



## CALIFORNIA ASSOCIATION OF LONG TERM CARE MEDICINE

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### Reducing Unnecessary Hospitalizations of Nursing Home Residents

*Introduction by Jay S. Luxenberg, M.D. & Dan Osterweil, MD, CMD, FACP  
Originally Posted October, 2011*

[This editorial in the New England Journal](#) highlights INTERACT<sup>II</sup>. CALTCM has been one of the early adaptors of INTERACT<sup>II</sup>, which was conceived at the Los Angeles Jewish Home by Drs. Ouslander and Osterweil. CALTCM has been collaborating with the INTERACT<sup>II</sup> team and has trained more than 200 clinicians and administrators in 50 Nursing homes in California. To date 3 nursing home chains have started implementing INTERACT in their facilities.

### Why Go to an International Meeting?

*Jay S. Luxenberg, M.D.  
Chief Medical Officer, On Lok Lifeways, San Francisco, CA  
Originally Posted October, 2011*

Having recently returned from attending the [International Psychogeriatric Association](#) meeting in The Hague, I began to reflect on why I enjoy attending international meetings so much. I've been to geriatrics meetings such as the [International Association of Gerontology and Geriatrics](#), and disease specific meetings like [Alzheimer's Disease International](#). There are many, many more – [this site](#) lists a good share of them. Why should you consider incurring the expenses and hassle of traveling to a meeting, when there are too many excellent meetings for you locally and within the US?

One good reason is that there truly is a world of different approaches to handling the challenges of aging, and we in the US have a tendency to be very provincial. One of my favorite aspects of these meetings is getting to take tours of nursing homes – I have visited them in Turkey, The Netherlands, Sweden, The United Kingdom, Ireland, Chile, China, Spain, Canada and likely a few other countries. I have seen many variants of long term care less institutional than nursing homes. I have seen all kinds of interesting clinical programs and technologies. I remember when doctors in other countries were diagnosing Lewy Body Dementia at a much higher rate than we did, and when Pick's Disease and other Frontal Temporal Dementias were more commonly diagnosed overseas – it made me question my own practice at the time. I got to talk to colleagues who had years of experience with memantine and citalopram before they were released in the US. I have seen many superb presentations by world class experts in related fields – nursing, occupational therapy, social work, psychology, etc. I love reading the posters (most international meetings are in English) and getting to talk to the authors.

Geriatrics is one field of medicine that has strong cultural overlays. It is wonderful to see how other cultures handle things, and how their very different health systems allow them to develop innovative solutions that I am grateful to learn from. Perhaps the best aspect of attending international meetings is that I have found colleagues and friends all around the world. Now when I attend a meeting it is also a chance to see these friends once more. Generally, social events are built in to the meeting schedule. Many of the meetings I have attended offer pre-meeting intensives and special courses such as neuroimaging updates.

So don't concentrate on the prospect of a tax deduction to subsidize your travels. Think about the opportunities attending an international meeting offers. And be sure to allow some extra time – after all that traveling, you certainly want to experience the local sites while you are there!



Caption: CALTCM member Denise Rettenmeier savoring an African beverage during downtime at the International Psychogeriatric Association Congress in The Hague, The Netherlands this September.

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## Advancing Excellence Turns 5 Years Old!

by *Deb Bakerjian PhD, RN, FNP*

*Originally Posted October, 2011*

Advancing Excellence in America's Nursing Homes campaign (AE) is an all-volunteer coalition of stakeholder groups interested in enhancing the quality of care and quality of life of older adults. The coalition includes professional, trade, and consumer organizations as well as governmental agencies involved in nursing homes. The campaign established eight goals including reducing staff turnover, increasing consistent assignment of staff, reducing physical restraints, decreasing pressure ulcers, improving pain management, and assessing staff and resident/family satisfaction. In the five years since the start of the campaign, there have been a number of changes to the campaign including adding a goal on advanced care planning and expanding the organizational membership from 24 organizations to over 30 organizations.

In just five short years, the campaign has had many accomplishments:

- 50% of nursing homes nationally have joined the campaign
- Developed free online resources and tools for nursing homes to use for quality improvement and to track and trend their data
- Nursing homes participating in and using campaign resources, reduced the use of restraints, improved pain management and decreased prevalence of pressure ulcers
- We developed a network of 51 state Local Area Networks of Excellence (LANEs) that provide state level support to nursing homes
- Supported LANE performance with grant funds to conduct performance improvement projects at the state level
- Gained consistent support from Centers for Medicare and Medicaid Services (CMS) through the 9th and 10th Scopes of Work

The campaign is now the largest voluntary coalition of nursing home stakeholders in the country and has been recognized nationally as having a positive effect on quality of care at a national level. CALTCM is represented on the CA LANE and the national campaign. Members are encouraged to take a leadership role in ensuring their nursing homes are members of the campaign and to be actively involved in the campaign activities. Nursing homes can join at [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org). Membership is free and all tools and resources can be downloaded from the website.

*Dr. Bakerjian is on the Board of Directors of CALTCM and the Board of Directors of the Advancing Excellence campaign.*

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## CARE Recommendations

*Tim Gieseke MD, CMD*

*Originally Posted October, 2011*

If your grandmother were to die in one of your facilities, what would her death be like?

In the Spring of 2010, the [Coalition for Compassionate Care of California](#) released the CARE recommendations to improve Compassion and Respect at the End of Life. As a part of this expert panel, I was pleased with the consensus that principles of palliative care and culture change were foundational for the support of "dying well" in our nursing homes. This [free 64-page document](#) is available on their website under the Program Tab / Nursing Homes, and was also disseminated in bound pamphlet format to all skilled nursing facilities in California when it was first finalized and printed in 2010.

In the recommendations, we spent time defining a good death and then moved to concepts and tools available on our website that supports a good death. We clearly present the role of advance health care planning, AHCDs, POLST, and other tools that may avoid unnecessary hospital transfers near the end of life. The final section deals with the actual details of providing compassionate care to our patients and their families during the last chapter of their life. This section is particularly challenging since it is not directly reimbursed, has been relatively undeveloped, and requires a creative facility-wide interdisciplinary approach. We believe that this approach will enhance resident, family, and staff satisfaction as well as quality of life. A useful tool within the CARE recommendations is a patient information sheet about CPR, and there is another one about tube feeding. These can be printed and shared with residents and family members.

Please consider what you can do to improve the "Sacred Moments" at the end of life that occur on a regular basis in your facility. The CARE Recommendations are a valuable resource that we encourage you to download and use. This [free document is available at \[www.coalitionCCC.org\]\(http://www.coalitionCCC.org\)](#) under the Program Tab / Nursing Homes, I look forward to hearing stories of your successes at next year's CALTCM annual meeting, May 11 and 12th.

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### **UPDATE: Depression Practice Improvement Education Project**

*Janet C. Frank, DrPH and Rachel M. Price, MSG*

*Originally Posted October, 2011*

Within the August 2011 CALTCM Wave articles, Dan Osterweil, MD, CMD, FACP and Karl Steinberg, MD, CMD both shined a light on the California Geriatric Education Center's (CGEC) Depression Practice Improvement Education Project (PIE) and the 37th Annual Meeting's depression educational sessions. The comprehensive offerings included content on the Minimum Data Set (MDS 3.0) PHQ-9 depression screening, medication and non-pharmacological treatment options, and culture change's impact on depressed patients in long-term care settings.

Our thanks go to CALTCM for allowing the CGEC to kick off our PIE Project to improve depression assessment and management in long-term care facilities at the 37th Annual Meeting! The CGEC held a small orientation and recruitment session for those nursing home teams not already aware of the PIE Project. However, most of the excitement and collaboration was accomplished in the PIE Depression Quality Improvement workgroup session on July 16. Thirty-six attendees participated in small groups, representing 14 long term care facilities across the state of California. We were very pleased with the interest and eagerness to participate. Nursing home teams worked in facilitated workgroups to identify a workplace quality improvement project to implement in their facility. Teams brainstormed and drafted their proposed goal/solution, identified implementation steps and considered any foreseen barriers/problems that may occur back at their home facility. This process served as a beneficial process for the teams as many of them did not have a quality improvement mechanism in place to monitor depression care needs in their facility.

The PIE Project Administration, led by Joshua Chodosh, MD, MSHS and Janet C. Frank, DrPH, MSG, utilized this session to have one-on-one conversations with facility administrators, DONs, MDS Coordinators, and other team members to understand how each facility screens for depression and how sites could use their data to inform care. We were pleased to have a room full of interested and committed sites! The Quality Improvement Plans were collected to help select which nursing homes the CGEC could work with over the next year. Currently, six facilities have been selected and this cohort of nursing home teams will be involved in a series of interactive educational webinars and teleconference meetings. Another key feature of the project is the provision of on-site coaching and mentoring by CGEC faculty experts to facilitate the completion of the facility's Depression Practice Improvement plan. CGEC will offer webinar education to all interested facilities, even though funding issues limit the ability to provide the coaching expertise to more facilities at this time.

As our PIE Project goal is to build capacity within nursing facilities to create and sustain quality improvement processes, we have also worked with and been advised by the California Quality Improvement Network. These organizations include CALTCM, Aging Services of California, California Culture Change Coalition (CCCC), Health Services Advisory Group (HSAG), California Association of Health Facilities (CAHF), and the Coalition for Compassionate Care of California (CCCC). Since each of these organizations offers provider education programs, and focus on quality improvement, the CGEC plans to partner with these member organizations in future years.

We look forward to the next phase of the PIE Project – offering additional trainings online and sending our qualified, experienced and energized CGEC mentors to the sites to get started! Stay tuned for further updates as the project develops. For more information, please contact Ms. Rachel Price, MSG ([rprice@mednet.ucla.edu](mailto:rprice@mednet.ucla.edu)).

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### **Learning Pearls from the 37th Annual Meeting**

*by Flora Brahmhatt, PharmD, CGP*

*Originally Posted September 2011*

As the distance grows from the annual meeting, I reflect on one or two pearls that impacted my everyday practice. The most significant of which being Dr. Jane Weinreb's presentation during the diabetes segment.

As a consultant pharmacist it is critical part of my job to remind physicians that Metformin should not be used in patients with Chronic Kidney Disease . Or more specifically a creatinine clearance less than 60 ml/min, due to the increased risk of a lactic acidosis.

During the question/answers session, Dr. Weinreb referenced a 2009 consensus article from the ADA and EASD on management of hyperglycemia. In the part on Metformin, it was acknowledged that there is some evidence that it is probably safe to use Metformin down to a CrCl of 30, but at a reduced dose. While this has been common clinical practice in the U.S.A, this article supports cautious use of this medicine in stage 3 CKD, when the clinician documents the potential benefit exceeds the burden. When using Metformin in this range, ongoing close monitoring for a further decline of kidney function is necessary. In addition, the prescriber should have a low threshold for holding Metformin for the multiple changes of condition that may be associated with a decline in kidney function.

The article noted is available on the ADA's DiabetesCare website (<http://care.diabetesjournals.org/content/32/1/193.full>) and was published in its January 2009 issue of DiabetesCare.

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## House Calls Tool: GPS apps for Geriatricians

*Jay Luxenberg, MD*

*Originally published September, 2011*

This month I plan to discuss a family of applications that actually is not directly a medical application. As a geriatrician, I often find myself needing to find a place such as an assisted-living facility or a nursing home that I need to visit. As I now work in a multi-facility senior service, I also have to commute between different sites. Unfortunately, this means traveling to areas that I am unfamiliar with, or traveling through traffic that makes finding my destination a challenge. As you might guess, with this month's column I plan on highlighting navigation applications. It happens that my car comes with a built in GPS. You would think that that would suffice, and it certainly is better than having access to no GPS at all. Nonetheless, it is extremely useful to have a navigation application on my smart phone. For one thing, I often travel, and find myself in a rented car in an unfamiliar city where having access to the GPS is remarkably useful. Also, the GPS available as an application on my smart phone is smart enough to tell me to turn on "Main Street" as opposed to "make the next right". For a one-time fee, I enabled the feature where it checks real-time traffic and construction data, and reroutes me as needed. It also can direct me to the nearest gas station, which even my Prius apparently needs to visit periodically. The smart phone app plays it's instructions over the stereo in my car, and it even mutes the music I'm listening to when it has something to say. Annoyingly, but clearly to my economic benefit, it scolds me audibly when I am exceeding the speed limit. It also warns me in places where permanently installed speed cameras and red-light cameras are present. Yes, now you can have nagging even when you are driving alone.

I use Navigon, which is now owned by GPS giant Garmin. It is available for the iPhone, Windows phone and Android operating systems. The iPhone app also is formatted for the iPad. The price varies over time, and periodically there is a sale. Currently North America is \$39. There are many competitors on each platform. My system is for North America, where I find most of my patients live, but there are versions available for Europe, Russia, Australia, Turkey, Brazil, and other places as well. Of course, when using a navigation app on your smart phone it is handy to have a mount in your car which facilitates you being able to see it without taking your eyes off the road, but I have to admit mine seems to work just fine wedged in to the plastic door of a storage compartment on my dashboard.

I keep the nursing homes and other sites that I frequent as favorites. I can also look up facilities using the web browser, and then just click on the address to open it in the Navigation software. When I add the value of having navigation software on my smartphone to all the medical applications and general applications, it simply amazes me that technology has progressed so far. And to top it off, it usually works as a phone, too!

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## Dementia Care Process Session

*Dr. Denise Rettenmaier, Medical Director, Memory Care Center, Veterans' Home of California, Yountville, CA*

*Originally posted August 2011*

At the 37th Annual CALTCM meeting, "Culture Change: Innovations in Management of Depression, Dementia and Diabetes", it was my honor to be the moderator for the panel speaking on "Management of Dementia in the Nursing Home". This well-attended presentation by Drs. Joshua Chodosh, James Mittelberger and Jay Luxenberg and Smadar Gal, RNC, addressed several very important topics pertaining the dementia and concluded with a lively question and answer session by the full panel at the end.

### Diagnosing Dementia

The first presenter, Dr. Joshua Chodosh, Associate Professor of Medicine at the David Geffen School of Medicine at UCLA, focused on "Diagnosing Dementia in Long Term Facilities". Dr. Chodosh discussed the prevalence of dementia in nursing homes, the consequences of cognitive impairment, practical approaches to diagnosis, the use of the BIMS from MDS 3.0, as well as "Diagnostic Conundrums" and management issues. He spoke of how many nursing home residents, 25-74%, have cognitive impairment from a variety of etiologies but that this data is limited due to lack of reliable methods and lack of valid ascertainment in diverse populations. One study Dr Chodosh reviewed published in the Gerontologist in 2000 by Dr. Jay Magaziner, et al, found that 48.2% of more than 2000 new nursing home admissions in Maryland met DSM IIR criteria for dementia. The adverse consequences of dementia are significant, including increased need for assistance with ADL care, increased incidence of antipsychotic use without clear indication and decreased of 6-month survival. Dr. Chodosh discussed the newer DSM-IV criteria for screening for dementia and subjective vs objective assessment. With the DSM-IV dementia is defined as an acquired impairment two or more areas of intellectual function, one of which is memory impacting function and is not secondary to delirium. He also reviewed the improved evaluation of cognition with the new MDS 3.0 including the 15 point BIMS, the Brief Interview for Mental Status. One of Dr. Chodosh's final points was to encourage the use of the CAM, the Confusion Assessment Method, when delirium is a possible contributor or cause of the patient's loss of cognition.

