CALTCM 2014

Innovation to Action

Care of Wounds, Dementia and COPD

Promoting quality patient care through medical leadership and education

May 2-3, 2014

Omni Los Angeles Hotel at California Plaza
Los Angeles, CA

CALTCM
California Association of Long Term Care Medicine

Program Introduction

2014 is the year of QAPI (Quality Assurance Performance Improvement) implementation throughout our country. With that in mind, we have designed our meeting for practical training for key players in your facility in areas where LTC has struggled to improve quality. To help you implement QAPI, we have designed innovative case-based half-day workshops for your facility (or virtual facility) designed to help you put this new knowledge into constructive and sustainable action for the benefit of your patients.

We have purposely chosen the care of Wounds and Dementia, since these are areas where prior quality efforts have often had disappointing results. To facilitate interactive learning, we have chosen a round table format for all of our workshops.

In addition, knowing that our hospital partners are being penalized for early relapse of COPD patients, we bring to you advances in COPD care focused on reducing the 30 day relapse rate through integrated care models.

We anticipate another delightful Poster session where we will not only learn from organized presentations on facility innovation, but also have opportunities to discuss the project with the author(s).

An additional highlight will be the collegial working relationships that develop around the tables at our annual meeting.

Bring your team, enjoy the interactive learning, and return home reinvigorated for with actions that fulfill the QAPI mandates.

Program Learning Objectives

1. The participant will develop QAPI skills that they will then implement in specific action plans in their facilities;

2. The participant will identify at least 3 QAPI performance improvement projects for implementation in the coming year;

3. The participant will better understand models of improving care integration, the incentives for improving this care, and then make specific decisions about how they will improve care integration in their facilities.

CALTCM Annual Meeting Accreditation Statement

Continuing Medical Education (CME)

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

The California Association of Long Term Care Medicine (CALTCM) designates this Live activity for a maximum of 10 *AMA PRA Category 1 Credit(s)™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.
This course complies with Assembly Bill 1195 Continuing Education: Cultural and Linguistic Competency.

American Academy of Family Physicians (AAFP)

This live activity, CALTCM 40th Annual Meeting: Innovation to Action: Care of Wounds, Dementia, and COPD, with a beginning date of May 2, 2014, has been reviewed and is acceptable for up to 10 Prescribed credits by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Board of Registered Nursing (BRN)

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

California Board of Behavioral Sciences (BBS)

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

American Medical Directors Certification Program (AMDCP)

This course has been approved for up to 1.75 credit hours of clinical education and 8.25 credit hours of Management education toward certification or recertification as a Certified Medical Director in Long Term Care (AMDA CMD). The AMDA CMD program is administered by the American Medical Directors Certification Program (AMDCP). Each physician should claim only those hours actually spent on the activity.

Nursing Home Administrators Program (NHAP)

CALTCM Annual Meeting: Dementia Workshop has been approved by the Nursing Home Administrator Program for up to 4.0 hours of NHAP credit. Course approval number: 1699004-4399/P
CALTCM Annual Meeting: QAPI Workshop has been approved by the Nursing Home Administrator Program for up to 3.0 hours of NHAP credit. Course approval number: 1699003-4403/P
CALTCM Annual Meeting: COPD Workshop has been approved by the Nursing Home Administrator Program for up to 3.0 hours of NHAP credit. Course approval number: 1699003-4404/P

Continuing Pharmaceutical Education

SCAN Health Plan® is accredited by the California Accreditation of Pharmacy Education (CAPE) as a provider of continuing pharmacy education. Pharmacists completing this course on 5/2/2014-5/3/2014 will receive up to 10.00 hours of credit through SCAN Health Plan® (CAPE Provider #199). CEU credits are also accepted by the Pharmacy Technician Certification Board (PTCB) to meet re-certification requirements (please retain program brochure and the certificate in event of an audit).

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

Special Acknowledgements

CALTCM would like to extend our gratitude to all our sponsors

This program is supported in part by co-sponsorships from

American Society of Consultant Pharmacists—California Chapter
SCAN Health Plan®

Additional Co-Sponsorships

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Timothy Gieseke, MD, CMD

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Karl E. Steinberg , MD, CMD

Jennifer Wieckowski, MSG

Program Faculty

Debra Bakerjian, PhD, RN, FNP
Vice Chair for FNP/PA Studies, Department of Family and Community Medicine, Assistant Adjunct Professor, Betty Irene Moore School of Nursing University of California, Davis

Mary Ellen Dellefield, PhD
Researcher, VA San Diego Healthcare System

Shawkat Dhanani, MD, MPH
Associate Chief of Staff, Geriatrics & Extended Care Director, Geriatric Evaluation & Management Unit, VA Greater Los Angeles Healthcare System Clinical Professor of Medicine, UCLA

David Farrell, MSW, LNHA
Senior Director, The Green House Project

Rebecca C. Ferrini, MD, MPH, CMD
Medical Director, Edgemoor Hospital, Santee, CA, Co-Chair, CALTCM Education Committee

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

Janice Hoffman, Pharm.D., CGP, FASCP
Professor of Pharmacy Practice and Administration, Western University of Health Sciences, College of Pharmacy

Program Faculty (continued)

Jim Jordan
Administrator, Asbury Park Nursing and Rehab

Wendy Liu, RN
Registered Nurse, Edgemoor Hospital

Ken Lund
President and CEO Kennon S. Shea & Associates

James Mittelberger, MD, MPH, CMD, FACP
Chief Medical Officer, Evercare Hospice and Palliative Care/Optum, CALTCM President

Dan Osterweil, MD, FACP, CMD
Vice President/Medical Director, SCAN Health Plan; Founder of S+AGE program in Sherman Oaks; Immediate Past President of CALTCM; Associate Director and Clinical Professor in the Multicampus Program in Geriatrics and Gerontology at the UCLA David Geffen School of Medicine

Karl E. Steinberg, MD, CMD
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; Vice President, Coalition for Compassionate Care of California, CALTCM Secretary

Jennifer Wieckowski, MSG
Program Director, Care Transitions, Health Services Advisory Group of California, Inc.

Faculty Bios

Debra Bakerjian, PhD, FNP, RN, FAANP

Senior Director for Nurse Practitioner and Physician Assistant Clinical Education and Practice
Assistant Adjunct Professor

Debra Bakerjian is senior director for nurse practitioner and physician assistant clinical education and practice, as well as an assistant adjunct professor, at the Betty Irene Moore School of Nursing at UC Davis. Previously, Bakerjian was a Betty Irene Moore School of Nursing Postdoctoral Fellow with specialties in health policy and system change.

Bakerjian's research aims to maximize the role of advanced practice nursing and improve the quality of care for aging populations. Her research focuses on the role of nurse practitioners and physician assistants; patient safety and quality improvement practices in long-term care, particularly nursing homes; care transitions between acute-care facilities, nursing homes and assisted living centers; pressure ulcer prevention and management; pain management; chronic disease management in frail older adults; and interprofessional education and practice.

Bakerjian was a Pat Archbold Predoctoral Scholar and a Claire M. Fagin Postdoctoral Fellow at UC San Francisco in the Department of Social and Behavioral Sciences, where she was also an assistant adjunct professor. She 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 and a Bachelor of Science in Health Services Administration from the University of Phoenix in 1983. She received an Associate Degree in Nursing from Evergreen Valley College in San Jose, Calif., in 1977.

Bakerjian is active in both state and national organizations associated with the care of older adults. She serves on the board of directors for Advancing Excellence in American Nursing Homes' and on the National Quality Forum's Skilled Nursing Facility Technical Expert Panel for Serious Reportable Events and Common Formats. She is on the Health Sciences Executive Committee of the Gerontological Society of America and the Quality Measures Committee for the American Geriatrics Society. She is also chair of the Nursing Home Special Interest Group and past president of the Gerontological Advanced Practice Nurses Association and current president of the Gerontological Advanced Practice Nurses Association Foundation. She serves on the executive committee and is the incoming president of the California Association of Long Term Care Medicine. She is also a member of the advisory committee for the American Medical Director's Association Clinical Practice Guidelines.

Contact Information: Phone: (916) 734-2145 | E-mail: Debra.Bakerjian@ucdmc.ucdavis.edu

Faculty Bios

Mary Ellen Dellefield, PhD, RN

Mary Ellen Dellefield, PhD, RN is a Research Nurse Scientist at VA San Diego Healthcare System. She is a Clinical Professor at the Hahn School of Nursing and Health Sciences in San Diego, California and a Hartford Gerontological Nurse Leader. Dr. Dellefield has worked as a Director of Nursing, Director of Staff Development, Infection Control Nurse, staff nurse, and Minimum Data Set Nurse Coordinator over the past 25 years in San Diego county nursing homes. Her research area of interest includes pressure ulcer prevention in nursing homes, registered nurse practice in nursing homes, evidence-based practice, and the care planning process. Dr. Dellefield has written numerous articles in peer reviewed journals and book chapters.

Shawkat Dhanani, MD

Dr. Dhanani is a Clinical Professor of Medicine at UCLA and Associate Chief of Staff for Geriatrics and Extended Care at the VA Greater Los Angeles Healthcare System.

He is also the Director of Geriatric Evaluation & Management Unit at the VA Greater Los Angeles Healthcare System and is fellowship trained in both Geriatric and Pulmonary Medicine.

David Farrell, MSW, LNHA

David Farrell, M.S.W., L.N.H.A., is a licensed nursing home administrator who has spent his entire career in the long-term care profession. He started as a certified nursing assistant in order to earn extra money while attending college. That experience inspired him to pursue a Master's degree in Social Work with a concentration in Gerontology and Administration from Boston College. In the 25 years he has served as a nursing home administrator and regional director of operations, David has advocated for patient-centered care using quality improvement practices. A published author and member of the Board of Directors at the Pioneer Network, his award winning book, “Meeting the Leadership Challenge in LTC: What You Do Matters!" co-authored with Barbara Frank and Cathie Brady, has received widespread acclaim. Currently, David is the Senior Director of The GREEN HOUSE Project where he helps spread the evidence-based Green House Model across the U.S.

Faculty Bios

Rebecca Ferrini, MD, MPH, CMD

Medical Director, Edgemoor DP SNF

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. 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 has special interest in consent and capacity, Huntington's Disease, and behavioral management.

Timothy Gieseke, MD, CMD

Dr. Gieseke graduated AOA from UCI in 1076 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 on gerontology and palliative care. He left his office practice in 2005 to focus full time on LTC medicine. He teaches LTC medicine at the Sonoma County UCSF affiliated Family Medicine Residency where he is an Associate Clinical Professor. He is a past Associate Medical Director for Sutter VNA Hospice. He is a CMD and has been a Medical Director of CCRC since 1986 and is currently a Medical Director for 4 other SNFs.

