain, exact location, when the pain started, what you have done so far, has it changed?
- **Background:** What led up to this situation? Food intake (i.e., spicy) or lack of food, medications - particularly anything new, previous history of a similar event,
- **Assessment or Appearance:** Report physical exam results, vitals. If there was emesis or bowel movement, describe. What do you or the resident think is going on?
- **Request:** What do you think should be done to correct the problem? Meds, lab work or tests, monitor, other?

Typical Treatments/Meds: Initially, make NPO or hold tube feedings may be indicated; use of antacids are common, pain medications may be needed but need to consider that pain meds are often the cause for some of these problems such as constipation. Positioning is a safe non-drug therapy that often helps short term. Constipation is improved by increasing mobility along with increased fluids and roughage in the diet.

Discussion: Older adults with acute abdominal pain are at high risk for serious illness and require careful evaluation. Older adults are more difficult to diagnose. Various medications and lack of normal physiologic responses (fever, tachycardia may be absent despite infection or dehydration) make evaluation more challenging. Confusion, poor hearing and vision may also make exams more difficult. Certain co-morbidities may confuse or hide the appearance of symptoms. Older adults respond differently to physiologic processes. Accurate and timely assessment and communication from the nurse is essential to help the physician determine the appropriate action.

References:

1. Cartwright SL & Knudson MP. Evaluation of acute abdominal pain in adults. *Am Fam Physician.* 2008 Apr 1;77(7):971-8
2. Al Samarraie, A., Rhind, G., Saleh, U., & Bhattacharya, V. (2010). Factors contributing to poor post-operative abdominal pain management in adult patients: a review. *The Surgeon*, *8*(3), 151-158.
3. Hwang, U., Richardson, L. D., Harris, B., & Morrison, R. S. (2010). The quality of emergency department pain care for older adult patients. *Journal of the American Geriatrics Society*, *58*(11), 2120-2126.
4. Iyer, R. G. (2011). Pain documentation and predictors of analgesic prescribing for elderly patients during emergency department visits. *Journal of pain and symptom management*, *41*(2), 367-373.

For more information, visit the Geriatric Pain website at www.geriatricpain.org

Document Updated 1/2/2014

CALTCM 2016 Quality Through Best Practices

Notes:

Quality Improvement

- QI plan that aligns with Advancing Excellence processes
- Workbook NHs can use for QI plan
- Audit checklists
- Tracking tools for pain data
- Step by step guide

Notes:

Resources

- CPGs from AGS and University of Iowa
- Federal Regulations
- Links to Organizations related to pain

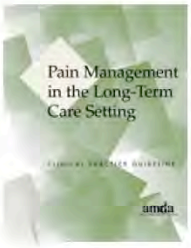
Notes:

Clinical Practice Guidelines

AMDA CPGs

American Geriatrics Society Pharmacological Management of Persistent Pain in Older Persons

Panel on the Pharmacological Management of Persistent Pain in Older Persons



Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain

Notes:

MDS 3.0

- OLD now
- CMS Training on pain assessment
- MDS 3.0 Pain Items

Notes:

Knowledge Assessment Test

- 46 True/False questons
- Based on 19 evidence-based competencies
- Geared toward licensed nurses – LPN/ LVN & RN
- Free PDF available to download OR access online

Notes:

Advancing Excellence

- National volunteer initiative to help NHs improve quality
- Numerous organizations participate
  - Gov't – CMS Survey & Certification, QIOs
  - Consumer – Pioneer Network, NCCNHR, Alzheimer's Association
  - Professional – AANAC, AGS, AMDA, GAPNA, NADONA-LTC,
  - Providers – AHCA/CAHF, Leading Age

Notes:

AE Campaign Resources

- Implementation Guides – offers guidance in how to implement a quality improvement process
- Webinars
- Fast Facts for Staff
- Consumer guide for families and residents
- New resources are coming
- www.nhqualitycampaign.org

Notes:

AE Circle of Success

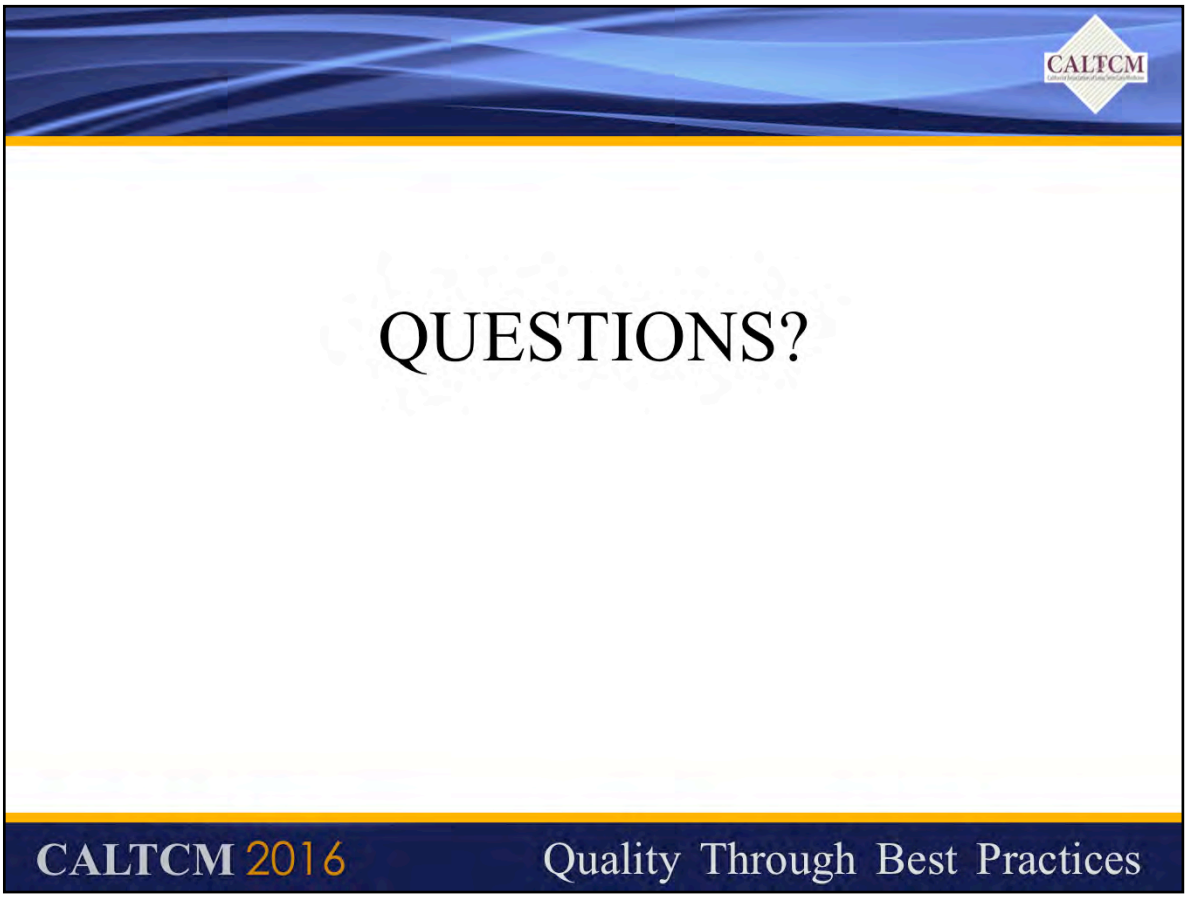
CALTCM 2016 Quality Through Best Practices

Notes:

In Summary

- geriatricpain.org provides a number of useful tools for NHs – clinicians, residents & families, staff
- Free, easy to use
- Extensive resources available
- Other NH specific resources
  - AE Campaign
  - AMDA CPGs
  - AGS tools

Notes: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QUESTIONS?
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Notes:


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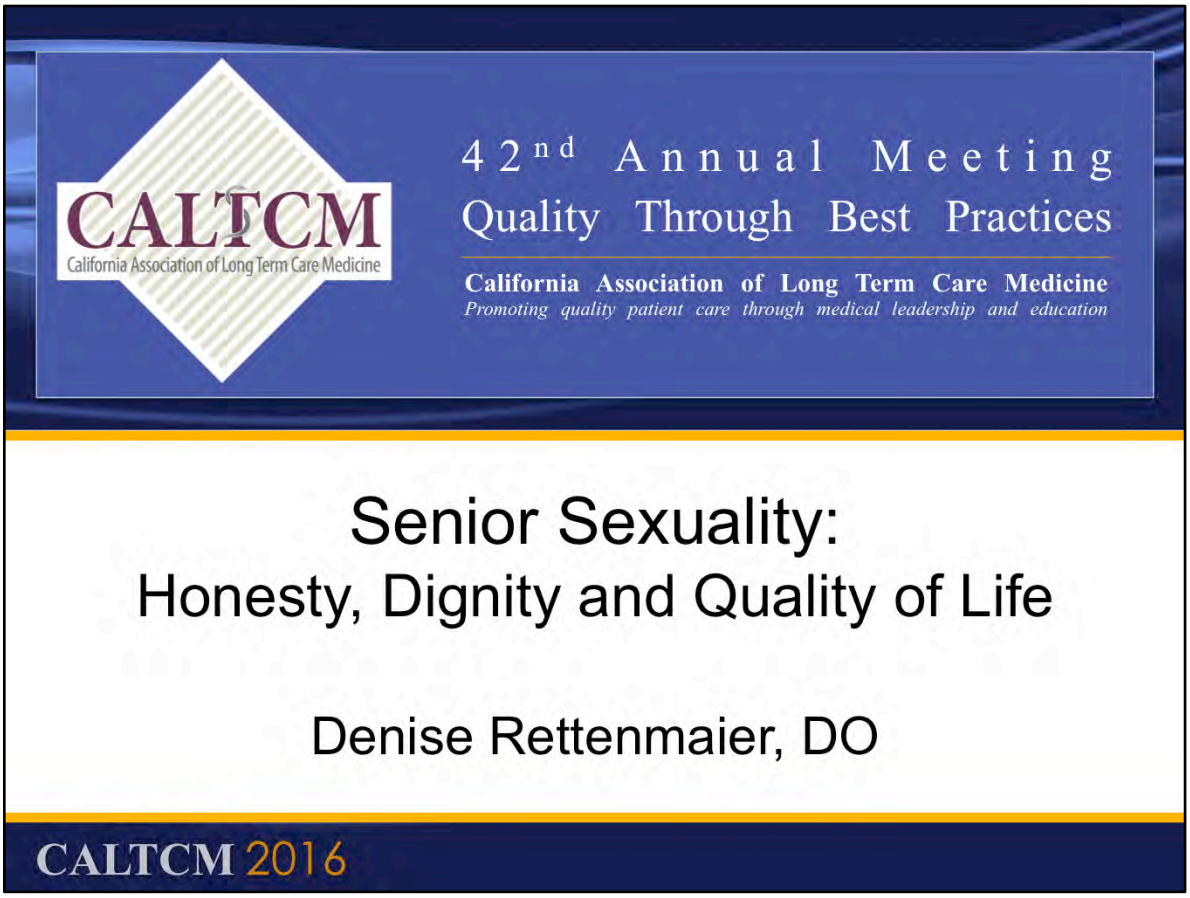
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Intimacy, Sexuality & Autonomy in Long-Term Care
Patricia L. Bach, PsyD, RN
April 30, 2016
CALTCM 2016

Notes:


CALTCM
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Senior Sexuality:
Honesty, Dignity and Quality of Life
Denise Rettenmaier, DO
CALTCM 2016

Notes:

Disclosure

I have no relevant relationships with financial interests to disclose.

Notes:

Learning Objectives

At the conclusion of this activity attendees will have the ability to:

- Recognize normal sexual function in LTC
- Describe model policies and procedures for respecting the sexuality of residents
- Identify the challenges in LTC with sexual
- Understand the need for staff education towards sexuality in older adults

Notes:

Introduction

- The Primary Principles:
  - Honesty ---Dignity ---Quality of Life
- Patient Care Aspects and Issues
  - Patient Autonomy
  - Facilitating Sexuality/Sexual Expression and Intimacy
  - Healthcare Issues
  - Inappropriate or Problematic Sexual Behavior
- Patient Cases
- In Summary

Notes:

The Primary Principles

Honesty

- With Patients and Their Surrogates
- With Staff

Dignity

- Respecting Patients' Choices
- Putting their needs ahead of our attitudes
- Staff education

Quality of Life

- Recognizing the importance of sexual expression for each individual

Notes:


CALTCM
Patient Care Aspects and Issues
CALTCM 2016
Quality Through Best Practices

Notes:

Patient Autonomy:

Supporting Patient Choices

- Understanding patient's expectations and needs
- Family Attitudes
- Family resistance
- Difficulty with parents/elders as sexual beings
- Honesty/Transparency

Staff Attitudes

- Recognizing cross-cultural/religious differences
- Recognizing the power and influence of staff input
- Staff education

Notes:

Facilitating Sexuality / Sexual Expression and Intimacy

- Recognizing Patients' Rights to a Sexual Life
- Dignity/Respect
- Staff Support for Patients Needs
- Providing Privacy: "Pulling the Curtain"

Notes:

Healthcare Aspects

- Practical aspects of Facilitating Intimacy
- Supportive Measures/Equipment
- Physical mechanics
  - OT /Rehab consult
- Safety considerations
- Consultant referrals: Cards, Pulm, GU

Notes:

Healthcare Aspects

- Sexual Dysfunction Men
  - Oral medications
  - Localized treatment
  - Surgical treatments
  - Hormonal therapy
  - External devices (ex: vacuum pump)
- Women
  - Medication for decreased libido
  - Vaginal dryness
  - Oral and topical hormonal therapy

Notes:

Medications and Side Effects

- Sexual dysfunction as side effects of multiple medications:
  - Diuretics
  - Anti-hypertensives (beta/calcium channel blockers)
  - Antidepressants and other psychotropics
  - Antihistamines/Anticholinergics
  - NSAIDs
  - Chemotherapy
- Hypersexuality with excess dopamine Parkinson's Disease

Notes:

Healthcare Aspects

STD/HIV- Increased risks for seniors

- Increased ED treatment
- Decreased use of barrier contraception with decreased pregnancy risk
- New CDC research: 25% of patients with HIV are over 50

Medical Decision-Making Capacity

- Giving Permission
- Patient choices in the moment
- Ability to consent/refuse “in the moment”

Notes:

Addressing Problematic or Inappropriate Sexual Behavior

Inappropriate public sexual activity

- Public masturbators
- PDA couples
- Public Disrobing
- Inappropriate sexual language

Inappropriate affection between staff and residents

- Unwanted advances towards staff "Groping"
- Setting Boundaries and Staff education
- Creatively addressing each situation

Utilizing the IDT : problem solve, care plan and DOCUMENT

CALTCM 2016 Quality Through Best Practices

Notes:

Addressing Problematic or Inappropriate Sexual Behavior

Unwanted advances towards other residents

- Inappropriate sexual pressure on partners
- More capable elder towards more vulnerable elder
  - Examine to assess if actual contact or harm
  - Legally report if appropriate
  - Notify family/surrogates
  - Establish plan to prevent recurrence
    - Separate residents >>ongoing monitoring
    - Staff education
- Sex Workers!

Notes: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Case #1-Mr. A and Rose
CALTCM 2016
Quality Through Best Practices

Notes:

Case #1-Mr. A and Rose

- 89 yo man transferred from independent living to LTC due to FTT after loss of wife after 50+yrs of marriage.
- In LTC, each problem was addressed: depression, wt loss, generalized pain, insomnia, ill-fitting dentures, inadequate bowel care, insomnia, deconditioning.
- Mr. A began to recover . Finally he allowed Therapeutic Activities to take him to the local Sunday dance, and there he met Rose.
- They fell deeply in love and Mr. A wanted to spend his weekends with her at her home near the LTC facility.
- However, his daughter strongly objected to his new relationship.

Notes:

Issues of concern:

- Complicated grieving and depression with FTT
- Medical decision-making capacity
- Family resistance
- Environmental safety off-grounds

Notes:

IDT/staff action:

- Met with pt and daughter to address her objections to his new relationship and discovered her deep fears about his safety; negotiated with her for home health assessment of Rose's home and garden and provided needed safety equipment
- Arranged weekly trips to Rose's: pass meds, Van Go, wheelchair, walker, clean clothes, toiletries

Notes:

On follow-up:

- Mr. A soon stated that he and Rose wanted to consummate their relationship and he needed treatment for erectile dysfunction.
- After trial and error, we found that two muse/ alprostadil intraurethral tablets and one Viagra were effective.
- Eventually they were willing and able to use the vacuum pump.
- Additional issues of concern: ED, STD/HIV risk

Notes:

Case #2-Miss Penny and Her Beau

Notes:

Case #2-Miss Penny and Her Beau

- 89 yo woman, transferred to secured dementia unit because she was getting turned around on the facility grounds.
- Visited daily by her 93 yo BF at lunchtime.
- Staff soon realized they were having sex and would anticipate the need to pull the curtain,close the door.
- Her beau was so reliable, the staff began to order him an extra lunch tray.

Notes:

Issues of concern:

- Patient privacy
- Frequent sexual activity/potential need of supportive measures
- STD/HIV risk
- Gynecological care
- Evaluation of Informed Consent ability
- Assessment for possible dependent elder abuse

Notes:

IDT/Staff Action:

- Notification of niece
- Care plan for accommodating her privacy
- Increased monitoring of her gynecological health

Notes:

Case #3-Mrs. H, The Frequent Masturbator

Notes:

Case #3-Mrs. H
The Frequent Masturbator

- 78 yo genteel woman s/p CVA, MCI, wheelchair dependent who enjoyed watching soap operas polishing her nails in the communal day room.
- At night she masturbated frequently, with audible and sometimes very loud moaning that could at times be heard throughout the unit.
- Staff already supported her personal choices by providing privacy; they routinely pulled the curtain and closed her door during these times.
- Then the staff discretely brought forward what was troubling them greatly: during her pericare they found her vaginal/labial/ perineal areas to be very irritated and inflamed.

Notes:

Issues of Concern:

- Risk of infection/UTI's
- Potential for self-injury related to long nails
- Ward community comfort/discomfort related to her loud moaning
- Pragmatic issues of support with discretion
- Supportive measures/equipment needed

Notes:

IDT/Staff Action:

Amongst a trusted group of ward staff we met and discussed what to do at great length, in an area of the unit where we would not be overheard

Notes:

Discussion and Solution

Discussion

KY Jelly and Petroleum jelly -small foil packets
Mineral oil-large glass bottles, could spill or break
Lotions/creams –uncomfortable on delicate areas

Pt was on a very limited income, so it would need to be supplied to her. Pharmacy? Central supply? Have her son purchase it along with her nail polish?

The Solution:

Her PMD provided “samples” of “personal moisturizer”, small bottles of personal lubricant that were easy to handle, non-toxic and could be left at bedside.

Patient was so pleased, she kept them in her nail polish basket on her tray table at all times, including in front of the big communal TV

Notes:

Case #4- Mr. L- The Inappropriate Masturbator

Inappropriate Sexual Behavior after ED treatment

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Notes:

Case #4 - Mr. L

87 yo male WWII hero with advanced Parkinson's Disease , wheelchair dependent, known for his adventurousness and frequent crashes, was also well-known for his frequent inappropriate sexual behavior after ED treatment.

Urology prescribed muse/alprostadil tablets for his ED and many times after applying them intraurethrally, he would cover his erection with a towel and roll down the hall to the nurses' station, then remove the towel in front of staff

Notes:

Case #4- Mr. L (Cont.)

- He purchased a vibrator on-line, had a large porn collection in his room with his own video player and often invited his buddies from the unit in to watch and join him
- It was rumored that in addition to ordering pizza late at night he had ordered a female escort that staff had to call security to remove

Notes:

Issues of Concern

- Patient Autonomy vs. Staff Discomfort
- Inappropriate Sexual Behavior towards staff
- Disruptive Behavior on and off the ward affecting other residents
- Awareness of patient's Parkinson Disease and PD
- Dementia:
  - Decreased safety awareness
  - Increased poor judgement
  - Disinhibition
- Possible over-medication with dopamine resulting in hypersexuality; increased "freezing" episodes during Neuro appts

Notes:

IDT/Staff Action:

- Set limits and boundaries; Staff education
- Contract established for access to ED treatment and vibrator dependent on his appropriate behavior
- Agreed to respect patient's privacy and right to sexual expression: ex, staff would pull the curtain and close the door during his "porno parties" if participants' behavior remained appropriate and not disruptive
- PMD discussed with Neurology to decrease Sinemet
- Son notified; very supportive of his father but also of staff

Notes:

Case #5 - Mr. Smooth and Mrs. Max-Potential for Elder Abuse

Notes:

Case #5- Mr. Smooth and Mrs. Max-Potential for Elder Abuse

- Mrs. Max, 85 yo widow with advanced dementia, wheelchair dependent, became the focus of sexual attention from another resident, Mr. Smooth.
- Mr. Smooth was a 79 yo ambulatory, handsome man with early Alzheimer's disease who was transferred to the dementia care bldg by his wife, because he was getting lost while driving, but was otherwise capable
- On rounds they were found together in Mrs. Max room; Mrs. Max was in bed with her blouse off, Mr. Smooth was standing at bedside fully clothed

Notes:

Case #5- Mr. Smooth and Mrs. Max-Potential for Elder Abuse

- No evidence of trauma, harm, sexual contact, or inappropriate behavior on exam of both parties, however, unclear how Mrs. Max got herself out of her blouse and into bed

- Mr. Smooth stated “She called for help”
- Mrs. Max, while too demented to recall events, displayed no fear towards Mr. Smooth. “He’s nice”.

- Initial staff plan was to monitor them, as they lived on separate wards
- Mrs. Max’s son was notified and attempts to reach Mr. Smooth’s wife were made.

Notes:

Case #5- Mr. Smooth and Mrs. Max-Potential for Elder Abuse

- A week later, Mr. Smooth was again found in Mrs. Max's room; she was partially disrobed and he was starting to undress near her bed.
- He admitted, "We just want to be together" She was smiling and pleasant, appearing calm.
- Exams of both parties again negative for harm

Notes:

Issues of Concern

- Has a crime occurred? Is this elder abuse?
- Clarify if elder abuse or other crime has occurred.
- Dependent/vulnerable with more capable elder
- Determine Informed consent or refusal
- Notify surrogates
- Legally report if appropriate
- Need plan to monitor if surrogates decline contact
- STD/HIV risks if sexual contact has occurred

Notes:

IDT/Staff Action:

- Notify surrogates
- Clarify if elder abuse or other crime has occurred.
- Legally report when appropriate
- If surrogates approve contact, document exactly what is and is not allowed
- Plan for monitoring residents if surrogates decline contact and careplan it:
  - Keep residents separated whenever possible
  - Watch closely with direct line of sight if the two residents are in close proximity
- Staff education with staff awareness on how to monitor

Remember: if concerns exist about a vulnerable elder exist, examine them carefully and monitor for any evidence of stress or repercussions

Notes:


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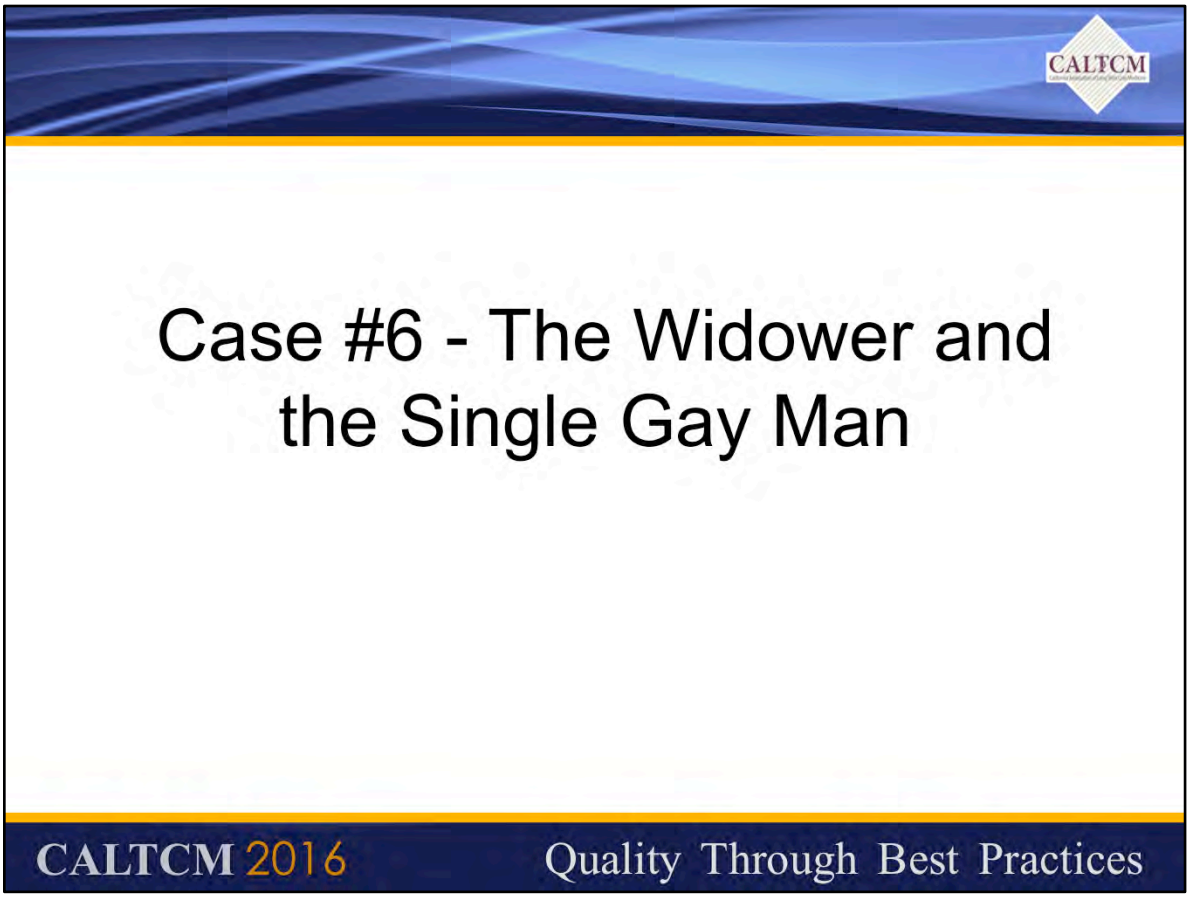
Summary
CALTCM 2016
Quality Through Best Practices

Notes: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Case #6 - The Widower and the Single Gay Man
CALTCM 2016
Quality Through Best Practices

Notes:

Case #6- The Widower and the Single Gay Man

- 86 yo widower s/p CVA with gait disorder, HOH, wheelchair dependent, was overheard reminiscing with another LTC resident about WWII.
- The other resident was slightly younger and never married, with no significant health issues except MCI
- The widower was very hard of hearing and as they became closer, they spoke of their time in the trenches of WWII-loudly
- And then of their sexual experiences with other men in the trenches of WWII-again, loudly!