### Non Pharmacological management

Dr. James Mittleberger, Medical Director of the Medical Hill Neurobehavioral Unit in Oakland, California, spoke on "Non-Pharmacological Management of Agitated Behaviors in Cognitively Impaired Older Persons". He stated that the audience would learn how to identify which patients are at risk for behavioral issues, utilize protocols and policies for non-pharmacological management of agitation and other behavioral derangements, review the role of the interdisciplinary team and the differences between delirium and dementia. Dr. Mittleberger began his presentation by discussing scientific evidence for non-pharmacological management of problematic behaviors, specifically the "VA Health Services Research and Development: Evidence Synthesis Program, March 2011", which he stated was excellent. Limited evidence supports some interventions familiar to many in LTC such as pet therapy, exercise, behavior management techniques, massage and music therapy, but other modalities such as acupuncture, aromatherapy, light therapy are not supported by the evidence. He encouraged the audience to develop a mission and build the interdisciplinary team, and to include a "culture of caring". Dr. Mittleberger also encouraged broad team interactions to keep all the care providers, medicine, nursing, mental health, and ancillary services, informed and aware about the patients being served, and to have the team meet weekly. Within this dedicated team, effectiveness of approach and consequences of staff actions are reviewed and improved or changed, with focus on development of appropriate responses for each individual. He also emphasized the "value of creating a home-like environment and meaningful relationships". The final part of his talk focused on how to define and implement the processes of patient care, using the clinical algorithms he provided. These "ABCDEs" of Neurobehavioral Management are to identify the Antecedents of problematic behaviors, the Behaviors themselves, clarify the Consequences of the behaviors, with encouragement to Document the work of the IDT and lastly to identify the Emotion or personhood of the individual receiving care.

Using these tools, Dr. Mittleberger stated that his facility had greater than an 80% success rate for the very difficult patients referred to them.

### Pharmacological management myths and facts

Next, Dr. Jay Luxenberg, UCSF Clinical Professor and Chief Medical Officer at On Lok in San Francisco, spoke on the "Pharmacological Management of Agitated Behaviors in Cognitively Impaired Older Persons". He began with the recent Health and Human Services (HHS) Inspector General's Report of May, 2011 which included several concerning facts regarding psychotropic drug use. For example, one-half of antipsychotic medications are prescribed without clear medical indication and 22% of the atypical antipsychotics administered were deemed unnecessary by CMS standards. Additional concerns included excessive doses, excessive duration, inadequate monitoring, and adverse consequences. Dr. Luxenberg clarified the requirements by which psychotropic drug use can qualify for Medicare reimbursement as per the Medicare Benefit Policy Manual and the Prescription Drug Benefit Manual. Drugs must either be used as approved by the FDA or, if used off-label, supported by one or more of three compendia: The American Society of Health System Pharmacists Inc.'s Hospital Formulary Service Drug Information, the US Pharmacopeia-Drug Information and/or the Thomson Reuters' DrugDEX Information System. Many medications have been proposed for managing agitated behaviors in dementia, but may not be effective. Much of the data for non-antipsychotic medications used for agitation is weak or non-existent; some limited data exists for citalopram or sertraline being somewhat beneficial in agitation but valproate and benzodiazepines have no evidence of efficacy. In terms of antipsychotics, statistics indicate that the number of patients needed to treat (NNT) to achieve effectiveness in one individual is seven, and that side effects from many of the drugs used for agitation include death and cognitive impairment. Dr. Luxenberg summarized the CATIE-AD trial and the JAMA 2005 Schneider meta-analysis of atypical antipsychotics, noting that since the NNT ranged from 4-12, and the number-needed-to-harm was 100 that "for every 9-25 people helped there was one excess death". However, he pointed out that the risk with typical antipsychotics, such as Haldol, "if anything is worse". Obtaining consent is required and must be obtained by the physician or surgeon; he recommended including a modest dose range on the consent for each medication which can help maintain awareness of usage and dosage. As outlined in his final comments, Dr. Luxenberg strongly encouraged participants to be aware of what is the actual need for pharmacotherapy, to maintain efforts to manage the environment and resident interactions without medications if possible and to document everything as thoroughly as possible. Lastly, he recommended asking that if a 1 out of 7 chance for improvement in symptom improvement is worth the 1 in 100 risk of death in the next

12 weeks following antipsychotic initiation, to document this well and to keep the dose ranges low.

### **Enhanced activity program as pillar of resident care Plan**

The final speaker of the panel, Smadar Gal, RNC, Director of Nursing at Garden Crest Convalescent Hospital, spoke on "Real-Life Implementation and Management of Dementia Patients". She demonstrated her commitment to this and charmed the audience in the process by bringing to the stage her pet therapy dog. Her primary objectives were to demonstrate that a non-pharmacological approach to dementia patient management requires a strong Activity Program, which serves as the "Pillar" of the Resident Care Plan, and has a positive effect on appropriate drug utilization. According to Ms. Gal, as her slides and talk revealed, a busy active day results in happier residents whose problematic behaviors are reduced, who sleep well and subsequently require fewer psychotropic medications. The audience was delighted and touched at the slides and video clips she shared of visiting children, clowns and animals interacting with the residents of Garden Crest. Miniature ponies, llamas, exotic birds and even a Holstein calf have been involved with their Activity Program.

As Ms. Gal stated in her outline, "Activities are the basis of dignity, the foundation of care and primary strategy in behavior management".

It was the perfect ending to an excellent panel on dementia in the nursing home.

## **CALTCM Diabetes Workshop**

*Tim Gieseke, MD, CMD*

*Originally posted August 2011*

As the boomers join the ranks of the retired, CMS and other payers for healthcare are concerned that we prepare for optimizing the care for persons with diabetes. As many of you are aware, age is the greatest risk factor for diabetes. In 2008, according to MDS data, over 30% of SNF patients had diabetes. Dr. Jane Weinreb, acting Chief of Endocrinology and Chief of the Diabetes Program for the VA Greater LA Healthcare System, gave a wonderful session on optimal evidence-based care of persons with diabetes in the LTC setting. She used 5 case studies to deliver a powerful message of change. Many participants were grateful for the clarity and comprehensiveness of her presentation. I had the privilege with Janice Diez, DNS, CNL, to present on the development of an implementation project in our facility in Santa Rosa. We focused on improving measurable care outcomes identified by CMS and other stakeholders. While the tools are not yet tested, participants were challenged to adapt/develop tools and care processes specific to their needs. Finally, Deborah Greenwood challenged us to improve self-management by our patients with diabetes. For our rehab patients, this will be the ultimate measure of our success.

## **Depression Experts "Shock" CALTCM Attendees**

*Karl Steinberg MD CMD, Immediate Past President, CALTCM*

*Originally posted August 2011*

Drs. Debra Saliba, Randall Espinosa, Jay Luxenberg and Christa Hojlo presented a lively, evidence-based half-day on the topic of depression in long-term care at the CALTCM annual symposium in July, and I was privileged to moderate this discussion. Some of the experts' conclusions differed from the prevailing conventional wisdom about treatment of depression and served to expose attendees to the latest evidence-based principles on treating this prevalent and serious condition, including consideration of electroconvulsive therapy (ECT) and the finding that there is no clear benefit to adding a second antidepressant (or adjuvant treatment) versus merely switching antidepressant medications.

The half-day kicked off with Dr. Saliba's review of the PHQ-9 depression screening and surveillance tool, which is part of the recently updated Minimum Data Set (MDS 3.0), and which is administered to all nursing facility residents soon after admission and at least quarterly thereafter. Dr. Saliba was one of the primary architects of the MDS 3.0, and explained how valuable a tool the PHQ-9 can be in assessing depressive symptoms and response to therapy. During the process improvement session held on the final half-day of the symposium, some groups brainstormed ways to ensure that data acquired on residents from the PHQ-9 are considered and, when appropriate, acted on. Five facilities will be participating in a pilot project on depression, with in-house support from a CALTCM- and CGEC-based expert team, to improve the identification and treatment of depression in their facilities (to be discussed in a separate article).

Next, Dr. Espinosa, who is director of the UCLA geriatric psychiatry fellowship program, spoke on diagnostic criteria and non-pharmacological measures for treatment of depression in LTC residents. There is no question that depression is underdiagnosed and undertreated in our setting, and Dr. Espinosa shared data to support that statement. Differential diagnosis of depression was reviewed. Psychotic depression is among the most serious forms of major depressive disorder, but sometimes it is not identified—so clinicians must specifically and repeatedly ask about psychotic symptoms (e.g., delusions, extreme guilt, paranoia, and in unusual cases hallucinations). In some severe cases, patients refuse food and fluids, which can be life-threatening in the short run. These cases respond most effectively to ECT, although it can be associated with an increase in memory problems and cognition, especially short-term. Indeed, most cases of severe

(catatonic or psychotic) or even treatment-resistant depression can be successfully treated with ECT, although it is expensive and involves general anesthesia, etc. The exact mechanism of this therapy is not known, but clearly the induction of seizure activity in the brain (not in the body) does something to improve depressive symptoms. Usually a series of 6-12 daily treatments is given, often in an inpatient setting. Obviously, there are a limited number of hospitals that offer this kind of treatment, and ECT has a generally frightening reputation that is largely undeserved. Nonetheless, it is an exceptionally effective treatment for severe depression, especially in the elderly, and it should absolutely be considered as one option in our armamentarium.

Other, more routine depression treatments were also discussed, including medication, psychotherapy, behavioral strategies, and other types of brain stimulation. Also, not everybody who exhibits depressive symptoms upon admission to a skilled nursing facility requires formal treatment, as in some cases it is a brief reaction to a medical illness, loss of function/independence, or adjusting to a new living environment—and sometimes these symptoms improve promptly as a resident becomes acclimated to his or her new situation. But those who exhibit significant symptoms for longer than two weeks should be considered for treatment, and in many cases it is appropriate to commence therapy immediately, depending on the clinician's judgment.

Finally, Dr. Espinoza reminded the attendees that the risk of suicide is highest in elderly individuals, especially men—and that our LTC population is at high risk for completed suicide because of a number of risk factors. Suicide screening must be undertaken in people who show depressive symptoms. However, some degree of passive suicidal ideation (e.g., "I wish I could just go to sleep and not wake up") may not require aggressive treatment—one of the attendees mentioned that in his facility, any resident with the slightest bit of expressed suicidality was immediately sent to the hospital by ambulance (which might contribute to thoughts of suicide for many people!), which is clearly overkill as these types of thoughts are not uncommon in our LTC residents.

Dr. Jay Luxenberg then discussed the latest evidence on pharmacotherapy in geriatric depression and some specific data on depression in LTC. In 2004, roughly 45% of LTC residents over 65 were on antidepressant medication, with the highest prevalence in females over 85. Citalopram (Celexa) and mirtazapine (Remeron) were the two most highly prescribed agents. Dr. Luxenberg reminded attendees of the difference between response (an improvement in depressive symptoms, but with some residual symptoms still present) and remission (where essentially the treatment has eradicated any significant depressive symptomatology). Obviously, treatment to remission is the goal. Pooled studies showed that with medication (of any kind) versus placebo, depression response rate had an odds ratio (OR) of 1.4, while remission rate had an OR of 1.27. Interestingly, and in line with many previous studies, about 35% of depressed patients treated with **placebo** had a response (compared to about 45% with active medication). Hence, the number needed to treat (NNT) was 10. But the fact that 45% of patients improved with medication is still a pretty good number.

In patients with dementia and depression, there are limited data available (only a total of about 300 subjects from several pooled studies), there was an apparent odds ratio of about 2.0 for response and remission for medication versus placebo, but the P value was between 0.07 and 0.11, and the confidence interval crossed the 1.0 line, so these studies did not reach statistical significance. However, these small studies should be taken in context, and certainly many of us have seen excellent responses to antidepressant medication in demented patients.

Another study, called the STAR\*D, focused on real-world treatment of depression. STAR\*D demonstrated that some two-thirds of depressed patients eventually reached remission with multiple attempts at treatment, but only about a third reached remission with single-agent therapy with citalopram. This study suggests that if at first you don't succeed, try, try again. There was no clear advantage to adding a second antidepressant (or adding adjuvant/augmentation medication) over merely switching to a different antidepressant. Depressed patients with concomitant anxiety had lower response rates, and treatment of anxiety typically requires higher doses of medication than depression alone. As to which medication to try first, Dr. Luxenberg cited a 2004 study comparing the SNRI venlafaxine to the SSRI sertraline, which found no clear advantage to the SNRI (despite pharmaceutical companies' touting the dual neurotransmitter activity) and increased adverse effects. Of course, this study only compared these specific two medications, so it is not clear whether the class of medication really makes a difference—but there is no evidence one way or the other, so medications should be chosen on the basis of side effect profile, cost and formulary concerns, and potential drug interactions.

As to the use of antipsychotic medication as augmentation therapy for depression treatment, there are several atypical antipsychotics that have been FDA approved for this indication, and there is evidence to back up the notion that for psychotic depression, outcomes are better with a combination of antidepressant and antipsychotic pharmacotherapy. However, antipsychotics are clearly more dangerous and their use must be carefully weighed before initiation of therapy, with informed consent an important requirement.

Interestingly, and hot off the press this year, it appears that non-steroidal anti-inflammatory medications (NSAIDs) antagonize both biochemical and behavioral responses to SSRI antidepressants. While NSAIDs are not widely used in our LTC population, this potential confounder needs to be kept in mind. SSRIs and SNRIs are also known to cause hyponatremia, so Dr. Luxenberg suggests considering monitoring of sodium levels. He suggests routine lab studies prior to initiating any antidepressant therapy, including a CBC, basic chemistry including calcium and liver functions, and thyroid testing.

As to the requirement for consideration of Gradual Dose Reduction (GDR) on antidepressants, Dr. Luxenberg reminded the

audience that for patients who have had more than one previous episode of major depression, lifelong treatment is recommended, and gradual dose reduction is generally contraindicated. However, there may be some patients in whom reducing the medication can be considered. If this is done, it should be done slowly as rebound depression may occur.

Treating clinicians/prescribers should document why they feel a GDR is indicated or contraindicated, and that risks and benefits have been considered and discussed.

Christa Hojlo, Ph.D., our speaker who came the longest distance (from Washington DC, where she is in charge of the Department of Veterans Affairs' Community Living Centers) wrapped up the didactic sessions, presenting on culture change and its ramifications for depressed patients. Dr. Hojlo prefers the term "Culture Transformation" to the more widely used "culture change." She spoke eloquently on the meaning of this movement, and the transformation of our traditional medical model of providing long-term care into a person-centered, home-like environment that respects and celebrates individuality. A holistic approach to transformational change ("HATCH") was recommended to attendees who are trying to convert to the "I"-care plans and initiate a more resident-centered culture in their buildings. Sleep-wake cycles, bathing preferences, meaningful use of time, and age-appropriate activities are to be evaluated and promoted. Our residents should be referred to by name, and who they are (life experiences, things of importance to them), as opposed to being called a room number or a diagnosis. The environment should be transformed, to the extent possible, into a homelike setting and a non-institutional looking premises. Wellness should be promoted in all senses of the word. The President's New Freedom Commission findings from 2003 called for an improvement in mental health services, which clearly are a large portion of the care received in the LTC setting. This report emphasized recovery, which includes a lot of positive elements: peer support, self-direction, empowerment, concentrating on strengths, hope, respect and responsibility. Dr. Hojlo stressed the importance of consistent assignment and recognized the work of the Advancing Excellence campaign. It takes courage to move in this direction, and it takes time, but it appears that the LTC industry is indeed inching forward. Certainly as we baby boomers approach our golden years, it is hoped that those of us who are not "morning people" will not be awakened at 6 a.m. to have our blood pressures taken!