He was President of CALTCM (California Association of Long Term Care Medicine) July 2005-2007, and is the Chairperson of the Education committee since last May and was the Chair from July 2008 to July 2010. He is a member of the POLST physician leadership council and was a member of the state taskforce for developing the CARE recommendations for LTC. CARE stands for Compassion and Respect at the End of Life. He has presented on Culture Change, the POLST, the CARE Recommendations, and Diabetes care at CALTCM annual meetings and the POLST/CARE at AMDA annual meetings. He has been involved in CARE Transition projects in Sonoma County and has been a faculty participant in INTERACT workshops and subsequent implementation projects.

He has been interested in international medicine since participating in a medical project in Ecuador in 1990. He subsequently has been a participant on 16 medical educational projects in Albania and 2 in Pristina, Kosovo.

Faculty Bios

Janice Hoffman, PHARM.D. CGP, FASCP

Dr. Janice Hoffman is a Certified Geriatric Pharmacist and a Fellow of the American Society of Consultant Pharmacist. She is an Associate Professor of Pharmacy Practice and Administration for Western University of Health Sciences and her clinical practice sites are S+AGE clinic and at Jewish Home for the Aging where she is a clinical consultant. She received her Pharm.D. from the University of Southern California and completed a specialty Residency in Clinical/Administrative Psychiatric Pharmacy Practice with an emphasis in geriatrics from the University of Maryland at Baltimore. She is currently President for the American Society of Consultant Pharmacists – California Chapter and on the Board of Directors for the Academy of Long-Term Care Pharmacists as well as the Editorial Review Committee for the California Pharmacists Association. Her areas of interest and research include: geriatric psychiatry, interdisciplinary health care teams and complementary herbal medications.

James Jordan

Administrator, Asbury Park Nursing & Rehab

Wendy Liu, RN, BSN, PHN

Wendy Liu is a Registered Nurse at Edgemoor Skilled Nursing Facility in Santee, California. Ms. Liu has worked in long-term care facilities for four years, and she loves to work with the geriatric population. Her passion in helping the elderly stemmed from living and caring for her grandparents while she was a child.

Born in China, her family immigrated to the United States in 1990. Ms. Liu was raised in the City of Alhambra in the Los Angeles Area. Ms. Liu's education includes undergraduate degrees in Biochemistry from UCLA and Nursing from Azusa Pacific University, and a Master's degree in Biochemistry from Cal State Los Angeles. Her hobbies include eating out with her husband, watching Chinese dramas, and visiting social media websites on the internet. Ms. Liu's goals are to strengthen and utilize her skills in challenging positions which will afford advancement and professional growth.

Faculty Bios

Ken Lund, CEO

As CEO of Shea Family since 2010, Ken transitioned a traditional custodial based nursing company into a leading edge post-acute provider offering a single point of entry to a full array of services throughout the healthcare continuum. With over 30 years of experience in top management industries ranging from banking, real estate to nationwide distribution, Ken has spent the last decade revitalizing senior living and skilled nursing companies using a lifestyle and service based approach. Accomplishments have included: As CEO of Westlake Senior Living, increasing the market value from $50M to $120M in less than two years by changing their industry paradigm. Over the same period, occupancy rates climbed from 65% to 98% and customer satisfaction increased from 50% to 95%. While at Shea, he has repositioned the company into a true post-acute recovery continuum, by adding complementary businesses and support services that function as independent profit centers while enhancing continuity of care. Ken has a BBA in Finance and Human Resources from Pacific Lutheran University in Tacoma, WA.

James Mittelberger, MD, MPH, CMD

Dr. James Mittelberger MD MPH CMD FACP has 30 years of ongoing active clinical practice in the fields of Internal Medicine, Geriatric Medicine and Palliative Care and Hospice. He has over 20 years experience as Chief of a Division of Geriatrics and Palliative Care at the Alameda County Medical Center including specialty geriatrics & dementia clinics. clinical experiences include over 25 years as a nursing home medical director, physician home care, hospitalist medicine. Leadership and management roles have included health clinic medical director, medical staff president, President of Oakcare Medical Group, a multi-specialty medical group, Interim CEO of the Alameda County Medical Center, founding board member and Chair of the Board of the Alameda Alliance for Health and regional CMO for a United Healthcare's Medicare division. His training includes an MPH in health services, a faculty development fellowship in Clinical Ethics, and a CHCF leadership fellowship. He is currently national CMO of the Optum Palliative and Hospice Care and a Senior medical director for Optum as well as CALTCM President.

Faculty Bios

Dan Osterweil, MD, FACP, CMD

Dan Osterweil, MD, FACP, Msc Ed., CMD, Vice President/Medical Director, SCAN Health Plan and Professor of Medicine at UCLA, completed a geriatrics fellowship at UCLA. Dr. Osterweil is the founder of the Specialized Ambulatory Geriatric Evaluation (S+AGE™) Clinic, a community-based, geriatric assessment center in Sherman Oaks. He is the Emeritus-editor of the Journal of the American Medical Directors Association (JAMDA) in which he has founded. He is a member of the editorial board of Caring for the Ages. Dr. Osterweil co-authored two editions of *Medical Care in the Nursing Home*, is the co-editor of Comprehensive Geriatric Assessment, and has published over 60 articles in peer-reviewed journals. His areas of expertise include cognitive and functional assessment, management of dementia, and continuous quality improvement in the nursing home, planning and implementation of the work processes in the nursing home, in-depth knowledge of nursing home state and federal regulations, and practice innovations. Dr. Osterweil is Director of a UCLA training program entitled Leadership and Management in Geriatrics (LMG) and Associate Director of the Multicampus Program in Geriatrics and Gerontology at UCLA (MPGMG).

Karl Steinberg, MD, CMD

Dr. Karl Steinberg is an experienced clinician with over 20 years in practice in San Diego County. He is a geriatrician and board-certified family physician with a subspecialty certification in hospice and palliative medicine. He serves as chief medical officer for Shea Family Health, an El Cajon-based nursing home and post-acute care chain, medical director of two other skilled nursing facilities, Kindred Village Square and Life Care Center of Vista, and medical director of Hospice by the Sea in Solana Beach. Dr. Steinberg has been a nursing home medical director and hospice medical director since 1995 and is probably best known for taking his dogs on rounds with him almost every day.

Dr. Steinberg got his undergraduate degree in biochemistry and molecular biology from Harvard in 1980, then taught high school in New York City for three years. He attended medical school at The Ohio State University, graduating in 1987, then completed his family medicine residency at UCSD in 1990. Dr. Steinberg serves as voluntary faculty and community preceptor for UCSD and Naval Hospital Camp Pendleton's family medicine residency programs as well as for Samuel Merritt's P.A. program, Point Loma Nazarene's Clinical Nurse Specialist program, and others. He also has an appointment as adjunct faculty for Case Western Reserve University's graduate school of biomedical engineering, where he teaches a course on the U.S. healthcare system.

(Dr. Steinberg's Bio is continued on the next page)

Faculty Bios

Karl Steinberg, MD, CMD (continued)

Dr. Steinberg is the Editor-in-Chief of *Caring for the Ages*, a monthly periodical with a print circulation of 25,000, on behalf of the American Medical Directors Association (AMDA). He is on AMDA's board of directors and serves as vice chair of AMDA's Public Policy Committee, as well as vice chair of the Compassionate Care Coalition of California. He is secretary and past president of the California Association of Long Term Care Medicine (the California chapter of AMDA, called CALTCM). Dr. Steinberg is also CEO of Stone Mountain Medical Associates, Inc., a consulting company, and serves as an expert consultant in legal, regulatory, quality and risk management matters.

Among Dr. Steinberg's professional interests are advance care planning, palliative care, care transitions, dementia, depression, bioethics and addiction medicine. In his extensive spare time, Dr. Steinberg enjoys playing tennis and guitar, traveling, photography, hanging out with his dogs (including taking them on nursing home rounds), and running on a treadmill while playing Words With Friends and listening to classic rock.

Jennifer Wieckowski, MSG

Program Director, Care Transitions
Health Services Advisory Group

Jennifer Wieckowski currently serves as Program Director, Care Transitions, for Health Services Advisory Group of California, the Medicare Quality Improvement Organization. In this position, she is responsible for working with communities throughout California to improve care transitions across health care settings and reduce statewide readmissions. Her previous role at HSAG was the Director, Nursing Homes, Patient Safety in which she directed and implemented quality improvement activities with nursing homes throughout the state. Prior to joining HSAG, Ms. Wieckowski managed several federal Administration on Aging and National Council on Aging research projects of the California Health Innovation Center at Partners in Care Foundation investigating the delivery of evidence-based disease prevention programs throughout California. Jennifer's passion for the aging field began at the age of eleven when she began volunteering in adult day health care programs and nursing homes. After volunteering for seven summers at multiple healthcare settings, Jennifer pursued her Bachelor of Science Degree from Cornell University in Human Development and Family Studies, with a certificate in Gerontology, and her Master of Science Degree in Gerontology from the University of Southern California. She resides in Valencia, California with her husband, Kris, daughter Allison (age four) and twin 18 month olds, Nick and Kelly.

Faculty and Planner Disclosures

Notice of Incorrect Disclosure

At the CALTCM 40th Annual Meeting - Innovation to Action: Care of Wounds, Dementia, and COPD, presented on May 2 - 3, 2014, incorrect information appeared in the Faculty and Planner Disclosures, and in COPD Q&A Panel Discussion. These sections should have contained the following information: “Dr. Steinberg has received honoraria for being on the non-branded speakers bureau for Boehringer Ingelheim. No other faculty or planners have any relevant financial relationships with a commercial interest to disclose. Activity planners have resolved the potential conflict of interest and determined the presentation is without bias.”