Notes:

Case #6- The Widower and the Single Gay Man

Soon they were together in each other's rooms, holding hands, kissing or "snuggling", but they never disrobed or had sex.

Notes:

Issues of Concern:

- Medical decision-making capacity
- STD/HIV risks
- Privacy
- Assess for possible elder abuse, especially if one party is more vulnerable and dependent on the other
- Family/Surrogates Attitudes/Input
- Staff Attitudes/Input
- Community reactions, acceptance, rejection

Notes:

IDT / Staff Action

- The Supervising RN wanted orders written so that the two men could be separated onto different wards
- An impromptu discussion with staff revealed two equal camps, each group of staff ethnically diverse, consisting of men and women in a spectrum of ages
- One group wanted the men separated like the SRN
- One group wanted the men put in the same room and given privacy

Notes:

IDT / Staff Action

Both men were:

- Examined
  - no evidence of injury or physical harm
- Interviewed
  - determined to have medical
  - decision making capacity
  - giving informed consent
- Requested of the social worker to organize a large IDT with key members of both families present.

Notes:

Results of IDT

- The younger man was known to be gay to his family
- They supported him and his choice of a partner
- The widower's previous homosexual experiences were a surprise to his adult children but they lent their support to his choice of partner also
- However his niece voiced her strong objections
- The widower did not want family discord and in the end, he agreed to be separated from the single gay man.

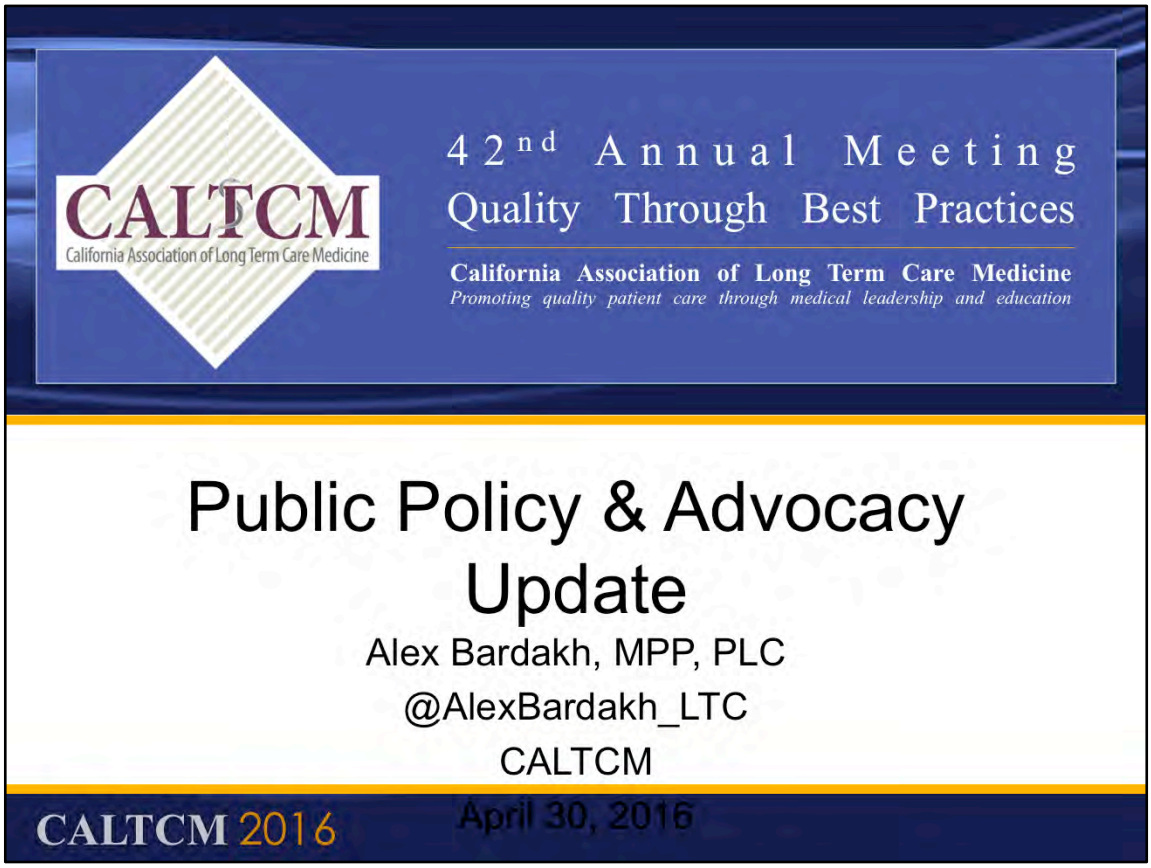
Notes:

Summary

- Honesty
- Dignity
- Quality of live

- Staff Education

Notes: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Alex Bardakh, MPP, PLC
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CALTCM 2016
April 30, 2016

Notes:


Speaker Disclosures
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I have no relevant financial relationships with commercial interests to disclose.
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Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Outline key policy issues for AMDA-The Society for Post-Acute and Long-Term Care Medicine
- Understand various models being implemented in value-based medicine
- Understand the challenges for PA/LTC medicine in new healthcare payment models

Notes:

Year in Review: AMDA Success

Regulatory

- Medicare Payment for advance care planning codes (99497/99498) – are you using them?
- Removal of SNF visits from ACO attribution methodology – physicians no longer responsible for total cost they don't control
- CMS acknowledgement of issues with value-based payment modifier for LTC patients
- GAO report focusing on antipsychotic use outside the nursing home setting

Notes:

Year in Review: AMDA Success

Legislative

- Repeal of SGR legislation Medicare Access and CHIP Reauthorization Act of 2015 - (MACRA)
- Passage of NOTICE Act
- Reauthorization of Older Americans Act
- Funding for Alzheimer's Research in Appropriations legislation
- Support for S. 1549-Care Planning Act of 2015
- Reintroduction H.R. 1571 & S. 843-Improving Access to Medicare Coverage Act of 2015

Notes:

AMDA Points of Influence

- **Congress**
  - Relationships with key Congressional committees
- **Federal Agencies**
  - CMS
  - ONC/HIT Policy Committee (need more representation)
- **National Stakeholders**
  - National Quality Forum
  - Physician Consortium for Performance Improvement
  - AMA Specialty Society Relative Value Scale Update Committee (RUC); CPT Editorial Panel
  - AMA House of Delegates
- **Partner Organizations**
  - Physician specialty societies (AMA, SHM, AAHCM, AAHPM, AAFP, ACP, ACEP, AGS, SGIM)
  - Post-Acute/Long-Term Care Organizations (AHCA, LeadingAge, LTPAC HIT, Advancing Excellence, ASCP, Eldercare Workforce Alliance, NTOCC)

Notes:

Year in Review: AMDA Advocacy

- Comment Letters
  - CMS implementation of the Medicare Access and CHIP Reauthorization Act (MACRA)
  - CMS Requirement for Participation for Long Term Care Facilities
  - Senate Finance Committee Chronic Care Paper
  - CMS Physician Fee Schedule Proposed Rule
  - CMS ACO Proposed Rule
  - CMS Proposed Rule on Meaningful Use Stage 3
  - CMS Proposed Rule Joint Replacement Payment Model
  - CMS Quality Measure Development Plan
  - IMPACT Act Quality Measures

Notes:

AMDA National Involvement

- In-person special invitee to White House Conference on Aging in July and in regional forum in Tampa – Dr. Naushira Pandya
- Participation on National Nursing Home Convergence Group
- National Partnership to Improve Dementia Care
- Participant in the LTPAC HIT Collaborative (founding member)
- Represented on the Board of National Transitions of Care Coalition
- Physician Consortium for Performance Improvement
- Eldercare Workforce Alliance
- and more…

Notes:

AMDA Members in National Spotlight

- National Quality Forum
  - Post-Acute Long Term Care Workgroup – Cari Levy, MD, CMD; Jim Lett, MD, CMD
  - Dual Eligible Workgroup – Gwen Buhr, MD, CMD
  - Special Physician Panel – Naushira Pandya, MD, CMD
  - Workgroup on Facility-Based Providers – Dheeraj Mahajan, MD, CMD
  - End-of-Life – Karl Steinberg, MD, CMD, HMDC; Paul Tatum, MD, CMD
- CMS Technical Expert Panels
  - IMPACT Act Readmission Measure – Arif Nazir, MD,CMD
  - IMPACT Act Drug Regimen Review Measure – Susan Levy, MD, CMD
- Physician Consortium for Performance Improvement – Dheeraj Mahajan, MD, CMD
- AMA RUC/CPT Editorial Panel – Chuck Crecelius, MD, PhD, CMD; (need volunteer)
- AMA House of Delegates – Eric Tangalos, MD, CMD, Rajeev Kumar, MD, CMD
- American Academy of Neurology Stroke and Stroke Rehab Measure – Barbara Messinger-Rapport, MD, CMD
- CMMI Readmission Demonstration – Chuck Crecelius, MD, CMD;
- National Transitions of Care Coalition – Jim Lett, MD, CMD
- LTPAC HIT Collaborative – Bill Russell, MD, CMD

Notes:

The Year Ahead: Top Policy Issues

- MACRA Implementation
- SNF Requirements for Participation
- IMPACT Act
- SNF Value-Based Purchasing
- Value-Based Payment Models
- Primary Care Equity in CPT Coding
- 5-Star Rating Changes
- Sizing up 2016 Election

Notes:

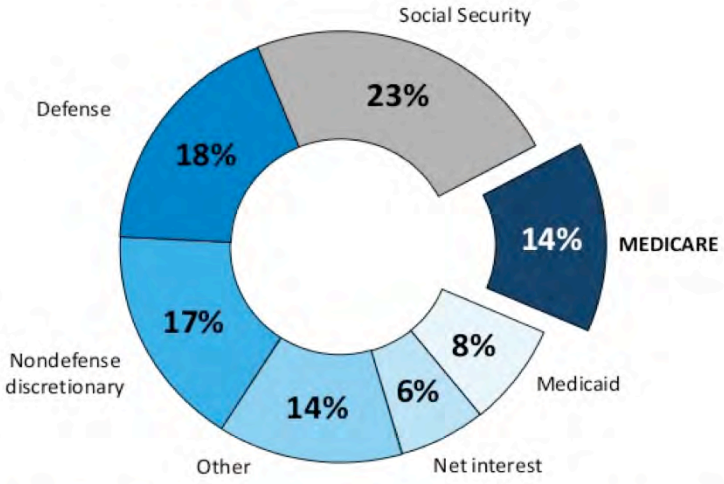
" … ask not what healthcare can do for you, ask what you can do for healthcare"

Notes:

Medicare Spending Keeps Growing

Medicare spending is 14% of the federal budget

Total Federal Spending in 2013: $3.5 Trillion



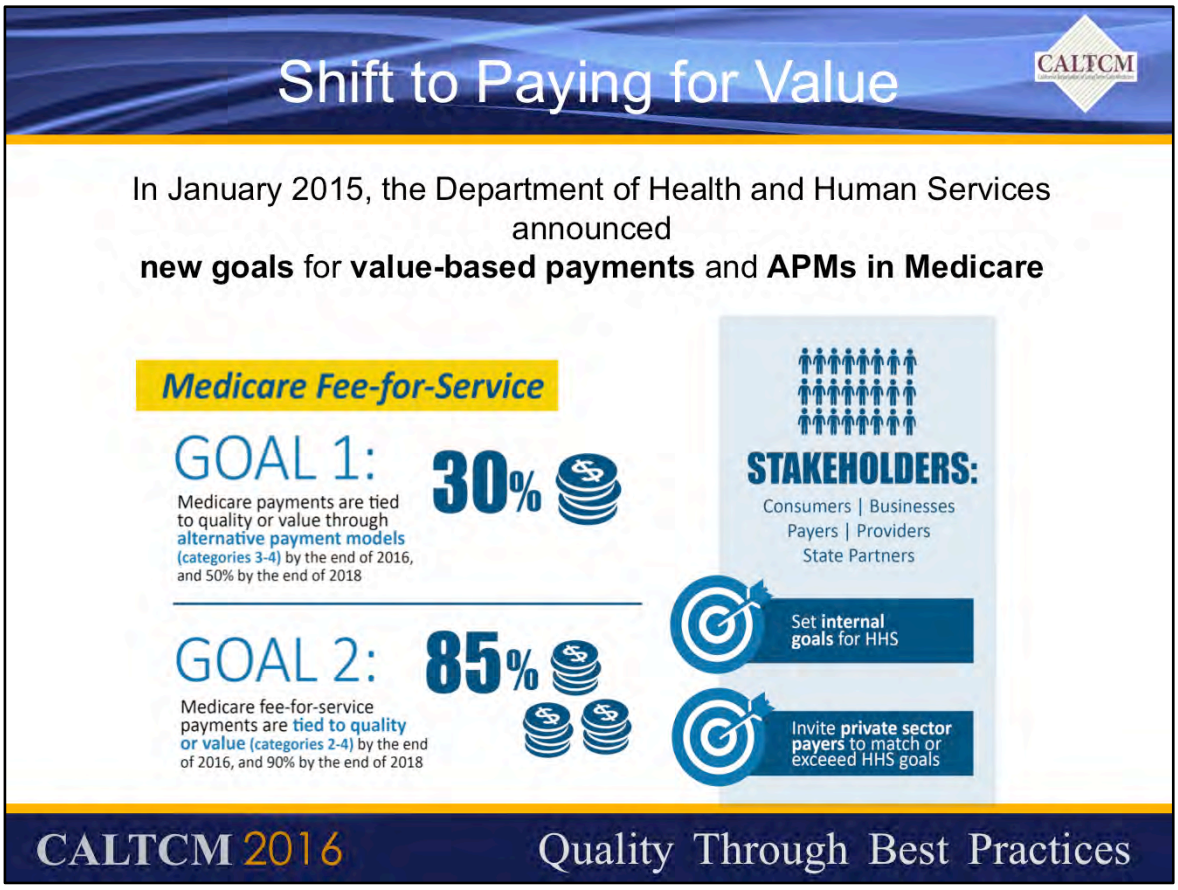
NOTE: All amounts are for federal fiscal year 2013. [1]Consists of Medicare spending minus income from premiums and other offsetting receipts.
[2]Other category includes spending on other mandatory outlays minus income from offsetting receipts.
SOURCE: Congressional Budget Office, Updated Budget Projections: 2014 to 2024 (April 2014).

Notes:

Is Fee-for-Service Part of the Problem?

- Encourages overutilization to maximize profit
- Good and bad doctors paid the same
- Poor quality determination
- Unable to compare efficiency, costs of care
- Have not kept up with the shift from inpatient to outpatient care
- Newer codes (AWE, TCM, CCM, ACP) not proven to be of value

Notes:


Shift to Paying for Value
CALTCM
In January 2015, the Department of Health and Human Services announced
new goals for value-based payments and APMs in Medicare
Medicare Fee-for-Service
GOAL 1:
30%
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018
GOAL 2:
85%
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018
STAKEHOLDERS:
Consumers | Businesses
Payers | Providers
State Partners
Set internal goals for HHS
Invite private sector payers to match or exceeed HHS goals
CALTCM 2016
Quality Through Best Practices

Notes:


Healthcare Reform Goals
CALTCM
• 3 Goals of Healthcare Reform:
1. Improve Quality
2. Improve Population Health
3. Decrease Cost of Care
• 6 National Priorities
• Safer Care
• Engage Patients and Families in their Care
• Communication and Coordination of Care
• Promote Best Practices
• Population Health
• Make Quality Care Affordable (spread new delivery models)
CALTCM 2016
Quality Through Best Practices

Notes:

What is Meant by Value?

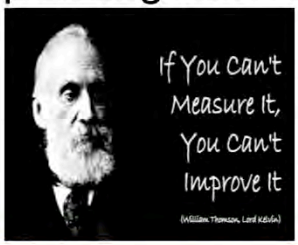
Quality

Resource Use (Cost)

Notes:

Quality/Cost Measures as the New Currency

- Must meet quality measure benchmarks in all value-based programs
- Quality Measures can be different in Part A and Part B programs but some align (i.e., SNF VBP measures vs PQRS measures)
- Cost measures part of evaluation of all value-based program (i.e., Medicare Spending Per Beneficiary)



Notes:

Value-Based Models Across Healthcare System

- Part A
  - Hospital Value Based-Purchasing
  - Nursing Home Value-Based Purchasing (demonstration for now)
  - Coming to a setting near you
- Part B
  - MACRA
    - Merit-Based Incentive Payment Program (MIPS)
      - PQRS – Resource Use-Clinical Practice Improvement-EHR Use
    - Alternative Payment Models

- Part A & B Demonstrations
  - Bundled Payment Care Initiative
  - Accountable Care Organizations
  - Comprehensive Care for Joint Replacement Model (mandatory)
  - Independence at Home

Notes:

All About MACRA

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015

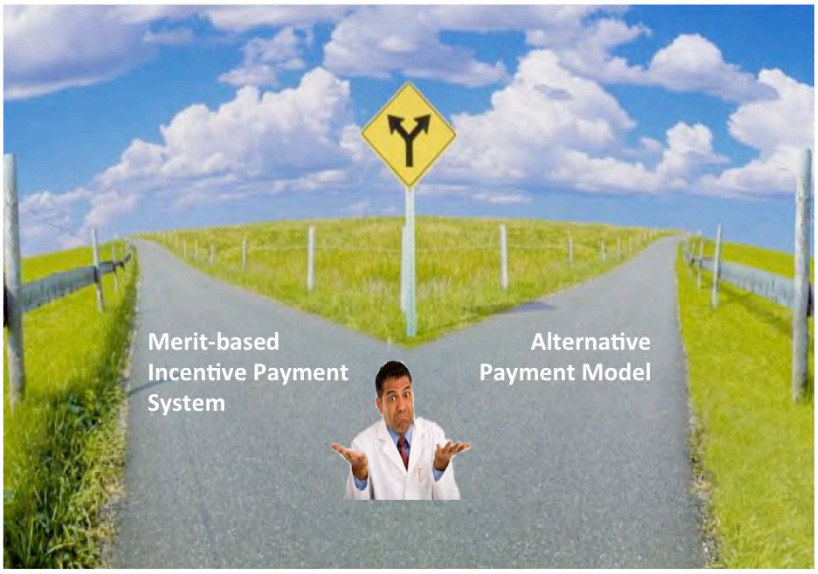
What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value**
- over volume
- **Streamlines** multiple quality programs under the new **Merit- Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

Source: www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf

Notes:

MACRA: starting in 2019*, physicians will choose from or land in one of two paths: MIPS or APMs?



* This decision will actually need to be made sooner than 2019.
The initial performance period for MIPS in MACRA is 2017.

Notes:

MIPS Combines Current Pay-for-Reporting Programs

- There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

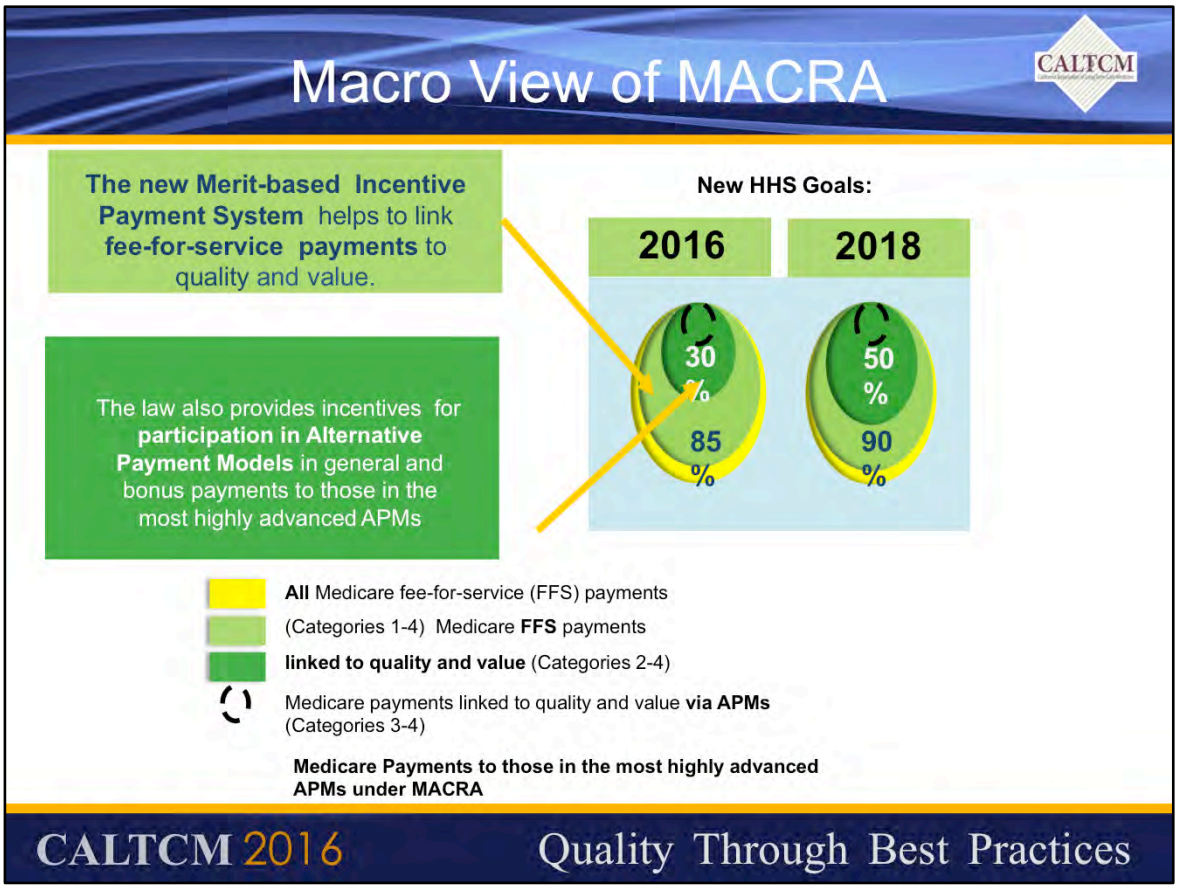
Physician Quality Reporting Program **(PQRS)**	Value-Based Payment Modifier	Medicare EHR Incentive Program

- **MACRA** streamlines those programs into **MIPS**:

Merit-Based Incentive Payment System **(MIPS)**

Source: www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf

Notes:


Macro View of MACRA
CALTCM
The new Merit-based Incentive Payment System helps to link fee-for-service payments to quality and value.
The law also provides incentives for participation in Alternative Payment Models in general and bonus payments to those in the most highly advanced APMs
New HHS Goals:
2016
2018
30 %
85 %
50 %
90 %
All Medicare fee-for-service (FFS) payments
(Categories 1-4) Medicare FFS payments
linked to quality and value (Categories 2-4)
Medicare payments linked to quality and value via APMs (Categories 3-4)
Medicare Payments to those in the most highly advanced APMs under MACRA
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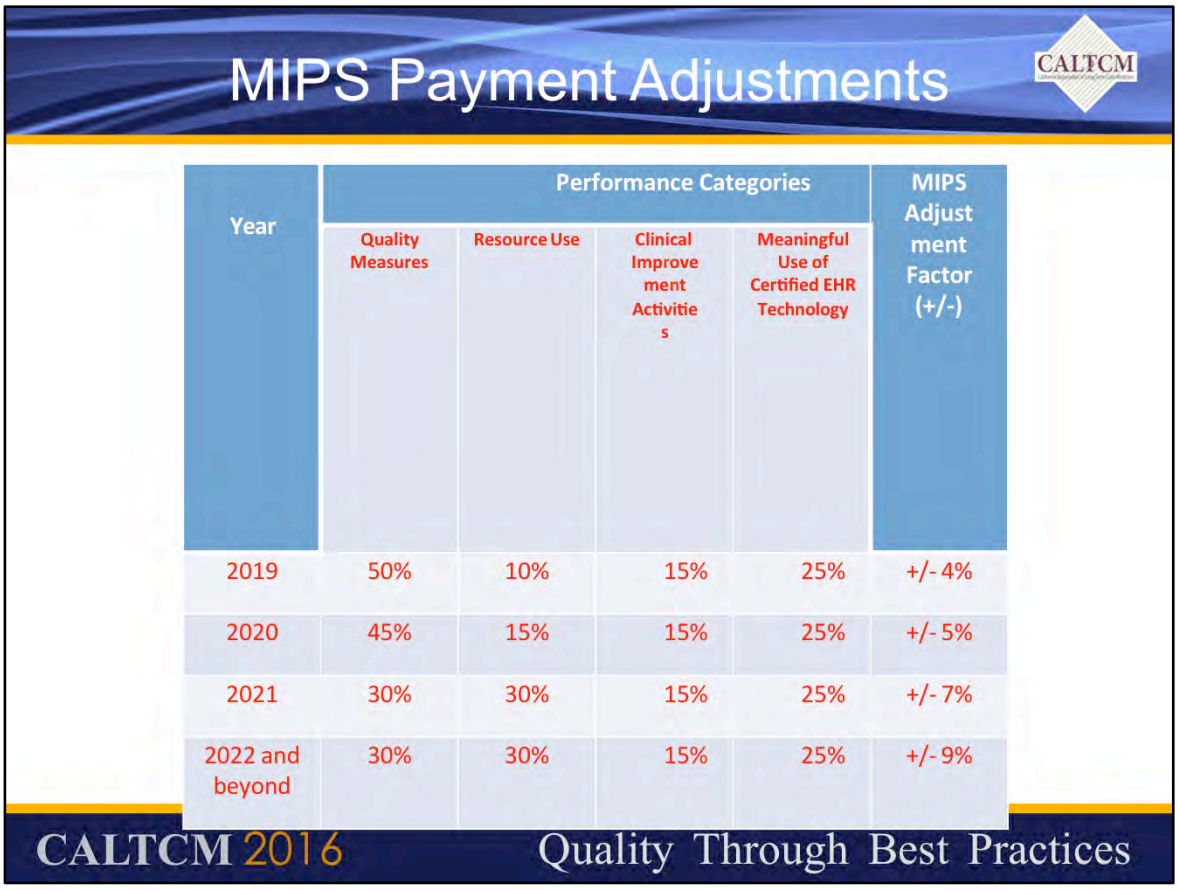
Notes:


MIPS Payment Adjustments
CALTCM
Year
Performance Categories
Quality Measures
Resource Use
Clinical Improvement Activities
Meaningful Use of Certified EHR Technology
MIPS Adjustment Factor (+/-)
2019
50%
10%
15%
25%
+/- 4%
2020
45%
15%
15%
25%
+/- 5%
2021
30%
30%
15%
25%
+/- 7%
2022 and beyond
30%
30%
15%
25%
+/- 9%
CALTCM 2016
Quality Through Best Practices

Notes:

Alternative Payment Models

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

According to MACRA law, APMs include:

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by Federal Law

- MACRA **does not change how any particular APM rewards value**.
- APM participants who are not "QPs" will receive **favorable scoring under MIPS**.
- Only **some** of these APMs will be **eligible** APMs.