All in all, a huge amount of information was disseminated during our half-day on depression, and a lively discussion with Q&A wrapped up the session. As mentioned, multiple groups worked on process improvement strategies to get more cases of depression identified and appropriately treated. The sessions will be available through SCAN CME sometime later this year, for those who were unable to attend. We should all be increasingly aware of the impact of depression on our patients, and be sensitive to their need for treatment when appropriate.

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## Late Breaking News on the Treatment of Depression in the Setting of Dementia

Jay Luxenberg, MD

*Originally posted August 2011*

At our annual meeting, I gave a talk that included discussion of treating depression in the setting of dementia. I discussed Craig Nelson and colleagues' meta-analysis, which showed no benefit from antidepressant therapy. Sometime, however, late breaking news comes out immediately after a talk that I just wish I could have discussed. In this case, the July 30 Lancet has a very important article reporting a placebo-controlled trial of antidepressant therapy for depression in the setting of dementia - [Sertraline or mirtazapine for depression in dementia \(HTA-SADD\): a randomised, multicentre, double-blind, placebo-controlled trial](#) by S. Banerjee, et al. Professor Banerjee, along with premier investigators such as Clive Ballard, Clive Holmes, Alistair Burns, John O'Brien and Robert Baldwin performed this multi-institution study primarily on out-patients of old-age psychiatry services in the UK (the term they use for what we call geropsychiatry), with around 15% in institutions. All participants had NINCDS criteria probable or possible Alzheimer's disease plus coexistent depression. The target doses were 150 mg per day for sertraline and 45 mg per day for mirtazapine. 326 participants were enrolled. By the end of the study, for participants who remained on prescribed medication the mean dose was 95 mg per day for sertraline and 30 mg per day for mirtazapine. Bottom line – there was no significant difference in depression between the placebo and either of the active treatments. Perhaps not surprisingly, though, there were significantly fewer side effects in the placebo-treated participants. What primarily distinguishes this study from previous studies in similar populations is the large size and high quality of the study.

In the same issue, Professor Henry Brodaty from Sydney explains it all in a [Comment: Antidepressant treatment in Alzheimer's disease](#). In one of my talks I discussed Professor Brodaty's role as the initial reporter of the association of antipsychotics and excess mortality in his 1993 publication of a large randomized placebo-controlled trial of risperidone for the treatment of aggression, agitation, and psychosis of dementia. In this commentary, he gives his perspective on why the HTA-SADD results should not result in us abandoning the use of antidepressants in dementia, but rather suggests that therapeutic trials for individual patients are warranted, and that other symptoms in dementia such as agitation, delusions and hallucinations have been reported as improving in clinical trials. It certainly is worth reading both the study and the accompanying commentary. I think we need to be mentioning the accumulating evidence of lack of efficacy as we discuss risk/benefit factors before prescribing antidepressants in the specific setting of dementia.

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## Psychotropics Attract Scrutiny, Regulatory Changes

Karl Steinberg MD CMD, Immediate Past President, CALTCM

Originally posted August 2011

Recent developments impact the use of psychotropic medications in long-term care in several ways, pertaining to informed consent, antipsychotic prescribing, and regulatory oversight.

Most pertinent to California clinicians is the Department of Public Health (CDPH)'s recent reinterpretation of longstanding Title 22 regulations with respect to informed consent. While the statute has always mandated that the physician is responsible for obtaining informed consent—for all psychotropic medications (not just antipsychotics, but antidepressants, mood stabilizers, anxiolytics, etc.) as well as any type of restraints—historically, nursing facility personnel have been permitted to do this on the part of the prescribing clinician. Now the surveyors will be scrutinizing records more closely to ensure that the prescriber indeed personally participates in the obtaining of informed consent. In fact, except in unusual situations, administering a psychotropic medication will not be permitted until the informed consent is obtained by the physician—even if the patient has been on the medication for many years prior to SNF admission. There will be some exceptions, particularly for a first dose, and for emergency situations, but in general every psychotropic on admission, every new start in a SNF, and every dose increase of a psychotropic during the SNF stay, must document that informed consent has been obtained by the physician.

If patients come in with explicit documentation from previous treating physicians (e.g., primary physicians, outpatient psychiatrists, hospitalists or psychiatric consultants) that informed consent from a drug and dose have been obtained, then facilities may continue those medications—although the attending physician should also document the obtaining of informed consent at the time of the visit at the facility. CALTCM believes that the more stringent interpretation of these Title 22 regulations is in response to SB 303, which would have required very strict requirements to any psychotropic prescribing, and was passed by the California Assembly and Senate, but was vetoed by Gov. Schwarzenegger. He did instruct CDPH to take other actions primarily to address excessive prescribing of antipsychotics. More detailed information is available at the links below.

CALTCM has concerns that the new interpretation of the Title 22 regulations may negatively impact LTC patients by delaying the provision of necessary medications, or by making it impossible to provide these medications in some cases. A patient with a history of lifelong major depression with multiple suicide attempts, who has been stable on an antidepressant for many years, should not be subjected to abrupt discontinuation of the medication because of an inability of the SNF attending physician to independently (and again) obtain informed consent. The same applies to a chronic paranoid schizophrenic with a history of violence, who has been well controlled on an antipsychotic for many years. It seems unfair to create a special class of individuals merely on the basis of their being admitted to a long-term care facility. According to Dr. Loriann DeMartini, chief pharmaceutical consultant for the CDPH, it should be emphasized that CDPH understands the potential difficulties, and surveyors will consider the overall situation and the individual factors if a facility (or attending physician) decides to continue a medication before a new informed consent is obtained and documented. However, facilities may still receive deficiencies or citations in some cases if they do not follow the new guidelines. This informed consent policy creates new obstacles for physicians, non-physician practitioners, facilities and their staff, and patients, but it is hoped that we will all work together to ensure our patients get their needs met—as we have with the DEA's policies on Schedule II opioid dispensing in LTC in recent years. We must always recall that our patients are our primary concern, as Dr. DeMartini mentioned at the California Association of Health Facilities' annual legislative conference in March, and we must do what we can to provide the best care possible to those we serve.

On a related topic, the U.S. Office of the Inspector General (OIG) recently released a report about the use of antipsychotics in skilled nursing facilities, which was critical of perceived overuse, excessive use, and off-label prescribing. This topic is too complex to address in detail here, but essentially echoes the concerns of advocacy groups that in at least some cases, these medications are inappropriately used in dementia patients with agitation. The American Medical Directors Association has drafted some talking points about antipsychotics in LTC, and acknowledges that these medications carry significant risks and have not been shown conclusively to improve behavior in large studies of patients suffering from dementia with agitation. On the other hand, they certainly can be useful in some cases (especially when psychosis is present), and no drug from any category is actually FDA approved for dementia with agitation, so any prescribing is off-label (and not necessarily inappropriate).

Clearly, except in emergency situations where safety is at issue, non-pharmacological measures should be exhausted before contemplating use of antipsychotics in these patients. And clearly, careful discussion of the risks, benefits and alternatives with documentation of informed consent from a responsible party is essential when using this class of medication, since it is associated with increased risks of death and has an appropriate "black box" warning. It should also be recalled that antipsychotic medications are FDA approved for a number of indications, including bipolar disorder, schizophrenia, and (for some products) major depressive disorder. So, even though these medications have significant risks, there are clearly appropriate uses for them in our patient population. We at CALTCM share the position of AMDA that a balanced, prudent approach to the use of antipsychotics in the LTC setting, especially patients with dementia and agitation, should be maintained—but these medications do indeed have a place in our armamentarium.

## An Invitation

*Mira Cantrell, MD, CALTCM Chair, Education Committee*

*Originally Posted June 2011*

As the Chair of the CALTCM Education Committee, I would like to personally invite you to attend this year's Annual Meeting taking place in Los Angeles on July 15 & 16. This year's conference will concentrate on three highly important issues in long-term care medicine: dementia, diabetes and depression. A superb group of faculty will dissect these topics in detail and provide you with the most up-to-date information regarding clinical advancements, evidence-based practices, quality improvement and care planning. All presentations will be followed by an interactive round table discussion between the conference participants and the faculty. In addition, the final conference session will be a workshop where participants will have the opportunity to develop a quality improvement project with faculty providing sample scenarios and all necessary guidance and mentoring.

In addition, the poster submission deadline has been extended to 6/20/2011. I encourage you to showcase and share your work experiences and submit them in the form of a poster presentation. Accepted posters will receive one free conference registration! ([Poster submission guidelines.](#))

And finally, since the 37th Annual Meeting is not "all work and no play" we hope you enjoy the networking opportunities and the comfortable setting of the Omni Hotel which has easy access to many downtown LA sites and activities.

If you have any questions regarding the conference, please feel free to contact me directly at [mira.cantrell@cdva.ca.gov](mailto:mira.cantrell@cdva.ca.gov).

Thank you and I hope to see you in Los Angeles in July!

## Smoking Cessation

*Paul Duranczyk, NHA*

*Originally Posted June 2011*

Within California skilled nursing facilities, the journey to becoming a tobacco free facility can be long and complex. There are various laws, regulations, and ordinances relating to tobacco use in health care facilities. While there is no constitutional right for anyone to use tobacco, a patient right of self determination exists under federal and state regulations. The state regulations are piecemeal and contradictory. Skilled nursing and intermediate care facilities are required to maintain designated smoking areas while other health care facility types are not. For example, State Hospitals are not required to maintain designated smoking areas. Add to the mix the state labor codes of promoting employee health and maintaining a smoke free workplace. Until recently, skilled nursing facilities desiring to become tobacco free had one option. They implemented policies prohibiting tobacco use by all newly admitted patients after a certain date. Existing tobacco users were grandfathered and through attrition, the facility would become tobacco free. Now, there are additional measures that can speed up the process of becoming tobacco free. A "program flex" can be requested from the state waiving the requirement to maintain a designated smoking area. Many cities have local ordinances prohibit smoking which can trump state regulations. There are allies and resources available to facilities. Some include local tobacco control advocates, generally within the county department of public health, Technical Assistance Legal Center ([www.talc.phil.org](http://www.talc.phil.org)), The Center for Tobacco Policy and Organizing ([www.center4tobaccopolicy.org](http://www.center4tobaccopolicy.org)), The Center for Cessation ([www.centerforcessation.org](http://www.centerforcessation.org)), and Smoking Cessation Leadership Center (<http://smokingcessationleadership.ucsf.edu/BehavioralHealth.htm>).

## Wheelchair Dancing and "A Culture of Change"

*By Deborah I. Wolff-Baker MSN, CHPN, FNP-BC*

*Originally Posted June 2011*

In 1987 Ronald Reagan signed the landmark Omnibus Budget Reconciliation Act (OBRA). This piece of legislation included federal Nursing Home Reform Laws requiring Nursing Homes to provide care for residents in such a manner and environment as to promote the quality of life of every resident. This requirement emphasizes dignity, choice, and self-determination of each resident by providing services and activities to attain or maintain their highest degree of physical, mental, and psychosocial well-being.

"A Culture of Change" is about creating an environment in nursing homes that fully reflects these values. It is one that de-institutionalizes nursing homes and revolutionizes how chronically frail and disabled individuals live and are treated. The key to improvement is through implementing systems of care around individuals' lifestyles, needs, and preferences.

Nursing Home care has dramatically improved since the implementation of the OBRA law in 1987, but as with any change

it is important to continuously strive to improve quality with new ideas for ways to provide this care in an environment that is truly home-like with activities that are meaningful and stimulating as well as reflecting the types of choices that residents would participate in if they were able to live on their own.

One such idea came to me in the form of a Newsletter from the National Council of Certified Dementia Practitioners (NCCDP) this past month. An Article written by the organization's Executive Director, Sandra Stimson, introduces the concept of Wheelchair Dancing. This article presents a great case for starting a program of physical and musical activity by implementing a Wheelchair Dance program in Long Term Care (LTC) facilities as a way to enhance both health and quality of life in LTC residents. <http://www.nccdp.org/nccdpnewsletter31.htm>

How many of our residents grew up watching Fred Astaire and Ginger Rogers trip the light fantastic? How many enjoyed the jitterbug, swing, or ballroom dancing with their sweetheart in their younger years? Why should the need for wheelchair fittings stop them now? The health and psychological benefits are many, only to be limited by one's imagination; not the least of which is laughter and joy.

"If dance is an expression of the human spirit, then it is best expressed by people of all abilities." ~*Mary Verdi-Fletcher, President/Founding Artistic Director, Dancing Wheels.*

Wheelchair dancing may be a way for LTC facilities to reach residents in ways not possible through other activities, even if only as a spectator.

Resources for starting such an activity can be found in the referenced NCCDP article cited above.

**References:**

1. <http://www.nccdp.org/nccdpnewsletter31.htm>
2. <http://content.healthaffairs.org/content/20/6/128.full.pdf+html>
3. [www.youtube.com/user/AmericanDanceWheels](http://www.youtube.com/user/AmericanDanceWheels)
4. <http://www.dancingwheels.org/about-us.asp>

**Public Library of Science App**

*by Jay Luxenberg, MD*

*Originally Posted June 2011*

This issue I want to address the needs of those that are not lucky enough to have access to the journals subscribed to by a university via some affiliation like a faculty appointment. You have to pay for each journal you subscribe to. I am sure this applies to most physicians and others interested in the medical literature. What can you do to have interesting articles to read while you are away from your home or office base? One app that I find simply wonderful is the free [PLoS Reader](#) for the iPad. The Public Library of Science (PLoS) is a group of free, peer-reviewed journals that have published more than 20,000 articles. The good news is that by the time you finish reading these 20,000 articles, they almost certainly will have published a few more. Think how smart you will be! The reader is well designed for the iPad, taking full advantage of the large screen with a page-turning interface. You can select articles while you have access to the internet, and they will be available to read later – a wonderful way to pass a plane ride productively. Titles include [PLoS Biology](#), [PLoS Medicine](#), [PLoS ONE](#), [PLoS Computational Biology](#), [PLoS Genetics](#), [PLoS Pathogens](#), and [PLoS Neglected Tropical Diseases](#). How does all this goodness occur for free? Well, of course, it isn't really free, but it is free to you because a modest publication fee is charged to the authors or research sponsors for each article they publish. The quality of articles is really very high, and the app makes browsing for and choosing articles to read pleasant. You can even e-mail the paper as a pdf or as a reference right from the app. Unfortunately, so far this app is only available for the iPad, but hopefully the other platforms will be supported in the future.

**From the President's Desk**

*Dan Osterweil, MD, FACP, CMD*

*Originally Posted June 2011*

It is with great pleasure and pride that I am inviting you to participate in CALTCM's 37th annual symposium scheduled July 15 - 16, 2011 at the Omni Hotel in downtown Los Angeles. You will enjoy a superb training experience. CALTCM has been a pioneer in taking an innovative approach to professional training. We are "pushing the envelope" beyond information dissemination. Our planning committee, with input from educators, has devised a program geared to providing you with the opportunity to acquire knowledge and competencies in carrying out your professional duties. Participants will be able to implement appropriate care processes in their own nursing homes. These care processes are not only the most scientifically sound, but also consistent with the new requirement for quality and efficiency, thus reducing redundancy in what we do in the nursing home. These processes are patient centered focusing on the right care at the right time for the right person.