Faculty and Planner Disclosures

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

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

Faculty and Planners	Affiliation/Financial Interest	Name of Organization
Debra Bakerjian, PhD, RN, FNP	National Advisory Board Member National Quality Forum	Omnicare Pharmacy Common Formats
Joseph Bestic, NHA, BA	None	
Mira Cantrell, MD	None	
Jodi Cohn, Dr. P.H.	None	
Heather D'Adamo	None	

Faculty and Planners (Continued)	Affiliation/Financial Interest	Name of Organization
Mary Ellen Dellefield, PhD	None	
Shawkat Dhanani, MD, MPH	None	
David Farrell, MSW, LNHA	None	
Rebecca Ferrini, MD, MPH, CMD	None	
Timothy Gieseke, MD, CMD	None	
Janice Hoffman, Pharm.D, CGP, FASCP	Grant	Novartis
Barbara Hulz	None	
Ashkan Javaheri, MD, CMD	None	
Jim Jensen, MHA, MA	None	
James Jordon	None	
Wendy Liu, RN	None	
Ken Lund	None	
Renee McNally	None	
James Mittelberger, MD, MPH, CMD, FACP	None	
Sheryl Nespor, PhD, FNP	None	
Dan Osterweil, MD, FACP, CMD	None	
KJ Page, RN, NHA, ND	None	
Glenn Panzer, MD	None	
Rajneet Sekhon, MD	None	
Karl Steinberg, MD, CMD*	Non-Branded Speakers Bureau*	Boehringer Ingelheim*
Jennifer Wieckowski, MSG	None	

*REVISED JUNE 2014

Program Schedule – Friday May 2, 2014
QAPI: Care of Wounds

Moderator: Dan Osterweil, MD, FACP, CMD

11:00 a.m.	**Registration/Exhibits Open**
11:45 a.m.	**Industry Supported Lunch**
1:00 p.m.	**Welcome & Introductions -** James Mittelberger, MD, MPH, CMD, FACP
1:10 p.m.	**Opening Comments -** Timothy Gieseke, MD, CMD
1:15 p.m.	**QAPI Overview -** David J. Farrell, MSW, LNHA
1:45 p.m.	**Wound Diagnosis and Management - Workshop** **Wound Diagnosis and Management - Case Study Presentation** **Wound Diagnosis and Management - Small Group Discussion** Debra Bakerjian, PhD, RN, FNP, FAANP
2:30 p.m.	**Break**
3:00 p.m.	**Wound Diagnosis and Management - Interactive Lecture** Debra Bakerjian, PhD, RN, FNP, FAANP
3:40 p.m.	**Pressure Ulcer Prevention - Mary Ellen Dellefield, PhD**
4:00 p.m.	**Action Planning Session - Wound Care**
4:30 p.m.	**Q&A Panel Discussion - QAPI and Wound Care** Debra Bakerjian, PhD, RN, FNP, FAANP; Mary Ellen Dellefield, PhD; David J. Farrell, MSW, LNHA; James Jordan
5:30 p.m.	**CALTCM Update**
6:00 p.m.	**Poster Session & Reception | Exhibits Close**
7:00 p.m.	**Industry Sponsored Dinner**

Program Schedule – Saturday May 3, 2014
Care of the Difficult Dementia Patient

Moderator: James Mittelberger, MD, MPH, CMD, FACP

7:00 a.m.	**Exhibits Open**
7:00 a.m.	**Breakfast**
8:00 a.m.	**Welcome**
8:05 a.m.	**Care of the Difficult Dementia Patient Upon Admission** **Case Study** (Admission Presentation) **-** Timothy Gieseke, MD, CMD **Mock MDS Care Conference -** Wendy Liu, RN **Small Group Discussions -** Rebecca Ferrini, MD, MPH, CMD
9:00 a.m.	**Care Planning for Difficult Patients** Mary Ellen Dellefield, PhD
9:20 a.m.	**Break/Exhibits**
9:50 a.m.	**Reducing Inappropriate Antipsychotic Use in Dementia Care** Janice Hoffman, PharmD, CGP, FASCP
10:20 a.m.	**Difficult Dementia Cases, a Facility Specific Approach** Rebecca Ferrini, MD, MPH, CMD
11:00 a.m.	**Action Planning Session - Dementia Care**
11:25 a.m.	**Q&A Panel Discussion - Dementia Care** Mary Ellen Dellefield, PhD; Rebecca Ferrini, MD, MPH, CMD; Timothy Gieseke, MD, CMD; Janice Hoffman, Pharm.D., CGP, FASCP; Wendy Liu, RN

Program Schedule – Saturday May 3, 2014
Improving COPD Care in Long Term Care

Moderator: Karl E. Steinberg, MD, CMD

12:00 p.m.	**Exhibits**
12:00 p.m.	**Industry Supported Lunch**
1:00 p.m.	**CALTCM Awards**
1:30 p.m.	**Expanding Incentives to Improve Care** Jennifer Wieckowski, MSG
1:45 p.m.	**Improving COPD Care in Long Term Care** Timothy Gieseke, MD, CMD
2:05 p.m.	**COPD Care in Older Adults - Acute & Long Term Care Setting** Shawkat Dhanani, MD, MPH
2:45 p.m.	**Break/Exhibits**
3:15 p.m.	**Quality and Efficiency Care Model** Ken Lund
3:40 p.m.	**Green House Model for Post-Acute Care** David J. Farrell, MSW, LNHA
4:15 p.m.	**Action Planning Session - COPD**
4:40 p.m.	**Q&A Panel Discussion: COPD Care and Integrated Care Models** Shawkat Dhanani, MD, MPH; David J. Farrell, MSW, LNHA; Timothy Gieseke, MD, CMD; Ken Lund; Jennifer Wieckowski, MSG

Dementia

Saturday
May 3, 2014

CALTCM Dementia Care Workshop

Tim Gieseke MD, CMD
Wendy Liu RN
Rebecca Ferrini MD, CMD

Disclosure Statement

- No one involved in the planning or presentation of this activity has any relevant financial relationships with a commercial interest to disclose.

Objectives

- Critically evaluate group processes of interdisciplinary team members to identify at least two opportunities for improvement in your own site.
- Identify at least three aspects of care planning.
- State what happens to physician orders and recommendations within the nursing home environment.

The Case of Mr. James (Dr. Gieseke presenter)

- 82 y/o married retired successful attorney with Parkinson's with dementia with significant functional decline over the past 6 months including: multiple falls, anorexia, 20# wt. loss, and increasing confusion with "sun-downing".

- He had a fall with probable concussion **4/18/13** and was admitted to an acute hospital.
  - CT scan: generalized atrophy with microvascular changes, but no subdural or tumor.
  - Staples placed for scalp laceration
  - Delirium managed with Risperdal 2 mg hs and Ziprasidone 20 mg q6 hr.
  - Wife cannot care, Mr. James needs therapy.

He is transferred to your facility on 4/23/13

Hospital Records Revealed:

- **Co-morbid illnesses**: HTN with concentric LVH, Paroxysmal A. Fib., BPH with nocturia x 4-5, Glaucoma, hypothyroidism, and chronic low back pain.
- **Medications**: Coumadin, ASA 81 mg daily, Amiodarone daily, Atenolol daily, Sinemet bid, Finasteride daily, Tamulosin daily, L-thyroxine 50 mcg daily, Travoprost q h.s., DSS 250 mg bid, Senokot 17.2 mg h.s., Miralax 17 gm daily, Tylenol 650 mg q 4 hr. prn mild pain.
- Risperidal 2 mg h.s. and Ziprasidone 20 mg q 6 hr were added during this hospitalization for delirium. Citalapram 10 mg daily was added for agitation. Ativan .5 mg q 6 hr prn agitation was included in the transfer orders.

Initial SNF Assessment

- Patient arrived believing he was at the airport awaiting a flight home
- His wife left the facility when she realized he was getting more upset when she reminded him that he was just in the hospital and had come to this facility for rehab.
- His PCP no longer works in the SNF setting.
- When I saw the patient shortly after his wife went home, he was very focused on catching his flight, didn't recall his hospitalization, and wasn't aware of his high fall risk or need for rehab.
- He refused to talk to me and declined an examination. He appeared agitated and a significant risk for elopement.
- His wife confirmed that they used to live in another state. He commuted there by airplanes from here when he semi-retired. However, he hadn't worked in 8 years.
- She noted he had been extremely independent, competitive, and was a tennis player up until 2 years ago. She believed he was having trouble adjusting to his declining health.

What happens at the facility for new admissions?

Mock initial MDS Conference

On the stage are volunteer actors playing unscripted roles to illustrate the contributions of various disciplines and the process.

Please be kind!

Mock MDS Conference for this Case (35 min.)

- Team Leaders:
  - Wendy Liu RN – MDS Coordinator
  - Rebecca Ferrini MD, CMD – Medical Director

- Volunteer Actors
  - MDS Coordinator
  - Patient
  - Wife
  - CNA
  - RN (Charge or D.O.N.)
  - Social Services
  - Activities Director
  - Rehab
  - Medical Director
  - Dietary

How Would this Case be Managed in Your Facility?

- Have you been to an MDS conference? Have you seen an MDS?
- Did this dramatization reflect what “really happens” where you work?
- What do you see as the role of the physician in the MDS conference?
- How does your facility deal with patients who do not arrive with a doctor? How often would the doctor see this patient?
- What might the physician problem list include?
- What concerns do you have about the medications?
- What about advance care planning?

Table Assignments (15 min.)

- At each table address questions on the previous slide as well as other elements you identify.
- Goal is to come up with a rapid comprehensive assessment and care plan within the care processes, expertise, and resources available in your facility.
- For purposes of this case, assume your table represents 1 facility
- You will have 10 minutes to do this, and then we will have 5 minutes to have a spokesperson from some of the tables present their initial approach to this patient and his wife.

Interdisciplinary Care Plans – An Evidenced-Based Approach

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Disclosure

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Objectives

- Identify three components of the Resident Assessment Instrument (RAI).
- Describe two approaches to care plans:
  - Traditional approaches
  - Evidence-based approaches
- Develop a care plan for the session case study and focus on management of high risk resident behaviors.

What is a Care Plan and Care Planning?

- The care plan is a written or electronic document developed based on Resident Assessment Instrument (RAI).
- Care planning is a dynamic process.
- RAI has 3 parts:
  - Minimum Data Set (MDS) – a comprehensive interdisciplinary assessment;
  - Care Area Assessments (CAAs) - used to guide clinical decision making and care planning to create a care plan;
  - Utilization Guidelines.

Brief History of Care Plans

- 1900's: used as teaching tool for nurses and a work tool for student nurses regularly staffing hospitals
- 1950's: linked with unique role of RN and included in BSN and advanced degree programs to the present
- 1965: mandated as nursing care plan for SNF
- 1987: mandated comprehensive interdisciplinary care plan (Nursing Home Reform Act, OBRA 1987)

What Purpose Does the RAI Serve?

- CMS believes-
  - RAI/MDS functions as best means by which resident preferences and choices regarding quality of life and quality of care are identified and communicated among team members

Care Plans and Regulatory Compliance

- In 2012, care planning was 5th of 10 most common deficiencies received by nursing homes.
- According to Office of Inspector General -
  - In 2012, 99% of care plans failed to meet at least 1 requirement for assessment and/or care plans.
  - In 2013, 37% of reviewed stays did not meet care plan requirements.

RN's Responsibilities for Care Plans and Care Planning

- Federally:
  - When the RN is coordinating the MDS process & others complete specific sections, the RN signature certifies completion of the MDS alone.
  - When the RN is completing the MDS, the RN signature certifies accuracy of the assessment

RN's Responsibilities for Care Plans and Care Planning

- In California:
  - A RN shall directly provide the planning, supervision, implementation and evaluation of nursing care provided
  - The implementation of nursing care may be delegated by the RN to others, subject to any limitations of their licensure

What Information is Required for Inclusion in Care Plans?

- It must:
  - Address all interdisciplinary services provided
  - Derived from the MDS and CAAs
  - Be customized to the resident's preferences and choices regarding quality of life and quality of care
  - Have measurable objectives & timetables
  - Be developed within 7 days of assessment/no more than 21 days

Who Contributes to the Care Plan Document?