Source: www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf

Notes:

Current Part B Valued-Based Payment Programs

- PQRS, value-based modifier, Meaningful Use are still in existence today!

PQRS in VBM Penalties in 2018 Based on 2016 Reporting Year			
Group Size	PQRS Non-Reporting Penalty	Potential VM Penalty	Total Potential Penalty
10+ EPs	-2.0%	-4.0%	-6.0%
Solo, 2-9 EPs	-2.0%	-2.0%	-4.0%

- Participate in
  http://www.pa
- Apply for MU ents – deadline July 1, 2016
  http://www.pa ncentive-programs

Notes:

SNF Value-Based Purchasing

- Requirement of ACA and Protecting Access to Medicare Act of 2014 (PAMA)
- 2% SNF Part A withhold → incentivize performance
- Performance = **30-day all cause readmission (NQF #2510)**
  - Claims-based measure
  - Bottom 40% won't receive any incentive
  - 50-70% of withhold will be paid back
- Must be in place by 2019

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

Notes:

SNF Quality Reporting Program (IMPACT Act)

- ***Rationale for Standardized Assessment Data –*** To facilitate comparisons of patient outcomes, and resource utilization
- ***Facilitates Creation of New Payment Models –*** Using the standardized assessment data, MedPAC and the Department of Health and Human Services must submit reports to congress regarding potential future payment reforms.
- ***Protects Beneficiary Choice and Access to Care –*** Directs the Secretary to develop regulations encouraging the use of quality data in patient discharge planning while continuing to take into account patient preferences.
  - Balancing patient preferences with quality performance

Notes:

5-Star Changes

Beginning April 2016, CMS will begin posting data for **six** new quality measures (QMs) on Nursing Home Compare

Further Improvements to the Nursing Home Compare Five-Star Quality Rating System

March 3, 2016

https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/fsqrs.html

Notes:

4 New Short Stay Measures

Percent of Short Stay Residents

- successfully **discharged to the community** *(Claims-based)*
- had an outpatient **emergency department visit** *(Claims-based)*
- were **re-hospitalized** after a nursing home admission *(Claims-based)*
- made **improvements in function** *(MDS-based)*

Notes:

2 New Long Stay Measures

Percent of Long Stay Residents

- whose **ability to move independently worsened** *(MDS-based)*
- received an **antianxiety or hypnotic** medication *(MDS-based)*

Notes:

5-Star Rating Changes

- Beginning in **July 2016**, five of the six measures will be used in the calculation of 5-Star Quality Rating QM ratings.
  - **Antianxiety/hypnotics not be used in 5 –Star**
    - specificity and appropriate thresholds concerns
- **Proposed Benefits**
  - Increase the number of short-stay measures
  - Cover important domains not covered by other measures
  - Claims-based measures may be more accurate than MDS-based measures.

Notes:

VBM Issues for PA/LTC Professionals

- Ensure appropriate comparator for cost AND risk adjust by more accurate means
- Incentivize PA/LTC to adopt meaningful HIT use
- For now - exclude PA/LTC professionals from penalties that they have no control over (i.e. meeting current EHR Incentive Program requirements)
- Ensure seamless integration with pharmacy
- Advocate for appropriate measures in new systems (eCQM that meaningfully combine EHR and PQRS incentives)
- Alignment with PA/LTC VBP Programs
- PA/LTC physicians as a specialty?? (SHM just received a specialty code from CMS)

Notes:

Future of Fee-for-Service

- Many models use fee-for-service to calculate inputs for bundled payment
- E&M Services do not adequately describe all of the work done by primary care physicians
- Need more granularity in the coding system – AMDA working with coalition to propose new codes
- Possible research to revamp E&M altogether
- CMS auditing frequent use of higher level codes – must have clear documentation of medical necessity
- Late Breaking: CMS says CCM billable in nursing facility if not under Part A! … but must meet all code requirements

Notes:

A Word About the Election

- That the ACA is a key issue in the 2016 presidential race is not surprising, key piece to Republican talking points after many attempts to repeal
- What's more surprising is that the ACA's future has become a central issue in the debate between the two *Democratic* candidates.
- Former Secretary of State Hillary Clinton promises to maintain and build upon the ACA, while Senator Bernie Sanders (D-VT) pledges to replace it with a "Medicare for All" (single-payer) system.
- Aspects of value-based medicine unlikely to go away – more about individuals mandate/coverage issues

Notes:

This is not fiction: So What Can You Do To Prepare?

- Understand the rules
- Speak with your facility administrators
- Participate in pay-for-reporting programs now!
- Start thinking about the future now!

Notes:

AMDA Public Policy & Advocacy Contacts

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abardakh@amda.com

Karl Steinberg, MD, CMD
Chair,
Public Policy Committee
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Dheeraj Mahajan, MD, FACP, CMD
Chair, Quality Committee
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Gaby Geise
Manager, Public Policy & Advocacy
ggeise@amda.com

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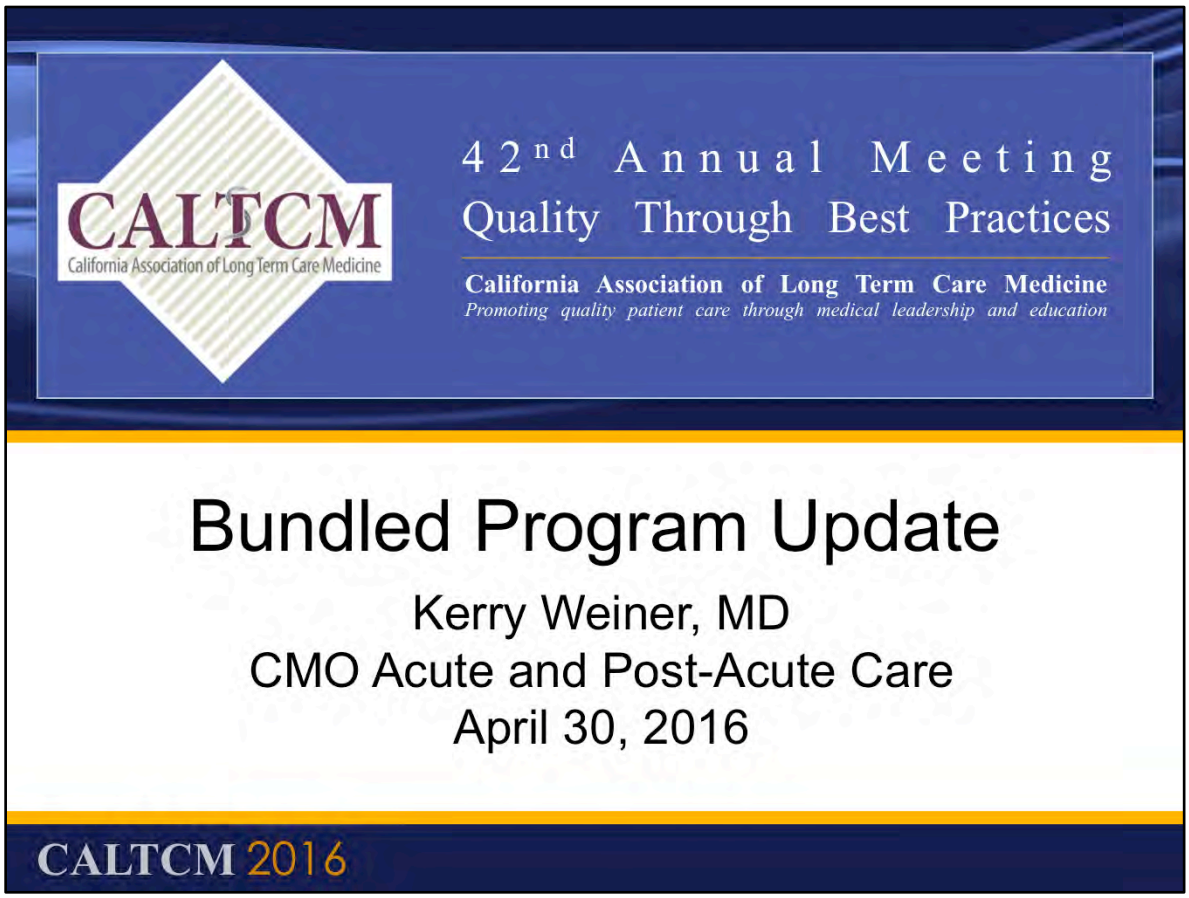
Notes:

QUESTIONS? COMMENTS?

THANK YOU!

Notes:


CALTCM
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Bundled Program Update
Kerry Weiner, MD
CMO Acute and Post-Acute Care
April 30, 2016
CALTCM 2016

Notes:

Disclosure Statement

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

Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Define the Bundled Payment model as it relates to SNFist's
- Compare the advantages and limitations to the Bundled Payment model
- Identify future trends with the Bundled Payment model 4
- Explain the Mandatory Joint Bundled Payment model
- Identify physician reimbursement models under Bundled Payment

Notes:

HHS Website: Better, Smarter, Healthier

"Historic Announcement" from Sylvia Burwell January 26, 2015

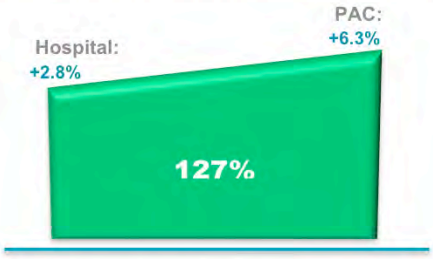
Set goals and timeline for shifting Medicare reimbursements from volume to value

- 2016: 30% payments to APMs; 85% FFS to quality or value
- 2018: 50% payments to APMs; 90% FFS to quality or value
- 2019: Payment by APM or FFS MIPS

Notes:

CMS is Focusing on PAC: Costs rising fast

Annual PAC spending > Hospital spending:

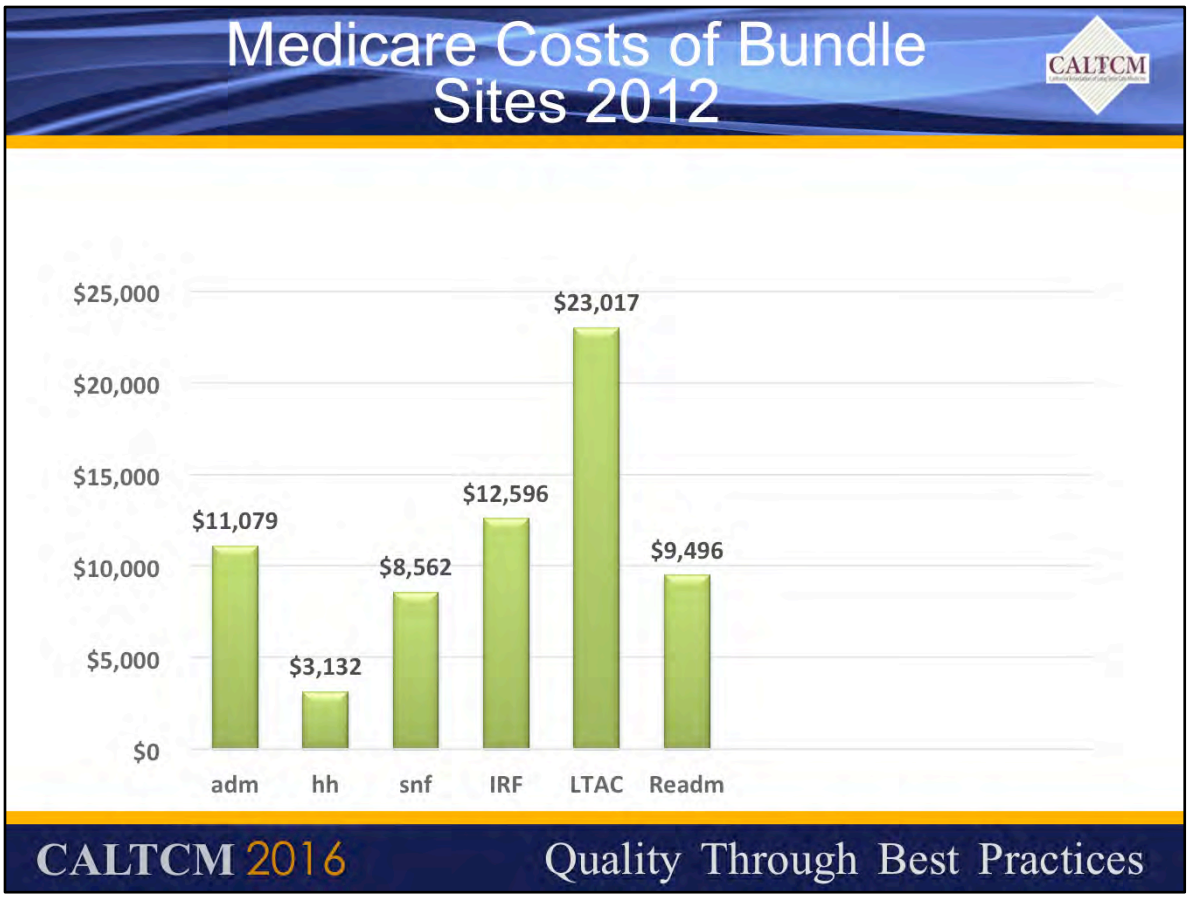


The annual rate at which PAC expenditures are outpacing hospital costs; 2002-2012[4]

Rate of Cost Growth by Condition, 1994 - 2009

Service	Heart attack	CHF	Hip fracture
PAC	256%	168 %	99 %
Other services	17%	26%	15%

Notes:


Medicare Costs of Bundle Sites 2012
CALTCM
$25,000
$20,000
$15,000
$10,000
$5,000
$0
$11,079
$3,132
$8,562
$12,596
$23,017
$9,496
adm
hh
snf
IRF
LTAC
Readm
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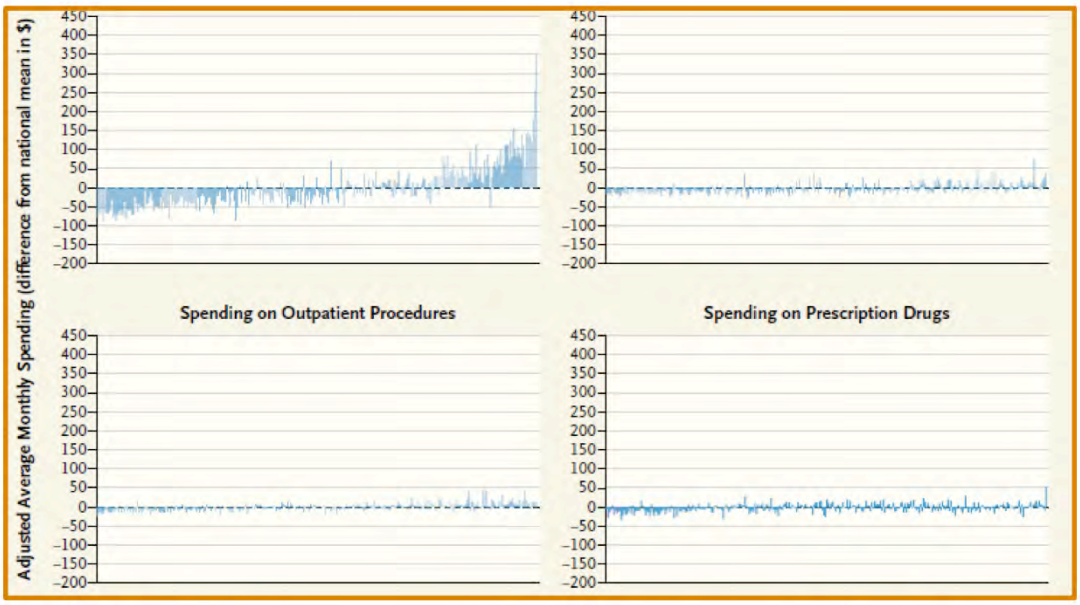
Notes:

Variability in Medicare Spending related to PAC



Notes:

Bundled Payment: Definition

- Covers all services for an “episode of care” that is defined in scope and period
- Reimbursement of multiple payors combined into single comprehensible payment
- Aims: Control cost and integrate care
- Past Examples: Hip repair, CABG, Obesity & Cataract Surgery
- Future Programs: Specialty (Oncology), ED, Surgical

Notes:

CCMI Bundle Payment for Clinical Improvement July 1015

Model	Episode	Conditions	Episode Initiators	Medicare Discount
1	Inpatient stay	All	Hospital	0 – 2 %
2	Inpatient stay + 30,60 or 90 days	48 episodes	Hospital, PGP	3 or 2 %
3	PAC + 30, 60 or 90 days after hospitalization	48 episodes	PACF, PGP	3%
4	Inpatient stay	48 episodes	Hospital	3 %

Notes:

Key Concepts

- Awardee
- Episode Initiator
- Target Price
- Convener
- Precedence
- Risk Sharing
- Waivers

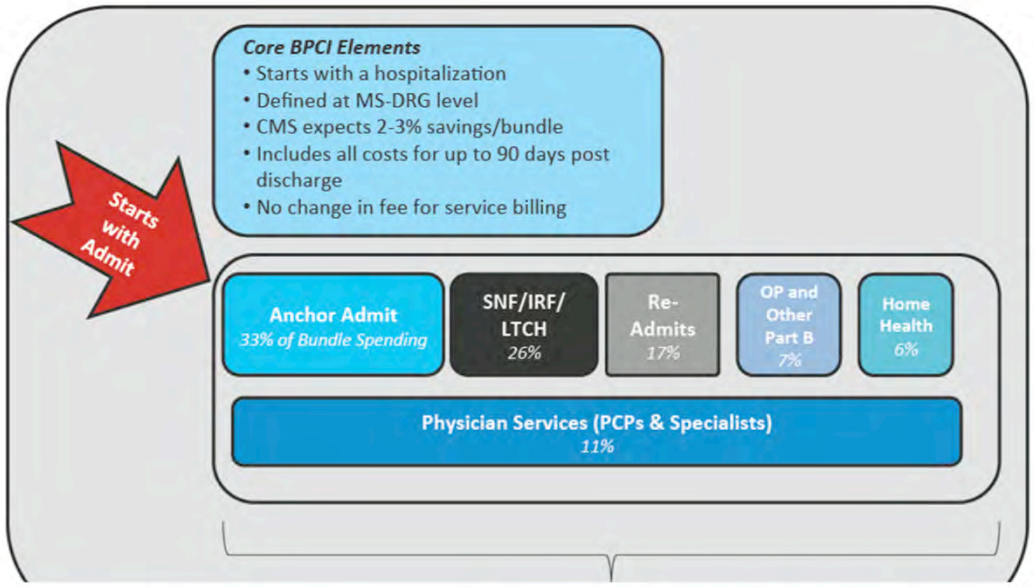
Notes:

Role of Convener- From Provider Perspective

- Analyze opportunity from retrospective data
- Buffer risk
- Ongoing interface with CMMI
- Audit and scrub data
- Identify best practices
- Real- time performance feedback
- Clinical utilization tools
- High risk case management

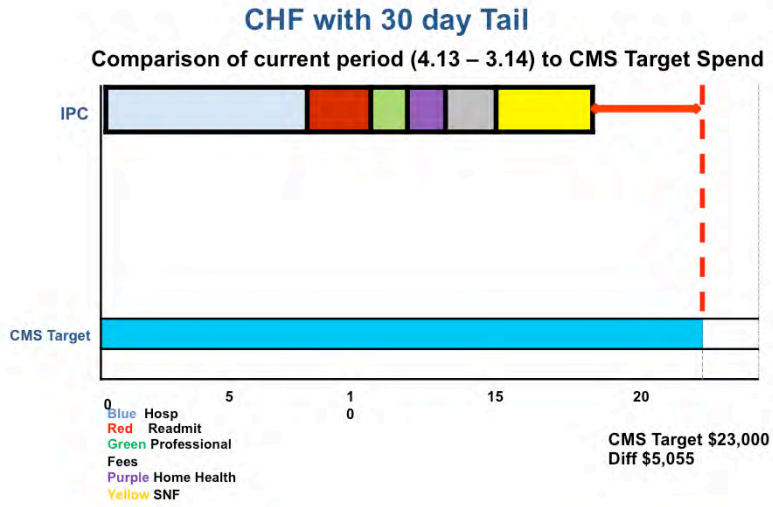
Notes:

Bundled Payment Concept



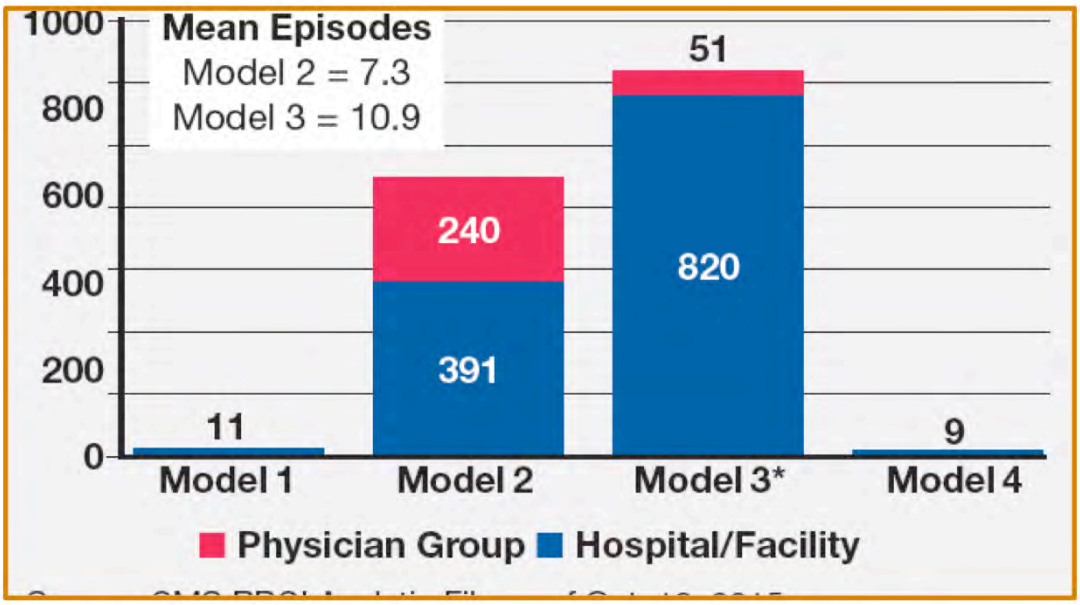
Notes:

Bundled Payment for Care Improvement (BPCI)



Notes:

BPCI Participation

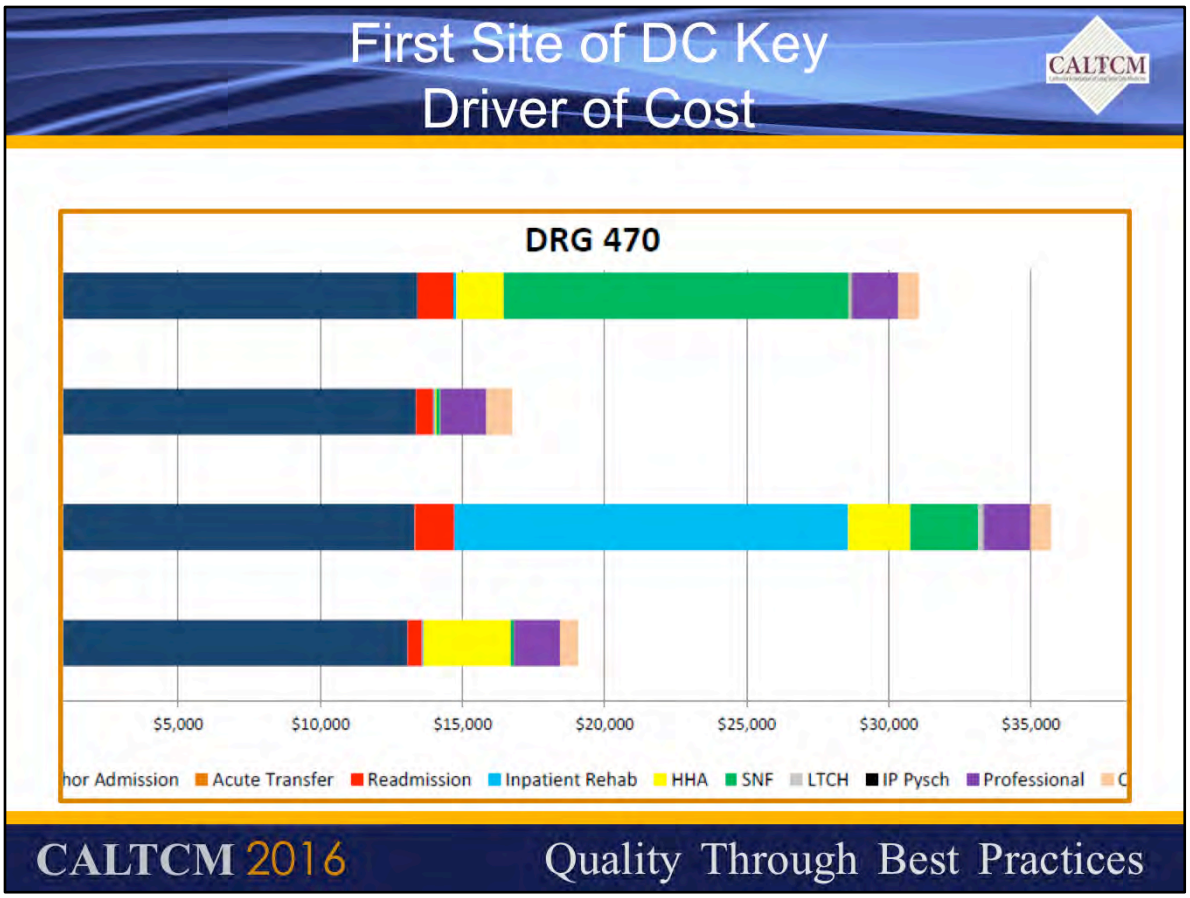


Notes:

TOP 10 DRGS

- Sepsis
- UTI
- COPD
- Renal Failure
- CHF
- PN
- Medical Non-Infectious Ortho
- PTCA
- Nutritional and metabolic
- MJR (CJR)
- Pneumonia
- MJR

Notes:


First Site of DC Key Driver of Cost
CALTCM
DRG 470
$5,000
$10,000
$15,000
$20,000
$25,000
$30,000
$35,000
hor Admission
Acute Transfer
Readmission
Inpatient Rehab
HHA
SNF
LTCH
IP Psych
Professional
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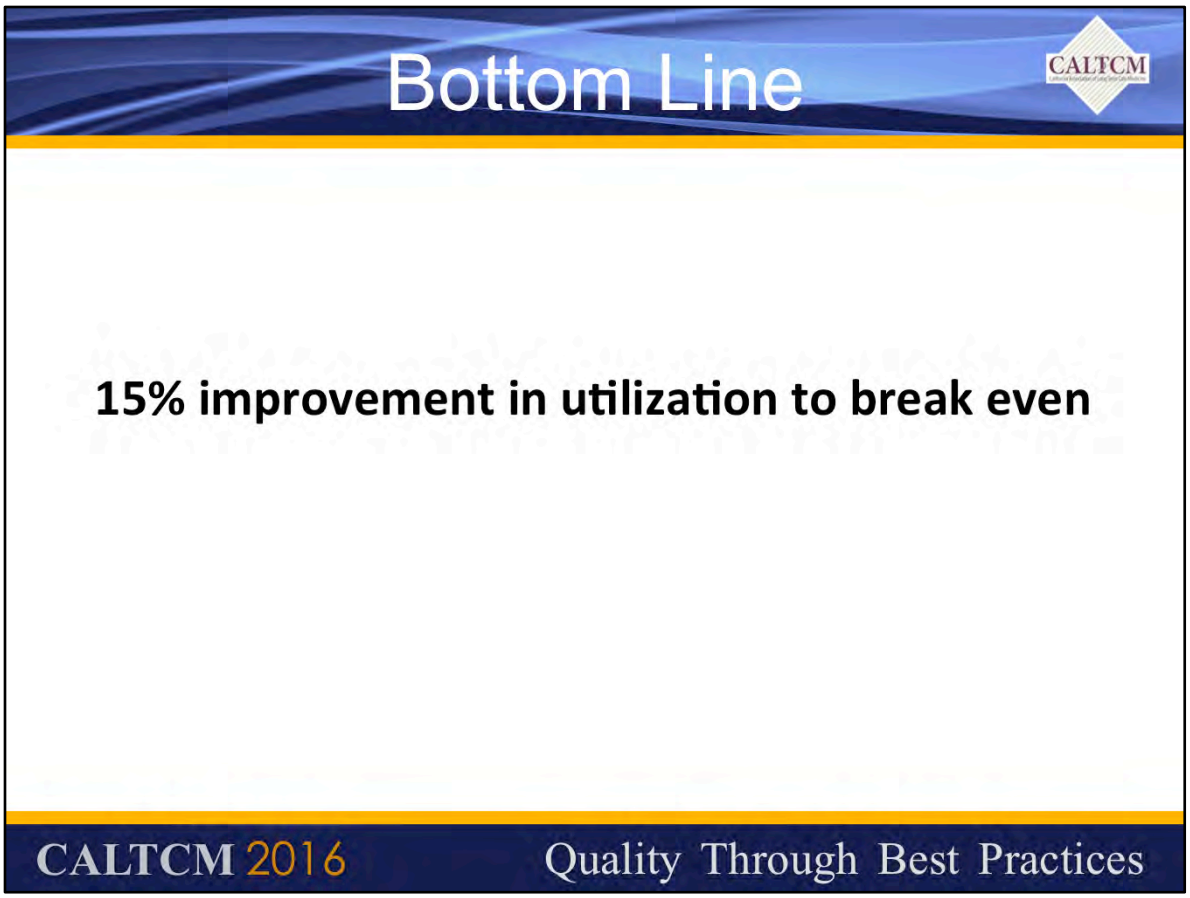
Notes:

TeamHealth BPCI Demographics

- Range of Bundles 7-35
- Estimated Annual Cases 96,000
- Target Price Average $24,000
- Estimated Total Bundle Spend $ 2.1 billion

Notes:


Bottom Line
CALTCM
15% improvement in utilization to break even
CALTCM 2016
Quality Through Best Practices

Notes:

Narrowing SNF Network by Grading Facilities

Major Criteria

- Census -Volume
- TH-IPC Presence
- Readmission Rate
- LOS
- Star Rating
- Special Expertise (BH, CHF)

Minor Criteria

- Therapy availability & staffing
- Behavior health services
- Anti-psychotic medication rate
- Patient complaints
- Formal pain management plan
- Nurse Staffing

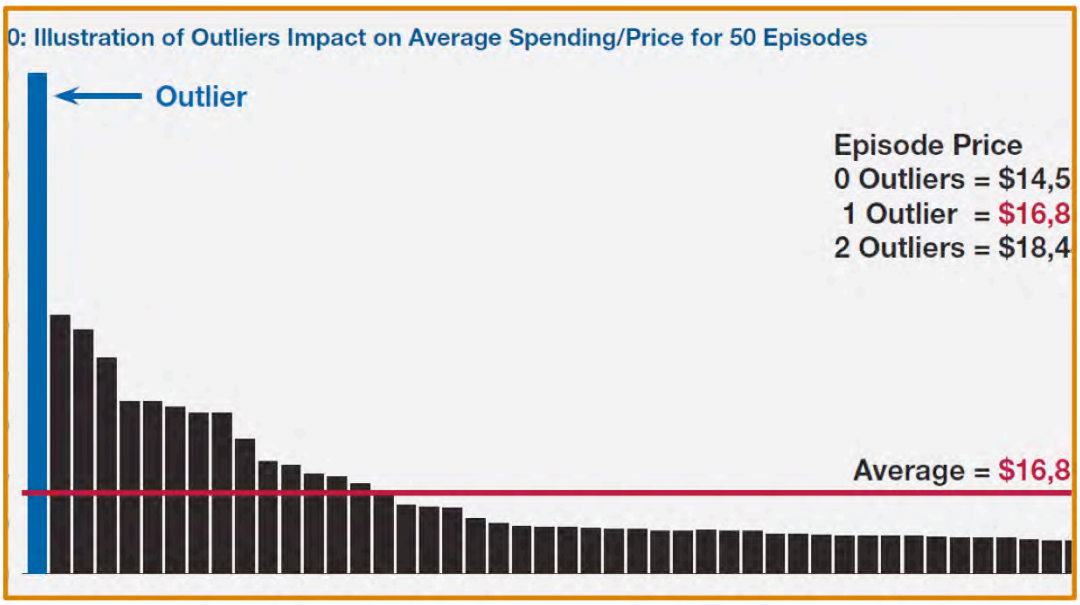
Notes:

Non – Clinical Challenges

- CMS Physician Reassignment: 2400 / 2100 errors
- CMS Delay in accurate financial and utilization data
- Real time identification of patients
- Case mix variations within a bundle for small numbers. MJLE 2 MS DRGs; COPD 5 MS DRGs

Notes:

Case Mix Problem



Notes:

Clinical Challenges

- Provider Engagement
- Provider Alignment
- Facility Alignment

Notes:

Providers and Facilities Must Work Together

BP: PGP and PAC Episode Initiator option continues

SNF: Better Quality and Efficiency leads to higher census

IRF/LTAC: Mandate to document better outcomes

Notes: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Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Telehealth and
Telemedicine in Geriatrics
Joshua Chodosh, MD, MSHS, FACP
Michael L. Freedman Professor of Geriatric Medicine
Professor of Medicine and Population Health
NYU School of Medicine
April 30th 2016
NYU School of Medicine
NYU LANGONE MEDICAL CENTER
CALTCM 2016

Notes:

Disclosures

- National Institutes of Aging
- New York State Department of Health
- SCAN Health Plan

- I have no conflicts of interest to report.

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Notes:

Overview

- Definitions and Rationale
- History of telehealth
- Telehealth and aging
- Remote and more recent applications
- Effectiveness? What evidence
- Some additional considerations
- Conclusions

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CALTCM 2016 Quality Through Best Practices

Notes:

Definition

- Telemedicine and telehealth both describe the use of medical information exchanged from one site to another via electronic communications to improve the patients' health status.

American Telemedicine Association: *IOM (Institute of Medicine). 2012. The role of telehealth in an evolving health care environment: Workshop summary. Washington, DC: The National Academies Press.*

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Notes:

Rationale

Why has there been so much focus on technological solutions to issues related to aging?

- US population over 65 years: 12 percent in 2005; will increase to 20 percent by 2030.
- 78-million member baby boom generation born between 1946 and 1964
- > 3/4s of adults over age 65 suffer from at least one chronic medical condition that requires ongoing care and (self) management.
- Currently, 20 percent of Medicare beneficiaries have five or more chronic conditions.

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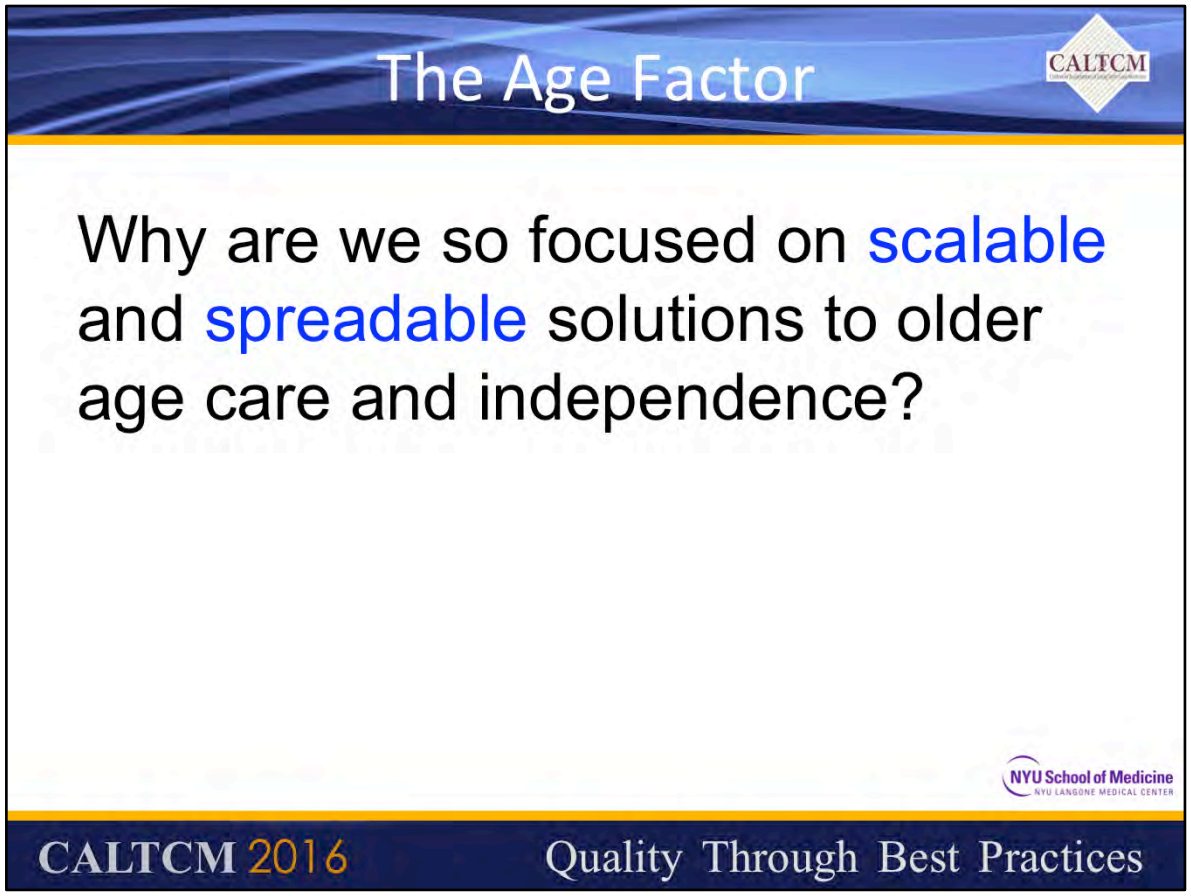
Notes:

History of Telehealth

- "Telemedicine" coined in the 1970s by Thomas Bird (American) literally means "healing at a distance"
- Willem Einthoven, Dutch physiologist, developed first electrocardiograph (Leiden). Using string galvanometer and telephone wires, he recorded electrical cardiac signals of hospital patients 1½ km away. Published 1906
- 1967, Bird and colleagues created audiovisual microwave circuit between MGH in Boston and Logan Airport.
  - ➢ Evaluated >1000 medical consultations for airport employees and travellers who were ill.

Murphy RL. Am J Public Health 1974 64:113-9

Notes:


The Age Factor
CALTCM
Why are we so focused on scalable and spreadable solutions to older age care and independence?
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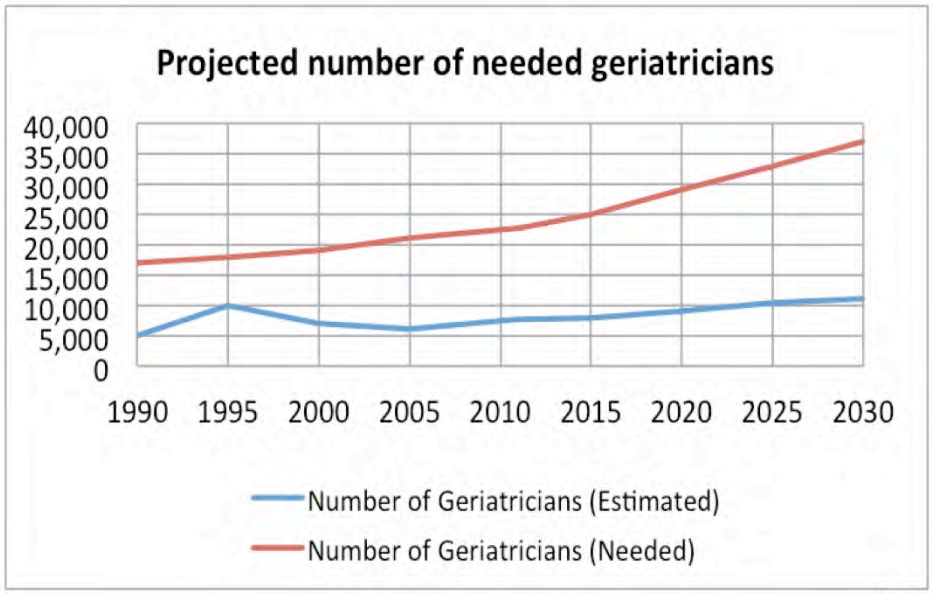
Notes:

Workforce Issues - Geriatricians



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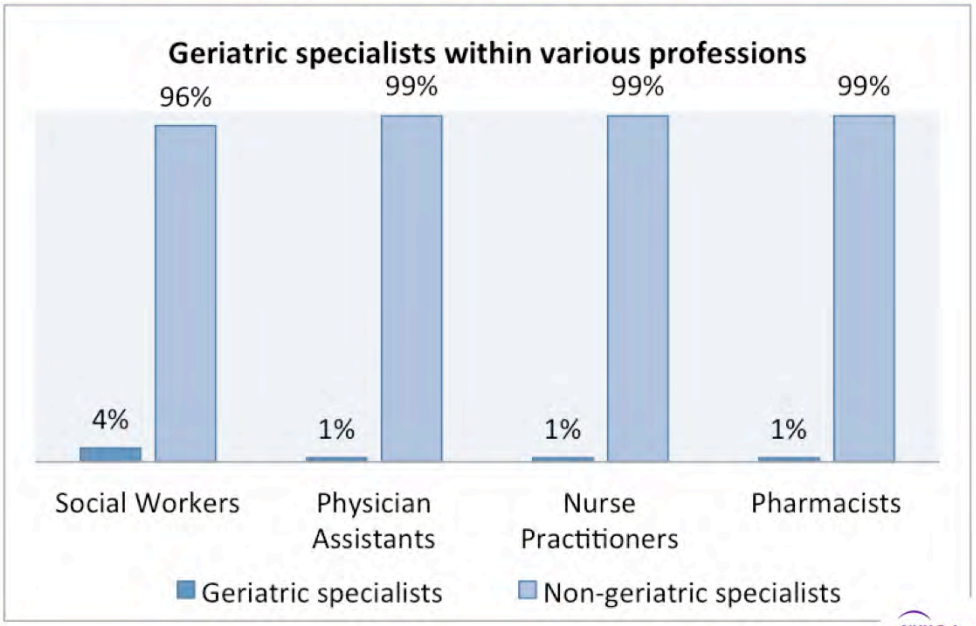
Notes:

Workforce Issues – Other Professions



Notes:

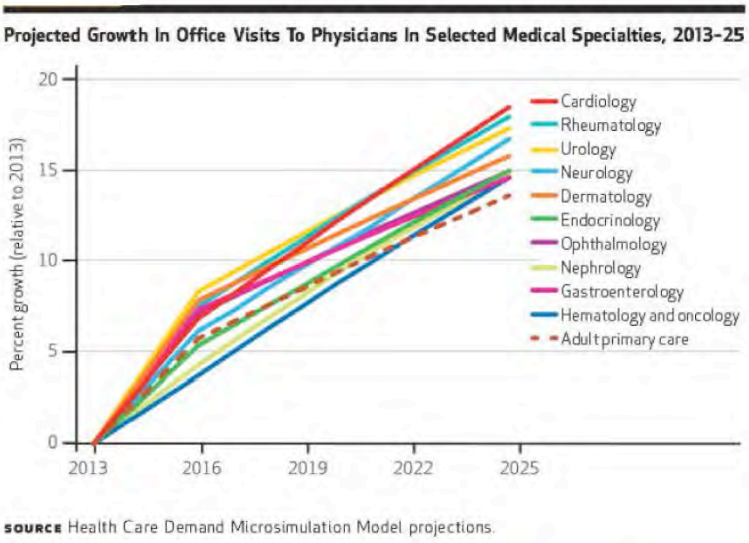
Increasing Need for Geriatric Care

Methods:

- Population modeling w/Health Care Demand Micro-simulation Model
- From 2013 to 2025

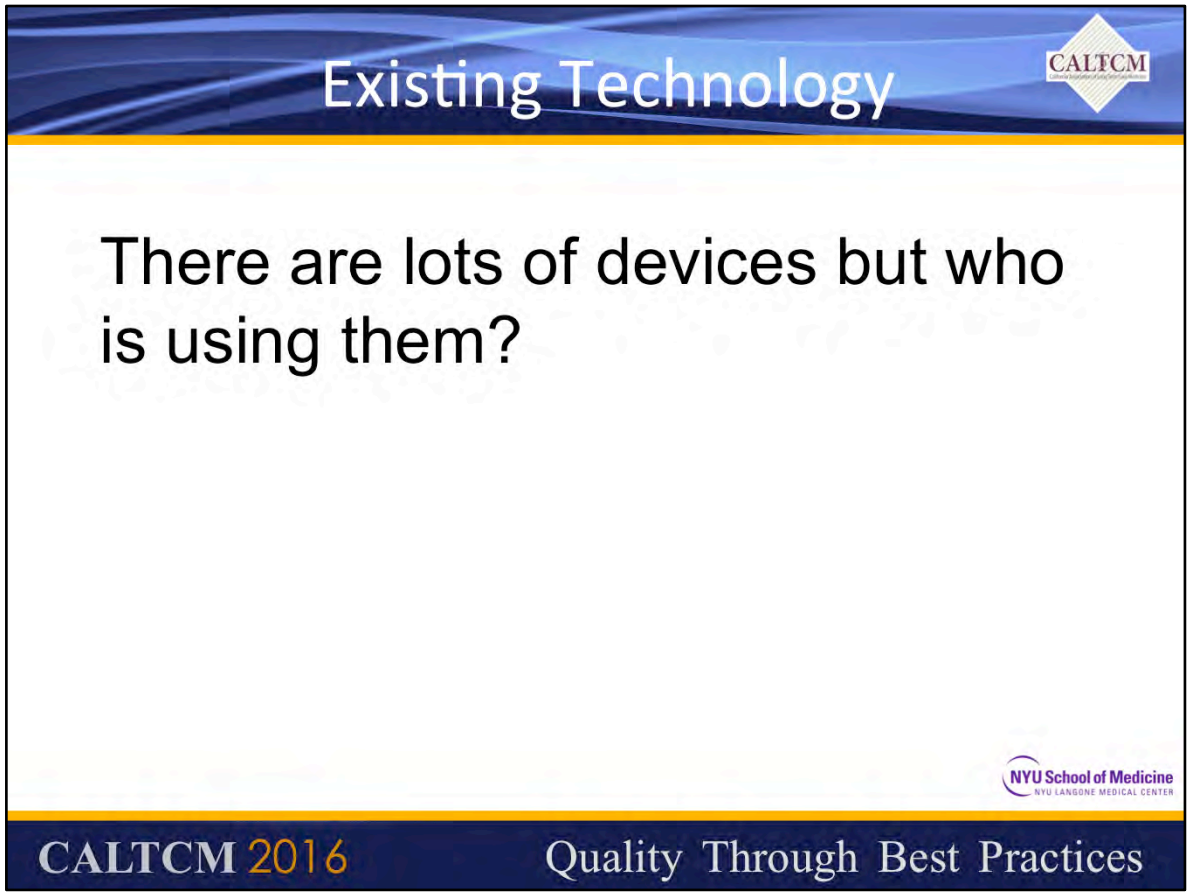
Results:

- number of office visits, outpatient visits, and emergency visits will increase 8-12%
- CV disease proportion will increase almost 27 %



Dall, TM; Gallo, PD; Chakrabarti, R; West, T; Semilla, AP; Storm, MV Health Affairs, 2013

Notes:


Existing Technology
CALTCM
There are lots of devices but who is using them?
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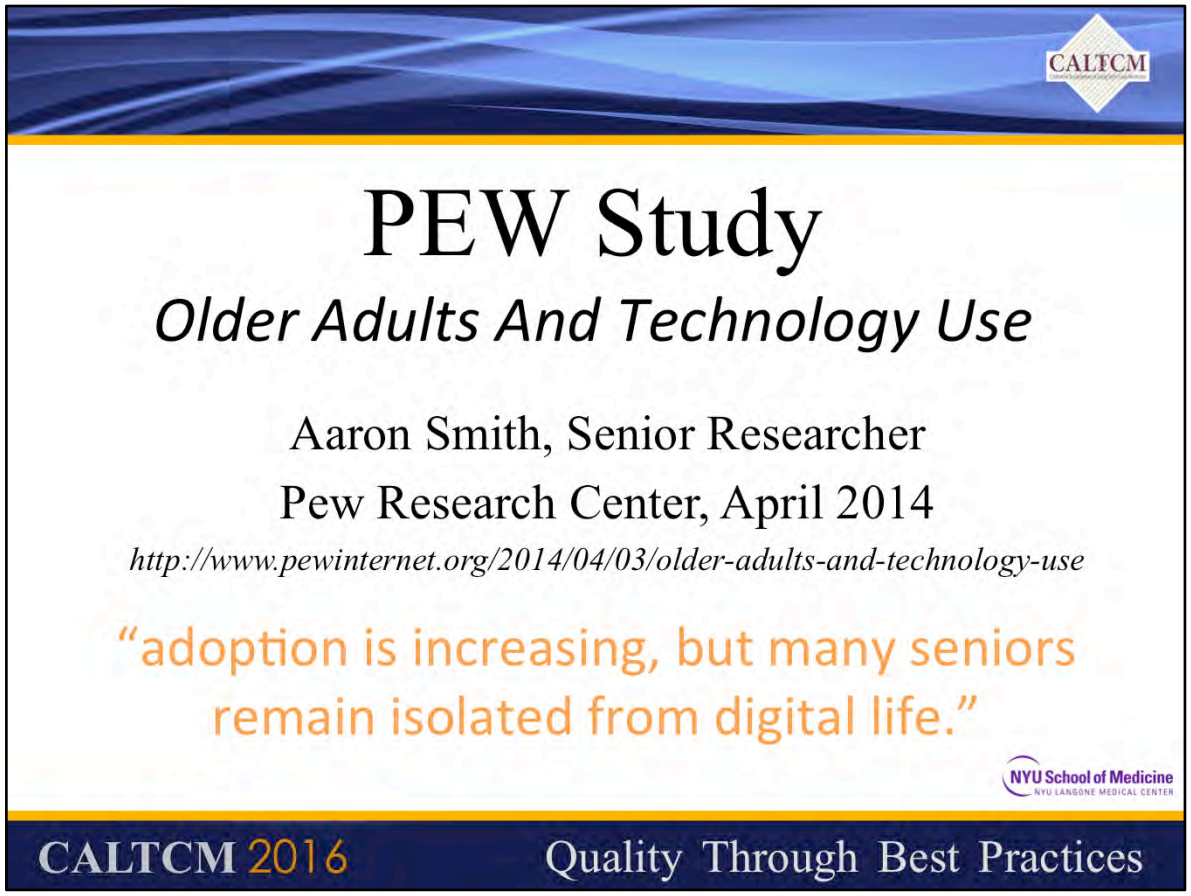
Notes:


CALTCM
PEW Study
Older Adults And Technology Use
Aaron Smith, Senior Researcher
Pew Research Center, April 2014
http://www.pewinternet.org/2014/04/03/older-adults-and-technology-use
"adoption is increasing, but many seniors remain isolated from digital life."
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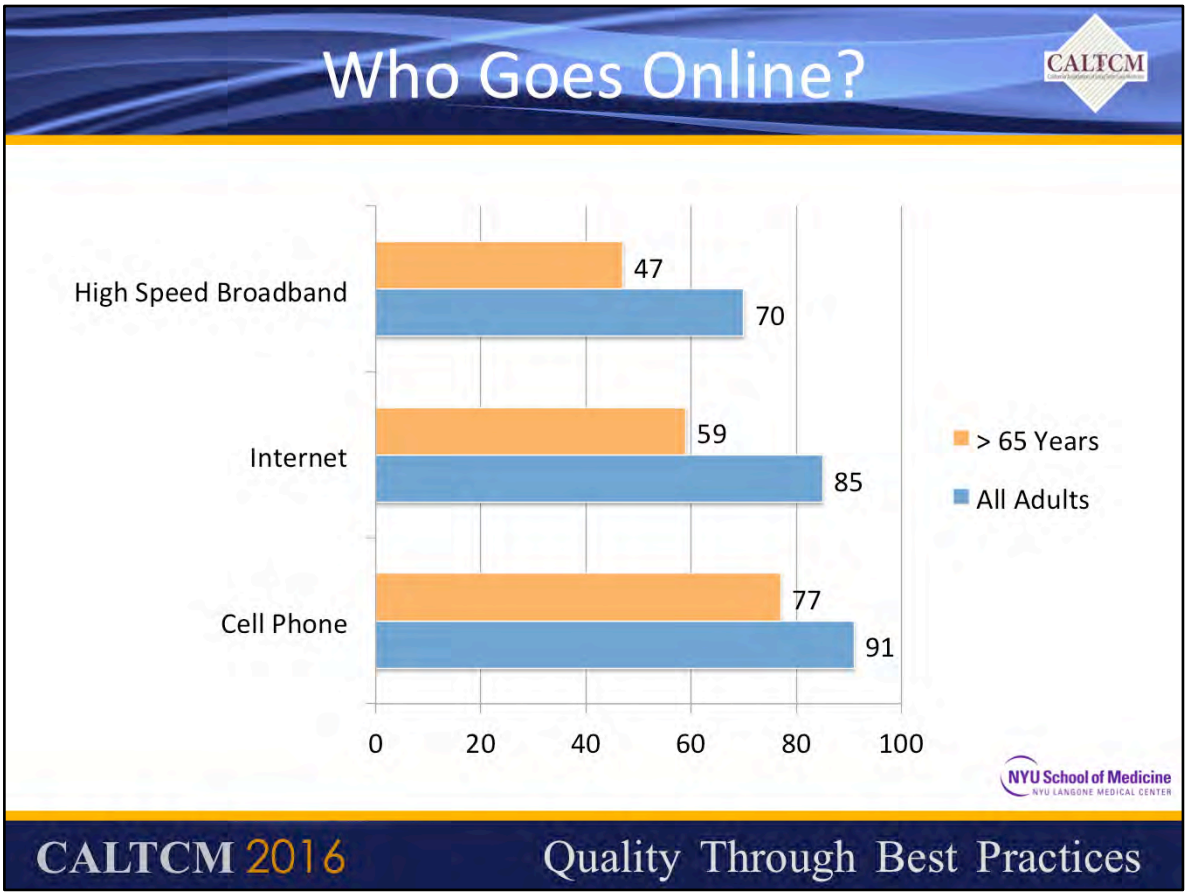
Notes:

Background

- Phone survey: July through September 2013
- Administered to 6010 adults > 18 years
- 1,526 people > 65 years
- Conducted in English and Spanish

Notes:


Who Goes Online?
CALTCM
High Speed Broadband
47
70
Internet
59
85
Cell Phone
77
91
0
20
40
60
80
100
> 65 Years
All Adults
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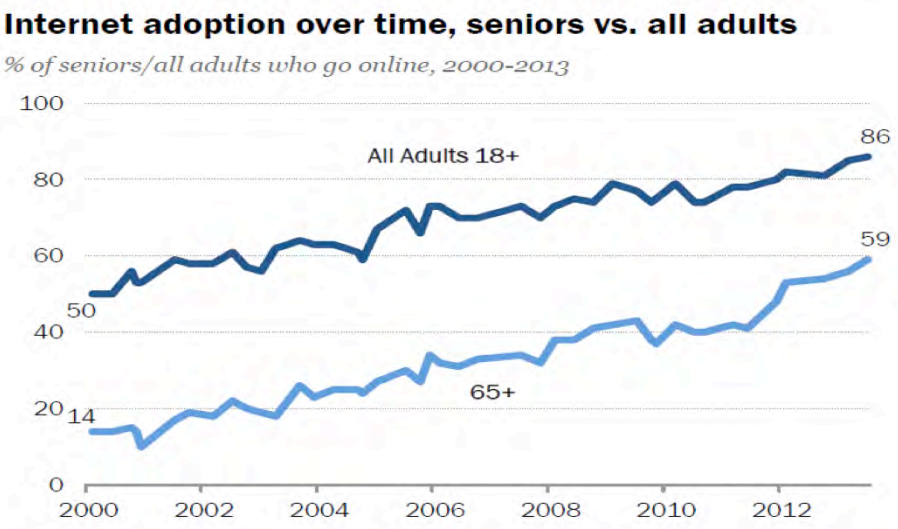
Notes:

"Internet and broadband adoption rates among seniors are steadily increasing, but still well below the national average."