Patient safety and avoiding errors and use of unnecessary medications is the core of our strategy. The additional innovation this year consists of Technical Assistance to a select number of facilities in the care of depression in the nursing home. Facilities interested in participating in this unique program will be trained at the CALTCM symposium and will be assigned an expert in the field of aging and LTC to guide them in implementation of the program in their own facilities. Thanks to a federal grant obtained by the California Geriatric Education Center at UCLA, facilities will get this training free of charge, thus making them more competitive in this new era of evidence-based care. Facilities that acquire the skills during our training will meet and exceed regulatory requirements related to providing appropriate diagnosis and medication management to their residents.

Our education committee, with input from many of you, chose two additional topics which are at the center of all nursing homes: Diabetes and care for the demented elderly. These conditions are associated with many co-morbidities and frequent hospital admissions. With the new rules published by the Centers for Medicare and Medicaid Services (CMS), readmissions to hospitals within 30 days for later complications in post acute care will be negatively impacting reimbursement for those hospitals and marking them as providers of lower quality of care. Should your facility fail in managing those conditions resulting in premature readmission, your facility may be singled out as an unfavorable site for nursing home discharge from those hospitals, thus affecting your employer's economic status and competitiveness. Furthermore, surveyors trained in those particular care processes may cite your facility if the care you provide does not meet those standards, and require you to retrain at future CALTCM Symposia. So you see, CALTCM is the place to go for the best training you can obtain in California. Last but not least, CALTCM is focused on [team training](#) where physicians, nurses, CNA's and other professionals collaborate and share the burden and expertise to provide the best coordinated care to our seniors.

Come and join us at the CALTCM Symposia July 15 & 16 in Los Angeles at the Omni.

Dan Osterweil MD CMD  
CALTCM President

## Why Attend CALTCM Diabetes Care Workshop at July Annual Meeting?

*Tim Gieseke, MD, CMD*

*originally posted May 2011*

One half-day of CALTCM's annual symposium in Los Angeles will be devoted to current trends in diabetes management. This is a huge topic, and one with plenty of room for improvement. If you need more reasons to attend, keep on reading! On March 31, 2011, the NEJM article by Dr. Berwick proposed quality measures for ACOs (Accountable Care Organizations). Diabetic Health was one of 7 focus areas for improving health. This is not surprising. Diabetes prevalence is rapidly increasing. In 2008 according to MDS data, diabetes had a prevalence of 32.1% in the nursing home population. In 2007, 18.5 Billion was spent on Diabetes care. 32% of CMS expenditures are related to Diabetes.

In the era of health care reform, the proposed metrics for diabetes should incentivize ownership and management of our facilities to improve and document the care for patients with diabetes. This is not an easy task. In JAMDA, a 6 state retrospective study reported on the status of diabetic management in the Nursing Home setting. They found, disappointingly but perhaps not surprisingly, the following areas of substandard treatment:

1. 15% of facilities had a policy for the use of treatment algorithms in residents with diabetes
2. 7.1% had a policy for A1C testing
3. 1% had a target for A1C established
4. 30.8% had a policy for glucose monitoring
5. only 57% of diabetics were taking ASA or Clopidogrel

6. 29% of those taking Metformin had GFR < 60
7. 71% of residents on insulin were doing so on a sliding scale basis, despite evidence for inferiority of this strategy.
8. A common frustration of many interviewed DONs was: "Too many different approaches –standardization would be helpful"

At CALTCM, we have heard this "common" frustration. Dr. Jane Weinreb of UCLA will teach about core diabetes care issues in LTC. Janice Diez, DON, and I will focus implementation of optimal diabetes care practices in your facilities. Then Deborah Greenwood will provide critical information that empowers our rehab patients to "thrive" on discharge back into the community. You will then have time with other IDT teams to adapt what you have learned to your care processes for diabetics in your facilities.

Bring your facility's change champions to this meeting. Together, we can improve the quality of life of our diabetics and do so at a lower cost to our patients and our payors. See you there!

## **CALTCM 37th Annual Meeting Session Addresses Mood Assessment and Management**

*Debra Saliba, MD, MPH*

*originally posted May 2011*

Depression is a prevalent condition that affects the quality of life of residents. Learn about the PHQ-9 screen used in the new MDS 3.0, approaches to diagnosis and management, benefits and risks of pharmacotherapy and the role of environment and culture change in improving mood and behavior.

## **Dementia**

*originally posted May 2011*

The session on dementia will start off with a discussion of factors relevant to the long-term care setting. This includes the impact of the diagnosis on institutional vs. community setting as well as its effect on the plan of care for the subacute vs. custodial patients. New ICD coding, especially in regard to neurobehavioral problems, will be discussed in detail. Next, the approach to managing agitated behavior in cognitively impaired patients using non-pharmacological and pharmacological management will be presented with emphasis on innovative approaches to decreasing and/or eliminating psychotropic use whenever possible. The presenters will showcase protocols and policies for non-pharmacological management of agitated behavior in demented patients that facilities may adopt for their own use. The presenters will emphasize the differences in approach between the delirium and problem behaviors due to dementia, and the session will conclude by addressing differences in approach for different types of dementia.

## **New Transfer Form Proposed for use for RCFE Residents Going to the ER**

*originally posted May 2011*

There is a new transfer form which was created by the San Diego Dementia Consortium (SDDC). It is geared to give a cognitive and functional baseline of a cognitively impaired patient, so that the ER knows the recent premorbid cognitive and functional status of the patient presenting to them. The form is to be revised monthly by RCFE's. It is based on the idea that when a patient arrives at an ER with a history of cognitive impairment or dementia there is no way of knowing what the patients premorbid cognitive or functional status is. There is also no way of knowing whether the patient has dysphagia or is usually combative.

The SDDC was created to advance public knowledge and awareness of dementia and cognitive health as well as to develop and promote clinical and research programs to benefit those patients with dementia and cognitive disease. The SDDC is composed of representatives from several Assisted Living Facilities/ RCFE's in North County Inland, the San Diego/ Imperial Chapter of the Alzheimer Association, the County of San Diego Aging and Independence services, some elder care management companies and home care agencies, Palomar Pomerado Health (a hospital district health care system), the San Diego POLST Coalition, a geriatric neurologist, a geriatric psychiatrist, and two geriatricians (both geriatricians are board members of CALTCM, one is president of CAGS, and one VP of CALTCM).

The SDDC presented the form to the state regional office that oversees RCFE's. The person we spoke to saw value in the form and had encouraged us to look into having legislation proposed to require the use of the transfer form by RCFE's. This would include assisted living facilities, board and care facilities, and non-SNF dementia units. (SNF's should use INTERACT.)

The SDDC discussed the form with a group that called themselves the California Senior Legislature. They are presenting a proposal to the state legislature. The proposal will ask for a requirement that RCFE's use this form when sending patients to the ER.

Palomar Pomerado Health hopes to do an IRC, quality improvement study, at Pomerado Hospital ER with the help of local RCFE's to show the benefit of the form.

Also the San Diego POLST coalition is going to recommend the form to be used with the POLST for patients going to the hospital from RCFE's and from their home in the community. For patients living at home it could be placed in the Vial of Life.

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## Who Doesn't Have Questions on How the Department of Public Health Will Interpret the Regulations Concerning Informed Consent?

*originally posted May 2011*

Who doesn't have questions on how the Department of Public Health will interpret the regulations concerning informed consent, particularly as it relates to psychotropic drugs? Fortunately, on April 12 (and not on April 1) the DPH released a series of questions and more importantly answers on this very topic. Those of you who practice with a nurse practitioner or physician's assistant may be particularly interested in this: "so in a SNF a Licensed Practitioner other than a physician can not order antipsychotic medications and you would need a physician or surgeon to obtain the informed consent". [Check it out.](#)

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## AMDA House of Delegates Passes CALTCM's Prison Resolution

*originally posted May 2011*



At the March 2011 annual meeting of AMDA, the California delegation representing CALTCM presented a successful resolution at the House of Delegates concerning the expected influx of post-prison residents into the long-term care setting. This resolution was crafted primarily by the CALTCM Policy & Professional Services Committee, including Robert Gibson, PhD, JD, Jim Lett, MD, CMD, and Chairman John Fullerton, MD, CMD.

The P&PC Committee worked with CAHF and other California stakeholders in addressing concerns about relocation of convicted criminals—both after completing their sentences and on parole status—into the LTC setting. A significant increase in this population is expected in the years to come, and CALTCM leaders feel it is important to be prepared for this challenge. The resolution directs AMDA leadership to work on a national level with other organizations, including CMS and the AMA, to explore this topic and begin taking appropriate actions to address the matter. There was strong support for the resolution from other state chapters, and the vote to approve the measure was unanimous. Here is a link to the text of the [resolution](#). CALTCM is grateful to Drs. Gibson, Lett and Fullerton for taking the lead on this important, forward-looking issue and giving it a national exposure.

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## "There's an App for That!"

*Jay Luxenberg, MD*

*originally posted May 2011*

During my residency, I started collecting photocopies and reprints of key medical papers. It became apparent that the discussions on rounds centered on more recent material than was found in my textbooks, and that there was particular interest in the latest studies that had impact on clinical care. As these papers grew, I started to file them in manila folders. Eventually, I bought a file cabinet and started to file these folders so I could retrieve what I needed.

It soon became evident that there were some problems associated with this approach. First, many of my papers could logically be filed in several folders. The same paper, for example, might reference a study on withholding digoxin from heart failure patients in sinus rhythm. Did that go in my digoxin folder or my heart failure folder? What about my polypharmacy folder? Some papers were even worse – they could easily be filed in a half dozen different folders. The second big problem became evident later. Eventually, some of these folders grew very thick. Many of the papers were no longer relevant. I learned how time-consuming it could be to thin the papers.

Times changed, and soon many of the journals I read became available online. I could download papers as pdf files, but the same storage and filing problems occurred. Initially, I just duplicated my filing system by creating folders for each topic. Eventually, I began to use software to facilitate my searching for articles, and to help with organizing them in a way that I could use to easily find pertinent articles. I was already using software like Endnote (available for Windows and Mac OS) to list my references for writing articles. Eventually, versions of Endnote were released that allowed attaching pdfs to each reference, so I could use [Endnote](#) to search for papers as well. I started to scan my most useful older “paper” papers to pdfs, and eventually was able to retire the old filing cabinet and manila folders. After being frustrated over the years by being forced to do an expensive upgrade on Endnote every time there was a new version of Microsoft Word or a new version of the operating system (as well as having to buy a version for Windows and a version for the Mac, but that is a different story), I explored different software that was more friendly, particularly liking [Bookends](#) and [Papers](#) for the Mac. They both allowed me to search PubMed for references, and to download the pdfs from journals I subscribe to and journals made available via the universities that I have access to from my faculty appointments. I can search by text elements, titles, or authors. With Papers, I can drag in a pdf and it finds the reference on PubMed or Google Scholar, allowing me to simply import the tags to the metadata that labels the reference. Both programs also let me insert references in papers that I write or in slides for talks that I give. If perchance a paper is rejected or needs to be revised, both programs allow reformatting the references into a zillion journal styles or automatically renumbering references if I need to add one.

Well, this is a column on apps, so you have probably guessed that eventually I would talk about one. Papers makes an app for the iPad and iPhone or iPod Touch. It syncs with the library on my computer. It allows me to carry the pdfs of 5000 papers on my iPad, and a smaller number on my iPhone. Why, may you ask, would one want to do this? Well, one thing I haven’t found an app for yet is one that manufactures more minutes in the day. It’s hard to keep up on all the medical reading I would like to keep up on, and I find the iPad a particularly nice way to read papers while I am traveling, and the iPhone a good way to read an article while I am in line at a supermarket. Both serve as an admirable alternative to reading “People” in your dentist’s waiting room. Better yet, I can look up a paper and e-mail it to a colleague or student. I can look up a paper to put a reference in a medical chart. I can search for a topic on PubMed when a clinical question comes up, download a pdf, read what I need, and then the next time I sync my phone the paper and reference will be on my desktop computer and laptop. It is a brave new world.

For other platforms, there is a new program, [Mendeley](#), which is free for Windows, Mac, and Linux. It has free iPhone, iPad, and iPod Touch versions and reportedly an Android version is coming soon. If free is your price point, [Zotero](#) integrates into any platform Firefox is available for, and can be browsed from an iPhone. I would love to hear from you if you have experience with either of these, at [jay@luxenberg.net](mailto:jay@luxenberg.net).

If you just want an app to search PubMed and download a reference, without syncing it to a desktop program, then there are many apps that will meet your needs. Here’s a review of six of them for the iOS devices on [imedicalapps.com](http://imedicalapps.com). Several are available for the Android as well - PubMed Mobile and AgileMedSearch-Android are just two examples. Once again, I have no experience with these, so please feel free to let us know your experience with any of them.

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## Update on the POLST Form 2011

*originally posted April 2011*

The current California POLST form (Physician Orders for Life-Sustaining Treatment) went into effect January 1, 2009. At the recommendation of the National POLST Task Force, and as part of its Quality Improvement process, the California POLST Task Force reviews the California POLST form every two years, and makes recommendations for improvements in response to feedback based on actual usage of the form in the field. From January 1, 2009 through mid-2010, over 250 comments and suggestions about the form were received from healthcare providers, consumer advocates, and others. The POLST Task Force created a Documentation Committee to process the suggestions and make recommendations. Several of CALTCM’s leaders were active on this committee, with Dr. Jim Mittelberger taking the lead. The Committee’s recommendations were reviewed and approved by the full POLST Task Force, and later by the California Emergency Medical Services Authority (EMSA) Commission.

Here is the link to the new form: [http://capolst.org/documents/CAPOLSTform2011v13web\\_003.pdf](http://capolst.org/documents/CAPOLSTform2011v13web_003.pdf)

It is important to emphasize that:

- The POLST form is voluntary.
- Previous POLST forms are still valid, and people with previous POLSTs do not need to fill out a new version unless there are changes in their wishes.
- The new version of POLST does more to help ensure that when there is an Advance Directive, the POLST and advance directive are consistent with each other.
- The Legally Recognized Decisionmaker should always make decisions that are consistent with previously stated wishes of the patient, when known.

Several educational materials have been created or updated to highlight the changes to the new POLST form:

- A document that summarizes each change and provides the rationale for making the change.
- Minor modifications have been made to the standardized POLST curriculum (What is POLST, Community POLST Presentation, POLST Conversation PowerPoint presentations).
- A newsletter article that can be published by local coalitions and providers in their newsletters.

Also available now is the new video, "POLST: Facilitating Meaningful Conversations about Goals of Care," which featured several CALTCM leaders as "actors." It was released in March at the annual POLST Meeting in Burbank and is designed for use by health care professionals. For more information on the video, please contact the CCCC or visit their website.

The POLST form has been translated into 6 languages – Chinese, Spanish, Farsi, Korean, Russian, Tagalog, and Vietnamese. It will be available on several websites as well, in addition to the [California POLST website](#), and the EMSA website. CCCC is working with CDPH to issue a new All Facilities Letter regarding the new form, and to make appropriate changes to the questions related to POLST in Section S on the MDS (Minimum Data Set).

The standard color of California's POLST form has changed from Pulsar Pink to Ultra Pink (still on 65# cardstock). This is because some copy and fax machines have not been able to duplicate forms printed on Pulsar Pink legibly, due to being excessively dark. Ultra Pink was tested to confirm a better result on a wider range of copiers and fax machines. Also, throughout the POLST form, the term health care 'professional' was changed to health care 'provider' to be consistent with language in the POLST law.