- This varies by facility
- It could include RNs, LVNs, all interdisciplinary team members or only 1 or 2 nursing staff members
- The resident and/or family member acting on her behalf

Negative Aspects of Traditional Care Plans

- The care plan is:
  - not a useful or dynamic means of communication among team members
  - too long
  - takes too much time to develop
  - does not include resident's preferences/choices
  - duplicates information provided elsewhere
  - just lists routine practices
  - focused on more than care implementation/delivery
  - physically removed from the bedside
  - not developed with much input from staff providing direct care

Positive Aspects of Evidence-Based Care Plans

- The care plan is:
  - comprehensive (due to CAAs)
  - focuses on whole person
  - communicate specific resident preferences and choices
  - a practical & useful ‘work tool’
  - part of an excellent RAI software package
  - created with input from direct care nursing staff, whether CNA, LVN, or RN
  - does not include routine interventions

What Do We Know About Traditional and Evidence-Based Approaches to Care Plans?

- **High quality facilities** freely share clinical information and observations.
  - All nursing staff contribute ideas.
  - The care plan is an actual working tool addressing individual resident preferences and choices and interventions tailored to the individual.
- **Low quality facilities** restrict the care plan to the admitting RN, LVN, Minimum Data Set Nurse Coordinator.
  - The care plan is not a useful tool.
  - It is a requirement.
  - It has lots of standardized interventions.

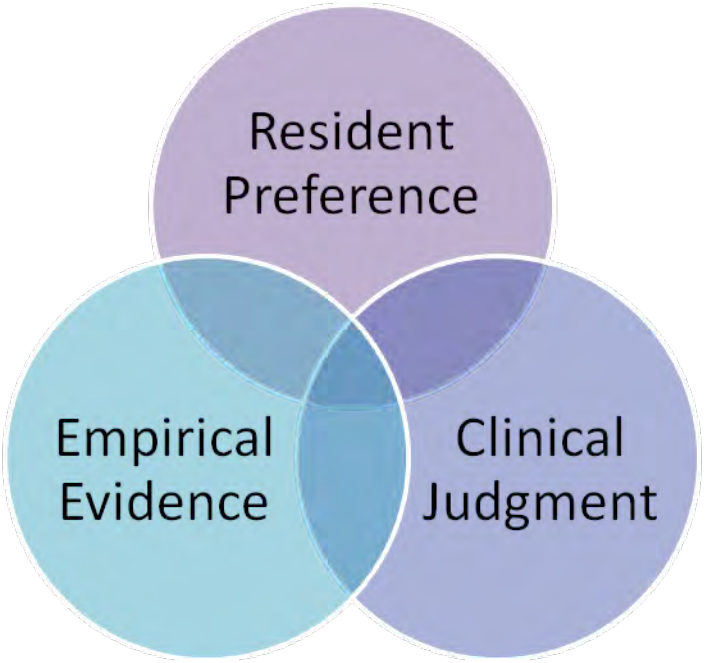
Review Care Plans in Your Facility! Are They…

- Filled with routine interventions;
- Redundant information;
- Reflect input from direct care nursing staff, IDT members, in addition to MDS Nurse;
- Used and if not, why not;
- Filled with information about a resident's preferences and choices?

Evidence Based Suggestions

- Flow chart current care plan and care planning processes as **QAPI project**
- Involve staff in care plans/care planning, especially direct care staff (nursing and IDT)
- Connect their work /tasks to care plan goals to increase meaning
- Write a policy about all standardized policy/ procedures applicable to care plan and plan for demonstration of staff training and competency implemented

Applying Evidence-Based Principles to Care Plans and Care Planning



Example Of Case Study

- Mr. James,82 y/o, with Parkinson's and dementia
- Falls, anorexia, weight loss, confusion
- At risk – falls, pressure ulcers

Traditional Example

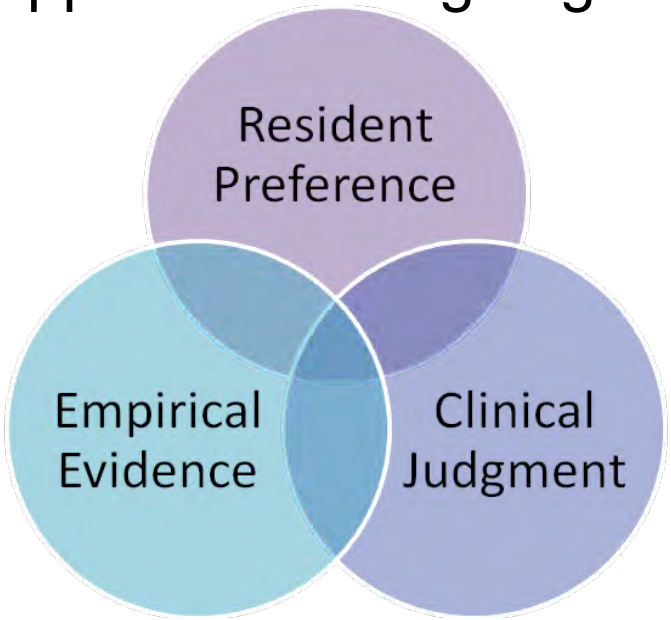
- Standardized care plans
  - ADLs
  - Dementia
  - Nutrition
  - Monitoring of drug side effects
  - Toileting
  - Mobility/Falls
  - Prevention of pressure ulcers

  - The care plan is generic
  - NO information about aspects of care unique to him

A Care Plan That Reflects:

Resident preferences/choices for high risk behaviors

- Any education provided to Mr. James and significant other to promote informed decision-making
- Facility approach for ongoing monitoring of behaviors



A Care Plan That Reflects:

- Empirical evidence related to his clinical profile
  - Not available in treatment sheet/med sheet/ADL sheets
  - An intervention tailored to Mr. James' needs
- Staff clinical judgment
  - Observations of what works for Mr. James
- Measureable, realistic objectives and timetables
- Related services of all team members (IDT)

Evidence-Based Example

INTERSECTION OF RESIDENT PREFERENCES, EMPIRICAL EVIDENCE, CLINICAL JUDGMENT -

- ADLs
  - Any routines that he has
- Dementia
- Nutrition
- Mobility
- Toileting
  - (for all of these - approaches that staff have observed that work for Mr. James and help him achieve goals)

- Mobility/Falls
- Prevention of pressure ulcers
  - Mr. James and wife's informed choices
  - Facility's monitoring/surveillance intervention

Care Plan: Identification and Communication of Care

- Think about other ways that you have opportunities to do this and improve performance
  - Change of shift report or rounds
  - Conversations at beginning and end of shift between licensed nurses and CNAs focused on specific observations/insights about Mr. James
  - Care planning conference

Conclusions

- Opportunities for improvement
  - Analyze your care plan and care planning process
  - Analyze all the ways information is shared about a resident
  - Use QAPI program and empirical evidence to support care plan innovations to surveyors
  - Would an I-care plan work for your case mix?

Research Findings

- Research findings to support your efforts at innovation approach as a QAPI project
  - See slides

Research Evidence

- **Nyman, 1988**
  - No association between nurse staffing & assessment of quality of care plan document
- **Hawes et al., 1997**
  - RAI/MDS process associated with more comprehensive care plans; 4 health conditions declined in prevalence
- **Cott, 1997; 1998**
  - IDT involved in decision-making/problem solving; direct care providers perform tasks
- **Daly, 2002**
  - Computerized care plans more comprehensive

Research Evidence

- **Tauton, 2004**
  - Association between planning process & facility approach to RAI/MDS
- **Colon-Emeric, 2006**
  - Facilities with open communication vs “chain of command” had high level of information flow
- **Colon-Emeric, 2006b; 2007**
  - Higher care plan specificity (individualized approaches) & innovation associated with higher level of staff connection;
  - Connection of front-line staff essential for care plan implementation & informal care planning
  - Higher performing NHs had
    - connectivity, information flow, cognitive diversity
    - vs low trust, poor communication, role isolation

Research Evidence

- **Forbes-Thompson, 2007**
  - Higher performing NHs associated with connectivity among staff, information flow, cognitive diversity
  - Lower performing NHs associated with low trust, poor communication, role isolation

Research Evidence

- **Colon-Emeric, 2007**
  - Emphasis on regulatory oversight resulted in less specific care plans and abandonment of effective care planning processes
- **Adams-Wendling, 2008**
  - Barriers to translation of care plan to practice :
    - Care plan length
    - Duplication of interventions
    - Inconsistent language use for problem
    - Fragmented location
    - Includes routine practices

Research Evidence

- **Lee et al. 2009**
  - No relationship between cost of care planning (i.e. time spent in care planning) and quality

- **Nazir, 2013**
  - Systematic review of RCT interventions & use of teams in NHs
    - IDT interventions had positive impact on outcomes
    - Team communication & coordination consistent feature of successful interventions

Evidence - Based Interventions To Reduce Inappropriate Antipsychotic Use For Dementia Care

Janice Hoffman, PharmD, CGP, FASCP

Disclosure

- I have received a performance improvement grant from Novartis. Activity planners have resolved the potential conflict of interest and determined the presentation is without bias.

Objectives

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

- Recognize at least 3 risk factors when using antipsychotics in dementia patients.
- Define the regulatory impact of antipsychotic agents.
- Cite literature-based criteria for use of antipsychotics (agent and duration)
- Choose at least 2 alternative pharmacologic agents to treat behavioral symptoms in dementia.

What is wrong with Antipsychotics Anyway?

- Patients are old and frail
- Patients have multiple medications and diseases and potential for interactions
- Antipsychotics are particularly dangerous in older people increasing risk of death
- **Antipsychotics should be a last resort.**

Adverse Drug Events (ADE) rise with age

- Frailty
- Reduced reserves (cardiac, hepatic, renal)
- Reduced ability to detoxify drugs
- Lower albumin
- High risk of delirium
- Multiple medications
- Multiple chronic illnesses
- Symptoms of ADE may be missed as nonspecific

Drugs related side effects are

- COMMON
  - Drug-related hospitalizations account for 2.4 to 6.5% of ALL medical admissions [3,4].

- PREVENTABLE
  - 88 % of ADE hospitalizations among older adults were preventable, compared to 24% among young persons [6]

- DANGEROUS

HAZARDS OF ANTIPSYCHOTICS

Antipsychotics are known to be dangerous in elders with dementia

- Black Box warning (BBW) for use in dementia
- Meta-analysis of 15 studies involving > 5100 patients showed there is a 1.6 to 1.7 fold increase risk of death (sudden cardiac, stroke, pneumonia) (71)
  - DNR status was not reviewed

71. Schneider LS, Dagerman KS, Insel P. "Risk of Death With Atypical Antipsychotic Drug Treatment for Dementia Meta-analysis of Randomized Placebo-Controlled " *JAMA*. 2005;294(15):1934-1943.