Notes:

Factors that impact internet use

- Higher rate of adoption for older adults who more affluent and better educated compared to those with lower income levels and years of education
- 21% reduction in internet use between early 70s and late 70s.

Pew Research: Older Adults And Technology Use, 2014

Notes:

Physical and Cultural Challenges

- 2/5 seniors report having a physical or health condition that would make reading or doing daily activities hard; this group is less likely to go online (49% vs 66% for healthy surveyed elderly)
- Adoption trouble: 77% "indicate that they would need someone to help walk them through using a new smartphone or tablet"
- Only 18% comfortable learning new technology without help.

Pew Research: Older Adults And Technology Use, 2014

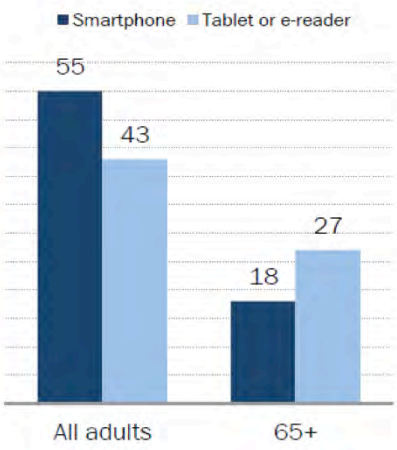
Notes:

Device Ownership

- 55% of adults owned a smartphone, but among adults >65, only 18% own a smartphone
- More likely to own a tablet or e-reader

Seniors are more likely to own a tablet or e-book reader than smartphone

% who own a ...



Pew Research Center's Internet Project July 18-September 30, 2013 tracking survey.

PEW RESEARCH CENTER

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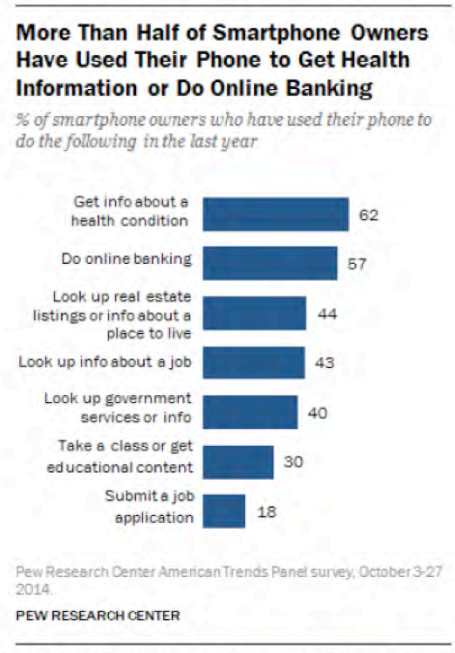
Notes:

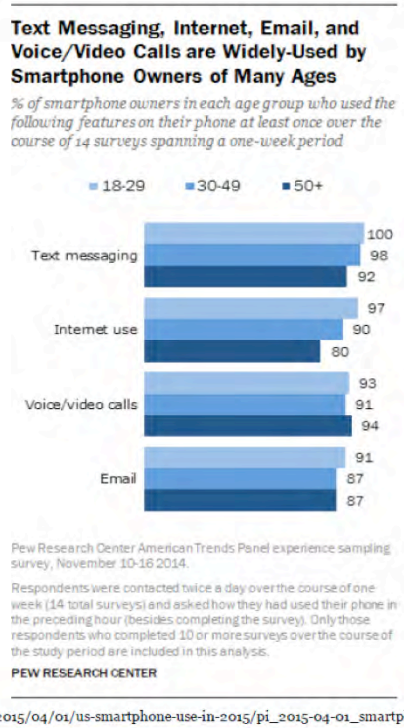
More Than Half of Smartphone Owners Have Used Their Phone to Get Health Information or Do Online Banking



(http://www.pewinternet.org/2015/04/01/us-smartphone-use-in-2015/pi_2015-04-01_smartphones_14/)

Notes:

Text Messaging, Internet, Email, and Voice/Video Calls are Widely-Used by Smartphone Owners of Many Ages



(http://www.pewinternet.org/2015/04/01/us-smartphone-use-in-2015/pi_2015-04-01_smartphones_23/)

Notes:

Skill and Preferences for text entry methods: older versus younger smartphone users

- 50 subjects (25 younger, 18–35 years; 25 older, 60–84 years)
- Text entry task using five text input methods (physical Qwerty, onscreen Qwerty, tracing, handwriting, and voice). Entry [WPM] and error rates, perceived usability, and preference

Results:

- Equally fast at voice input
- Older adults slower at all other methods.
- Both groups low error rates when using physical Qwerty and voice,
- Older adults committed more errors with other three methods.
- Both groups preferred voice and physical Qwerty
- Handwriting consistently worst performance: rated lowest by both

Smartphone Text Input Method Performance, Usability, and Preference With Younger and Older Adults
Smith AL; Chaparro BS, Wichita State University

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Notes:

Systematic review: do mobile technologies enhance care? At what risk?

- Search of publications 2007-2013
  - terms: 'smartphone healthcare', 'mobile phone healthcare', 'mobile phone monitoring', 'smartphone health monitoring' and 'smartphone applications'
- 6 studies met inclusion criteria
- Remote access to patient data increased fall detection and early assessments, reduced errors, saved time and costs
- Challenges:
  - Continuous data transmission reduces battery life
  - Data security and privacy is a significant (*perceived*) threat
  - Cost is substantial barrier

Baig, M; Gholam Hosseini, H; Connolly, M.Australia's Phys Eng Sci Med, 2015

Notes:

Does telehealth using mobile reminders improve medication adherence?

N=60 adults with heart failure (HF)

65% male; mean age: 69 years; 83% white

- feasibility study: electronic pill box and an m-health intervention using smartphone app for 4 medications over 28 days in older adults with HF.
  - pillbox silent (TH: built-in modem)
  - pillbox reminding (TH: built-in modem)
  - smartphone silent (iPhone, Med Adherence app – logging)
  - smartphone reminding (iPhone: Med Adherence app – (logging and reminders.)

Goldstein CM; et al Journal of Telemedicine and Telecare 2014

Notes:

Telehealth intervention with mobile reminders does not improve medication adherence

Adherence Results:

- Telehealth – 80%
- Smartphone – 76%
- Reminders – 79%
- Passive medication reminders – 78%

  Reminding did not improve adherence
  Patients preferred m-health approach
  Usability – 100%

- High adherence may reflect a well-managed sample of patients
- But smaller group with relatively poor adherence

Goldstein CM; Gathright, EC; Dolansky MA, et al.
Journal of Telemedicine and Telecare 2014

Notes:

Senior Living Center residents who use TM experience a reduction in ED visits

22 Senior Living Centers (SLCs) subjects consented for tele-medical intervention – augmented care, not substitute

– Compared ED use among subjects at 3 intervention levels:

1) those with access to high-intensity telemedicine for acute illness care at units where residents used the telemedicine service more frequently (more engaged)
2) those with access to high-intensity telemedicine for acute illness care at units where residents used the telemedicine service less frequently (less engaged)
3) control subjects at facilities without access to telemedicine

Gillespie SM; Shah MN; Wasserman EB; et al. McConnochie KM
Telemedicine and e-Health 2016; 22(6):1-8

Notes:

Senior Living Center residents who use TM experience a reduction in ED visits

Healthcare use per Patient-Month by Level of Engagement of Senior-Living Community Site in Telemedicine, Unadjusted

Visit Type	Rate Ratio for More Engaged Versus Control Units; 95%CI; *p*-value	Rate Ratio for Less Engaged Versus Control Units; 95%CI; *p*-value
ED Use, All Types	0.76 (0.63-0.91) p=0.003	0.80 (0.64-1.00) p=0.055
Hospital Obs., Admission	0.89 (0.73-1.09) p=0.27	0.77 (0.60-0.99) p=0.04
ED Treat and Release	0.60 (0.46-0.78) p<0.001	0.84 (0.63-1.14) p=0.266
PCP	0.83 (0.78-0.88) p<0.001	1.07 (1.00-1.14) p=0.06
All types of care	0.94 (0.87-1.00) p=0.07	1.07 (1.00-1.15) p=0.07

"More Engaged": > 5 telemedicine visits / 100 patient months

CI: confidence interval; ED: emergency department; Obs: observation; PCP: primary care physician

Gillespie SM; Shah MN; Wasserman EB, et al. Telemedicine and e-Health 2016; 22:1-8

Notes:

Meeting Health Care Needs of Aging Rural Veterans

As of 2015 VA offers telehealth services in 44 subspecialties

- VA quality management study found that:
  - telehealth reduces patient hospitalization
  - associated with higher levels of patient satisfaction
  - cost effective
  - "Moreover, telemedicine improves rapport with patients."
- VA has a large elderly and rural network
  - 5.3 million of the nation's 22 million veterans live in rural areas
  - 75% rural veterans are over the age of 55
  - Distance is health care is major barrier for veterans age 65 and older

- 2013, VA-specific telehealth > 608,000 patients at 151 VA medical centers and 705 community-based outpatient clinics: 1.8 million telehealth episodes of care
- 2014 VA Telehealth served > 690,000 veterans: > 2 million telehealth visits

Telehealth can meet the health care needs of aging rural veterans
Win, AZAging Clin Exp Res (2015) 27:939–940

NYU School of Medicine
NYU LANGONE MEDICAL CENTER

Notes:

Telemedicine and Cognitive Evaluation

Veteran's Cognitive Assessment and Care Management Program (V-CAMP)

- Interdisciplinary dementia care using clinical video teleconferencing
- Real-time high resolution video interactions between dementia subspecialists in a major metropolitan medical center and patients in 3 outlying clinics located 180, 150, and 100 miles away.
- Comprehensive neuropsychological assessments, to address referral questions related to neurocognitive disorders as one component of interdisciplinary care.

Outcomes: First 31 patients

- 81% had inaccurate neurocognitive diagnosis at the time of referral
- 77% identified as having unmet and unrecognized mental health treatment needs
- Satisfaction was high for patients, caregivers, and clinicians.

Harrell K, Connor MK, Wilkins S, Chodosh J..
J Am Med Dir Assoc. 2014; 15:600-6

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Notes:

Better compatibility with devices and evaluation of legal and ethical problems are next steps

Many types of home telecare technologies available

- Diabetes: computerized BG monitors, gluco-watches
- At-home sensors (GPS), clothing sensors
- Health watches for BP, pulse, temperature, skin moisture
- Home lab work

Barriers:

- Standards to combine incompatible information systems
- An evaluation framework incorporating legal, ethical, organizational, economical, clinical, usability, quality and technical aspects
- Guidelines for practical implementation of home telecare applications
  - In 1996, Norway the first with official telemedicine fee schedule reimbursable by NHS
- Scientific evidence for effectiveness of home telecare applications

Botsis T; Demiris G; Pedersen S; Hartvigsen GJournal of Telemedicine and Telecare 2008; 14: 333–337

Notes:


CALTCM
WHAT IS THE FUTURE OF TELEHEALTH?
NYU School of Medicine
NYU LANGONE MEDICAL CENTER
CALTCM 2016
Quality Through Best Practices

Notes:

ECG technology at home

- Medical-grade ECGs from Smart Phones and Watches (currently undergoing FDA approval)
- Not yet available for purchase in US ($99)
- **Bluetooth connectivity**

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Pictured: AliveCor brand Kardia ECG Pictured: QuardioCore

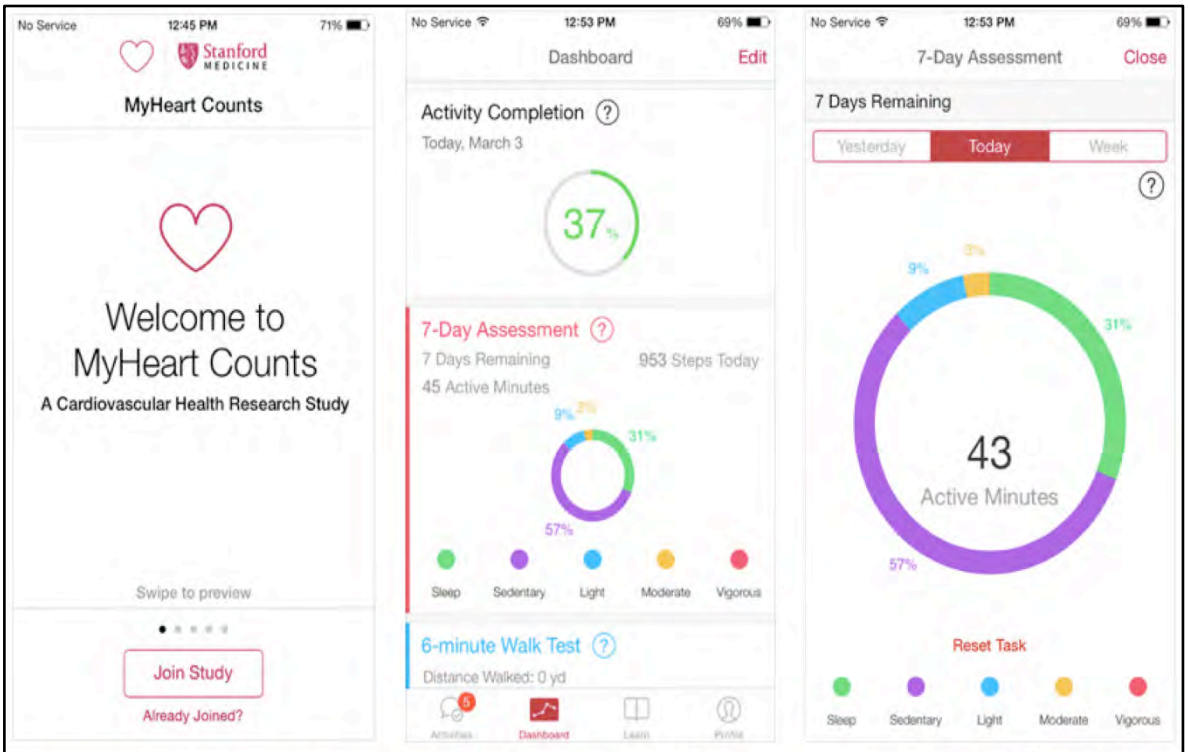
Notes:

Stanford: My Heart Counts app

- Free app to help track movement
- Study activity and heart health through mobile phone.
- Large cardiovascular research trial
- Stanford University scientists will use data from app users to improve heart disease prevention and treatment.

https://med.stanford.edu/myheartcounts/faq.html

Notes:



Screenshots from the My Heart Counts App (Stanford Med)

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Notes:

Robots as caretakers and helpers

The Future of Robot Caregivers

The New York Times

Art: Souther Salazar for the NYT

By LOUISE ARONSON JULY 19, 2014

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Notes:

Possible roles for nursing care robots

Mobility assistance	**Help elderly or impaired with walking and movement**
Monitoring	Using in-home or in-clothing sensors, cameras, infrared, etc. to monitor the safety of the elderly and reduce solo-living risks
Lifting and bathing assistance	Reduction of caregiver burden; help staff and family assist with ADLs

http://www.roboticstrends.com/article/japan_to_create_more_user_friendly_elderly_care_robots/medical

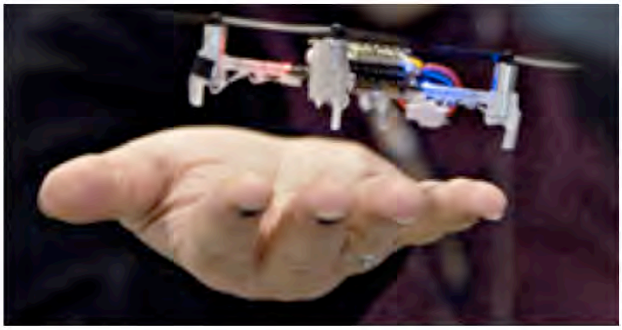
Notes:

The New York Times

Social Robots

As Aging Population Grows, So Do Robotic Health Aides

By JOHN MARKOFF DEC. 4, 2015



Small drone that may eventually carry out household task like retrieving medicines.

"Artificial-intelligence-derived technologies to be commercially available in the next decade include intelligent walkers, smart pendants that track falls and location, room and home sensors to monitor health status, balancing aids, virtual and robotic electronic companions, and even drones."

Notes:

RoboCoach

- New to Senior Homes in Singapore
- Personalized exercise routines for the elderly to encourage movement

Photo: http://www.cnn.com/2015/10/20/asia/singapore-aging-robot-coaches-seniors/

Notes:

Conclusion

- Telemedicine and the technology to support its use is rapidly evolving
- Increased experimentation and research to create a useful evidence base will accelerate best applications
- There are opportunities with new spaces like this to reexamine medical care and carve out what is ritualistic versus effective
- Caution is advised in finding applications for expanding technologies as opposed to developing new technologies to address healthcare challenges

Notes:


CALTCM
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Avoiding Technology through Technology: Reducing Admissions
Diane Chau, MD
CALTCM 2016

Notes:


CALTCM
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Sensing the Future
Through Health Monitoring
Thomas Osborne, MD
April 30 2016
CALTCM 2016

Notes:

Disclosures

- I have no relevant financial relationships with commercial interests to disclose.
- I am Medical Director for HealthVerge, a medical-technologcal consulting agency, and am Radiologist, Neuro-radologist & Director of Medical Informatics for Virtual Radiologic.

All conflicts of interest have been resolved in accordance with the ACCME's Standards for Commercial Support.

Notes:

Critical Note:

- **This is about medicine utilizing technology**
  - Medical professionals must lead the thoughtful implementation of technology, not the other way around.
  - Technology is just another powerful tool.
  - Without deep clinical & medical system understanding and tech collaboration it will fail.
  - None of this means anything if we don't improve patient health and value.

Notes:

Learning Objectives

1. List **3+ potential uses** of sensors in health care of older adults
2. Discuss **future trends** in technology and health assessments
3. Describe 5 evolving **health technology terms**
4. List **3 major related technology advancements** for health care

Notes:

Learning Objectives

1. List **3+ potential uses** of sensors in health care of older adults
    - Home Health Care
    - Diabetes Monitoring
    - Disease Diagnosis
    - bonus: Advanced Prosthetics + more

Notes:

Home Health Care Perspective

Very Low tech

Safety eval

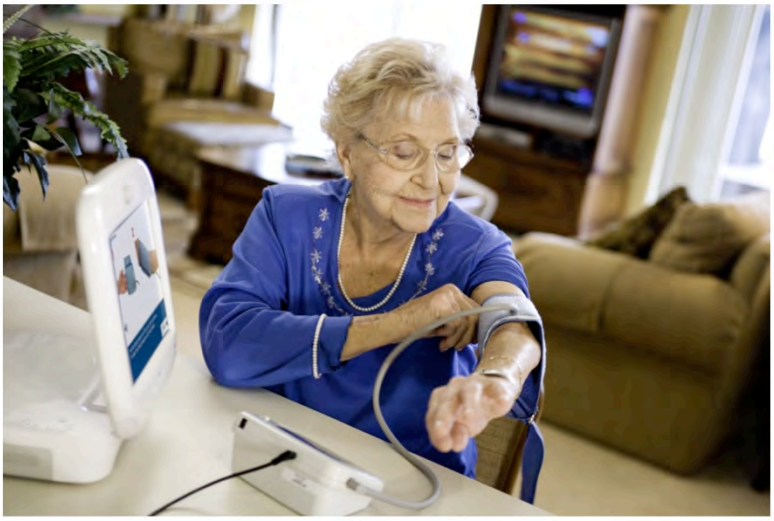
Low tech

Motion sensor light switch

Notes:


Uses of OTC clinical sensors for older adults:
Home Health
CALTCM
SMARTHEART
120
80
MEM
SET
START
STOP
96 | 82
Sleep
102
AliveECG
80

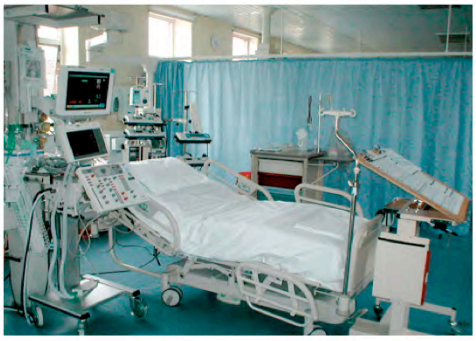
Notes:



CALTCM 2016 Quality Through Best Practices

Notes:

Uses of clinical sensors for older adults:
Home Health

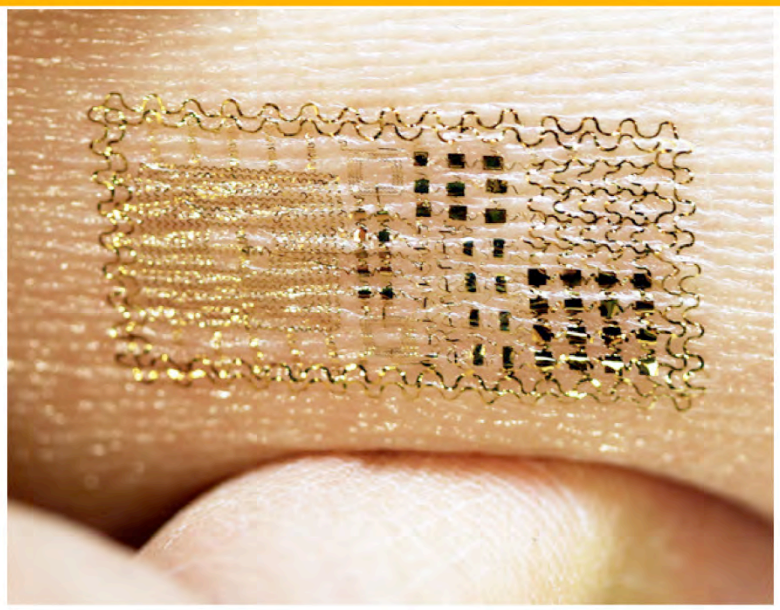


Extensive Monitoring

- HR
- SpO2
- BP
- EKG
- Temp
- BG

Samsung Simband

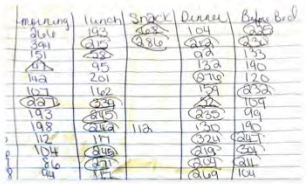
Notes:



Newest tattoo like sensors are small wireless and disposable

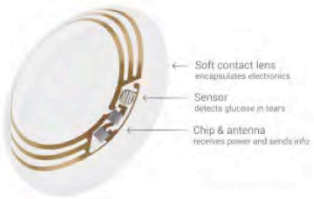
Notes:

Uses of clinical sensors for older adults: **Diabetes**



Negatives:
Pain
Convenience
Log accuracy
Log standardization
Contributing factors

Google Contact Lenses
(Google + Novartis)



- Measure the glucose levels in tears
- Restore the eye's natural autofocus
- Under development

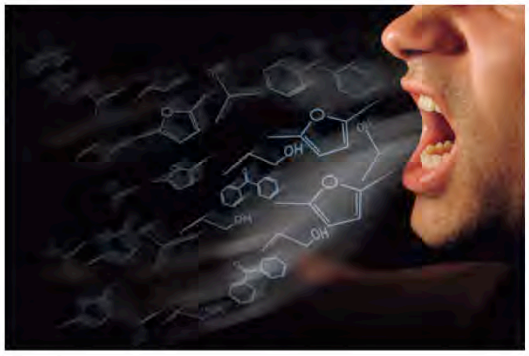
Abbott
FreeStyle Libre System

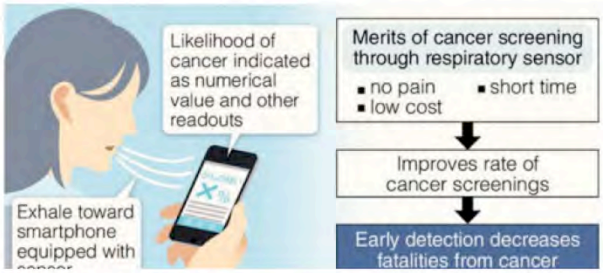
(United Kingdom only)

Notes:

Uses of clinical sensors for older adults:
Disease Dx Through Breath

Sensors to pick up biomarkers for diseases ranging from cancer, metabolic disease and Alzheimer's/Parkinson's





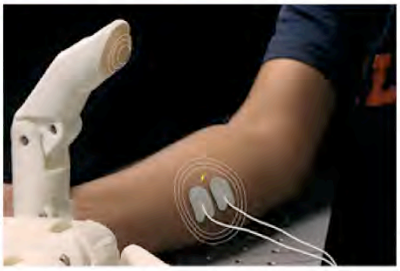
SNIFFER DOGS IN THE MELANOMA CLINIC?
Williams, Hywel et al.
The Lancet , Volume 333 , Issue 8640 , 734 1989

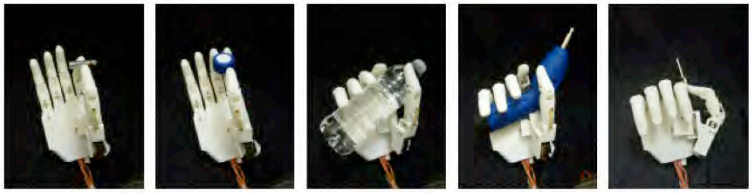
Breath sensors for lung cancer diagnosis
Biosensors and Bioelectronics, Volume 65, Issue null, Pages 121-138
Yekbun Adiguzel, Haluk Kulah

Dynamic Nanoparticle-Based Flexible Sensors: Diagnosis of Ovarian Carcinoma from Exhaled Breath
Nicole Kahn, Ofer Lavie, Moran Paz, Yakir Segev, and Hossam Haick
Nano Letters **2015** *15* (10), 7023-7028
DOI: 10.1021/acs.nanolett.5b03052

Notes:

Uses of clinical sensors for older adults: **Prosthetics**





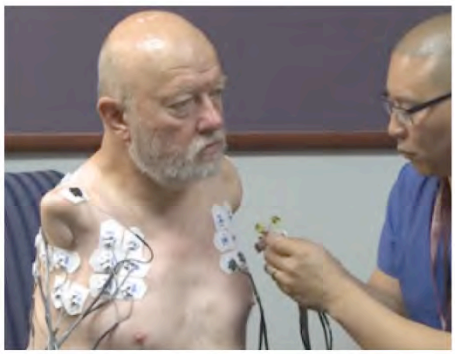
- Touch sensor relays information to the residual limb that feels like a vibration or pressure
- Machine learning algorithms recognize different patterns of muscle activity from the user's residual limb

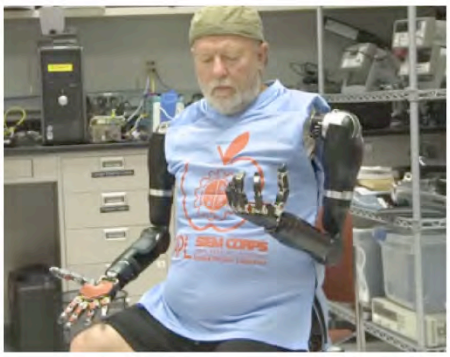
2015 IEEE International Conference on Robotics and Automation (ICRA)
Washington State Convention Center Seattle, Washington
May 26-30, 2015

http://static1.squarespace.com/static/53d016d6e4b0e86a1a65f38a/t/556bbaece4b01a352bb1fa94/1433123564061/Slade2015.pdf
http://www.mindsofmalady.com/2016/01/psyonic-develop-3d-printed-prosthetic.html

Notes:

Neuro-controlled Modular Prosthetic Limb





Notes:

Robotic Nurse Assistant

Move or lift patients in bed or after an emergency from a fall
Tactile guidance methods using high-accuracy tactile sensors.