Among other specific changes are:

- The addition of this sentence to the introductory paragraph: "A copy of the original POLST form is legal and valid." This emphasizes to providers who are acting on the form that a copy of the POLST form is valid. There are additional instructions about copies and faxes on the back of the form, but adding this sentence here gives more prominence to the validity of copies.
- The addition of this sentence to introductory paragraph: "POLST complements an Advance Directive and is not intended to replace that document." There has been confusion among providers about whether POLST replaces an Advance Directive. Adding this sentence conveys the relationship between POLST and the Advance Directive. Additional instructions were also added to the back of the form regarding reviewing Advance Directives and POLST to confirm agreement between the two forms.
- A clarification of the language concerning artificial nutrition and tube feeding.

There are a number of other changes to the new POLST, which can be found in detail on the CCCC's website. It is recommended that new POLST forms be implemented immediately, rather than "using up" the supply of old POLST forms before implementing the 2011 version. Also, remember that POLSTs are valid regardless of the color of the paper they are printed on.

CALTCM welcomes the changes in our California POLST form and continues to salute the excellent work being done at the Coalition for Compassionate Care of California—and will continue to work closely with this organization and other stakeholders to promote appropriate advance care planning and the goal of honoring our patients' wishes to the greatest extent possible.

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## Knowing the Facts: Advance Directives & End-of-Life Care

*a ReachMD Interview with Karl E. Steinberg, MD, CMD*

*originally posted April 2011*

"Advance directive" is an umbrella term that encompasses end-of-life documents, including a living will and durable power of attorney for healthcare. Such documents can be scary for many patients, and as such, advance directives are not very common among the general US population. Yet these documents can be powerful tools in ensuring patients receive the type of care they desire. What do physicians need to know about advance directives in caring for patients at the end of life? Dr. Karl Steinberg, associate medical director for skilled nursing care at Scripps Coastal Medical Center in Vista, California, discusses variations, misconceptions and confusion surrounding advance directives, and says there is room for improvement. Many states have enacted Physician Orders for Life Sustaining Treatment (POLST) programs to address



end-of-life care issues. What do these programs involve, and how effective are such programs in alleviating confusion with end-of-life care? Dr. Eric Tangalos hosts.

To access the podcast, please [click here](#).

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## So, You're Thinking About a Poster?

by Rebecca Ferrini, MD, CMD

originally posted April 2011

The annual CALTCM conference is a great opportunity to do something new and different—present a poster on something your facility has done to improve quality. The following gives you some ideas and some guidelines on submitting, developing, laying out and presenting a poster at a meeting of your colleagues.

### What To Write About

In long term care we are operating with thin margins and constant, unrelenting work with frequent crises to liven things up. We are constantly improving, but many times, rather than celebrate an improvement, we just move to the next problem. Making a poster is about reflecting on what you have done better, documenting what you did and why it made it better, and publicizing that to an audience of people who are also interested in making things better.

So what can you write about? What have you done new? Have you tried a new product? A new form? A new educational technique? Have you had a problem that you addressed and the solution worked? Implemented a new policy? Changed your practice? Have you changed mealtimes, medication distribution, added some new activities? Reduced deficiencies or improved a MDS quality indicator? Think—what is different in my facility now compared to six months ago? Did you ever try something on one unit and something different on another and compared which one worked better?

You might look in long-term care journals—have you ever looked at something published and said—“hey, we did that, too!” or thought that you had a better solution? The difference between them and you is that they published what they did and got publicity and began to be looked at as experts—and you did something great that no one knows about.

Looking at your facility, comparing it to others, and looking at the literature are all places to get great ideas about what to do with a poster.

### What About Data?

Data collection is one of the big struggles—it takes time to get it and to analyze it, and it is very easy to spend a lot of time collecting data that is not meaningful. Collecting data is usually not the problem, it is the thinking part—what should I collect and how should I interpret it? Many times we work on a project to change or improve something without getting data—we just know it is a problem. One source of data we all have is the MDS—if you want to present something that has anything to do with information available on the MDS, this can be a good place to start. It's a good idea to get in the habit of collecting some data before you try something new, then after you do it, to see if the new strategy was any better. You can conduct a survey or an audit before and after, or you can make observations. In general, a sample size of at least 30 is the best. Let's say you have a new form for diabetic orders. You might then look at 30 diabetic orders before the form is put in place and measure a few things—how many times were these telephone orders rather than in-person orders? How many times was a clarification required? What percentage used sliding scale insulin? What was the average total insulin per day? How many fingersticks a month were ordered for each and what was the average? Then look at your diabetic monitoring—how many episodes of hypoglycemia (you have to define, how about below 60?) were identified in all those people in one month. How many measurements of blood sugar were taken total? How many blood sugar measurements were over 400? How many had HbA1c measurements taken within the last quarter (or six months)? What was the minimum, maximum and mean of HbA1c? How many minutes did it take to complete the form? How many minutes for each fingerstick? How many minutes to “manage” an episode of hypoglycemia? Then implement your form and do this same audit again—what changed? Notice this is a little different than saying: “the nurses liked the form.” You would be surprised once you get the hang of it how easy it is to get the data, and how the data tells the story of what really happened. If you are not a person with a lot of experience in data, find someone who has a strength in that area to help you. If you can't find someone locally, e-mail me and I can help!

Another thing to consider is that not all important “data” may be reflected in numbers. Some issues may be important areas of staff training like patient dignity, spirituality, risk-management or privacy issues that reflect ways to avoid deficiencies or liabilities where we actually don't want numbers (i.e., zero deficiencies or areas of heightened liability is good). While these sort of things may be difficult to quantify and numbers may not be practical, sharing a good approach may be quite beneficial. In other words, if you don't have a lot of numbers, it still may be a good poster.

### Writing It Up

You have to be able to succinctly express what you did and how it was effective (that is the abstract) and then have enough data to expand on more (for the poster). Most abstracts include one sentence in each of the following categories, then the poster expounds more. The categories may vary, but they are similar to these, with some suggestions noted.

**Title:** Make it catchy, no colons, and have it summarize what you did.

**Introduction:** What the problem was and why you bothered to do something about it.

**Materials/Methods/Interventions:** What exactly did you do? How did you audit? What data did you extract, what steps were done to make this change—who was educated (how many people and how)? You may use a flow chart here.

**Results:** What did you find out? We had a 20 percent reduction in time for CNA to place briefs, we used 30% fewer briefs, we reduced the incidence of dehydration from 1 a month to one in 6 months. Staff reported a 20% improvement in morale, we went from 5 fingersticks a week per patient to 3 on average and reduced hypoglycemia events from 4/month per 30 patients to 0 for three months.

**Timeline:** What happened where?

**Barriers:** What got in your way of success and how were these barriers overcome?

**Conclusions:** Remind the reader of what was said and how it is important.

**Literature Cited:** Look for others who have studied the same thing and read what they did.

**Acknowledgments:** Thank individuals for specific contributions to project and if you have any potential conflicts of interest, mention it here.

**Further Information:** Provide your e-mail address, your web site address, and perhaps a URL where they can download a PDF version of the poster.

### Design

Once you are accepted to present, it is time to think about designing your poster. Many people find this the most daunting step because it is something many of us have never done before. First, relax—the poster was accepted and the information sharing is the most important thing. And the great thing is that there are templates which can guide you through the process. I like to use the templates in PowerPoint that already even have headings in them and have all the colors and margins and borders set up for you. Publisher also has templates to use. A humorous, but thorough article on making a poster is found at <http://www.swarthmore.edu/NatSci/cpurin1/posteradvice.htm>, which provides more detail than you need. But here are some highlights: Remember that the poster is meant to be read and digested quickly; people like to see if it relates to them and they like to skip to the main points. Each section can stand alone. The poster itself does not need an abstract (which saves you space). Lay it out so it is easy to read while standing up from 6 feet away. The templates often pre-set the font and column size which helps. Try to avoid shrinking the font to get more on the poster—less is more. Edit and have people look at it before you spend money to print it. The whole poster should have 800 words or less with maybe 11 words in a line/column and no more than 10 lines of text in a box. Embrace the white space and try to avoid crowding. Don't use colors that are too dark. When you have photos or clip art, watch out—because these often look very grainy when blown up. Avoid all caps or capitalizing the first words in a title—this is actually harder to read. When you are done laying it out, you can put it on a thumb drive and take it to a printing shop (e.g. Kinko's)—I find the poster costs \$150-200 to print on nice paper. Alternatively, if your budget is an issue, while not as "finished," it is also possible to print your poster as a series of PowerPoint slides and paste or tack these to your display board.

### Target Audience

Think of the audience for your poster. The audience is mainly long-term care professionals, but will this target the physician, the nurse, the administrative team or perhaps the public, highlighting a great program? Might it be for your employees—to highlight and celebrate a success and build morale and professionalism? Knowing the audience will make a difference in the design, the text (for example, you often use more big words and diagnoses and such with a physician audience on a scientific paper than you would if the audience is the public where you would use less medical terminology or explain the words you do use).

### Presenting

Hang it up on foam board with thumbtacks, bring blue tape. Stand with your poster. Have business cards and a legal or letter size shrunken version of your poster or other handouts. Prepare a one to three sentence summary for those people who come up to the poster so you can say something quickly.

### What to do afterwards?

When you take your poster down, roll it up and put it back in the cardboard sheath, but when you get back to your facility, take it out again. Find a place to hang it. Many of these fit nicely on a hallway, where people who pass can read about the great things your facility is doing. If it happens to be a more controversial topic (say, for example, sex offenders in long term care), then the display site might be in a "staff-only" area. Look for other opportunities to show the poster—local meetings, for example. Make sure the presentation is on your resume and that the administrator or other "higher-ups" in your facility know you presented at a scientific meeting. And last but not least, begin to think—*“what can I do next year?!”*

## Technology Report: Medical Apps to Assist in Your Practice

by Jay Luxenberg, MD, CMD

originally posted April 2011

A few months back, we highlighted some apps that aren't specifically medical, but are incredibly useful in a medical practice. This month I'd like to talk about a few apps that actually are targeted to us.

I'm sure everyone with a smartphone, PDA (assuming PDAs are still in use at all) or tablet uses at least one and probably several apps to access news. We are all interested in what is happening in the world. As medical folk, though, we have more specific interests that are poorly served in the general news media. For example, those of us in the long-term care world in California are desperate for accurate and timely information on the state budget process and the impact of the recent cuts on various programs serving the elderly. Although the general newspapers and news sites have some of this information, it takes searching and the articles are often general rather than containing the specific information (and dare I say it – gossip) that we crave. That is where the California Healthline app comes in. California Healthline is published by the California Healthcare Foundation. [California Healthline](#) itself is a website that is updated frequently and one can follow them on Twitter or Facebook, or your favorite RSS newsreader (more on those in a future article) but I prefer their app. It's currently available for the [iPhone and iPad](#). It allows you to store recent news content directly on your device for offline reading, for times you are off the internet, so you can even read it on an airplane. The app is free of charge and free of advertisements. I haven't noticed any particular evident problems with interpretation of news, but of course your mileage may vary. I hope it soon becomes available for other platforms, particularly the fast growing Android platform.

What about medical news? I'm sure we each have our favorites, and I'll share mine. For me, it's easy to decide which apps I use the most – they find their way to the first page on my phone and iPad. **Medscape** seems to always reside there. It has many functions helpful for medical use, but today I am talking about the “news” function. Medscape has a “Medscape Today” function reached by clicking on “news”, which brings you to news from several wire services as well as Medscape's parent company, WebMD. Medscape is available for [iPhone, iPad, Blackberry, and Android](#). Once you have it – explore the rest of the app as well. You will be amazed at all the useful information it has. There are more than 4000 clinical reference articles, available off-line. There is access to more than 2500 medical images and 150 videos. It essentially serves as a portable textbook. You can be stranded on a ski lift for 10 hours and end up knowing more medicine than your old chief of service. It also serves as an excellent drug reference, much like Epocrates. It has good coverage of herbal treatments and vitamins as well. It has a nice drug interaction checker. I am not sure why, but Epocrates is behind the times in supporting the iPad's screen resolution, and I find myself using Medscape instead most of the time.

Speaking of Epocrates, one of the initial developers of Epocrates has a new app that I have been having fun with. It is called **Doximity**, and it's available for [iPhone and Android](#) so far. It is free, and after signing up it almost magically (or perhaps symptomatic of the loss of privacy associated with a career in medicine) it finds all the folks you went to medical school and the folks you trained with in residency. Find out what specialties they chose, and where they are living. See if any have addresses in jails or prisons. You can download their contact information and set the ones you liked as “colleagues”. Add you consultant network as colleagues, and you can send them encrypted e-mail. It also let's you look up physicians by specialty nearby or by zip code. Put “90210 plastic” in search and you will have a list of the more than 200 plastic surgeons in Beverly Hills. You can even do special searches like finding physicians that speak a certain language in a particular specialty. Telugu speaking cardiologists, anyone? It also has the phone numbers of medical students – handy for when you will be late to attending rounds. The app also finds and gives you phone numbers for your local hospitals, medical facilities and pharmacies. It starts with a map of your vicinity, and with a touch of a button you can identify all the 24-hour pharmacies and touch them to dial. For the other pharmacies it has their hours. Of course, this works for locations other than your local one as well. All-in-all, a very nice start for a relatively new app.

## Impact of an Enhanced Activity Program on the Utilization of Psychotropic Medication in a Nursing Home

by Smadar Gal, RN, Limor Ness, Paul Baron and Dan Osterweil, MD, FACP, CMD

with introduction by Jay Luxenberg, MD

originally posted March 2011

We live in very perilous financial times for long term care right now. Programs that we all feel contribute greatly to resident satisfaction and quality of life are threatened. Any evidence that would bolster support for programs like activities is worthwhile to consider. This article reports one facility's experience with an enhanced activity program.

Although not strictly blinded, the attending physicians who were responsible for the gradual dose reduction process we are all used to under the OBRA regulations were apparently not actively aware of which residents were getting the enhanced activity. Therefore the association between this enhanced activity program and a decrement in anti-psychotic, anti-anxiety and hypnotic drug use is very interesting.

This quality improvement study is exactly the kind of information worthy of sharing with other facilities, and we are very glad that the authors agreed to share it with our membership. QI studies are not held to the same standards as peer reviewed studies, and need to be interpreted with that in mind, but they are still extremely important to disseminate and discuss. QI

studies are often the raw material that prompts formal research studies, so we encourage all our members to consider writing up high quality QI studies such as this one and share them via the *Wave*, our monthly e-newsletter!

To read the full article, please [click here](#).

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## Face-to-Face: The Rule, the Benefit, and the Opportunity

by Deborah I. Wolff-Baker, MSN, CHPN, FNP-BC

originally posted March 2011

**Background:** The Affordable Care Act (ACA) signed on March 23, 2010 put in place health insurance reforms intended to unfold over four years and beyond, with most changes taking place by 2014. ACA mandated changes coming April 1st, 2011 will affect the way Physicians refer patients receiving either Home Health or Hospice services: In order to implement the changes mandated by the ACA, CMS has created a Final Rule requiring Face-to-Face Encounters with patients prior to Home Health Certification and for Hospice re-certifications beyond 180 days. This article summarizes the major points of this new legislation.

**The Rule for Home Health:** A Physician must have seen a patient being referred to a Home Health Agency (HHA) within 90 days prior to the referral for the condition which he or she is being referred. Additionally, the Physician must certify that the patient is homebound. When it is not possible for the encounter to occur prior to the Home Health referral, it must occur within 30 days after the patient is admitted to a HHA. This requirement means to ensure that a referral is based on the Physician's current knowledge of the patient's condition.