BBW Antipsychotics

- FDA ALERT [6/16/2008]: FDA notified healthcare professionals
  - both conventional and atypical antipsychotics are associated with a 1.6-1.7 increased risk of mortality in elderly patients treated for dementia-related psychosis.
  - (Sudden Cardiac, pneumonia and stroke)
- In April 2005, FDA notified healthcare professionals that patients on atypical antipsychotics (Olanzapine, Risperdone) had:
  - an increased risk of Diabetes, Stroke, Hyperlipidemia
- Antipsychotics are not FDA approved for the treatment of dementia-related psychosis.

But there is more than the BBW…

- Sensitivity to ADE
  - EKG changes: QTc interval prolongation
  - Movement disorder
    - (EPS) – irreversible?
    - Worsening of agitation/irritability - akathisia
  - Risk of a fall: sedation, low blood pressure, unsteady gait
  - Diabetes
  - Hyperlipidemia
  - Stroke
- Family dynamics - risk of legal action(?)

Highest Risk Antipsychotics Agents for Hypotension

- Risperidone:
  - Tachycardia (1% to 5%)
  - hypertension (I.M. injection 3%)
  - postural hypotension (≤2%)
  - hypotension (≤1%)

- Olanzapine: (1% to 10% for each)
  - Chest pain, tachycardia
  - Hypertension, postural hypotension
  - peripheral edema

- Clozapine:
  - Black Box Warning: Orthostatic hypotension
  - High affinity for the alpha 1 receptor
  - Seen in 25% of geriatric patients

SGA Cardiovascular Side Effect Summary

Drug[1]	OH	WT GAIN	Lipid	DM	QTc
ARIPiprazole (Abilify®)	Low	Very low	Very low	Very low	Low
Asenapine (Saphris®)	Low / moderate	Low	Very low	Very low	Low
CloZAPine (Clozaril®)	High	High	High	High	Low
Iloperidone (Fanapt™)	Low / moderate	Low / moderate	Very low	Very low	Moderate
Lurasidone (Latuda®)	Low	Very low	Very low	Very low	Low
OLANZapine (ZyPREXA®,ZyPREXA® Zydis®)	Low / moderate	High	High	High	Low
Paliperidone (Invega™)	Moderate	Low	Low	Low	Low
QUEtiapine (SEROquel®)	Moderate	Moderate	Moderate	Low / moderate	Low
RisperiDONE (RisperDAL®)	Moderate	Low / moderate	Low	Low / moderate	Low
Ziprasidone (Geodon®)	Low	Very low	Very low	Very low	Moderate[4]

OH: Orthostatic Hypotension; DM: Diabetes Mellitus;
QTc: correct QT interval prolongation

QTc Prolongation:Torsade de Pointes (TdP)

- Factors that increase risk of TdP and/or sudden death
  - bradycardia
  - hypokalemia or hypomagnesemia
  - use or mutliple drugs that prolong the QTc interval (i.e. Beta blockers, AChE-I, Digoxin)

BEHAVIORAL PROBLEMS PROMPT USE OF MEDICATION

If antipsychotics are so bad, then why do we use them at all?

- Lack of alternatives that work for behavior problems with dementia
- Readily available when nurses/families say “do something!”
- Can sedate and calm and so may believe they are working
- They do work sometimes in some people —the trick is to find out when the benefit outweighs the risk

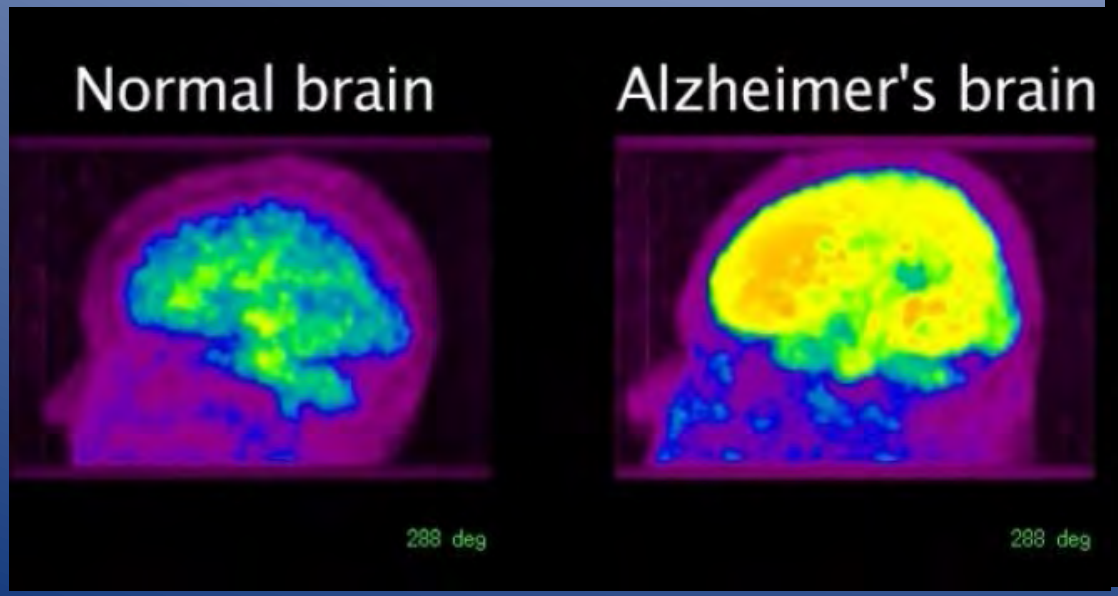
Behavioral Symptoms with dementia trigger the use of Antipsychotics

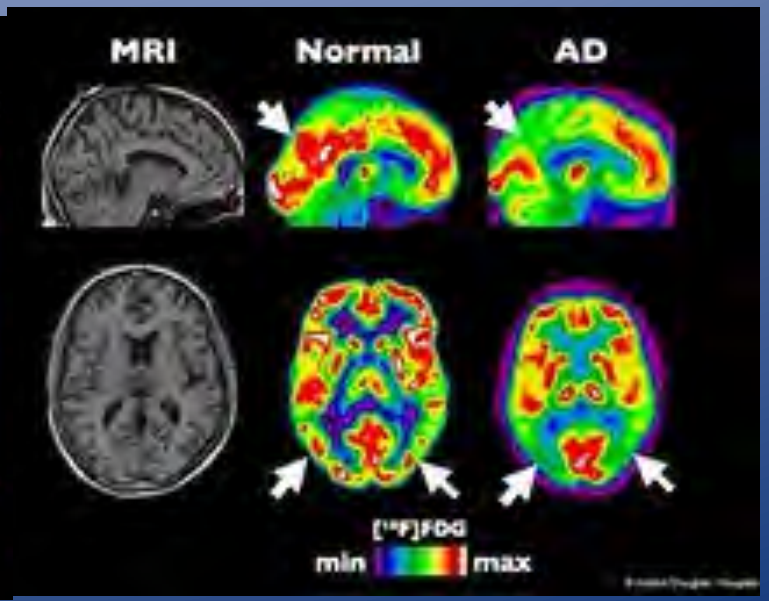
Neuropsychiatric symptoms common[7,8].

- Agitation, aggression
- Delusions, hallucinations
- Wandering
- Depression
- sleep disturbances

- Seen in 61 to 92%; increases with severity [9-13].
- Associated with functional impairment [13,15]

Sophisticated neuroimaging techniques are increasingly able to define neuroanatomical involved in behavior. The right hemisphere and right frontal lobe appear important in the mediation of social and emotional behaviors [14]





Neuropsychiatric Symptoms

- Agitation, hallucinations, depression, and aggression in patients with dementia often lead to nursing home placement (15-18)
- If aggression appears to emerge in moments of confusion, management is probably behavioral after analysis of the antecedent episodes. (18)
- If delusions appear to trigger aggression, treatment with antipsychotic medication may be helpful (18)

What are the alternatives to antipsychotics for behavioral problems in dementia?

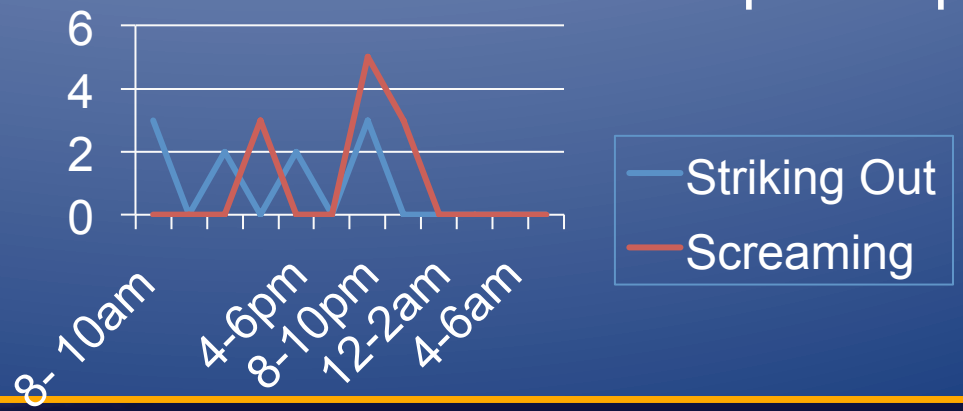
- Valproic acid and other anticonvulsants
- Antidepressants
- Trazadone
- Buspar
- Benzodiazepines (usually no)
- Lunesta (if sleep problems are primary)
- NMDA/alzheimer's medications
- Behavioral interventions

ALTERNATIVES TO ANTIPSYCHOTICS

Behavior Mapping

- short observations periods 15min intervals
- over 1-4 days
- tracking behaviors for
  - Frequency
  - Intensity
  - Duration
  - Time of day

- Consultant pharmacist can assist by looking at behavior patterns and make recommendations as to
  - Timing of medication
  - Nature of prescription



Step Therapy approach

- Non-drug interventions first [8]
  - **control your own voice and responses**
  - **stay calm /keep environment calm**
  - **tolerate behavior**
  - **distraction and redirection**
  - **structured routines**
  - **reassuring responses when patients seem anxious**

- Use Alzheimer's disease medications
  - acetylcholinerase inhibitors
    (Donepezil, Rivastigmine, Galantamine)
  - NMDA antagonist (Memantine)

Evidence:Aromatherapy

- At least three placebo-controlled trials have reported a significant benefit of aromatherapy compared with placebo in patients with dementia and agitation; almost complete compliance and no ADR [19-21]
  - **Lemon balm or lavender oil** are most frequently used (delivered by either inhalation or skin application).

EVIDENCE: Music, touch animals

- Massage and touch therapy appear to be potentially beneficial in the immediate management of agitated behavior and in encouragement to eat [26]
- Music therapy and pet therapy have some evidence of efficacy [23-25].

Evidence: Exercise[22]

- A randomized trial in 153 community-dwelling patients with AD found patients who were assigned to exercise (>30 min/day) and whose caregivers received training in managing behavioral problems had improved physical functioning and less depression.
- Regular physical activity can help.