RIBA (Robot for Interactive Body Assistance)

Notes:

Notes:

Learning Objectives

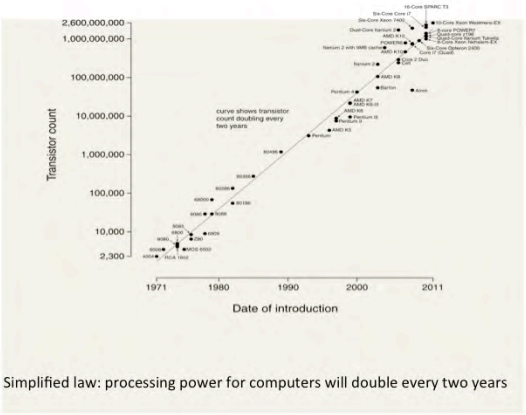
2. Discuss **future trends** in technology and health assessments
    - Trifecta:
        - Technology
        - Consumer Wants
        - Healthcare Cost
    - From disease to wellness

Notes:

Future Trends

Tech, Consumer Wants & Healthcare Cost

Microprocessor Transistor Counts 1971-2011 & Moore's Law



Simplified law: processing power for computers will double every two years

3D accelerometer abt $1

Notes:

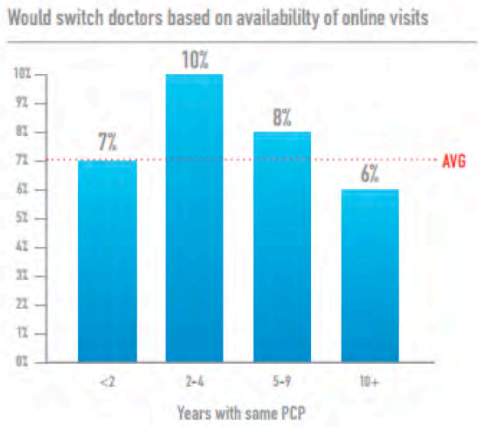
Future Trends

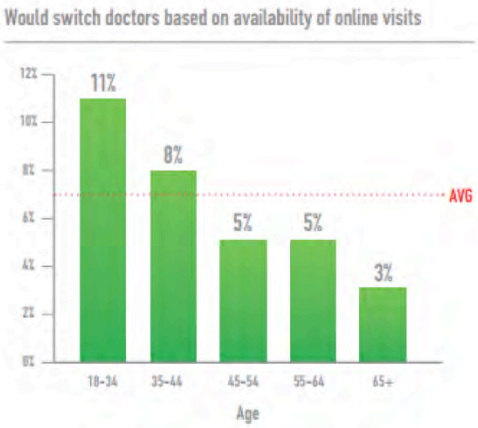
Tech, **Consumer Wants** & Healthcare Cost

Mobile Health Market To Reach $26B By 2017 - InformationWeek

Notes:

Future Trends
Tech, **Consumer Wants** & Healthcare Cost

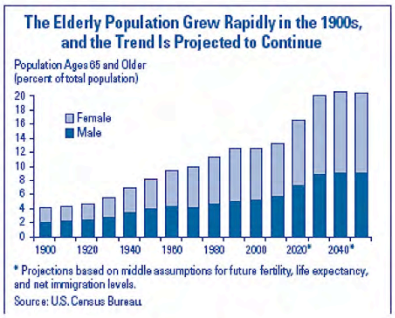




TELEHEALTH INDEX: 2015 CONSUMER SURVEY
cdn2.hubspot.net/hub/214366/file-2374840622-pdf/TelehealthConsumerSurvey_eBook_NDF_Electronic_Version_(2).pdf

Notes:

Future Trends
Tech, **Consumer Wants** & Healthcare Cost



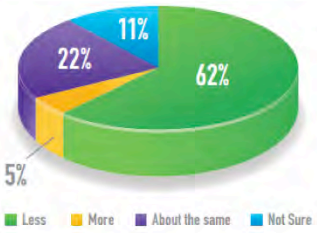
Source: U.S. Census Bureau

Baby Boomers

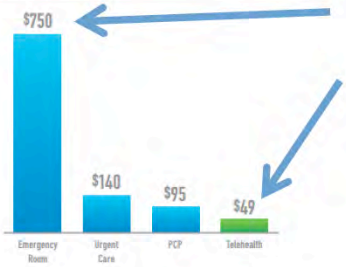
Notes:

Future Trends
Tech, Consumer Wants & **Healthcare Cost**

How much should online visits cost compared to an in-person visit? [7]



Cost of care



[6] Milliman (2011) actuarial analysis and American Well client data

[7] American Well Consumer data, 2014

People in Business Leader

Patients happy to rate their private hospital as the best

"Pay for Quality" Ex: 30d readmission penalty, etc

Notes:

Future Trends
Tech, Consumer Wants & **Healthcare Cost**

From treating disease to supporting wellness

Greater patient empowerment and responsibility/accountability

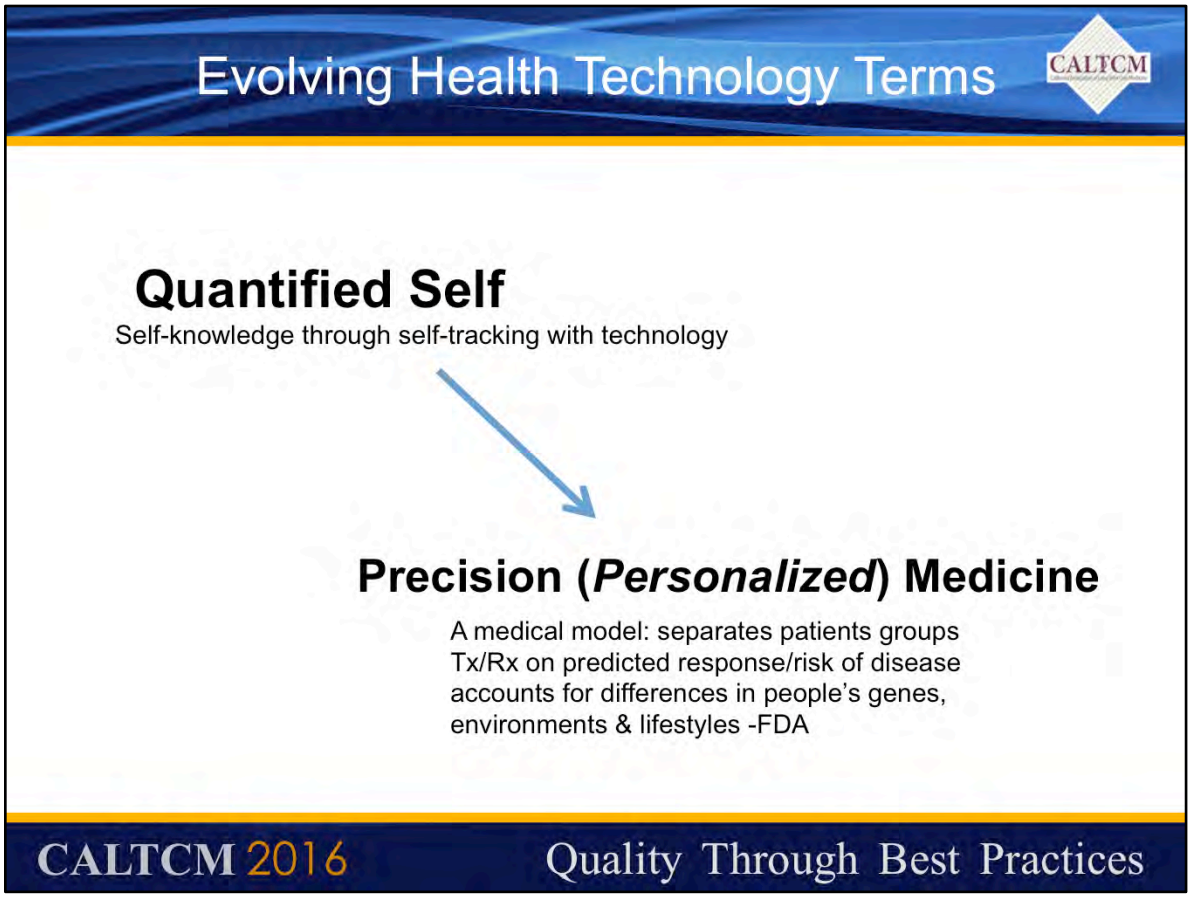
Notes:

Learning Objectives

3. Describe 5 evolving **health technology terms**

- Quantified Self, Personalized Medicine
- Interoperability & Convergence
- Translational Medicine

Notes:


Evolving Health Technology Terms
CALTCM
Quantified Self
Self-knowledge through self-tracking with technology
Precision (*Personalized*) Medicine
A medical model: separates patients groups
Tx/Rx on predicted response/risk of disease
accounts for differences in people's genes,
environments & lifestyles -FDA
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Quality Through Best Practices

Notes:

Notes:

Evolving Health Technology Terms

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Convergence & Interoperability

CALTCM 2016 Quality Through Best Practices

Notes:


SMARTHEART
120
80
MEM
SET
START
STOP
Medication 12:50
Nexium Oral
20 mg, 4:07 PM
Skip
Take
96
82
80
102
Source: Signostics

Notes:

Portable wireless device that can diagnose 13 diseases and continually monitor 5 vitals

Seven finalist teams. Deadline extended through early 2017

Notes:

Evolving Health Technology Terms

Translational Medicine:

- **Interdisciplinary** branch of the biomedical field
- Three main pillars: **bench-side, bedside & community**
- NIH major push to fund TM. Esp focus on cross-functional **collaborations**; leveraging new technology and data analysis tools

Translational Medicine definition by the European Society for Translational Medicine".
New Horizons in Translational Medicine. Volume 2 (Issue 3): 86–88. 11 December 2014. doi:10.1016

Woolf, Stephen H. "The Meaning of Translational Research and Why It Matters"
JAMA 299 (2): 3140–3148, doi:10.1001/jama.2007.26, PMID 12633190

Notes:

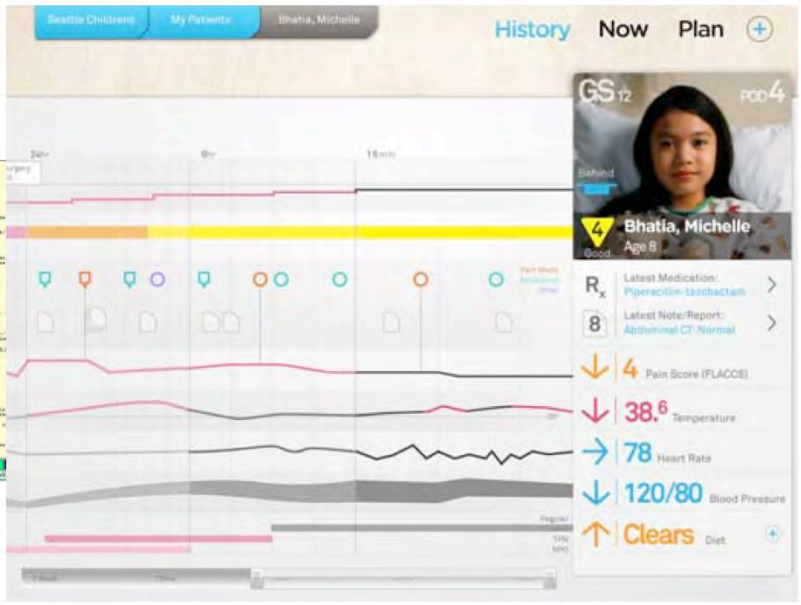
Learning Objectives

4. List **3 major related technology advancements** for health care
   - UI/UX
   - Analytics
   - Machine Learning

Notes:

3 Major Health Technology Advancements

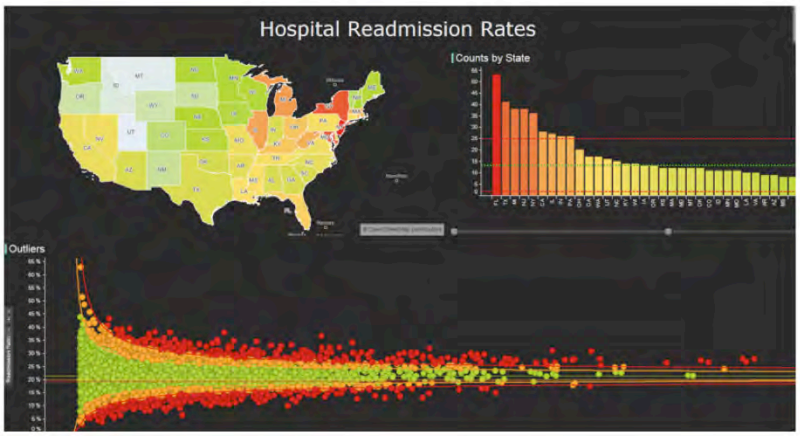
UI/UX:



Notes:

3 Major Health Technology Advancements

- **Analytics**



Notes:

3 Major Health Technology Advancements

Machine Learning (AI):

Field of study that gives computers the ability to learn without being explicitly programmed"

Notes:

Learning Objectives Covered

1. List **3+ potential uses** of sensors in health care of older adults
   - Home Health Care, Diabetes Monitoring, Disease Diagnosis
   - (bonus: Advanced Prosthetics + more)
2. Discuss **future trends** in technology and health assessments
   - Trifecta: Tech, Consumer Wants & Healthcare Cost
   - From disease to wellness
3. Describe 5 evolving **health technology terms**
   - Quantified Self, Personalized Medicine
   - Interoperability & Convergence
   - Translational Medicine
4. List **3 major related technology advancements** for health care
   - UI/UX, Analytics, Machine Learning

Notes:


Thank You
shift
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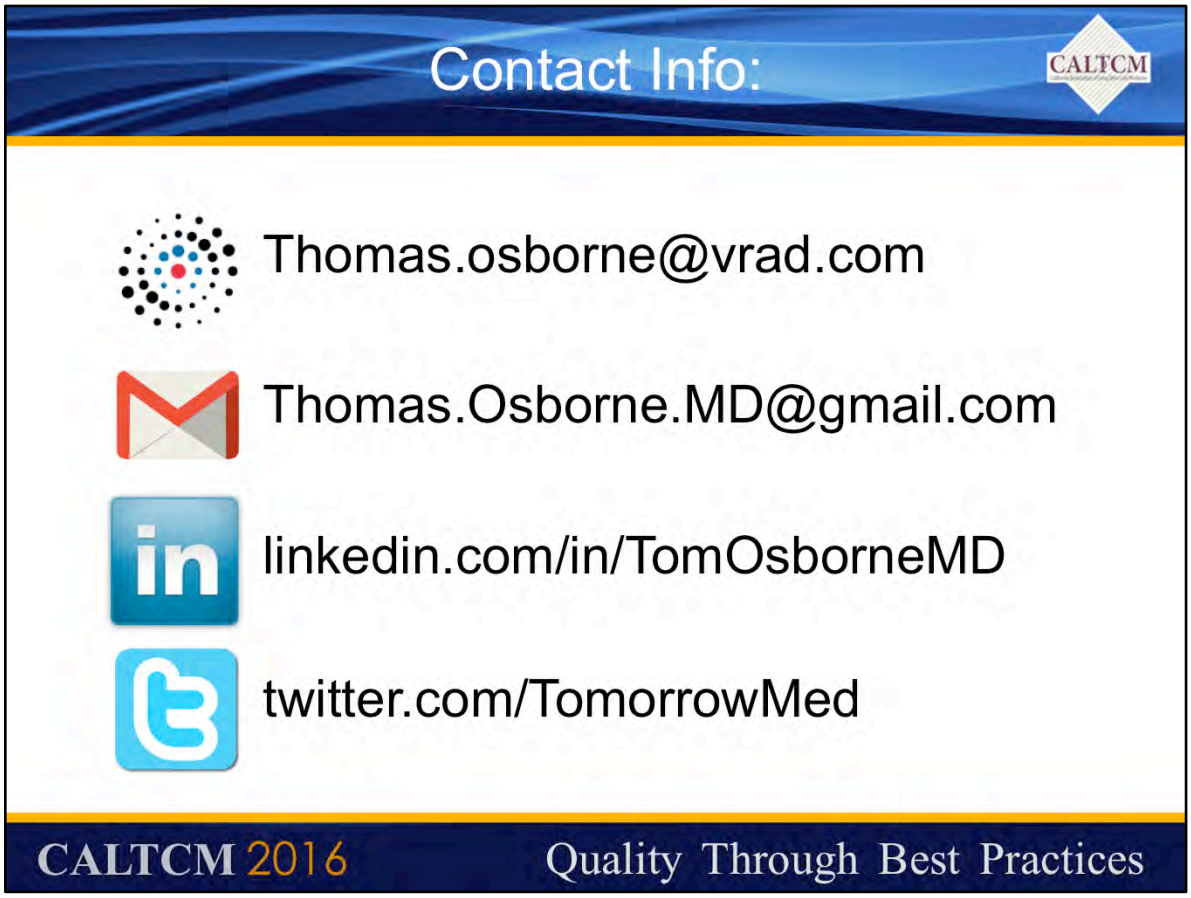
Quality Through Best Practices

Notes: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Thomas.Osborne.MD@gmail.com
linkedin.com/in/TomOsborneMD
twitter.com/TomorrowMed
CALTCM 2016
Quality Through Best Practices

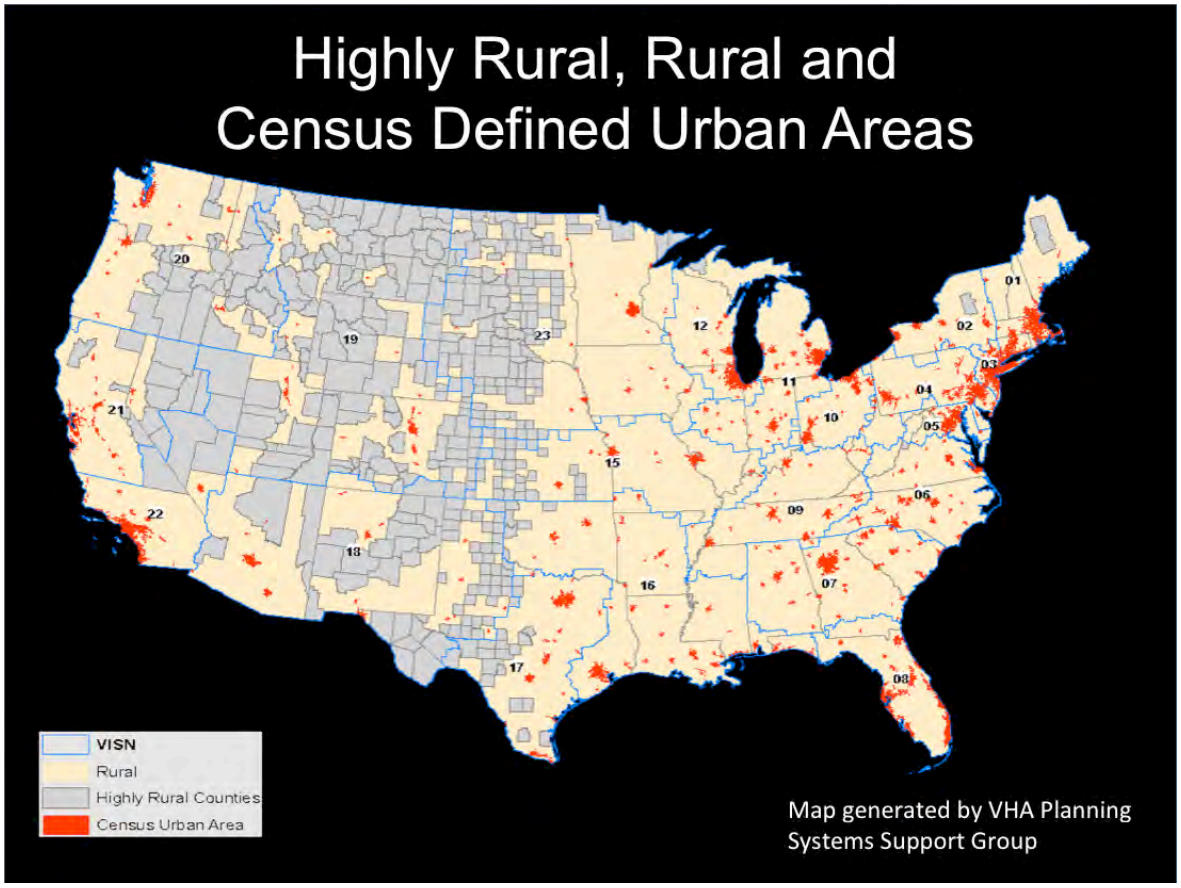
Notes:


CALTCM
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
Access to Care: The use of Telemedicine Across the Healthcare Continuum
Kevin Broder, MD
Telehealth Director, Surgery Service, Section of Plastic Surgery
VA Medical Center – San Diego, CA; Telemedicine and Wound Care Director, San Diego GWEP Collaborative
CALTCM 2016

Notes:

Rube Goldberg (1883-1970)

Notes:


Highly Rural, Rural and
Census Defined Urban Areas
VISN
Rural
Highly Rural Counties
Census Urban Area
Map generated by VHA Planning
Systems Support Group

Elderly Transport

- Costly Travel
- Special Assistance Personnel
- Special Equipment (Gurneys, Wheelchairs, Vehicles)
- Long Clinic Wait Times
- Family Inconvenience

Notes:

Telemedicine
4 Modalities

- Store and Forward Telehealth
  - Images/Data obtained by remote site and uploaded Imaging Database for later review by provider
- Home Telehealth
  - Home monitoring devices
- Clinical Video Telehealth (CVT)
  - Real Time 'Live' Videoconferencing
- Specialty Care Access Network (SCAN)
  - Consultation, Care Planning and Education with Tele-video conferencing

Notes:

Steps for Program Development

- Establish Conditions of Participation and Service Agreements
- Formation of Telehealth Team
- Identify Patients
- IT Collaboration/Equipment Allocation
- Informatics Collaboration
- Integration into Continuum of Care
- Ongoing Provider/Patient Support

Notes:

Telehealth Team

Identify the Patients Visit Types

- Post Acute Care Discharge
- Wound Care/Skin Assessment
- Specialty Consultation
- Medical Optimization
- Post-Op Evaluation
- Medication Reconciliation
- Psychology
- Nutrition
- Education

Notes:

More Visit Types
Veteran Affairs Examples

- TeleCardiology
- TeleGenomics
- TeleICU
- TeleNeurology
- TeleNutrition
- TelePrimary Care
- TelePulmonology (Sleep Services)
- TeleRehabilitation
- TeleAmputation Clinics
- TeleKinesiology
- TeleOccupational Therapy
- TeleSpinal Cord Injury/Disorder
- TeleMOVE! (Weight Loss)

Notes:

IT Support/Equipment

- Broadband Network
- Tele-video Conferencing Equipment
- Peripherals

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Notes:

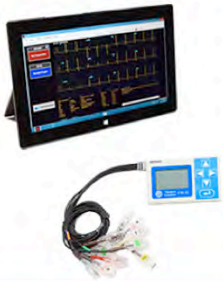
Peripherals

Digital Stethoscope

Exam Camera

Vital Signs Monitor

12 Lead ECG



Spirometer

Ultrasound

Notes:

Informatics Collaboration

- Customized automated Consult Requests for SCAN-ECHO and CVT
- Software based query of remote site patient data
- Template for guiding remote provider input

Template: IFC TELEHEALTH SCI PLASTICS

To minimize consult rejection, please complete all of the information.

Click below to indicate patient and provider amenability to utilizing telehealth technology for this consultation.

Inform the patient about using telehealth technology. Explain that to decline utilizing telehealth will not adversely affect access to healthcare services. Further explain that it will be up to the consultant to decide whether or not a telehealth visit is appropriate for this consultation.