**Who May Perform a Face-to-Face Visit for Home Health?:** A Nurse Practitioner or Physician Assistant may perform the Face-to-Face visit if she (or he) is working in collaboration with the Physician signing the POT (485), and may not be employed by the HHA for such a purpose. If a patient needs a HH referral in conjunction with a hospital discharge, a Hospitalist may sign the attestation that the Face-to-Face Encounter occurred and hand-off the patient to the community Physician. In Rural Areas, specified certified Tele-Health sites may also provide the Face to Face Encounter.

**What is Required?:** An Attestation of the Face-to-Face visit must accompany each Home Health Start of Care (SOC) when billed to Medicare as a condition of payment. Most HHAs have recently developed Attestation forms to accompany patient referrals. Required information for a Face-to-Face Encounter includes: the date when the Physician, NP, or PA saw the patient, along with a brief narrative that describes the clinical condition supporting the patient's homebound status and the need for specific skilled services. This must be in writing, signed by the provider performing the visit and the Physician. This document will accompany the 485 which the Physician must sign.

**The Rule for Hospice:** Hospice Face-to-Face provisions are somewhat different from HH requirements. No Face-to-Face encounter is required on admission to the benefit, but it does require that a Hospice Physician or Nurse Practitioner have a Face-to-Face encounter with a Medicare beneficiary enrolled in Hospice prior to their 180-day recertification (3rd lifetime benefit period) and for each 60-day recertification period after that. If a patient is being admitted into their third or greater benefit period, a Face to Face visit will need to be made prior to admission.

**Who May Perform a Face-to-Face Visit for Hospice?:** Given the differences between Home Health Face to Face and Hospice Face to Face requirements, it is important to understand who is eligible to make a Hospice Face to Face visit. The Final Rule clearly states that the Physician must be either employed by or contracted with the Hospice Agency. An NP must either volunteer or receive a W-2 form from the Agency as an employee. NP's may not be contracted with the Agency for this purpose, although may be hired per diem. A patient's Attending Physician may not make the Face-to-Face visit.

**What is Required?:** During the Hospice Face to Face visit, meaningful metrics must be applied to demonstrate that a patient remains eligible for the benefit based on a continued decline in function and a terminal diagnosis. Per the requirements, this visit must be made and a written narrative submitted up to 30 days prior to the re-certification date by the Hospice Physician. These visits may be performed in a convenient place for the patient such as a home visit or can be performed in an office setting if it is safe for the patient to travel.

**The Advantages of this New Legislation:** The CMS mandated changes may add an additional step to the HH referral process, but ultimately these required Face-to-Face encounters have the potential to improve patient care by ensuring that those who receive services are homebound, have skilled needs, and have been referred appropriately. Other potential benefits may include improved coordination between the Physician and HH agencies resulting in improved patient outcomes and an overall cost savings to Medicare. The same is true for Hospice. While the Hospice agency will not see additional Medicare reimbursement for the Face to Face visit, unless other medically necessary care is rendered at the same time, the potential for enhanced coordination of care as well as patient and family satisfaction may ultimately pay for itself.

**Challenges and Opportunities:** Given these referral rules with the narrow conditions under which patients may receive

services in their home setting, more patients with chronic illness and multiple co-morbid conditions will be considered inappropriate for either Home Health or Hospice care for the long term. Their complex needs will continue to grow and unless programs of Chronic Disease Management are put into place will remain under-served.

To download a sample **Face-to-Face Encounter Documentation** form, [click here](#).

#### REFERENCES

[http://www.cms.gov/HomeHealthPPS/Downloads/HH\\_Face\\_to\\_Face\\_heads\\_up\\_notice.pdf](http://www.cms.gov/HomeHealthPPS/Downloads/HH_Face_to_Face_heads_up_notice.pdf)

<http://www.cms.gov/center/hha.asp>

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Federal Register: November 17, 2010. Volume 75 (221) Rules and Regulations.

Retrieved February 20, 2011 from <http://edocket.access.gpo.gov/2010/2010-27778.htm>

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## INTERACT<sup>II</sup> Workshop Takes Us Northbound

by Flora Brahmhatt, PharmD, CGP

originally posted March 2011



CALTCM is proud to announce another successful INTERACT<sup>II</sup> event! On February 25, 27 facility teams and 10 faculty facilitators actively participated in **Interventions to Reduce Acute Care Transfers: A Practice Improvement Workshop** at the Claremont Hotel Club & Spa in Berkeley, California. The day was filled with interdisciplinary participation on how best to provide patient care.

The INTERACT program helps early identification of resident change in condition, guide team members through a comprehensive assessment which helps to improve documentation and enhance communication between team members.

In addition to this highly-prescribed and *sold out* event, the weekend also included a key stakeholders meeting on Performance Improvement Efforts (PIE). Later, the CALTCM Executive Board of Directors convened for their mid-year meeting. Overall, the weekend was a tremendous success! CALTCM looks forward to having more programs in Northern California!

## Medical Treatments of Unintentional Weight Loss in Long-Term Care: Including Current Issues Surrounding the Role of Medical Marijuana in Nursing Homes

by John H. Fullerton, MD, CMD, FACP, AGSF, FAAHPM et al

originally posted February 2011

From the days of “Reefer Madness” until the timing of Proposition 19 with the “Legalization of Marijuana Initiative” on the ballot last November, the controversies swirling around not only the recreational use, but also the medical use of marijuana, particularly in frail, elderly geriatric patients with clinically significant weight loss (and cachexia), has been fraught with controversy. Even though the ballot initiative from 2010 went down in defeat on November 2, 2010, rumblings of some of the authors bringing another more “targeted” CA initiative in 2012 are regaining momentum.

It is therefore incumbent upon long-term care (LTC) facility medical directors, practitioners and our IDT colleagues—who care for our frail elders in our states’s post-acute facilities—to understand the clinical, legal, and ethical ramifications of the commonly encountered medical “uses” of marijuana (including the synthetic derivative-Dronabinol).

In the summer of 2010, the California Society of Addiction Medicine (CSAM) went a long way toward assisting both clinicians and CA voters in both their understanding of the latest scientific evidence concerning CSAM’s Position on the role of “Medical Marijuana” as well as the “Medical Aspects of Cannabis Legislation” prior to the November state elections re: the vote on state-wide legalization (labeled: “The Regulate, Control, & Tax Act of 2010”).

To read full article, please [click here](#).

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## DPH Tightens Rule on Informed Consent: New Policy on Title 22, Section 72528(c)

by Flora Brahmhatt, PharmD, CGP

originally posted February 2011

Effective immediately, under California Code of Regulations, Title 22, Section 72528(c), all skilled-nursing facilities must verify that a resident’s health record contains documentation that informed consent had been obtained for the administration of psychotherapeutic drugs, physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function.

On January 3, the Department of Public Health issued a memorandum to all district managers and administrators directing that surveyors begin reviewing policies, procedures and records to ensure that the new policy is being followed by SNFs. The announcement marks a departure from the previous interpretation of Section 72528(c). Historically, a resident’s medical record was required only to contain documentation that the drug, restraint or device had been initiated prior to admission to the SNF.

To be in full compliance with the regulation, DPH suggests that SNFs:

- Obtain documentation that informed consent had been obtained for the proposed therapy and is in the patient’s medical record.
- Obtain new informed consent as described in Section 72528(c) and place the informed consent documentation in the patient’s medical record.

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## CALTCM Member Highlight: Phillips to Join AAHSA as Senior Vice President for Advocacy

originally posted February 2011



**Cheryl Phillips, MD** will join the American Association of Homes and Services for the Aging (AAHSA) – soon to become LeadingAge – as its new senior vice president for advocacy, AAHSA President & CEO Larry Minnix announced on January 12, 2011. In her new role, she will oversee the organization’s public policy development, government relations and advocacy efforts to benefit AAHSA/LeadingAge’s not-for-profit members and the people they serve. Phillips will officially start on May 1.

Dr. Phillips currently serves as chief medical officer for On Lok Lifeways, the country’s first Program of All-Inclusive Care for the Elderly (PACE) program. In this role, she provides medical leadership for On Lok’s five corporations and is responsible for medical policy and overseeing all medical affairs and clinical functions for both employed and contracted medical providers.

Previously, she served as the chief medical officer for Sutter Select and Medical Director, Chronic Disease Management,

for the Sutter Health System. Sutter Health System is a network of doctors, hospitals and other health providers who serve more than 100 communities in Northern California.

“As AAHSA becomes LeadingAge, we recognize that we need leadership to help our members understand the transdisciplinary perspective of serving the needs of the senior population and helping our members develop broader community-wide approaches for long-term services and supports. Cheryl Phillips is the perfect leader to join us on this journey of expanding the world of possibilities for aging,” Minnix said. “She is ideally talented, experienced and motivated to help us advance that mission.”

Dr. Phillips is currently the chair of the board of directors and immediate past –president of the American Geriatrics Society. She is also past president of the American Medical Directors Association, the physician organization for long-term care. She has served on the California Commission on Aging, as a delegate to the White House Conference on Aging, and a Primary Care Public Policy Fellow at the U.S. Department of Health and Human Services. Dr. Phillips’ post-graduate training includes a family practice residency and geriatrics fellowship at the University of California, Davis Medical Center. She was awarded her doctorate from Loma Linda School of Medicine, Loma Linda, California, and her bachelor’s degree in Biology from the University of the Pacific in Stockton, California. Dr. Phillips’ certifications include American Board of Family Practice, Certificate of Added Qualifications in Geriatrics, and Diplomate of National Board of Medical Examiners.

“Throughout my career in geriatrics and aging services, AAHSA has been to me a beacon of leadership, a leading voice of advocacy and a source of education, tools and resources,” Phillips said. “To join this remarkable organization is humbling. With the amazing network of not-for-profit organizations offering the range of aging services and the leaders and staff of AAHSA as it becomes LeadingAge, we are well on our way to changing the story of aging in America.”

“Dr. Phillips has been a very strong contributor to our senior team at On Lok, and we will surely miss her,” said Robert Edmondson, CEO of On Lok, which was the originator of the PACE model of care for frail seniors. “However, her new role will certainly benefit PACE nationally, and she will continue her mission as a champion for all seniors who will benefit from her visionary leadership.”

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## Technology Report: New Apps Lend Helping Hand to LTC Physicians

by Jay Luxenberg, MD, CMD

originally posted February 2011

As I watched group of attending physicians at work while they were admitting patients to our nursing home, I was struck by how often they were consulting their smart phones, iPads or laptops. In particular, smart phones seem to be the most commonly used resource. This year, CALTCM intends to highlight some of the technological tools, particularly “apps”, which facilitate better care for long-term care residents. As an Apple addict, I have to admit that my own familiarity is with Mac applications, iPhone and iPad apps. I’d love to hear of your own experience with other platforms.

Perhaps the best place to start when considering medical apps is a web site devoted to reviewing them.

[iMedicalApps.com](#) gathers reviews from medical professionals, including medical students, and I have found it a useful tool in identifying those apps that are truly useful while eliminating lots of the junk that is out there. They are platform agnostic, so there are plenty of Android and Windows Phone app reviews as well as iOS (Apple’s operating system for phones). They periodically issue useful lists such as the top 10 free iPhone medical apps.

I also think it is very important to think about apps that are not specifically medical, but make life in long term care medicine much easier. I am a big fan of [Evernote](#). Evernote is a program which runs on Macs, Windows, and Linux. There are versions that run on the iPhone, iPad, Blackberry, Android, and others. In fact, they tout that they are available for “nearly every computer, phone and mobile device.” What it is is a way to sync notes, pictures and sound files between your computer and your mobile device, while keeping copies “in the cloud” where you can access them from any computer you happen to be at. What good is this from a medical standpoint? Simply, I keep copies of all the state and federal regulations that we live and die by, I keep all the little tables and algorithms and lists that I find useful for differential diagnosis, etc. I keep information I need about the CCRCs and RCFEs and hospitals that I need to have handy. I keep copies of forms like the POLST, and scales like the GDS, and key papers, all as pdfs. I can then e-mail them to students or colleagues when they come up in conversation. I keep scans of my Passport and itinerary when I travel for meetings. I put in handouts, such as the pdf AMDA now uses instead of paper handouts at the national meeting. I put in the manual for the phone system at work, and “how to” instructions for tasks for our electronic health record system. I put in the manuals for my camera and all the other gadgets I use. I put in the budget categories I need in my role as an administrator. I put in ICD9 codes and E&M codes. I put in driving and bus directions to our facility from the university, so I can save time instructing students how to get there. I know of others that even record Grand Rounds on their cell phone, to play it back at their convenience. It also handles pictures, so I can snap a picture using my phone of a poster at a meeting and have it available when I get back to work.

Did I mention [Shared Notebooks](#)? Even with a free Evernote account, you can set up a notebook to share. There is a core group at our nursing home that is working on end-of-life care issues. We set up a shared notebook with shared resources like Joanne Lynn’s Sourcebook, the Handbook for Mortals, the Stanford End-of-Life Care Curriculum, a RAND

Heath White Paper, POLST forms in every language available, and lots more. I share it with a limited number of coworkers, but one could also share with the whole world. Paying customers can also allow their shared notebooks to be modified by any of the people sharing it. Think how useful it would be to have policies and procedures available, or protocols for informing the physician about changes of condition, similar to the AMDA "know-it-all"™ cards, but customized per each physicians preference. How cool.

You probably get it now – I use Evernote as a portable brain. I can clip a web page or put a note into my cell phone, and using the magic of "The cloud" it will be available wherever I am. I can organize these files, and share subsets with different teams at work, or different groups of friends and family. Best of all, unless you are a particularly heavy user, it is free! Of course, I am a heavy user, but the annual price for storing huge quantities of data is very modest.

In upcoming editions of the *Wave*, we plan to highlight many useful apps, and I would love to hear from you if you have a particular favorite. E-mail me at: [jay@luxenberg.net](mailto:jay@luxenberg.net)

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## Physician & Facility Pay Linked to Patient Satisfaction

by Timothy Gieseke, MD, CMD

originally posted December 2010

In 2006, Congress authorized CMS to develop a plan for value based payment for Medicare hospitals in 2009. The areas assessed include not only the traditional performance areas of CHF, pneumonia, and myocardial infarctions, but also includes **patient satisfaction**.

The assessment tool is called Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS). In 2012, hospitals with a composite score on 10 measures below the 50th percentile will receive less reimbursement. With the strong incentives in health care reform for aligning incentives of hospital medical staff, experts predict that any reduction in payments will also result in reduction in payments for physicians.

While this accountability system is not yet targeted at the Long Term Care setting, the current incentives for financial integration of acute and Long Term Care through Accountable Care Organizations (ACO) suggest those of us in LTC should also focus on consumer satisfaction.

### The ten composite measures are:

1. Willingness to recommend
2. Communication with nurses
3. Communication with doctors
4. Communication about medicines
5. Responsiveness of the staff
6. Discharge information
7. Pain management
8. Cleanliness of the hospital environment
9. Quietness of the hospital environment
10. Overall rating

### The physician-specific questions are:

1. During this hospital stay, how often did doctors treat you with courtesy and respect?
2. During this hospital stay, how often did doctors listen carefully to you?
3. During this hospital stay, how often did doctors explain things in a way you could understand?

This data is specific to physicians and specific units within hospital systems, allowing Administrators and Medical Directors to identify problem areas. While the threat of payment reductions is unpleasant, this evolving area is another reason for us to stay focused on improving our patients experience of care and to do so in a comprehensive systematic way that involves our medical staff.

CALTCM is committed to providing tools and education to support these efforts. Please plan to attend our 35th Annual Meeting on July 15 - 16, 2011.

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## For CALTCM Members Only

by Barbara Hulz

originally posted December 2010

We are pleased to announce that the [Members Only](#) section of the CALTCM website has officially launched! This new section is a secure online database, which is completely integrated and provides extensive tools to better serve you.



Our new, innovative database will allow you to manage your profile, pay your membership dues, register for upcoming events, participate in message boards and submit calendar events. In addition, all transaction records and messages will be archived within your personal profile for convenient access. Soon you will see additional resources like free CME opportunities and exclusive networking opportunities in Northern and Southern California in January 2011.

***Don't miss out on this exciting channel and update your profile today!***

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## **So, You're Thinking About a Poster?**

*by Rebecca Ferrini, MD, CMD*

*originally posted November 2010*

The annual CALTCM conference is a great opportunity to do something new and different—present a poster on something your facility has done to improve quality. The following gives you some ideas and some guidelines on submitting, developing, laying out and presenting a poster at a meeting of your colleagues.

### **What To Write About**

In long term care we are operating with thin margins and constant, unrelenting work with frequent crises to liven things up. We are constantly improving, but many times, rather than celebrate an improvement, we just move to the next problem. Making a poster is about reflecting on what you have done better, documenting what you did and why it made it better, and publicizing that to an audience of people who are also interested in making things better.

So what can you write about? What have you done new? Have you tried a new product? A new form? A new educational technique? Have you had a problem that you addressed and the solution worked? Implemented a new policy? Changed your practice? Have you changed mealtimes, medication distribution, added some new activities? Reduced deficiencies or improved a MDS quality indicator? Think—what is different in my facility now compared to six months ago? Did you ever try something on one unit and something different on another and compared which one worked better? You might look in long-term care journals—have you ever looked at something published and said—“hey, we did that, too!” or thought that you had a better solution? The difference between them and you is that they published what they did and got publicity and began to be looked at as experts—and you did something great that no one knows about. Looking at your facility, comparing it to others, and looking at the literature are all places to get great ideas about what to do with a poster.

### **What About Data?**

Data collection is one of the big struggles—it takes time to get it and to analyze it, and it is very easy to spend a lot of time collecting data that is not meaningful. Collecting data is usually not the problem, it is the thinking part—what should I collect and how should I interpret it? Many times we work on a project to change or improve something without getting data—we just know it is a problem. One source of data we all have is the MDS—if you want to present something that has anything to do with information available on the MDS, this can be a good place to start. It's a good idea to get in the habit of collecting some data before you try something new, then after you do it, to see if the new strategy was any better. You can conduct a survey or an audit before and after, or you can make observations. In general, a sample size of at least 30 is the best. Let's say you have a new form for diabetic orders. You might then look at 30 diabetic orders before the form is put in place and measure a few things—how many times were these telephone orders rather than in-person orders? How many times was a clarification required? What percentage used sliding scale insulin? What was the average total insulin per day? How many fingersticks a month were ordered for each and what was the average? Then look at your diabetic monitoring--how many episodes of hypoglycemia (you have to define, how about below 60?) were identified in all those people in one month. How many measurements of blood sugar were taken total? How many blood sugar measurements were over 400? How many had HbA1c measurements taken within the last quarter (or six months)? What was the minimum, maximum and mean of HbA1c? How many minutes did it take to complete the form? How many minutes for each fingerstick? How many minutes to "manage" an episode of hypoglycemia? Then implement your form and do this same audit again--what changed? Notice this is a little different than saying: "the nurses liked the form." You would be surprised once you get the hang of it how easy it is to get the data, and how the data tells the story of what really happened. If you are not a person with a lot of experience in data, find someone who has a strength in that area to help you. If you can't find someone locally, e-mail me and I can help!

Another thing to consider is that not all important “data” may be reflected in numbers. Some issues may be important areas of staff training like patient dignity, spirituality, risk-management or privacy issues that reflect ways to avoid deficiencies or liabilities where we actually don't want numbers (i.e., zero deficiencies or areas of heightened liability is good). While these sort of things may be difficult to quantify and numbers may not be practical, sharing a good approach may be quite beneficial. In other words, if you don't have a lot of numbers, it still may be a good poster.

### **Writing It Up**

You have to be able to succinctly express what you did and how it was effective (that is the abstract) and then have enough data to expand on more (for the poster). Most abstracts include one sentence in each of the following categories, then the poster expounds more. The categories may vary, but they are similar to these, with some suggestions noted.

**Title:** Make it catchy, no colons, and have it summarize what you did.

**Introduction:** What the problem was and why you bothered to do something about it.

**Materials/Methods/Interventions:** What exactly did you do? How did you audit? What data did you extract, what steps were done to make this change—who was educated (how many people and how)? You may use a flow chart here.

**Results:** What did you find out? We had a 20 percent reduction in time for CNA to place briefs, we used 30% fewer briefs, we reduced the incidence of dehydration from 1 a month to one in 6 months. Staff reported a 20% improvement in morale, we went from 5 fingersticks a week per patient to 3 on average and reduced hypoglycemia events from 4/month per 30 patients to 0 for three months.

**Timeline:** What happened where?

**Barriers:** What got in your way of success and how were these barriers overcome?

**Conclusions:** Remind the reader of what was said and how it is important.

**Literature Cited:** Look for others who have studied the same thing and read what they did.

**Acknowledgments:** Thank individuals for specific contributions to project and if you have any potential conflicts of interest, mention it here.

**Further Information:** Provide your e-mail address, your web site address, and perhaps a URL where they can download a PDF version of the poster.

### Design

Once you are accepted to present, it is time to think about designing your poster. Many people find this the most daunting step because it is something many of us have never done before. First, relax—the poster was accepted and the information sharing is the most important thing. And the great thing is that there are templates which can guide you through the process. I like to use the templates in PowerPoint that already even have headings in them and have all the colors and margins and borders set up for you. Publisher also has templates to use. A humorous, but thorough article on making a poster is found at <http://www.swarthmore.edu/NatSci/cpurin1/posteradvice.htm>, which provides more detail than you need. But here are some highlights: Remember that the poster is meant to be read and digested quickly; people like to see if it relates to them and they like to skip to the main points. Each section can stand alone. The poster itself does not need an abstract (which saves you space). Lay it out so it is easy to read while standing up from 6 feet away. The templates often pre-set the font and column size which helps. Try to avoid shrinking the font to get more on the poster—less is more. Edit and have people look at it before you spend money to print it. The whole poster should have 800 words or less with maybe 11 words in a line/column and no more than 10 lines of text in a box. Embrace the white space and try to avoid crowding. Don't use colors that are too dark. When you have photos or clip art, watch out—because these often look very grainy when blown up. Avoid all caps or capitalizing the first words in a title—this is actually harder to read. When you are done laying it out, you can put it on a thumb drive and take it to a printing shop (e.g. Kinko's)—I find the poster costs \$150-200 to print on nice paper. Alternatively, if your budget is an issue, while not as “finished,” it is also possible to print your poster as a series of PowerPoint slides and paste or tack these to your display board.

### Target Audience

Think of the audience for your poster. The audience is mainly long-term care professionals, but will this target the physician, the nurse, the administrative team or perhaps the public, highlighting a great program? Might it be for your employees—to highlight and celebrate a success and build morale and professionalism? Knowing the audience will make a difference in the design, the text (for example, you often use more big words and diagnoses and such with a physician audience on a scientific paper than you would if the audience is the public where you would use less medical terminology or explain the words you do use).

### Presenting

Hang it up on foam board with thumbtacks, bring blue tape. Stand with your poster. Have business cards and a legal or letter size shrunken version of your poster or other handouts. Prepare a one to three sentence summary for those people who come up to the poster so you can say something quickly.

### What to do afterwards?

When you take your poster down, roll it up and put it back in the cardboard sheath, but when you get back to your facility, take it out again. Find a place to hang it. Many of these fit nicely on a hallway, where people who pass can read about the great things your facility is doing. If it happens to be a more controversial topic (say, for example, sex offenders in long term care), then the display site might be in a “staff-only” area. Look for other opportunities to show the poster—local meetings, for example. Make sure the presentation is on your resume and that the administrator or other “higher-ups” in your facility know you presented at a scientific meeting. And last but not least, begin to think—“*what can I do next year?!*”

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## New MDS 3.0 Implemented on October 1, 2010

*originally posted October 2010*

The revised MDS provides facilities with an opportunity to evaluate their care processes and approaches to many important clinical and quality of life areas. The revised MDS has content changes in many sections that aim to improve the clinical utility, reliability and validity of the assessment. Sections with significant clinical changes include the assessment of cognition and delirium (section C), assessment of mood (section D), behavior (section E), preferences for customary routine and activities (section F), balance (section G), bladder and bowel (section H), pain and falls (section J), swallowing and weight loss (section K) and pressure ulcer reporting (section M).

Dr. Debra Saliba, a member of the CALTCM Board of Directors, and Director of the UCLA/Jewish Homes Borun Center was the principal investigator for the development and national testing of the MDS 3.0. The research involved nursing home providers and experts from across the country and included a national test of the instrument in nursing homes. The recommended form took nursing home staff 45% less time to complete when compared to MDS 2.0 and included significant changes to most sections. Based on subsequent payment analyses, CMS made some modifications before posting a final form in October 2010. CMS has conducted national trainings for MDS 3.0 and provided trainings guides. Some training materials are available at:

[http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp)

Several sections in the new MDS 3.0 will rely on direct interview of residents. This change brings the resident's voice directly into the assessment and improves the accuracy and efficiency of the assessment. In national testing of MDS 3.0, nursing home staff asked for assistance in acquiring and improving their interview skills. A Borun Center team has produced the Video on Interviewing Vulnerable Elders (VIVE). This video explains the reasons for using direct interviews, describes national test that showed that 84% of residents could complete all of the interviews, shows nurses who tested the interviews, describes interview approaches that make completion easier and shows the cognitive, mood, preference and pain interviews in MDS 3.0. The Los Angeles Jewish Home, Veterans Administration and Motion Picture & Television Fund provided support for the video. This video is available for download from the [Picker Institute](#) and is also available for order from CMS.

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### C. *diff.* Guidelines Revised

*by Karl E. Steinberg, MD, CMD, Immediate Past President, CALTCM*

*Courtesy of Caring for the Ages | Original Piece by Miriam E. Tucker*

*originally posted October 2010*

A recently issued clinical practice guideline for the management of *Clostridium difficile* infection reflects the impact of a severe disease strain widely circulating in recent years.

The joint guideline from the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America recommends using vancomycin instead of metronidazole for treating severe disease (Infect. Control Hosp. Epidemiol. 2010 March 22 [doi:10.1086/651706]). They also address epidemiology, diagnosis, infection control, and environmental management, as well as treatment of *C. difficile* infection (CDI). The new document is a revision of a 1995 SHEA position paper.

The document defines a case of CDI by the presence of symptoms (usually diarrhea) and either a stool test that is positive for *C. difficile* toxins or toxigenic *C. difficile*, or colonoscopic or histopathologic findings that reveal pseudo-membranous colitis.

Testing of stool from asymptomatic patients is not recommended, including as a test of cure, nor is repeat testing of the same episode of diarrhea.

The panel's recommendation to use vancomycin instead of metronidazole is a key element of the new guideline, Dr. Fishman said. "In the past, the standard therapy for CDI has been metronidazole. But it has become apparent that, in cases of severe disease, it is more appropriate to use oral vancomycin. That is one of the major significant differences [from the 1995] guideline. However, Dr. Johnson noted, many hospitals continue to use metronidazole inappropriately for severe cases.

Severe CDI is defined as leukocytosis with a white blood cell count of at least 15,000 cells/mcL or a serum creatinine level at least 1.5 times the pre-morbid level. Mild or moderate CDI is considered to be leukocytosis below 15,000 cells/mL and serum creatinine less than 1.5 times the pre-morbid level. The document notes that the criteria for defining CDI severity are based on expert opinion and may need to be revised when prospectively validated severity scores are published.

The recommendation for an initial episode of mild to moderate CDI is 500 mg metronidazole orally 3 times per day for 10-

14 days. For an initial episode of severe CDI, vancomycin should be given in a dose of 125 mg orally 4 times a day for 10-14 days. Treatment of the first recurrence of CDI is usually with the same regimen as the initial episode but should be stratified by disease severity, as recommended for the initial episode. Metronidazole should not be used beyond the first recurrence of CDI or for long-term chronic therapy because of the potential for cumulative neurotoxicity.

The document addresses the most important infection control measures to implement during CDI outbreaks, including sections addressing measures for health care workers, patients, and visitors; environmental cleaning and disinfection; antimicrobial use restrictions; and the use of probiotics, which are not recommended because data on them are limited. Implementation of the guideline can be influenced by the size of the institution and by the resources—both financial and laboratory—that are available in the particular clinical setting, the document advises.

The guideline is available online at: [www.journals.uchicago.edu/doi/full/10.1086/651706](http://www.journals.uchicago.edu/doi/full/10.1086/651706)

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## CDPH Targets Medi-Cal Dementia Patients on Antipsychotics

by Karl E. Steinberg, MD, CMD, Immediate Past President, CALTCM

originally posted October 2010

CDPH and DHCS recently launched a collaborative effort that was piloted in the **Sacramento** district office beginning in May 2010, and is now being expanded to **Chico, Redwood Coast, Daly City, Fresno** and **San Diego** district offices. As of September 2010, five investigations have been completed, with the results of four other investigations pending. The CDPH goal is to expand the project statewide in 2011.

CALTCM encourages its members to be aware of this campaign, and to be sure in cases where such prescribing is medically necessary, that ample documentation and justification are present in the chart. We are grateful to CAHF for sharing the specific information below, pertaining to the enforcement of this effort. And while we strongly support the goal of stopping inappropriate prescribing of antipsychotics, I feel this approach may be a bit heavy-handed—perhaps as a response to Gov. Schwarzenegger's mandate, when he vetoed SB303 (which would have virtually criminalized use of antipsychotics in nursing homes except under very stringent circumstances), that CDPH address overprescribing of these medications in long-term care. Specifically, the notion that a resident who is stable and doing fine will be categorically considered a "complaint" just on the basis of medications that in many cases will be well-considered, medically necessary and appropriate, is a little bit frightening. What's more, when as part of the plan of correction, prescribers and facilities stop these medications, there is a strong probability that patients will suffer some behavioral and psychiatric decompensation.

The concept of "chemical restraint" has a deservedly negative ring, but when a patient is flailing and screaming—clearly in a great deal of psychic distress, perhaps because of frightening hallucinations—and medication helps them become calm and comfortable, it is difficult for me to state categorically that this is inappropriate treatment. In fact, if I were that patient—and probably if that patient himself were in his "right mind" and could look at the situation from outside—I believe we would readily ask for and be grateful for the medication. I do not consider that a chemical restraint, I consider it a kindness—primarily to the patient, but also to other residents, to the patient's family, and finally to staff. It is clear that the evidence does not support the use of antipsychotics for dementia with agitation on a large-scale basis, but it is also clear that there are some cases in which these medications clearly do help. There is also no question that these medications are dangerous and do carry increased risk of bad outcomes. Despite that, I believe sometimes they are useful and medically necessary and appropriate.

In discussing the impetus for this project, CDPH representatives shared their view that the Collaborative represented a "proactive approach" to achieving the goal of improving the quality of antipsychotic medication prescribing in SNFs and that the prescribing of such medications occurs at a frequency that has caused the CDPH to target this area for improvement.

### **TARGETED RESIDENTS**

The collaborative targets Medi-Cal beneficiaries who are skilled nursing residents and are currently prescribed either:

1. Two antipsychotic medications concurrently, or
2. One (or more) antipsychotic medication(s) with a primary diagnosis of Alzheimer's or dementia with or without a co-existing diagnosis of a significant mental illness (SMI).

Based on the above criteria, CDPH will:

- **Initiate a complaint visit** when a resident is receiving two antipsychotic medications concurrently, (regardless of diagnosis). A CDPH consultant pharmacist and district office surveyor will conduct the complaint visit. Relevant state regulations and statute will be reviewed in conducting the investigation and evaluating facility compliance.
- **Review and consider whether or not to initiate a complaint visit** when a resident with a primary diagnosis of Alzheimer's or dementia is receiving one or more antipsychotic medications with or without a co-existing diagnosis of SMI.

### **RELEVANT FINDINGS**

A total of nine complaint visits have been conducted as a result of this effort. Five of the complaint investigations have been completed with an average of 6 deficiencies being issued. The deficiencies cited related to; 1) consultant pharmacist services; 2) nursing services ( assessment and care planning); 3) use of outside resources; 4) resident rights and 5) informed consent. CDPH further indicated that informed consent issues related Title 22 requirements at Section 72528 and Health and Safety Code, Articles 1418.8 and 1418.9.

### **FACILITY CONSIDERATIONS**

- Review to identify any residents who meet the criteria for triggering a CDPH complaint visit.
- Evaluate any identified residents for significant change in status, injury or other clinical indications of possible antipsychotic medication untoward effect.
- Enlist the assistance of the pharmacy consultant and medical director in addressing any patterns of physician practice related to antipsychotic medication prescribing that may warrant further discussions with attending physicians. Consider strategies for sending messages to prescribers on FDA warnings related to antipsychotic medication use in the elderly.
- Review the facility's system for educating and alerting staff for possible untoward medication side effects when antipsychotic medications are concurrently prescribed and/or antipsychotic medications are prescribed for residents with a dementia diagnosis.
- Review the Informed Consent requirements in Title 22 Section 72528 et al and Health and Safety Code 1418.8 and 1418.9 and ensure facility policies and practices are in compliance with these provisions.

**CAHF staff contacts:** Mary Jann at (916) 441-6400, extension 227, [mjann@cahf.org](mailto:mjann@cahf.org) or Jocelyn Montgomery, extension 214, [jmontgomery@cahf.org](mailto:jmontgomery@cahf.org)

## **CALTCM Signs Onto AMDA Letter to DEA Concerning Controlled Substances in LTC**

*by Karl E. Steinberg, MD, CMD, CALTCM Immediate Past President*

*originally posted September 2010*

In August 2010, AMDA solicited responses from its members nationwide, with respect to problems with the DEA policy interpretation that now (since 2009) requires direct contact between the prescriber and the pharmacist before controlled substances can be provided to skilled nursing facility residents. Not surprisingly, AMDA members—including medical directors and attending physicians—overwhelmingly oppose the strict interpretation of the regulations. Because the nursing facility nurse is not recognized by the DEA as functioning in a role of the prescriber's "agent," there are additional steps now required in obtaining necessary medication for our patients—and virtually all of us have witnessed the direct, unfortunate and in some cases devastating effects of the delays caused by this policy. For example, many respondents indicated that they had sent patients back to the hospital because they were unable to get pain relief, in turn because of this unfortunate new policy.

Along with members of our Policy & Professional Services Committee and other CALTCM leaders, I assisted in finalizing the AMDA letter that was sent to the DEA and Department of Justice in response to their request for feedback from LTC providers. With the approval of CALTCM President Dan Osterweil MD CMD, CALTCM endorsed the content of this letter. Attached below is the full text of the AMDA letter to the DEA, including the results of the survey sent to AMDA membership. We are hopeful that some good will come of this, but there are no guarantees. Other considerations on the table to remedy this problem include a federal legislative fix, which Sen. Herb Kohl is likely to sponsor, and a state-by-state option to reclassify SNFs as hospitals, in which case the nurse does not have to be the "agent" of the prescriber. However, many organizations oppose the latter option.

One thing is for sure: It is a shame that our patients are the ones who are suffering because of this wrongheaded policy interpretation, and whatever the solution is, it can't come too soon in my opinion.

To view a copy of AMDA's letter to the DEA, please [click here](#).

## **What Does Moral Judgment Have To Do With It?**

*originally posted September 2010*

Terry Hill, MD, CMD, CALTCM Board member and Past President, published a review in July that begins as follows:

*In 1926 Francis Peabody ended his most celebrated lecture with the oft-repeated conclusion, "the secret of caring for the patient is caring for the patient." It's a compelling line, resonant with wisdom and common sense, but it begs an obvious question. What if I don't care for the patient? In particular, what if my reaction to the patient is negative, perhaps intensely so, driven by social and/or moral disapproval?*

It turns out that while clinicians are familiar with such situations, healthcare educators and researchers have paid little attention. Some clinicians seem to manage these situations better than others, but we don't know the internal resources or external factors that help them achieve workable relationships.

By bringing together research findings from sociology, social psychology and neuroscience, Dr. Hill was able to sketch the dynamics that seem to be in play. Clinicians' curiosity and their sense of effectiveness appear to mitigate the effects of negative appraisals. If you're curious to learn more, the article entitled, ***How Clinicians Make (Or Avoid) Moral Judgements of Patients: Implications of the Evidence For Relationships and Research***, can be found online in the open-access journal, Philosophy, Ethics, and Humanities in Medicine at: [www.peh-med.com](http://www.peh-med.com)

To view a copy of the full article, please [click here](#).

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## **Article Review: Anemia in Older Persons<sup>1</sup>**

*by J. Frank Randolph, MD, CMD*

*originally posted September 2010*

This article is concise, offers paradigms for diagnosis, and takes a stand on treatment. It is well referenced. Take a look at the treatment recommendations. If you disagree, read the article and check the references. Based upon my experience in reviewing the average anemia work-up and treatment strategy, our profession could use some consensus.

The article points out that more than 10 percent of persons older than 65 years are anemic, using the World Health Organization definition of anemia (hemoglobin less than 13 g per dL in men/12 g per dL in women). The prevalence approaches 50 percent in patients living in nursing homes. There is increasing evidence that even mild anemia is associated with increased morbidity and mortality. Anemia warrants evaluation in all older persons, except those at the end of life or who decline interventions. About one third of persons have anemia secondary to a nutritional deficiency, one third have anemia caused by chronic inflammation or chronic kidney disease, and one third have unexplained anemia.

Nutritional anemia is effectively treated with vitamin or iron replacement. Iron deficiency anemia often is caused by gastrointestinal bleeding and requires further investigation in most patients. For iron deficiency anemia, the usual replacement dose is ferrous sulfate, 325 mg (65 mg of elemental iron) per day, or ferrous gluconate, 325 mg (38 mg of elemental iron) per day. Low-dose iron therapy, with 15 mg of elemental iron per day as liquid ferrous gluconate, effectively corrects hemoglobin and ferritin concentrations with fewer gastrointestinal adverse effects than higher iron doses. Treatment is usually continued for six months to replete iron stores. They recommend high-dose oral therapy (cyanocobalamin, 1 to 2 mg per day) to treat vitamin B12 deficiency, and treatment of folate deficiency with folic acid, 1 mg per day. Effective treatment of nutritional anemia is noted by reticulocytosis within one week, followed by a more gradual increase in hemoglobin level.

Anemia of chronic inflammation or chronic kidney disease may respond to treatment of the underlying disease and selective use of erythropoiesis-stimulating agents. The authors note that for most persons with anemia of chronic disease or unexplained anemia, there is little evidence that correcting the hemoglobin level decreases morbidity and mortality, or improves quality of life. In these patients, anemia may be a marker of frailty and physiologic decline. They suggest limiting erythropoiesis-stimulating agents to the treatment of severe anemia associated with chronic kidney disease and other approved indications, unless patients are part of clinical trials to evaluate erythropoiesis-stimulating agents.

Occasionally, anemia may be caused by autoimmune hemolytic anemia, malignancy, or myelodysplastic syndrome. Newer treatment modalities for myelodysplastic syndrome and multiple myeloma may prove beneficial regardless of patient age. Hematology consultation should be obtained if treatment is desired.

<sup>1</sup>*Bross MH et al: Am Fam Physician. 2010 Sep 1;82(5):480-487*

To view a copy of the full article, please [click here](#).

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## **Action: Response Requested on DEA Notice, Solicitation of Information**

*by Kathleen M. Wilson, AMDA Director of Government Affairs*

*originally posted August 2010*

On June 29, 2010, the Drug Enforcement Administration (DEA) issued a Notice seeking comments from the public to help determine whether any further revisions to the DEA regulations on controlled substances in long-term care are feasible and

warranted. Specifically, the DEA solicitation contains a series of questions on issues ranging from communication between practitioners to the use of chart orders to the number of facilities a medical director serves. AMDA has reviewed the Notice and selected those questions that are most relevant to physician practice. [Read more](#)

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## UPDATE: Presentations now posted and ready for download

### CALTCM Goes Green!

*last updated July 2010*

Our **36th Annual Meeting: *Creating a Culture of Patient Safety***, is rapidly approaching. As an added incentive to our membership and program participants, we have elected to post all CME/CEU/CE presentations [here](#) in a downloadable PDF format. CALTCM's decision to "Go Green" was primarily spurred by our ongoing effort to be an environmentally conscious organization. Secondly, by keep our printing and material costs down, CALTCM is able to pass along the savings to our membership and program participants by continuing to offer low and affordable registration rates. [Read more](#)

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## Hot Topics Abound at Annual Meeting

*originally posted July 2010*

July 16-18 marks CALTCM's 36th annual symposium and membership meeting, returning to the beautiful Omni Hotel in Los Angeles this year. The meeting, entitled "Creating a Culture of Patient Safety," kicks off with an exciting new pre-conference workshop (seating limited, with additional attendance fee) featuring the INTERACT-II tools pioneered by renowned geriatrician Joseph Ouslander, MD and his team. These tools are designed to improve nursing assessment and early detection of changes in condition, and hence to reduce unnecessary re-hospitalizations—a topic sure to carry increasing importance as "bundling" of post-acute hospital care seems inevitable. The INTERACT-II tools are available online at no cost at: <http://interact.geri.u.org>. Many other nationally renowned presenters are sharing their expertise with attendees. [Read more](#)

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## Opportunities to Improve Pain Management in LTC

*originally posted July 2010*

CALTCM's **36th Annual Meeting: *Creating a Culture of Patient Safety*** will provide an opportunity to critically assess your facility's program for pain—recognition, assessment, interventions, and monitoring. The new CMS quality of life surveyor guidelines at F-Tag 309 expect significant improvement in this area. Dr. Solomon Liao, UCI's Director of Palliative Care Services, will present "Preparing for Optimal Pain Management".

In addition, our own Dr. Debra Bakerjian recently gave a wonderful webinar on this subject for our State's Advancing Excellence Campaign. Please visit: [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org) and look under resources for their webinar on pain. The [www.geriatricpain.org](http://www.geriatricpain.org) web site has free evidence-based tools designed for improving facility pain performance. Finally, the new AMDA Clinical Practice Guideline on pain (available for purchase at [www.amda.com](http://www.amda.com)) is an excellent general resource and has helpful information addressing situations where pain management is particularly difficult.

Come help us improve LTC in our state.

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## CALTCM Annual Meeting: The Pharmacist Perspective

*originally posted July 2010*

*"CALTCM's educational content is superb and very applicable to the pharmacist's perspective."*

– **Moje Moradi, PharmD, CGP, FASCP**

Immediate Past-President, American Society of Consultant Pharmacists  
2009 Annual Meeting Participant

Education and appropriateness to long term care is something we focus on at our upcoming 36th Annual Meeting: *Creating a Culture of Patient Safety*. This year we present a dynamic group of speakers—most specifically, Loriann De Martini, PharmD, CGP from the California Department of Public Health's Center for Health Care Quality Licensing & Certification Program.

We have an exciting panel discussion featuring Dr. De Martini, and our very own Drs. James Mittelberger, MD, MPH, CMD, FACP (moderator) and Flora Brahmbhatt, PharmD, CGP (consultant pharmacist). Although all participants will gain something from this discussion, we are most excited for the pharmacists' response. We hope to generate an exciting dialogue with Dr. De Martini and allow clarification in current issues with regard to the survey process.

We hope to see you all there in a few short weeks!

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## Reducing the Likelihood of Long-Stay Nursing Facility Placement Through Health Plan-Linked Community Services

*originally posted June 2010*

When I mention to people that I work full time in a nursing home, I often see reflected on their faces a measure of the distaste that society has for nursing homes. I suspect tax collectors experience a similar phenomenon. *JAMDA (June 2010)*  
[Read more](#)

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## CALTCM Steps Up Collaboration With CAHF

*originally posted June 2010*

Within the past year, we at CALTCM have forged an expanding alliance with the California Association of Health Facilities (CAHF) to work together on several areas of mutual concern. CAHF is a large non-profit organization that represents about 700 of the 1200 skilled nursing facilities in California, and has strong advocacy and educational arms. [Read more](#)

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## Do Not Disturb: Passing Medications!

*originally posted June 2010*



Like many nursing homes, Edgemoor has a complicated medication pass system. Observations of the nurses passing medications showed that they are sometimes struggling to finish in the time allotted, and are interrupted as much as 300 times an hour. Every time they are interrupted, it takes a few seconds to get back on track; there is a loss of concentration, a need to start over, or a risk of making mistakes. [Read more](#)

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## Renowned Pharmacist DeMartini is Confirmed to Speak at the Annual Meeting!

*originally posted May 2010*

CALTCM is excited to announce we will have Dr. LoriAnn DeMartini, Pharm.D, Chief Pharmaceutical Consultant with the California Department of Public Health, as speaker at our annual meeting in July.

Dr. DeMartini, along with Drs. James Mittelberger and Flora Brahmhatt , will be presenting cases in a joint format that will explore issues that are relevant to current practice. Examples include psychotropic use as well as assessing for opioid tolerance prior to starting medications such as the fentanyl patch. Please check back on our website for updates on sample cases and tools for this extraordinary, one-of-a-kind presentation.

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## Care Transitions

*originally posted May 2010*

Qualitative studies have shown that patients are inadequately prepared for moving to the next setting of care. They receive conflicting advice for illness management. They get frustrated at the inability to reach the right practitioner. There needs to be a shift in the perspective from patient discharge “out of sight, out of mind” to patient transfer with continuous management. In the past there had not been a financial incentive for this but with Medicare’s anticipated bundling of the Part A rehabilitation benefit with acute-care hospital payments this will change. [Read more](#)



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## **Antipsychotics: Less is More** - An Interdisciplinary Team Approach to Appropriate Prescription, Monitoring and Reduction of Antipsychotics in Skilled Nursing Facilities

*originally posted in May 2010*

Overutilization of antipsychotic drugs continues to be an issue both nationally and internationally. The prescribing of these drugs by physicians in the long term care setting seems to be more based in cultural habit than sound clinical/scientific practice. [Read more](#)

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