Evidence: Which symptoms respond?

- Certain behavioral problems may respond better to behavioral therapies than to medical therapy. (27)
  - wandering
  - hoarding or hiding objects
  - repetitive questioning
  - Withdrawal
  - social inappropriateness

Consider Pain Management (32)

RCT evaluated a systematic approach in 352 patients with behavioral disturbances and dementia using a stepwise pain protocol (AGS).

- At 8 weeks, those in the intervention group
  - had reduced neuropsychiatric symptoms
  - lower agitation scores
  - cognition and daily function

  were not affected.

Alternative : SSRI

- Biochemical data suggest that serotonin deficits in AD may contribute to aggressive behavior and psychosis.
- The selective serotonin reuptake inhibitors (SSRIs) have been studied for treatment of these symptoms with varying results.
  - Most studies were small, did not control for concurrent depressive symptoms, and included patients with relatively mild symptoms.

SSRI: Citalopram best?

- 2011 systematic review analyzed 9 randomized controlled trials studying the effects of antidepressant medications in the treatment of neuropsychiatric symptoms [33]
  - Five studies compared SSRIs (citalopram, sertraline, fluoxetine, fluvoxamine) to placebo [34-38]
    - Only one trial found a significant benefit for citalopram in the reduction of neuropsychiatric symptoms [38]
    - There was no difference in the rates of trial withdrawals due to adverse events for SSRIs compared to placebo.

Alternative: Selective Serotonin Reuptake Inhibitors(SSRI)

- SSRIs (citalopram, sertraline, fluoxetine) were compared to antipsychotic agents (haloperidol, risperidone, perphenazine) in 4 trials (34,37,39,40)
  - **Overall: no difference between treatment groups in regard to benefit on neuropsychiatric symptoms nor on adverse events**

Conclusions:

- SSRIs (in particular citalopram) help in agitation and paranoia in patients with AD, as symptoms may be driven by a mood disorder that is poorly verbalized.
- Sometimes overlap with an antipsychotic (eg, quetiapine) in the first few weeks, as the efficacy of the SSRI may require that time frame to emerge.
- Trazodone may reduce anxiety and aggressive behavior, particularly at nighttime[43]

Alternative: Trazadone

- Trazodone was compared to placebo in one trial that found no benefit on neuropsychiatric symptoms compared with placebo [41]
- Two trials that compared trazodone to haloperidol found no significant benefit or harm with these two treatments [41,42]

Alternative: Anticonvulsants

Used in dementia for their **mood stabilizing properties**:

Carbamazepine was effective in a placebo-controlled study of agitation in nursing home patients with advanced dementia (44)

- Relatively low dose, with a modal dose of 300 mg/d achieving a mean serum level of 5.3 mcg/mL.
- However, a subsequent trial found no benefit (45)
- A systematic review concluded that there is currently not enough evidence of benefit for carbamazepine to recommend its use for neuropsychiatric symptoms (28)

Valproate improved aggressive behavior in early studies (46,47)

- A systematic review analyzed 3 randomized controlled trials and two studies of valproate concluded –neither short or long-acting preparations were effective for treatment of neuropsychiatric symptoms of dementia (28)

Alternative: Anticonvulsants

Gabapentin is used because of its mild side effect profile, but its efficacy is questionable: one open-label prospective study showing little benefit [48].

Lamotrigine has been advocated based on case reports, but no randomized, placebo-controlled studies have been published to date.

Alternative: Benzodiazepines

- One trial found IM benzodiazpines and IM Zyprexa effective compared to placebo at two hours, but effect not sustained. (49)
- Benzodiazepines have many side effects in elders that are worrisome *include worsening gait, potential paradoxical agitation, and possible physical dependence.*
- Limit use to brief stressful episodes, such as a change in residence or an anxiety-provoking medical event (50)

Alternatives: Memantine

- Patients assigned to memantine treatment may have diminished agitation/aggression, irritability, and other behavioral disturbances [51,52].
- However, systematic reviews have concluded that studies have not demonstrated a clinically significant effect of memantine for neuropsychiatric symptoms of dementia [28,53]
- **Conclusion:** The potential efficacy of memantine to ameliorate the behavioral effects in AD requires further study.

Alternative: Vitamin E[66]

- A new study looked at vitamin E (alpha tocopherol), memantine, or both slow progression of mild to moderate AD in patients taking an acetylcholinesterase inhibitor.
- A double-blind placebo controlled randomized parallel group trial with 613 VA patients with mild to moderate AD, received 2000iu Vit E or Memantine 20mg/d or both
- 2000 IU/d of alpha tocopherol compared with placebo resulted in slower functional decline.
- No significant differences in the groups receiving memantine alone or memantine plus alpha tocopherol.
- **Conclusion**: Suggest benefit of alpha tocopherol in mild to moderate AD by slowing functional decline and decreasing caregiver burden.

Alternative: Melatonin[54]

- Circadian rhythm disturbances and poor sleep may impact mood, cognition and behavior
- A RCT studied the effect of bright light and melatonin in 189 older patients residing in group care facilities; 87% had dementia.
  - Limitations : multiple analyses/outcome measures : substantial loss to follow-up.
  - Light therapy :a modest benefit on some cognitive and noncognitive symptoms.
- Melatonin improved sleep but had an negative effect on mood when given without light.

Alternative: Melatonin

- Randomized trial in 50 patients with AD found that combined light treatment and melatonin
  - improved some sleep quality measures but that light treatment alone showed no benefit [57].
- A smaller randomized trial in 41 patients with AD found that 10 days of melatonin had no effect on sleep or agitation [56].
- A meta-analysis of 3 trials of melatonin treatment in patients with dementia demonstrated no evidence of benefit [55].

Conclusion: Mixed results, but do not suggest convincing benefit [54-58]

Alternatives you can discuss – off-label

- Depo Provera and estradiol patches for hypersexuality
- Clonidine - ? Increased alpha 2 receptor binding in Locus Coeruleus with Lewy Bodies ? (72)
- Buspirone- more improvement in tension/ anxiety (73)
- Lunesta- increased REM may improve behaviors? No literature to support use

WHEN ANTIPSYCHOTICS MAY BE THE RIGHT CHOICE

Psychosis is common in dementia, but may not need antipsychotics.

- Delusions are more common than hallucinations in demented patients (30% in severe (AD) [9].
- A long-term follow-up study suggests among 456 patients with mild to moderate AD followed for a mean of 4.5 years [18]
  - 34 % had delusions at baseline with 70% during at least one evaluation .
  - Hallucinations were present in 7% at baseline and in 33% at some point over the course of follow-up
  - Delusions or hallucinations may be fleeting or unobtrusive.

Paranoid delusions can cause distress

- Paranoid delusions that the house has been invaded, family members are endangered or imposters, and spouses are unfaithful distress patients and caregivers.
- However, many times they are fixed and even with antipsychotics, they do not go away.

Psychosis: Treatment or not?

- Pharmacotherapy is not necessary if neither the patient nor the family are disturbed
- Antipsychotic therapy is warranted if these symptoms become problematic –
  - the patient is a danger to self or other or
  - so disabling that affects their ability to participate in ADL.
- Delusions or hallucinations are associated with: (18)
  - increased risk for cognitive and functional decline
  - hallucinations predict institutionalization and death

Antipsychotic use

- Atypical Antipsychotics have been the agents of choice for treating hallucinations in patients with dementia.
  - Benefits may outweigh their risks in patients with dementia when treatment of hallucinations and delusions is critical.
    - In the absence of other effective agents, we continue to use them cautiously, after informing the patients and families of the potential risks.

When are the situations when antipsychotics might be a good choice?

- If the resident has hallucinations or delusions or other distressing signs of psychosis.
- If the patient has history of response, symptoms returned when the drugs were reduced, and improved when drug restarted

Best literature Support (Antipsychotics)

- A multicenter, double-blind trial randomly assigned 421 patients with AD and either psychosis, aggression, or agitation to treatment with either olanzapine, quetiapine,risperidone, or placebo (31)
  - Median time to d/c drug for any reason similar in all four groups (5.3 to 8.1 weeks).
  - More patients taking placebo d/c medication for lack of efficacy compared with those on olanzapine or quetiapine (70% versus 39% and 44%).
  - At 12 wks, no differences among groups in the percentages of patients who improved on the Clinical Global Impression of Change (CGIC) scale (range 21 to 32%).
  - One limitation was the inclusion of patients with a broad array of behavioral symptoms.
  - It seems likely that a subset of patients, perhaps those with hallucinations, would have shown more clear improvement.

31. Schneider LS, Tariot PN, Dagerman KS, et al. Effectiveness of atypical antipsychotic drugs in patients with Alzheimer's disease. N Engl J Med 2006; 355:1525

Evidence: Antipsychotics

- A small randomized clinical trial that compared the cholinesterase inhibitor rivastigmine and the atypical antipsychotic agent quetiapine for agitation in nursing home patients with AD
  - found no benefit for either treatment compared with placebo (30).

Atypical Antipsychotics

- Most extensively studied in dementia
  - Clozapine
  - Risperidone
  - Olanzapine
  - Quetiapine
  - Two independently conducted systematic reviews have concluded that these agents have, at most modest efficacy (28,29).

  - Of seven trials studied, 4 found a statistically significant benefit for the primary endpoint with olanzapine or risperidone
  - there were no studies of clozapine and quetiapine for this indication.

Evidence: If it worked, discontinuing may lead to relapse (65)

- 180 patients open-label risperidone (mean dose, 0.97mg/day).
  - 112 pts met criteria for response – 110 randomized.
  - 1st 4 months after randomization, relapse rate higher in placebo group
  - Next 4 months, relapse rate higher in group switched from risperidone to placebo than those that continued to receive risperidone
- With risperidone, the severity of psychosis and agitation were reduced with mild increase in extrapyramidal symptoms
- In patients with AD who had psychosis or agitation that had responded to risperidone therapy for 4 - 8 months, D/C of risperidone was associated with an increased risk of relapse.

Conventional Antipsychotics - might help aggression

- Two meta-analyses of 12 trials plus two additional studies concluded : there was no clear evidence of benefit for conventional in patients with dementia (28)
- A Cochrane review concluded that haloperidol may help control aggression, but not other neuropsychiatric manifestations of dementia (64)
- No trials compared agents with one another.

Efficacy of Antipsychotics

- Have not been extensively studied in randomized controlled clinical trials.
- The trials that exist are often short, 6 to 12 weeks, despite the fact that patients are often maintained on these agents for much longer. Trials also often suffer from methodological limitations [28]
- Conclusion: general use of antipsychotic drugs for treatment of agitation in patients with AD should be avoided, as the benefit is likely to be small and offset by adverse effects.

Anticipation of Starting Antipsychotic

- Document treatment targets BEFORE any intervention
- Monitor outcomes and adjust approach
  - Is the medication meeting targets?
  - Improving quality of life?
- Try short duration (≤12 wks)

GETTING OFF ANTIPSYCHOTICS

Unnecessary Drugs: Federal Regulation: 42 CFR § 483.25(1) or F-tag – 329

- UNNECESSARY DRUGS
- Each resident's drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used:
  - *In excessive **dose** INCLUDING duplicative therapy; or*
  - *For excessive **duration**; or*
  - *Without adequate **monitoring**; or*
  - *Without adequate **indication** for its use; or*
  - *In the presence of **adverse consequences***

42 CFR § 483.25(1) or F-tag – 329

- Antipsychotics Based on a comprehensive assessment of a resident, the facility must ensure
  - *Residents who have not used antipsychotics are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition diagnosed and documented in the clinical record AND*
  - *Residents who use antipsychotics receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.*
  - *Guidelines Dementia Alzheimer's type with behaviors*
    - *Antipsychotic Use – during 1st year 2 quarters attempt reductions*
    - *Other psychotherapeutic agents- during 1st year 2 quarters attempt reductions*

HHS – OIG 2011 report on Antipsychotics

- 304,982/2.1 million 14% of at least 1 Medicare claim for an atypical antipsychotic (1/07 to 6/07)
  - Estimated cost $309 million
- 83% of Atypical Antipsychotics were used for off-label indications
  - 88% for indications in the FDA black box warning (not supposed to be prescribed)
- Over 700,000 of the 1.4 million atypical antipsychotics were “erroneous” costing $116 million
  - Not documented as being administered
  - Not used for a medically accepted indication
- 22% were not administered in accordance with CMS guidelines of unnecessary drugs ($63 million)

http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf

F329 gradual dose reductions

- Clinically contraindicated is:
- (A) For treatment of 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 likely impair the resident's function or increase distressed behavior.

Interpretive Guidelines

- ***Regulations do NOT mean Antipsychotics cannot be used***
- ***Need <u>DOCUMENTATION</u> proving why the specific drug is necessary – <u>benefits outweigh risks</u>***
- ***<u>EXCEPTION: Clinically contraindicated</u>***

Already taking an antipsychotic?

- **History:**
  - why started, when started?
  - What were symptoms,
  - what were negative and positive effects?
  - Was initiation of antipsychotics in hospital with delirium (if so, taper is indicated)

- **Current Status**

Is patient doing well on current dose (behavior, labs, functioning?) or are there still problems?

If doing well, can justify delay taper

if doing poorly or side effects, taper is more important

Withdrawal of an Antipsychotic in Patients with Dementia

- If there is NO Benefit within 1 month STOP the medication
- Taper should be slow over days/weeks/months (depending on individual response to taper)
  - The longer taking the medication slower/faster it can be withdrawn- individualize
- Risperidone use effective for 4-6 months may see risk of relapse (65)
- Withdrawal behaviors (during taper or after stop x 6 wks) (66)
  - Anxiety and irritability
  - Verbal or physical outbursts

How do you know if the taper worked?

- Observe what symptoms re-emerge if the drug is withdrawn.
  - Are these distressing to the patient ?
  - a danger to themselves or others?
- Monitor multiple behaviors and see what changes
- Try nonpharmacological approaches
- Try other pharmacology targeted to the symptom
- Return to antipsychotics ONLY if nothing else works
- Monitor to see if the behavior persists with antipsychotics—if so, stop again.

Summary

- Antipsychotics are not FDA approved for the treatment of dementia-related psychosis.
- Antipsychotic therapy may be warranted if behaviors are a danger to patients or others or so distressing to interfere with ADLs and nonpharmacologic interventions have not been effective
  - Documentation is key to support the need - behavior mapping, informed consent, IDT meeting discussions, MD progress notes
  - Choose- risperidone or olanzapine as the most evidence
- If there is NO benefit to antipsychotic within 1 month STOP the medication
- Include pain assessment and treatment when agitated
- Alternative therapy: may include Melatonin (Sleep) Trazodone, Citalopram (if no cardiac) and Vitamin E

Thank you !

See references

approach TO DIFFICULT ~~DEMENTIA~~ NEUROCOGNITIVE DISORDER PATIENTS

Rebecca Ferrini MD, CMD

OBJECTIVES

- Understand the concept of “risk sharing” and demonstrate strategies to converse about high risk situations with residents and their surrogates.
- Describe at least three non-pharmacological strategies to manage problem behaviors in dementia
- Demonstrate how to document an issue where there is a potential rights violation for safety,

Speaker Disclosure

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

Dr. Ferrini has no relevant financial relationship(s). Any off- label discussions of drugs are based on experience only and is not advice or recommendation.

When I hear hoofbeats….

Defining Dementia

- DSM V tells us to use Major or Mild Neurocognitive Disorder rather than "dementia."
- Now includes deficits in
  - Complex attention
  - Executive function
  - Learning and memory
  - Language
  - Perceptual motor
  - Social Cognition

Defining "Difficult"

- Aggressive or violent
- Annoying to staff or peers
- Fluctuating capacity/unpredictability
- Wants to do or does unsafe things
- Demanding/unrealistic expectations
- Risk of something dangerous happening with a sense of little control to prevent it.

Annika is very aggressive

- Annika is calm in bed alone, but when staff try to change her brief or shower her, she becomes violent, kicking, scratching, biting and kicking and shouting with profanity. This happens with all staff, but is worse with some individuals. Staff try to hold her down and use multiple caregivers, they try to do care quickly, and they sometimes just leave her alone and come back in a few minutes.

Managing “agitation” and "aggression”

- Agitation – behavior driven by extreme emotional disturbance
- Aggression – focused behavior with intent to harm

- ABC model
  - Antecedent – trigger
  - Behavior – observed behavior
  - Consequence –
    - reinforcer (increases behavior)
    - punisher (decreases behavior)

Antecedents/causes

- Pain? Fear? Discomfort?
- Psychotic delusion: hallucinating?
- Misinterpretation of your actions?
- Anxiety
- Irritability
- A way of refusing care?
- Depression—”leave me alone”
- Poor impulse control/low frustration tolerance

Behavior

- Intentional harming of another
- Way to get people away?
- Does the patient have ability to control it?
- Any insight? Are they sorry?
- Are they able to settle down? How long does it take?
- Is it a rigidity and variations cause anxiety?

Consequence: What happens

- Prn medication or other intervention—needs to be given BEFORE to prevent and calm, not after.
- Observe….Separate before escalate!
- Evaluate reinforcers and punishers—you may be surprised what reinforces.

Toolkit: Change the Milieu

- Establishing structured routines
- Promote long-term mutual relationships with peers and staff.
- Be aware of noise, chaos, tension
- Temperature, security, lighting
- Lines of sight
- Altering patterns and habits of where people sit, face, move
- How staff talk to each other and to the residents

Change the Milieu: how it feels

- Reducing or increasing stimulation—what happens at nursing station?
- Getting people outside, exercise
- Modeling appropriate conflict response,
- How people communicate
- Staff attention to behavioral triggers, antecedents, reinforcers and punishers
- Patterns of intervention—before not after
- Medications: targeting symptoms that cause behaviors.

Mark has a conservator

- Mark has a conservator who manages money. His wife signed him in, signed his POLST and signed consent for the zoloft. She says she is his power of attorney, but left documents at home.
- You want to put him in a locked unit and start some risperidal.
- Who provides the consent?

Conservatorship 101

- You have to know the legal decision making status of the resident to obtain informed consent.
- You have to know something about conservatorships to do this correctly.

Decision-Making Options

- Must be the “least restrictive alternative” per Probate Code section 1800.3
  - Agent Appointed in an Advance Health Care Directive or Power of Attorney for Health Care
  - Clinically appointed surrogate decision-maker
  - Inter-Disciplinary Team under HSC 1418.8, if applicable
  - Conservator - Appointed by a court

Conservatorship

- LPS – Mental health conservatorship.
- Temporary—renewed at least annually
- Requires:
  - Grave disability
    - Inability to provide for food, shelter or clothing

      Due to
    - Presence of a mental illness (can be “dementia”)

If needs are med by voluntary acceptance of support, e.g., residing in a LTC facility, it is not appropriate.

Conservatorships vary

- Probate conservatorship
  - Of the person
  - Of the estate
  - Of the person and estate
- Dementia powers
  - Placement in a secure perimeter facility
  - Use of psychotropics for management of dementia
- LPS conservatorship
  - Unable to provide food, clothing or shelter or danger to self or others from mental illness, temporary.
  - Probate can make decisions on end of life care or surgery, LPS needs court order.

Craig is a problem

- 59 year old man with dementia from multiple etiologies, unknown history but suspected substance abuse and maybe schizophrenia found down with head injury. No friends and family. Ambulatory, speaks in short dysarthric sentences of 1-3 words. Oriented to name only. Believes he needs to “get out of here” and tries to exit, hits those who try to stop him. Little response to redirection when he is perseverating. Large and strong. Has LPS conservatorship. On Haldol decanoate 200 mg/month, thorazine 50 three times a day, Ativan 1 mg prn severe agitation threatening himself or others which he receives almost every day and Depakote.

What do we do with Craig?

- What is the psychiatric diagnosis justifying antipsychotic therapy?
- How can we justify two antipsychotics?
- How can we use prns rationally in a SNF environment? Is there a place for near daily prn medications?
- What behavioral or environmental interventions might help?
- What code status would you recommend to the conservator and why? Should you take action to change the code status?

Capacity 101

- Competence is a legal determination; professionals determine *capacity* or decision-making ability.
- Everyone is assumed competent. Burden of proof falls on you to prove they can't decide for themselves.
- Capacity is time and decision-specific—assess anew whenever there is a decision to be made.

Norton

- Norton is in his 70s. He was admitted on conservatorship for head injury and history of schizophrenia but the LPS conservatorship was not renewed as he was compliant with medications and not an elopement risk. He has court order for no code/ comfort care and the conservator previously provided informed consent for antipsychotics, Depakote, Ativan and other psychotropics—these are signed more than 3 years ago. He has been taken off all psychotropics except Ativan given occasionally before a shower due to violent behavior, but there is a recommendation to trial Lexapro as the resistance to care and crying may be depression. He is aggressive with vital signs.

Problems with Norton

- Unbefriended—no friends and family to assist in decision making or for informed consent
- How often do we do vital signs?
- Who consents for Lexapro?

HSC 1418.8

- California has a unique statute that permits the interdisciplinary team to assist in decision making for unbefriended residents in long term care.

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

HSC 1418.8 Note

- Resident determined not to be capable of giving informed consent for medications and treatments, no surrogate is available so IDT will provide consent.
- *I have seen the resident and assessed their decision making capacity in the last 30 days. I have determined that the resident lacks the ability to provide informed consent and the team has identified no person who is available or willing to make decisions for the resident. Therefore, the IDT (interdisciplinary team) is acting as the decision-maker per H&S 1418.8 and is providing informed consent. I have assessed the resident and reviewed the rationale for the interventions proposed and ordered, alternatives, known or suspected preferences of the resident, frequency and duration, risks, benefits and probable impact on health with or without the medical intervention's ordered. I have consulted with the interdisciplinary team including licensed nurses, nurse assistants, social worker, and psychologist and other physician staff. Medical interventions include the informed consent for psychotropic or immunizations, intensity of care and other medical care as ordered.*

Smoking in a nonsmoking

- The facility is nonsmoking and only those residents who can sign out and leave by themselves can do so and leave the premises to smoke on the city street. Cheryl wants to smoke, and perseverates on this topic. She has moderate dementia, uses a wheelchair and lacks wayfinding abilities and good judgment and could be taken advantage of readily. She sees others going and she follows others out and resists attempts to bring her back.

- What to do?

Can a neurocognitively impaired person leave by themselves to smoke?

- How are they impaired? (how much and how so)
- Who is responsible for this decision?
- What are considerations/risks?

Can a neurocognitively impaired

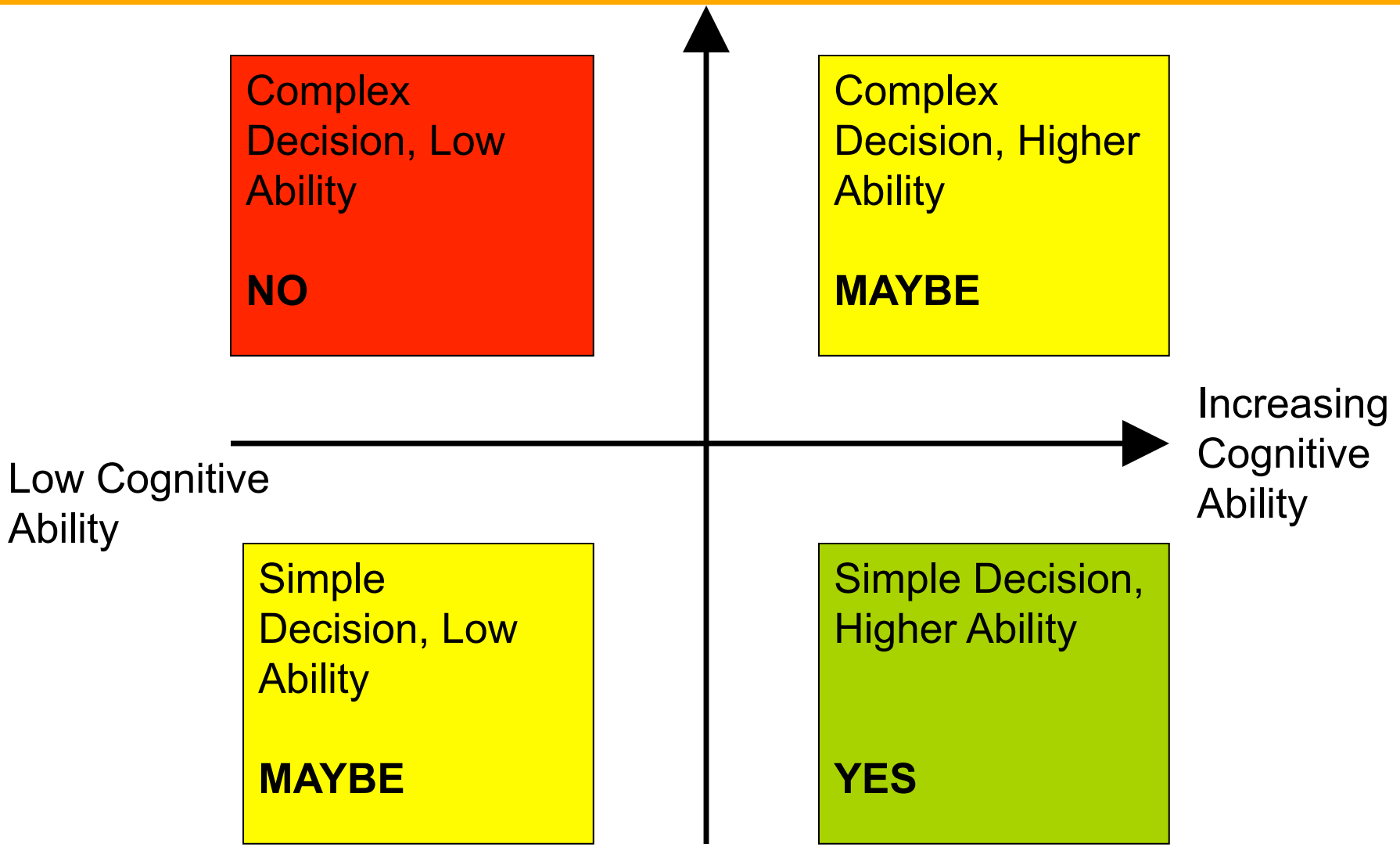
- Capacity assessment –how high should the standard be?
  - Cognitive assessment, physical assessment, local conditions, executive function
- Risk assessment and risk sharing
- What can the facility do and enforce?
- Staff role in enabling/helping invites liability
- Is leaving to smoke a type of "community integration"?

Capacity to Decide (U-CARE)

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

(Adapted from Grisso and Appelbaum, 1998)

Increasing Complexity of the Decision



Morris touched a female

- Morris is in his early 60s, uses a power wheelchair after suffering a stroke and was found to be a sex offender after a Megan's law search post admission. He is irritable, demanding, and cognitively impaired, but still makes his own decisions for the most part. He is incontinent and needs moderate assist in ADLS and a mechanical lift. He leaves the facility multiple times a day in the power chair to smoke cigarettes and sometimes marijuana. One early morning, he is noted to be touching the breast of a female resident in a common area—she is severely impaired and cannot consent.

Problems with Morris

- He is his own decision maker who knows his rights, but he is making poor decisions that harm others.
  - Intent or illness?
  - Who suffers the consequences of the poor decisions?
  - Whose “resident rights”?
  - How do you make sure this “never happens again”?

Suggestions

- Engaging law enforcement—Mandated reporting
  - Required under EJA and AB 40
  - May need to educate law enforcement about actual risk of resident to be taken seriously
- Power wheelchair policies and controls
- Violating the right of one resident to protect others—limits? How to document?
- Discharging a difficult resident

Sample note

- Because of risk to others of being unaccompanied in common areas with vulnerable females, Morris has been moved to a neighborhood with more alert residents. He is told not to come within 3 feet of female residents. He is not helped from bed until breakfast when the dayroom is supervised and cannot operate power wheelchair in the facility. He returns to bed after lunch and is up again at dinner when supervised. If the dayroom is not directly supervised, he is returned to his room. He can attend activities on other neighborhoods only when a companion is available and scheduled for Bingo twice weekly for socialization. SW continues to seek discharge options, but so far none is willing to accept this resident.

Rob wants to get out of here

- Rob is constantly focused on discharge and approaches staff, visitors and the Ombudsman about his wishes. His verbal skills are fairly intact and he presents well in some ways. At the same time, his ability to plan and judgment are very poor, and he is unable to sustain social relationships. Rob states that he “wants to leave” and that “I make my own decisions” though a family member has been appointed surrogate decision-maker. He has failed multiple supportive community placements and there are none who are willing to accept him. He regularly makes comparisons to higher functioning peers who did discharge, with no insight into his limitations.

Problems with Rob

- Intact verbal skills allow him to convince others to advocate for his discharge, despite profound impairments
- Rob has mobility via wheelchair and power wheelchair
- Remaining function makes restriction of rights challenging

Staff have “had it” with Pedro

- Pedro had a head injury and walks with a walker or uses a wheelchair. He has poor memory and asks the same things over and over again. He is paranoid and constantly accusing staff of harming him, but he can speak pretty nicely to you on your visits. He pushes his call light upwards of 50 times a day, but when you go to help him, he cannot recall what he did. He uses hurtful racial slurs to staff and many are in tears feeling they cannot care for him because he is so verbally abusive.

Personality issues with neurocognitive disorders

- Premorbid personality issues may be magnified or suppressed by neurocognitive impairment
- Disinhibition or other reactions to cognitive loss may create issues
- Type of neurocognitive impairment may interact with personality issues differently, e.g.:
  - Borderline traits with executive dysfunction may magnify impulsive or self-destructive behavior
  - Antisocial or Narcissistic traits with social cognition or executive function impairment may lead to aggressive or other harmful behavior

What works for personality

- Control environment not the individual—damage control
- Behavioral plans—consistently modifying triggers and reinforcers.
- Consistent staff to get relationships find staff with good boundaries
- Structure and disengagement of staff—help support them in doing something hard
- Minimize psychotropics, benzodiazepines and opioids.
- We have some success with SSRI and Depakote (off label!!)

Difficult Resident or Personality Disorder? A Long-Term Care Perspective

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Key words: Personality disorders, long-term care, difficult patients, behavior management, mental illness, ABC model.

A search for the term *difficult patients* in the literature yields a myriad of definitions, classifications, characteristics, and staff coping strategies. Examples of difficult patients often include patients who threaten lawsuits, don't listen to reason, constantly and reflexively challenge recommendations, do not adhere to treatment regimens, demonstrate manipulative behaviors, and make inordinate demands. The inability of caregivers to please and adequately treat these patients can wear providers down and have a negative impact within long-term care (LTC) facilities. Yet little has been written on the subject

WE CAN CHANGE US AND THE ENVIRONMENT MUCH EASIER THAN WE CAN CHANGE THEM.

Changes we make in the environment make a difference for all. Better relations improve lives.

Action Planning Session

Dementia Care

Disclosures

Dr. Hoffman has received a grant from Novartis.

No other faculty or planners have any relevant financial relationships with a commercial interest to disclose.

Activity planners have resolved the potential conflict of interest and determined the presentation is without bias.

Learning Objectives

- Decide on a measureable objective for improving dementia care
- Identify the core members at your facility who will Champion and Co-champion this quality improvement project
- Decide what care processes you will initially address
- Establish a timeline for completion of the initial intervention
- List the top 3 barriers you will need to address to move forward with this quality improvement initiative

Q & A Panel
Dementia

Mary Ellen Dellefield, PhD;
Rebecca Ferrini, MD, MPH, CMD;
Timothy Gieseke, MD, CMD;
Janice Hoffman, Pharm.D., CGP, FASCP; Wendy Liu, RN

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Dr. Hoffman has received a grant from Novartis.

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Activity planners have resolved the potential conflict of interest and determined the presentation is without bias.

Learning Objectives

- Identify at least two potential deficiencies in your facility care planning process which are targets for performance improvement
- Audit charts of residents with dementia and psychoactive medications, compare to best practices and provide feedback to individuals involved to improve care
- Plan a systems change which sets up barriers to “poor care” practices and facilitates best practices and guideline adherence in your facility