☑ Provider and Veteran are amenable to utilizing telehealth for this consultation. The Veteran understands that he/she has the right to decline the use of telehealth technology without adverse affect on continued access to health care services. Additionally, Veteran understands it will be the decision of the consultant as to whether or not telehealth technology will be used for this visit.

The Veteran location for this visit will be:

- ○ Phoenix
- ○ Tucson
- ○ Prescott
- ○ Loma Linda
- ○ Las Vegas
- ○ Other:

Contact Information - Physician Requesting Consult

Name: *

Phone #: *

Pager #:

Level of Injury: * Date of Injury: *

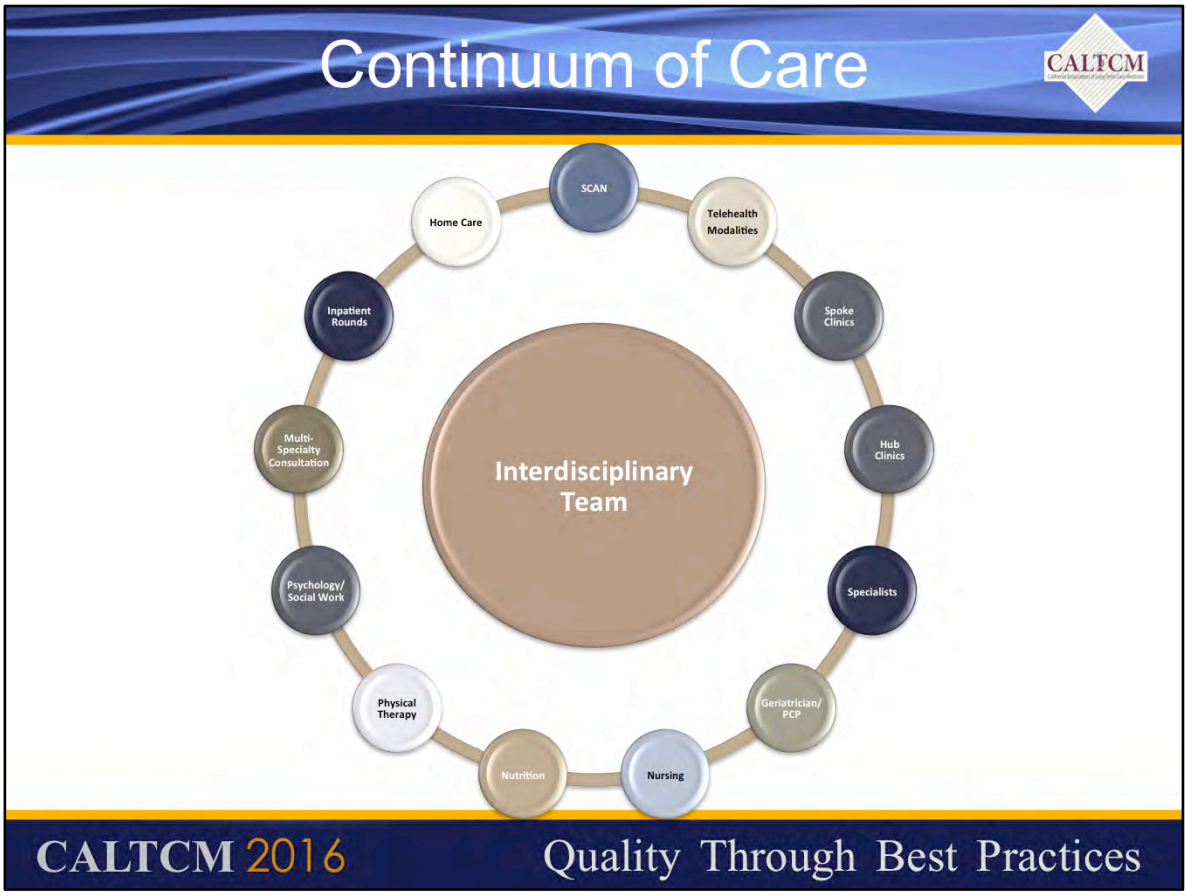
Can Veteran tolerate prone positioning: * ○ Yes ○ No

Is Veteran compliant with current treatment: * ○ Yes ○ No

Nutrition:

Diet: *

Notes:


Continuum of Care
CALTCM
SCAN
Telehealth Modalities
Spoke Clinics
Hub Clinics
Specialists
Geriatrician/ PCP
Nursing
Nutrition
Physical Therapy
Psychology/ Social Work
Multi-Specialty Consultation
Inpatient Rounds
Home Care
Interdisciplinary Team
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Quality Through Best Practices

Notes:

Ongoing Telehealth Support

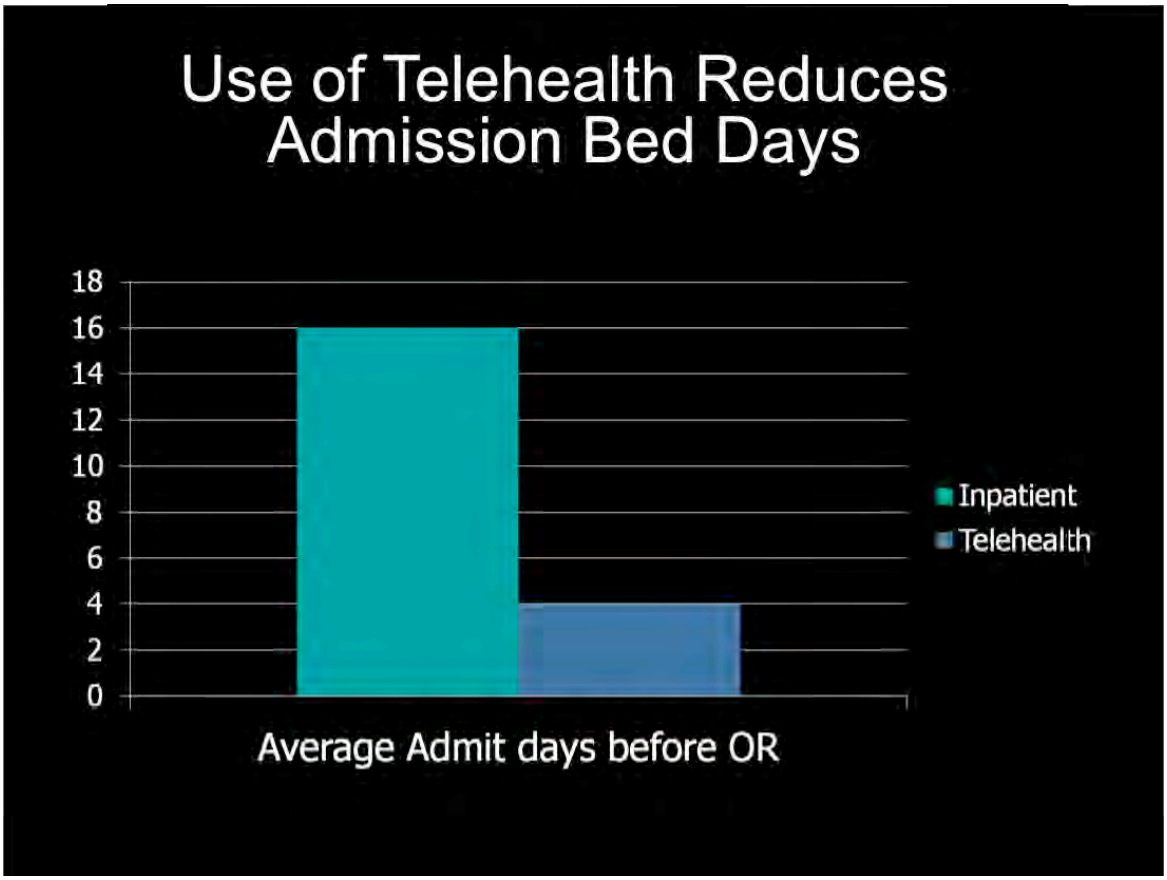
- Telehealth Coordinator - RN
- Telehealth Clinical Technician (TCT) – Health Tech/LPN
- IT Support
- Vendor Support
- Routine Education and Training
- Administrative Oversight

Notes:

Clinical Video Telehealth
CVT

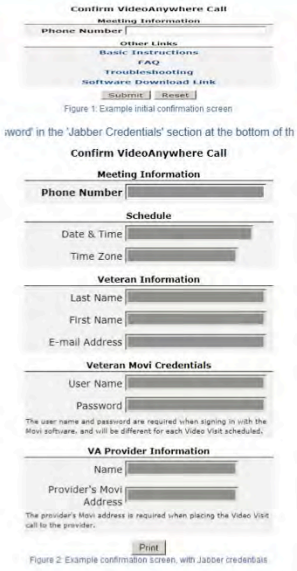
Patient/PCP at Spoke
Provider at Hub
'Consult/Post -op/Follow-up/Pre-op'

Patient/Provider at Hub
PCP/Family/Home RN at Spoke


Use of Telehealth Reduces Admission Bed Days
18
16
14
12
10
8
6
4
2
0
Inpatient
Telehealth
Average Admit days before OR

CVT to Home
Process

- Schedulers Create Appointments in Custom Web App
- Email Confirmation Sent to Patient for Secure Login
- HIPAA Compliant Software



Confirm VideoAnywhere Call

Meeting Information

Phone Number

Other Links

Basic Instructions

FAQ

Troubleshooting

Software Download Link

Submit Reset

Figure 1: Example initial confirmation screen

'word' in the 'Jabber Credentials' section at the bottom of th

Confirm VideoAnywhere Call

Meeting Information

Phone Number

Schedule

Date & Time

Time Zone

Veteran Information

Last Name

First Name

E-mail Address

Veteran Movi Credentials

User Name

Password

The user name and password are required when signing in with the Movi software, and will be different for each Video Visit scheduled.

VA Provider Information

Name

Provider's Movi Address

The provider's Movi address is required when placing the Video Visit call to the provider.

Print

Figure 2: Example confirmation screen, with Jabber credentials

Notes:

CVT to Home
Process

- Patients Connect to Enterprise Video Network from Home
  - Desktop
  - Laptop
  - Tablet
- Connect to Hospital Provider for Encounter
- Electronic Health Record Documentation

Notes:

CVT to Home
Equipment

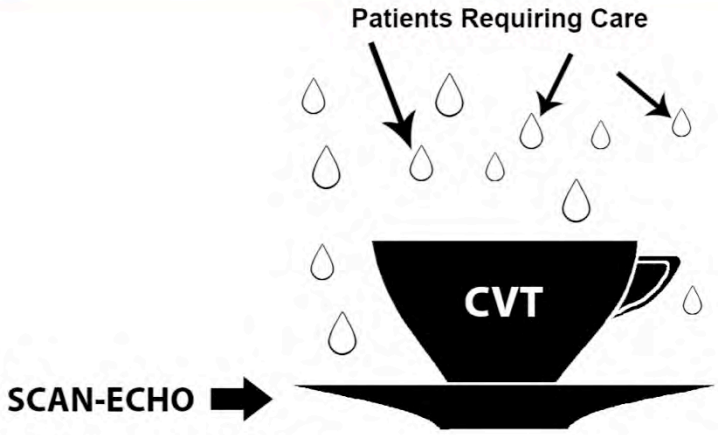
Patient/Home RN at Home
Provider at Hub
'Real Time Home Visit'

CVT to Home
Medical Problems Addressed

- Wound Care
- Nutrition
- Smoking Cessation
- Pressure Relief
- Medication Reconciliation
- Compliance
- Disposition (Remain home vs Urgent Care vs ED)

Notes:

Safety Net



- Widens the Safety Net
- Expands Knowledge Base
- Multi-team Collaborations on Complex Patients

Notes:

SCAN
SPECIALTY CARE ACCESS NETWORK

- An innovative model utilizing clinical tele-video conferencing equipment to allow healthcare specialists from an inter-professional care team to provide expert advice to remote providers in rural/underserved healthcare settings

- A 'Grand Rounds/Tumor Board' style multipoint tele-video consultation

SCAN Process

- Consent - verbal
- Inter-Facility Consultation Request Placed
- SCAN-ECHO Tele-Video Session
  - Case Presentation
  - Case Discussion
  - Didactic Lecture
- Documentation

Notes:

Steps for Program Development

- Formation of an Interdisciplinary Team of Consultants
- Identify Hub and Spokes
- IT Collaboration
- Informatics Collaboration
- Develop Didactic CME/CEU Accredited Lectures

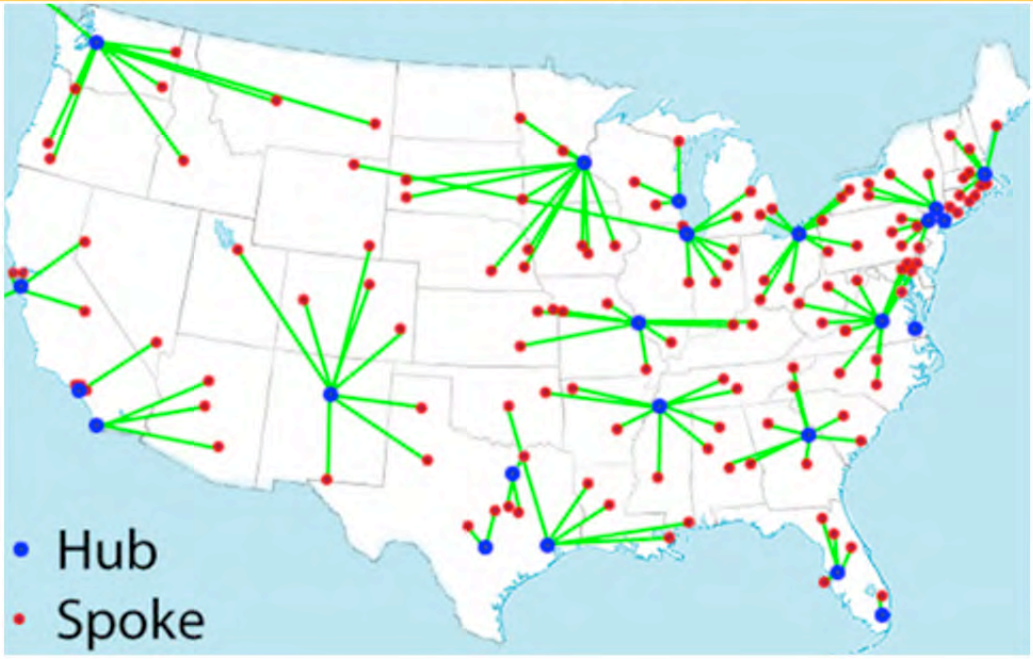
Notes:

Inter-professional Team Example
SCI Pressure Ulcers and Complex Wounds

- Plastic Surgeons
- Rehabilitation Physician
- Clinical Nurse Specialist/ Rehab Case Manager
- Physical Therapist
- Dietitian
- Telehealth Nurse Coordinator

Notes:

Hubs and Spokes
VA SCI Example



Didactic Lectures

- Wound Debridement
- Pressure Ulcer Reconstruction
- Adjuncts to Wound Healing
- Comprehensive Assessment of Pressure Ulcer Patients
- Topical Wound Care
- Nutrition for Wound Healing
- Pressure Relief Surfaces
- Specialty Mattresses & Beds
- Prevention of Amputation & Foot Screening
- Bioethics Roundtable: Autonomy and Other Issues
- Pre-Op Optimization Part I – The Surgical Checklist
- Pre-Op Optimization Part II – Nutritional Optimization for Wound Prevention and Healing

Notes:

Benefits for patients and Providers

- No-cost continuing education credits (CME/CEU)
- Opportunity to translate new knowledge into practice to improve outcomes
- Professional networking with colleagues of similar interests
- Avoid costly and time consuming travel to distant medical centers that puts patients at risk

Notes:


SCAN
FAR REACHING
CALTCM
United States
Mexico
Cuba
Venezuela
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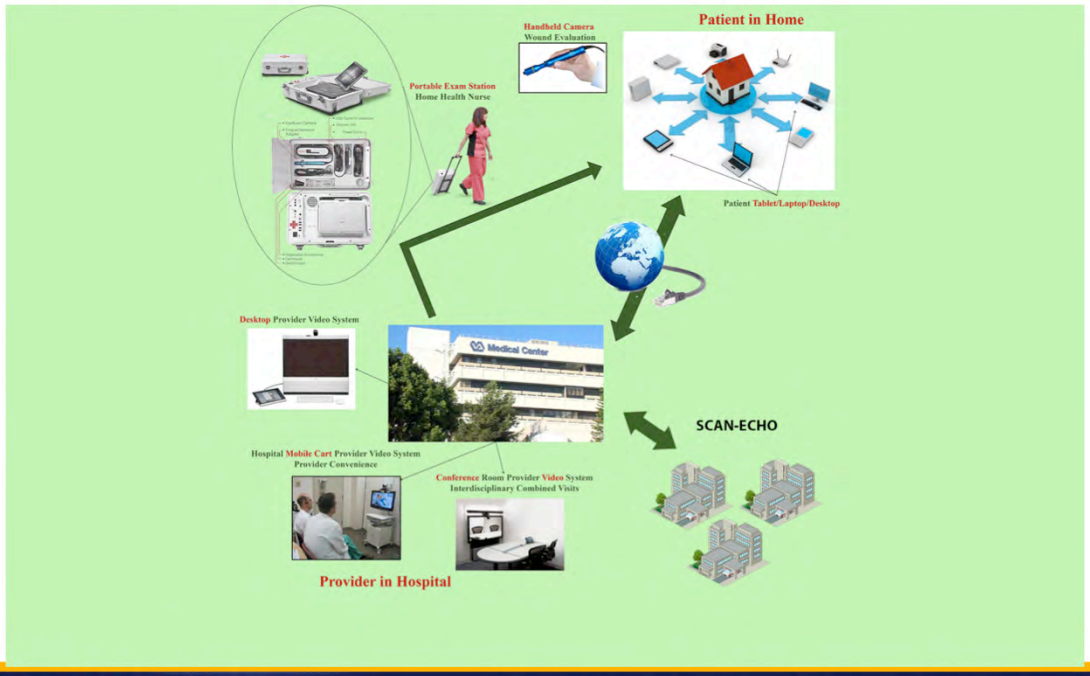
Quality Through Best Practices

Notes:

Telehealth
Continuum of Care



Notes:

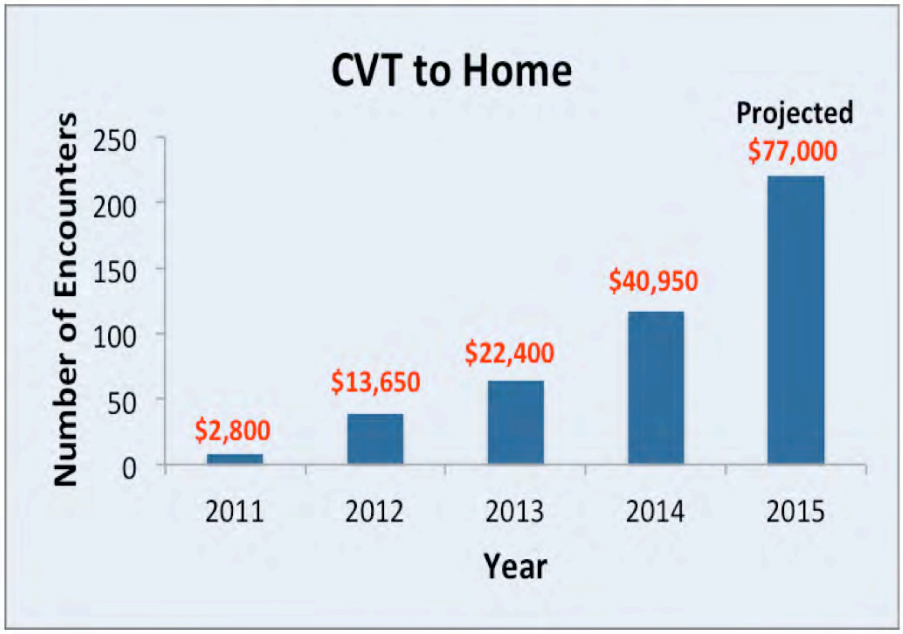
Veteran TeleWound Care: Initial VA San Diego Experience Utilizing Real-time Clinical Video Telehealth, Store and Forward Telehealth and Home Telehealth Technology in Comprehensive Wound Management.

Broder KW [1,2], Li A [3], Tesfamicael R [1], Bodor R [1,2]

[1] Section of Plastic Surgery, VA San Diego Medical Center, San Diego, CA
[2] Division of Plastic Surgery, UCSD Healthcare, San Diego, CA
[3] Department of Surgery, Harbor UCLA Medical Center, Torrance, CA

2010 Fall Symposium on Advanced Wound Care and Wound Healing Society Meeting, Anaheim, CA

CVT to Home
Transport Cost Savings & Increased Adoption
SCI Center – San Diego



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Notes:


Continuum of Care
Where Telemedicine Fits In
CALTCM
• SCAN-ECHO
• Spoke Telehealth Consultation
• Home Telehealth Monitoring
• Face to Face Consultation
• Clinic Visit
• Admission
• Inpatient Rounds
• Education
• Telehealth D/C Planning
• Telehealth Follow-up
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Notes:

No More Waiting for the Doctor to Arrive

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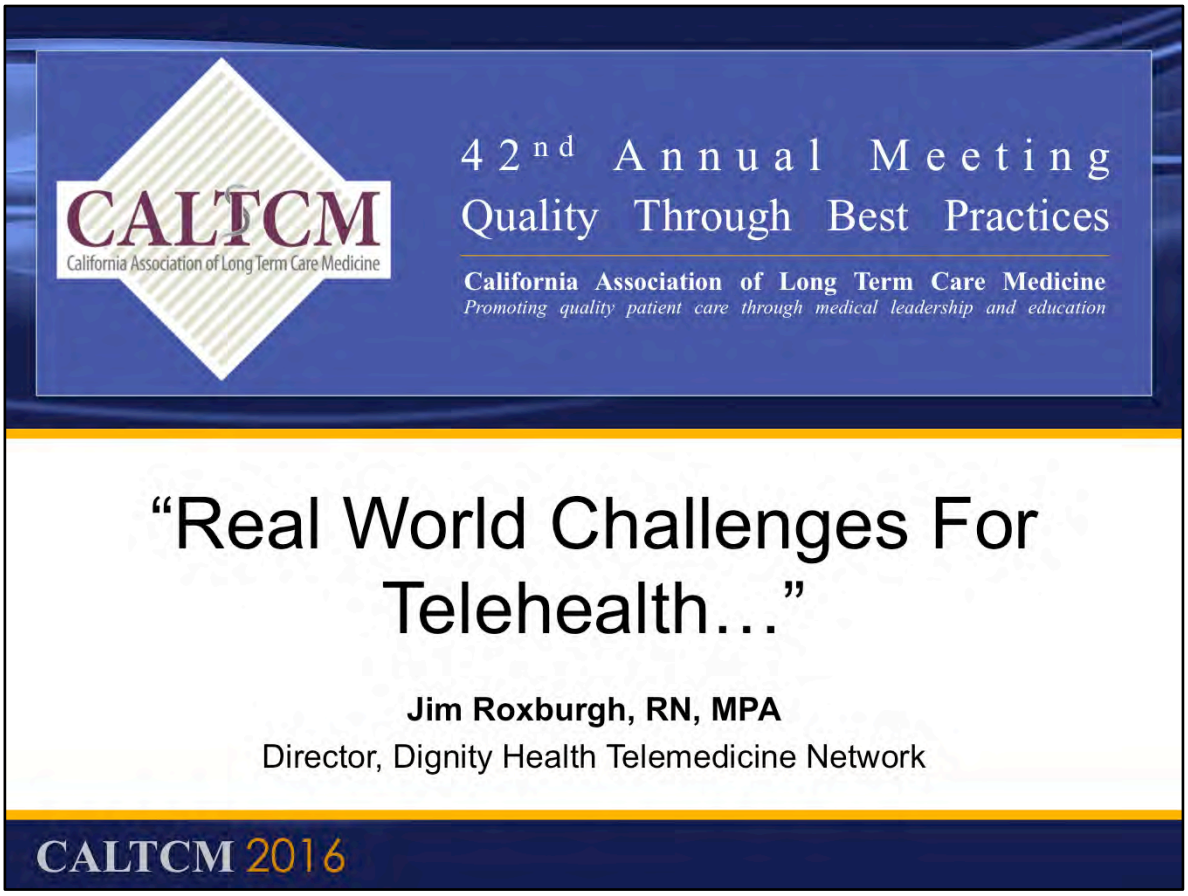
Notes:


CALTCM
California Association of Long Term Care Medicine
42nd Annual Meeting
Quality Through Best Practices
California Association of Long Term Care Medicine
Promoting quality patient care through medical leadership and education
"Real World Challenges For Telehealth…"
Jim Roxburgh, RN, MPA
Director, Dignity Health Telemedicine Network
CALTCM 2016

Notes:

“…and HOW TO SOLVE THEM”

Notes:

Disclosure

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

Notes:

Learning Objectives

At the conclusion of this activity, attendees should have the ability to:

- Provide an overview of the DHTN
- Describe the "barriers" to implementing a successful Telemedicine Program
- Describe the "ingredients" that are required for a successful Telemedicine Program
- Identify the clinical and financial benefits of telemedicine

Notes:

Notes:


DHTN PROGRAM GOAL
Provide timely access to high quality specialized healthcare services that are not readily available
“ LEAD WITH SERVICE… ”
DELIVER ON QUALITY.
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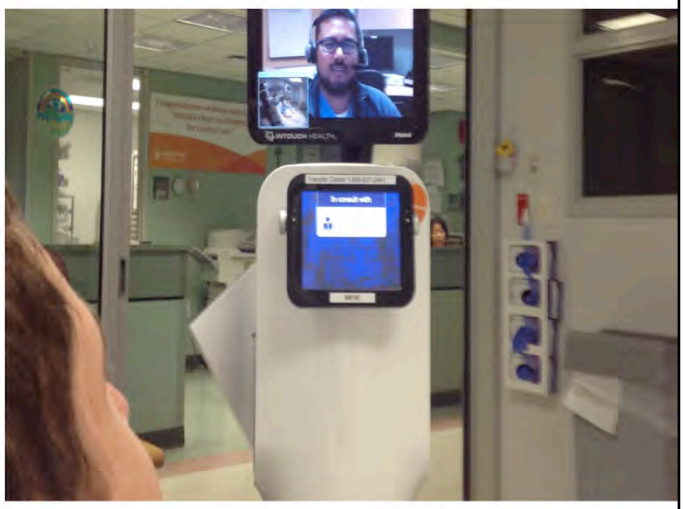
Notes:

DHTN The Facts…

- ✓ The Mercy Telehealth Network Founded (2008)
- ✓ Recognized as the Dignity Health Telemedicine Network (2014)
- ✓ 80 End Points (Robots)
- ✓ 52 Specialists
- ✓ 11 Different Services
- ✓ 48 Partner Sites
- ✓ 17,032 TOTAL Consults CY Ending December 2015



Notes:


DHTN Services
ACUTE
Stroke/Neurology
Mental Health
Critical Care
Nephrology
Pediatrics
Newborn Care
Cardiology
Infectious Disease
CLINIC/LTC
Geriatrics
Neurology
Endocrinology
Pulmonology
Thoracic Surgery
Oncology
TRANSITIONAL
CHF
COPD
Diabetes
Post Surgery
Wound Care
HOME
CHF
COPD
Diabetes
Post Surgery
Wound Care
BROADBAND
INTERNET
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Notes:


INCREASING ACUITY
EMS Ground
Acute Care
Broadband Internet
Home
Long Term Care
Clinic
Primary Care
Home
CARE CONTINUUM
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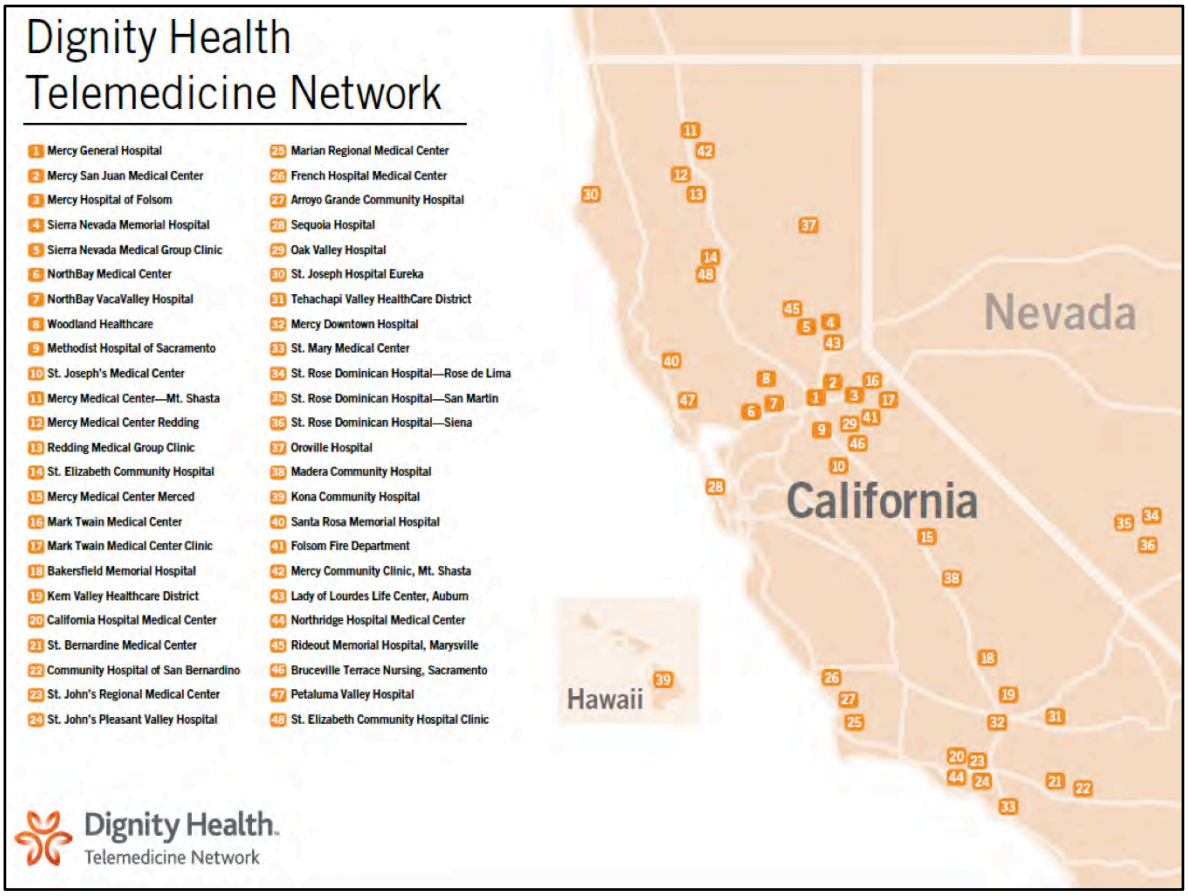
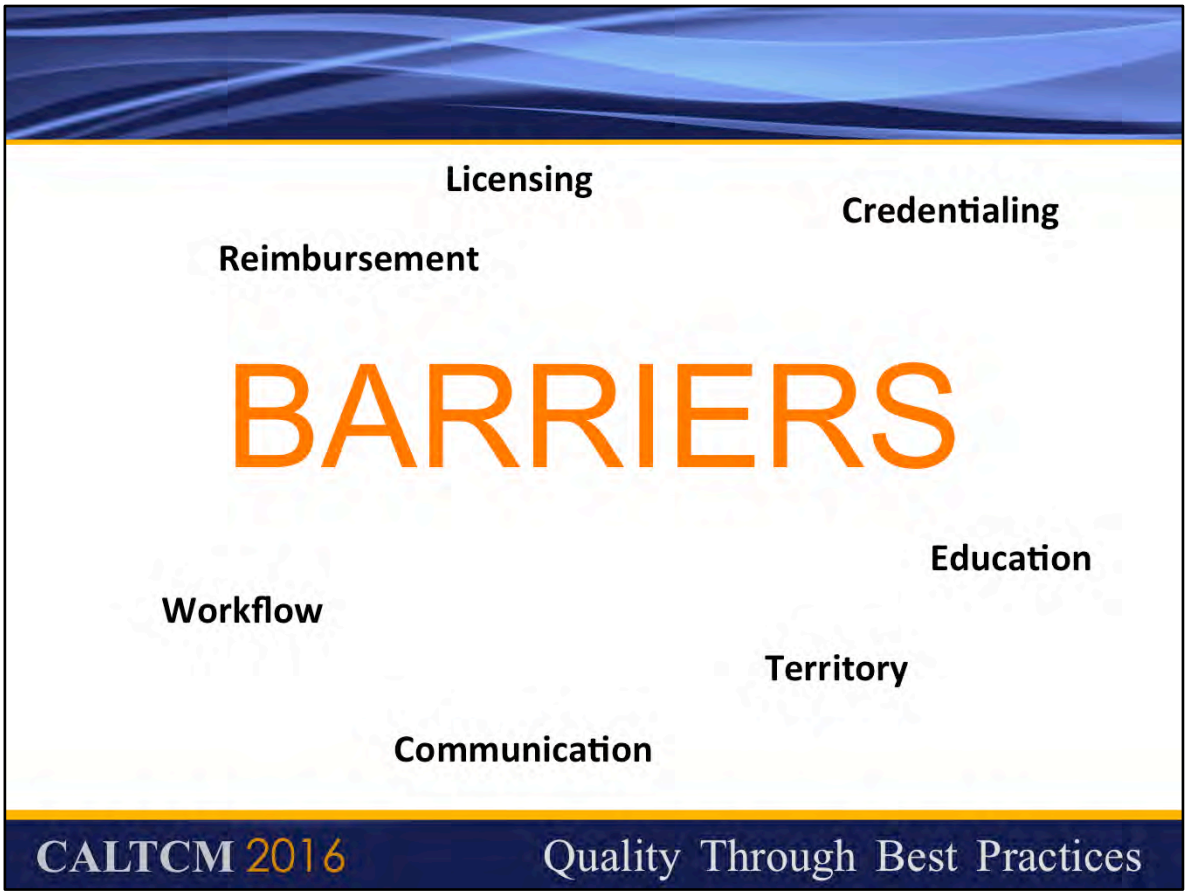
Notes:


Dignity Health
Telemedicine Network
1 Mercy General Hospital
2 Mercy San Juan Medical Center
3 Mercy Hospital of Folsom
4 Sierra Nevada Memorial Hospital
5 Sierra Nevada Medical Group Clinic
6 NorthBay Medical Center
7 NorthBay VacaValley Hospital
8 Woodland Healthcare
9 Methodist Hospital of Sacramento
10 St. Joseph's Medical Center
11 Mercy Medical Center—Mt. Shasta
12 Mercy Medical Center Redding
13 Redding Medical Group Clinic
14 St. Elizabeth Community Hospital
15 Mercy Medical Center Merced
16 Mark Twain Medical Center
17 Mark Twain Medical Center Clinic
18 Bakersfield Memorial Hospital
19 Kern Valley Healthcare District
20 California Hospital Medical Center
21 St. Bernardine Medical Center
22 Community Hospital of San Bernardino
23 St. John's Regional Medical Center
24 St. John's Pleasant Valley Hospital
25 Marian Regional Medical Center
26 French Hospital Medical Center
27 Arroyo Grande Community Hospital
28 Sequoia Hospital
29 Oak Valley Hospital
30 St. Joseph Hospital Eureka
31 Tehachapi Valley HealthCare District
32 Mercy Downtown Hospital
33 St. Mary Medical Center
34 St. Rose Dominican Hospital—Rose de Lima
35 St. Rose Dominican Hospital—San Martin
36 St. Rose Dominican Hospital—Siena
37 Oroville Hospital
38 Madera Community Hospital
39 Kona Community Hospital
40 Santa Rosa Memorial Hospital
41 Folsom Fire Department
42 Mercy Community Clinic, Mt. Shasta
43 Lady of Lourdes Life Center, Auburn
44 Northridge Hospital Medical Center
45 Rideout Memorial Hospital, Marysville
46 Bruceville Terrace Nursing, Sacramento
47 Petaluma Valley Hospital
48 St. Elizabeth Community Hospital Clinic
Nevada
California
Hawaii
Dignity Health.
Telemedicine Network

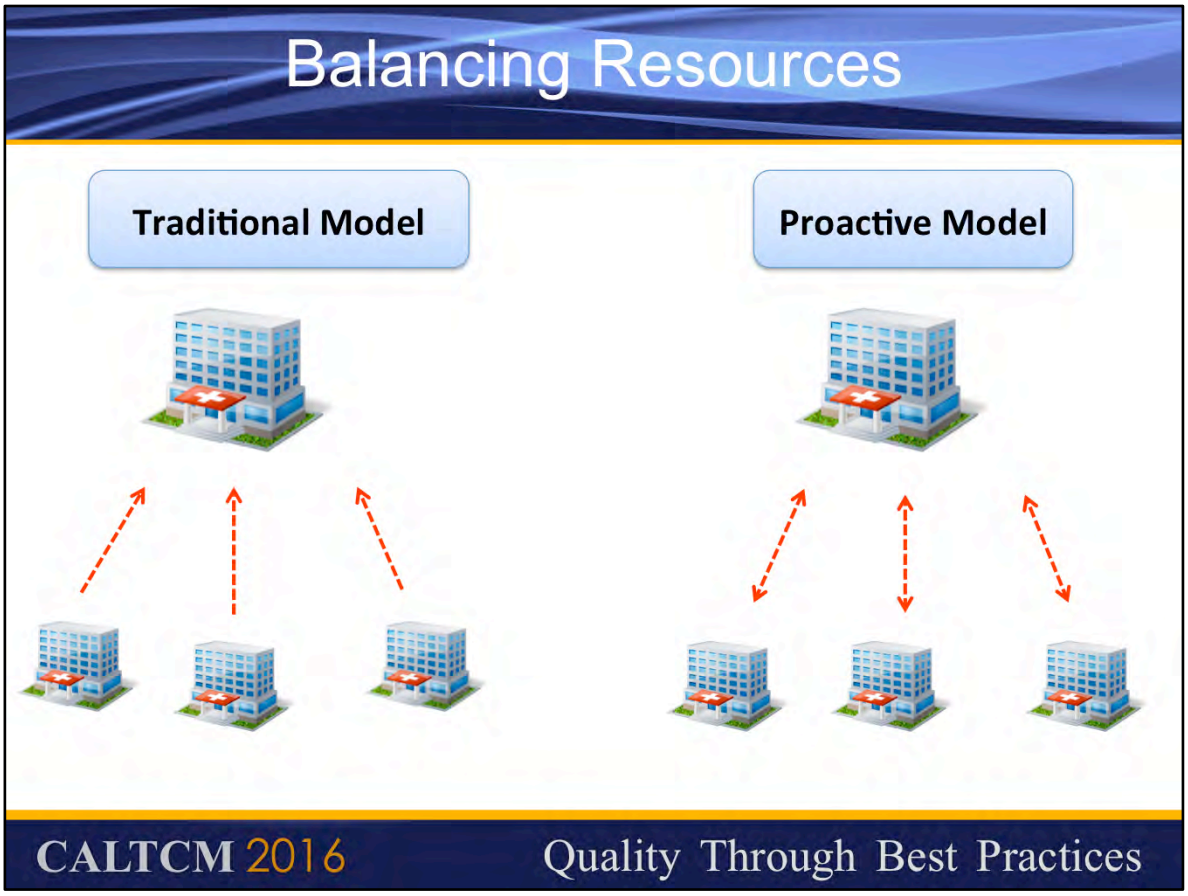
Notes:


Licensing
Credentialing
Reimbursement
BARRIERS
Education
Workflow
Territory
Communication
CALTCM 2016
Quality Through Best Practices

Notes:

Notes:

Notes:


Balancing Resources
Traditional Model
Proactive Model
CALTCM 2016
Quality Through Best Practices

Notes:

Steps to Success

Determine Patient Care Need(s)

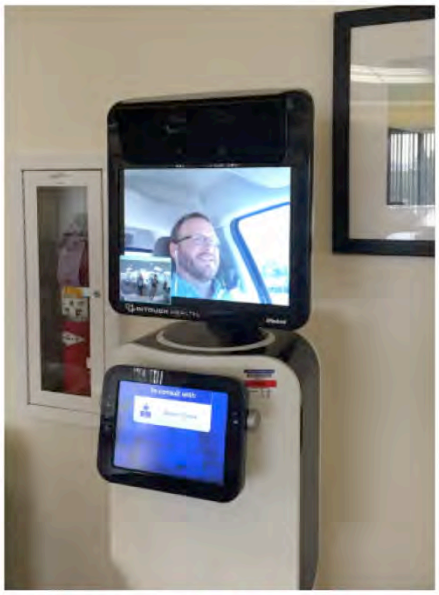
Define Service

Develop the Workflow

Then…

"Layer" on Technology & Clinical Applications

Implementation Plan & Follow-Through Plan



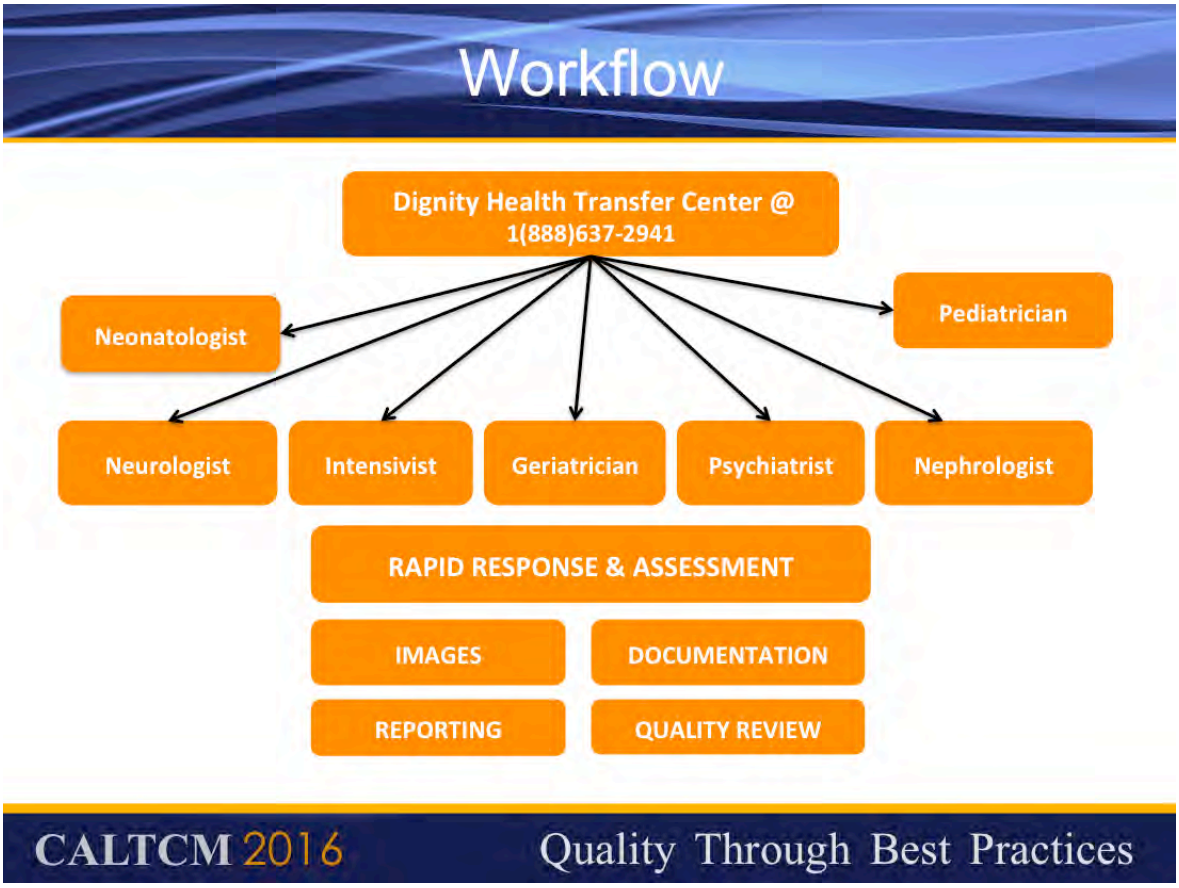
DO NOT TRY THIS AT HOME

Notes:

Implementation Process

- Implementation Kick Off Meeting
- Weekly (30 minute) Implementation Meetings
- Credentialing
- Meetings
- Technical/Technical Go Live
- Policies & Procedures
- In servicing/Education
- Mocks
- Marketing & Promotion
- Clinical Go Live

Notes:


Workflow
Dignity Health Transfer Center @ 1(888)637-2941
Neonatologist
Pediatrician
Neurologist
Intensivist
Geriatrician
Psychiatrist
Nephrologist
RAPID RESPONSE & ASSESSMENT
IMAGES
DOCUMENTATION
REPORTING
QUALITY REVIEW
CALTCM 2016
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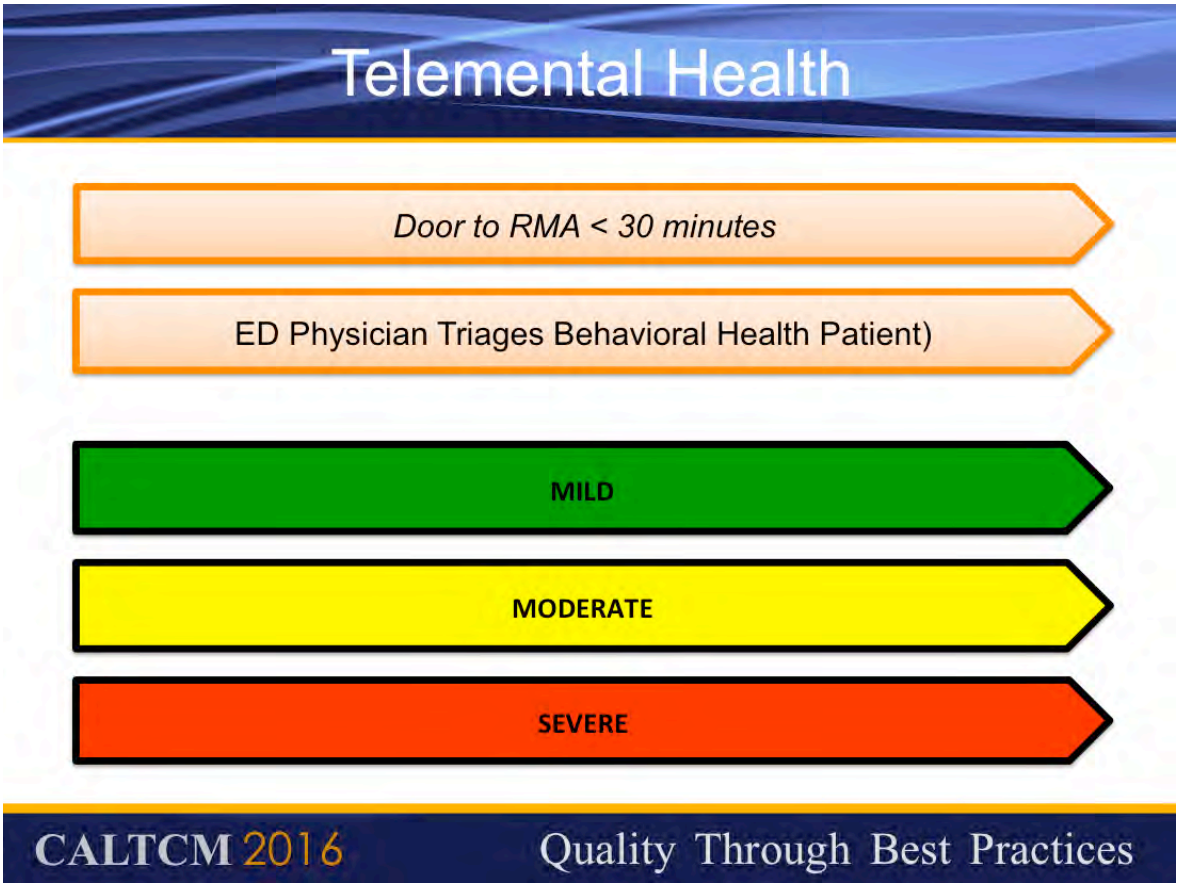
Notes:


Telemental Health
Door to RMA < 30 minutes
ED Physician Triages Behavioral Health Patient)
MILD
MODERATE
SEVERE
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Quality Through Best Practices

Notes:

Telemental Health

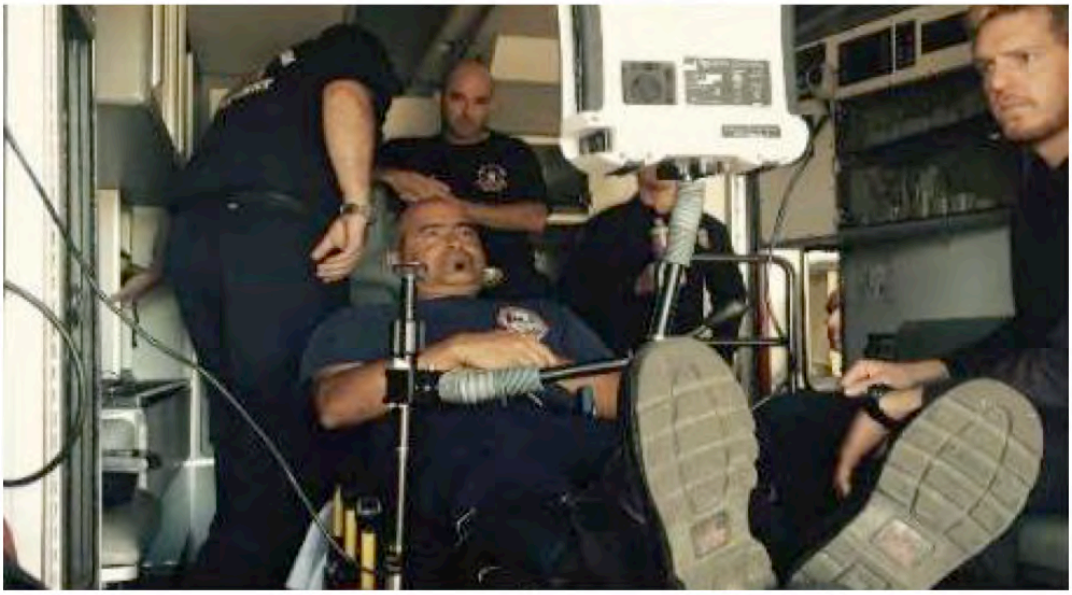
- **Background** - October 2015, "Partner" Hospital's ED averaged 181 patients visits per day
  - **Average length of stay for Behavioral Health patients was 35.77 hours**
- **Initiative Goals**:
  - Implemented the "first four-hour" timeline
  - Fully leverage Telemental Health capabilities
  - January 2016, "Partner" Hospital's ED averaged 198 patients visits per day ***Average length of stay for Behavioral Health patients dropped from 35.77 hours in October to 25.22 hours***
  - February 2016, Methodist Hospital's ED averaged 208 patient visits per day ***Average length of stay for Behavioral Health patients dropped further to 21.06 hours***
  - ***$272,200 cost avoidance***

Notes:

Telestroke

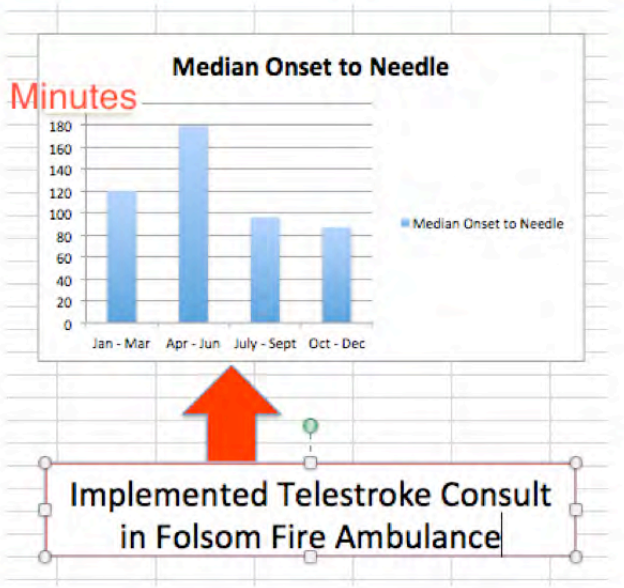
Notes:

Telestroke



Notes:

Telestroke



Notes:

TeleICU

CALTCM 2016 Quality Through Best Practices

Notes:

TeleICU

CALTCM 2016 Quality Through Best Practices

Notes:

TeleICU

	CY 2014	CY 2015
# of ICU Beds	6	6
Severe Sepsis & Shock Mortality	45%	19.4%
Ventilator Day ALOS	2.8	1.4
ICU Contribution Margin Increase	NA	$868,255

Notes:

Geriatric House Call

Notes:

Clinic

Notes:

Clinic

	CY 2014	CY 2015
# of ICU Beds	6	6
Severe Sepsis & Shock Mortality	45%	19.4%
Ventilator Day ALOS	2.8	1.4
ICU Contribution Margin Increase	NA	$868,255
Decrease Readmission Rate (seen in TeleClinic)	19%	5%

Notes:

Remote Patient Monitoring

CALTCM 2016 Quality Through Best Practices

Notes:

Remote Patient Monitoring

Proof of Concept Trial

INDICATOR	ONE YEAR PRE RPM	ONE YEAR POST RPM
Reduced frequency of hospitalizations due to Dx of: HTN, Diabetes, COPD, CHF or AFIB	91	53

N = 20

Notes:


Because
EVERY
Patient Matters
Dignity Health
Telemedicine Network
CALTCM 2016
Quality Through Best Practices

Notes: