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Keynoter Puts Patient Pleasure First

BY JOANNE KALDY

I n a recent New York Times editorial (“Too Young to Die, Too Old to Worry,” Sept. 20, 2014), author, educator, and physician Jason Karlawish, MD, presented a thought-provoking question: “When should we set aside a life lived for the future, and instead embrace the pleasures of the present?” He then offered an interesting idea: “A national investment in communities and services that improve the quality of our aging lives might help us to achieve this. Instead of Death Panels, we can start talking about Pleasure Panels.” Dr. Karlawish, who will present Friday’s keynote address at the 2015 AMDA annual conference in March, told Caring for the Ages: “This issue is significant for long-term care practitioners, as they are on the front line with patients who face multiple risks while considering the lingering question of how much time they have left.”

The issue of prognosis — what is to be gained or lost depending on various interventions and treatments — “looms large” for geriatrics practitioners, Dr. Karlawish observed. “How to talk about the many risks patients face is a necessary skill.” Practitioners, he suggested, need to be able to juggle truth, hope, and kindness at the same time.

There is no script for a successful conversation. However, Dr. Karlawish starts with a simple question: What’s a typical day for you? “Much can be gained from the answer to this. You can use this information as concrete data to understand what works and what doesn’t work for patients and what you can do to improve their quality of life,” he said. For example, “if they tell you that their days are filled with doctors’ appointments, this presents an opportunity to find a way to free more of their time for activities they enjoy.”

Dr. Karlawish asks family members this question even when a patient has advanced dementia. “This is a good way to focus on what is pleasant for the patient,” he said. For example, a family member may say, “Dad wouldn’t want to be in adult day care and listen to music or do arts and crafts all day.” However, as the practitioner talks with the family, he or she can help them realize that dad has changed as he’s become more ill, and he might enjoy those things now.

“We need to focus on what gives pleasure now in the present,” Dr. Karlawish said. This can be a challenge, but it’s an important one, he added. “When individuals have dementia, their lives — their very selves — are constructed by the people around them. We shape their personhood, and that is a tremendous moral responsibility.”

Sodium Controversy: More Fuel for the Fire

BY MARY ANN MOON

Three large international studies addressing sodium intake’s effect on blood pressure and on cardiovascular and mortality outcomes are unlikely to quell the controversy surrounding sodium. Rather, since the findings of one study directly oppose those of the other two, the results promise to fan the flames a bit higher.

All three studies were reported in the New England Journal of Medicine.

PURE Substudy

The first report concerned a substudy of data from the Prospective Urban Rural Epidemiology (PURE) study involving 102,216 adults aged 18-70 years residing in 667 communities in 18 low-, middle-, and high-income countries worldwide. Urinary sodium and potassium levels were used as surrogates for dietary intake of these elements, and these excretion levels were correlated with the participants’ BP levels, said Andrew Mente, PhD, of the Population Health Research Institute, Hamilton (Ontario) Health Services, McMaster University, and his associates.

Current guidelines recommend a maximum sodium intake of 1.5-2.4 g per day, depending on the country. Only 0.6% of the study population achieved the lowest level of 1.5 g per day, the level recommended in the United States, and only 10% achieved less than 3 g per day. The largest segment of the study population, 46%, had a
Alzheimer’s Risk Rises With Chronic Benzodiazepine Use

BY BRUCE JANCIN

BERLIN -- Chronic use of benzodiazepines by elderly patients is associated with a 43%-51% increased risk of being diagnosed with Alzheimer’s disease 5-10 years later, according to a large case-control study. “Considering the extent to which benzodiazepines are prescribed in the elderly population and the growing incidence of dementia, unwarranted chronic use of benzodiazepines in the elderly should be viewed as a public health issue,” Sophie Billioti de Gage said at the annual congress of the European College of Neuropsychopharmacology.

Her case-control study used the Quebec health insurance database. The subjects were 1,796 elderly individuals diagnosed with Alzheimer’s disease, each matched with four controls based on age, gender, and duration of follow-up. The Quebec database permitted identification of all subjects with prescriptions for benzodiazepines during 2000-2009, a period 5-10 years prior to diagnosis of Alzheimer’s disease. This substantial time lag was chosen because previous studies reporting a link between benzodiazepines and dementia have often been criticized for possible confounding due to reverse causality. That is, because many earlier studies featured a shorter interval between medication use and dementia diagnosis, skeptics argued that benzodiazepines might not have caused the dementia, but rather were prescribed to treat early manifestations of the disease, such as anxiety, depressive symptoms, and insomnia – all of which twofold increases in the risk for symptomatic stroke and dementia, respectively,” wrote Shadi Kalantarian, MD, MPH, and colleagues from the Institute for Heart Vascular and Stroke Care and Massachusetts General Hospital. “Consequently, the higher prevalence of SCI in patients with AF may put this population at a greater risk for cognitive impairment, future stroke, and disability.”

The study was funded by the Deane Institute for Integrative Research in Atrial Fibrillation and Stroke, Massachusetts General Hospital, and the Harvard Catalyst and the Harvard Clinical and Translational Science Center. Two authors declared grants and personal fees from private industry.

Although SCIs (silent cerebral infarctions) do not present with acute stroke symptoms, they have been reported to twice before prescribing a benzodiazepine, the investigator said.

The biologic mechanism by which chronic use of benzodiazepines by elderly individuals might predispose to Alzheimer’s disease hasn’t been worked out, but the medications’ short-term adverse effects on memory and cognition are well recognized. The case-control study was funded by the French Ministry of Health and the Funding Agency for Health Research of Quebec as well as by university grants.

Caring for the Ages

Atrial Fibrillation Doubles Silent Cerebral Infarct Risk

BY BIANCA NOGRADY

Atrial fibrillation was associated with a more than twofold increase in the risk of silent cerebral infarctions, even in patients with no history of symptomatic stroke, a systematic review and meta-analysis has found.

The analysis of 11 studies involving 5,317 adults with atrial fibrillation but no history of stroke or prophylactic values showed a significant increase in the risk of silent cerebral infarctions (OR, 2.62), independent of whether their AF was independent of whether their AF was associated with a more than twofold increase in the risk of future Alzheimer’s disease than nonusers. Those with a cumulative 91- to 180-day exposure had a 32% increased risk compared with nonusers, however, and patients with more than 180 days of benzodiazepine use had an 84% increased risk.

The association with later Alzheimer’s disease was stronger in patients who used benzodiazepines with a half-life of 20 hours or longer. In a multivariate analysis they had a 79% greater risk of Alzheimer’s, compared with nonusers. Patients who used a benzodiazepine having a half-life of less than 20 hours had a 43% increase in risk.

When the multivariate analyses were further adjusted for anxiety, depressive symptoms, and insomnia – all of which can be prodrumes of dementia – the results were not meaningfully altered, she added.

This case-control study confirms the results of an earlier prospective population-based study by Ms. Billioti de Gage and colleagues. That French study also found a roughly 50% increased risk of dementia in elderly patients who initiated chronic benzodiazepines (BMJ 2012;345:e6231). However, with only 1,063 participants, 253 of whom were diagnosed with dementia during 15 years of follow-up, the sample size was too small to draw firm conclusions. The current case-control study, with 8,980 subjects representative of the Quebec community-dwelling elderly population, is more persuasive, the investigator said.

Guidelines recommend preferential use of short half-life benzodiazepines and short durations of use in the elderly; however, in clinical practice the medica-tions are often used long-term.

One more good reason not to use benzos indiscriminately. Although I am not sure this observed increase in dementia is cause and effect, we already have plenty of evidence that these drugs can be harmful, increasing falls and causing more disinhbition of behavior. And we have better drugs for anxiety (e.g., SSRI) and insomnia anyway. Think twice before prescribing a benzo in this population, especially a long-acting one.

—Karl Steinberg, MD, CMD Editor in Chief

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—Karl Steinberg, MD, CMD Editor in Chief
Dear Dr. Jeff:

Our state is considering legalizing marijuana. Clearly, we will be admitting residents who are already using marijuana and some others for whom it might be recommended. I know that the details vary from state to state, but do you have any general or specific recommendations for our nursing home?

Dr. Jeff responds: As of this writing, 23 states have legalized marijuana for medical use under various circumstances and with various limitations and regulations. Several others are considering legislation or ballot propositions. Additionally, many localities have decriminalized possession of small quantities for personal use while retaining laws against sales. Legislation dates back to Alaska and Oregon in the late 1990s and includes states that have legalized marijuana but failed to create the regulations needed to make the laws effective and clear. Colorado, Washington, Oregon, and Alaska also have legalized recreational use, production, and distribution. From the viewpoint of a skilled nursing facility, these represent two quite different situations.

Despite these legislative activities, the Drug Enforcement Administration still classifies marijuana (or rather, tetrahydrocannabinols, which are believed to be the major psychoactive components in marijuana) as a Schedule I controlled substance, meaning only available for research purposes but without approved medical uses. Two cannabinoid preparations, dronabinol and nababin, have been approved by the Food and Drug Administration for the treatment of nausea and vomiting in cancer patients receiving chemotherapy and for anorexia in AIDS patients. These are synthetic oral preparations, not marijuana extracts, and were placed on DEA Schedule II.

Dronabinol, sold in the United States as Marinol, was moved from DEA Schedule II to Schedule III, allowing prescribers to authorize up to five refills, due to observational studies of its low potential for abuse or addiction. Thus, cannabinoid preparations are already available and used, albeit infrequently, in nursing homes all over the United States. However, due to the relative lack of success using this medication in patients with anorexia and weight loss unrelated to HIV or cancer treatments, along with its expense, its use has not become common. The FDA is fast-tracking a cannabinoid oromucosal spray to treat pain in patients with advanced cancer. But delta-9-tetrahydrocannabinol (THC) remains illegal. Federal “Just Say No” policies date to the Reagan Administration and seem unlikely to change, despite changes at the state level.

A Long History

The plant genus Cannabis has been cultivated by humans since antiquity, both for the strength of its stalks (hemp) and the bioactive properties of its seeds, leaves, flowers, and buds. Medicinal uses for cannabis, and particularly the sativa species, were widely described in ancient medical texts since the pharmacopoeia of Emperor Shen-Nung in 2737 B.C. It was considered a fundamental treatment in many herbal medication systems, along with extracts from opium poppies and ephedra plants. Its use is described on Egyptian papyri and was apparently used topically to treat hemorrhoids, including those of at least one Pharaoh. Cannabis preparations were used by Indian, Greek, and Arab physicians. A shaman from the Uighur region was buried 2700 years ago with bowls of cannabis at his head and feet, which have been confirmed to contain THC. And some scholars have suggested that the kaneh bosem described in Exodus 30:23 as one major ingredient of holy anointing oil (later used by Jesus and his followers to heal the sick – see Mark 6:13) – and which is variably translated as reeds, sweet cane, calamus, or other plants – is actually cannabis.

Cannabis for both medical and recreational use was legal in the United States until 1937. Extracts of cannabis were routinely sold in pharmacies for both ingestion and topical use. Nevertheless, it was not commonly prescribed nor – despite the miraculous properties ascribed by some enthusiasts – regarded as particularly effective for the treatment of common conditions. The analgesic properties of cannabis were known and explored in ancient times, when its numbering properties were used for anesthesia, but cocaine was considered a much more effective topical anesthetic for mucosal pain than cannabis smoke. There was little opposition from organized medicine when marijuana was outlawed, nor has there been any particular pressure from major medical societies for its legalization.

Limited Data

Medical use of marijuana is legal in many countries, but utilization is not very extensive. Although potential uses have been described for many different conditions, including glaucoma, neuropathic pain, cancer, multiple sclerosis, and seizure disorders, for most of these conditions the use of cannabis derivatives appears likely to be of symptomatic relief for a limited group of patients with refractory conditions rather than a routine or preferred treatment. Of course, anything that might relieve suffering should be seriously examined, and potentially useful treatments should not be denied to those who may benefit. Unfortunately, useful data to evaluate the risks and benefits of marijuana for the treatment of any of the proposed conditions are extremely limited. Although more than 200 researchers have been approved to use marijuana for research purposes, many of these studies relate to detection and evaluation of abuse potential. Only 16 researchers are conducting trials on smoked marijuana in human beings. Most published studies on therapeutic potential or adverse effects to date have been small in scale and poorly designed to answer clinicians’ questions.

A 2007 study in the British Journal of Pharmacology (Br J Pharmocol 2007;152:655-62) raised the exciting prospect that cannabis might be an effective treatment for Alzheimer’s disease. The authors noted that THC and other cannabinoids have been shown to have neuroprotective effects against beta-amyloid aggregation, inhibit the phosphorylation of tau protein, and decrease inflammatory and oxidative damage to neurons. Furthermore, THC may be a cholinesterase inhibitor in the brain, thus offering a trifficata for Alzheimer’s in a single drug. The brain has an entire cannabinoid system with binding sites present on a variety of neurons. Unfortunately, a recent review article of cannabis for the treatment of a variety of neurodegenerative diseases, and a Cochrane review specifically aimed at Alzheimer’s disease, both concluded that there is insufficient evidence to draw conclusions regarding the efficacy of cannabis for long-term treatment. But there is no doubt that the acute use of inhaled cannabis preparations inhibits short-term memory and that the potential for cannabis-induced sensory alterations and hallucinations represents a severe risk for dementia patients who already are susceptible to delirium.

Different Smokes for Different Folks

Understanding medical marijuana is complicated by the simple fact that there are many different strains of marijuana and that THC is only one of at least 468 compounds present in a typical Cannabis sativa plant (not counting possible pesticides or other substances used in its growth and preparation). The concentrations and ratios of these substances vary from plant to plant and certainly between C. sativa and C. indica, which may be more sedating and also contain more of the nonpsychoactive elements believed to control seizures and muscle spasms. States that have legalized medicated marijuana have generally allowed physicians to prescribe it on an as-needed basis and allowed patients to adjust the amount ingested – whether eaten or smoked – based on their symptoms. Because there is no standardization, with sale currently by product weight alone, and even the ratio of seeds to leaves or buds varying from sale to sale (not to mention twigs, soils, and bugs frequently present as well), consumers have only limited control over purchased products. (The Denver Post currently employs a pot critic to review locally available strains, comparable to their wine critic.) Some strains are known or believed to have much higher THC concentrations, and some plants grown primarily for hemp production have been bred to have very low THC concentrations to protect agricultural laborers from having contact with the plants. Some strains produce oilier THC, which may be present on the exterior of the plant. Dosage also varies with the route of administration as does the onset of biological action, which is much more rapid when absorbed directly across pulmonary membranes than through the gastrointestinal tract. Obviously, this makes actual prescribing by a physician or nurse practitioner for administration by licensed nursing staff in specific doses at specific intervals virtually impossible. Also, vendor pharmacies in most states are not licensed to distribute cannabis, which is generally sold through specialized outlets. New York State has proposed an integrated license from production through transport and sale, which would effectively exclude standard pharmacy supply systems from involvement with medical marijuana. Reimbursement through standard insurance mechanisms is also effectively impossible.

Too Much To Overcome

Given all these barriers, most facilities would be unwise to use medical marijuana as such in the nursing home. The early experience in states that have legalized marijuana for medical purposes has suggested that only a few physicians write the majority of prescriptions and that the typical user of medical marijuana is a 41-year-old male using marijuana for a chronic pain
Experts Predict: What’s Ahead for PA/LTC in 2015?

Nicole Brandt, PharmD, MBA, CGP, professor, geriatric pharmacotherapy, pharmacy practice and science, University of Maryland School of Pharmacy, Baltimore:
▶ There will continue to be this transformation to value-based health care and this will impact how the care is delivered in the PA/LTC market. Hopefully, we will see an integration of health information exchange during care transitions, especially in light of impact on reimbursement due to readmissions.
▶ Medication management and managing high cost medications will continue to be areas that need attention. Expensive specialty medications for conditions such as hepatitis C, cancer, and multiple sclerosis will continue to impact drug spending and the burden both on PA/LTC facilities and payers, as well as patients.
▶ There needs to be a concerted effort to look at how to effectively integrate or communicate with health care systems and providers to improve the delivery of care and minimize the transitions in care. There needs to be a collaborative, interprofessional approach to meeting the increasingly complex medical and medication needs of the patients served in the PA/LTC setting.

Robert M. Gibson, PhD, JD, senior clinical psychologist, Edgemoor DP SNF, Santee, CA:
▶ There is clearly a great deal happening with funding and growing financial pressures in long-term care. At the same time, I expect continued pressure on LTC facilities to cope with higher acuity, both medically and in terms of psychological and psychiatric issues. As placement pressures continue, we will likely see continued growth in the numbers of younger adults in long-term care, as well as a continued shift of medically impaired persons in the correctional system to the community and, in many cases, to long-term care. With declining mental health resources and a lack of resources for persons with brain injury or neurodegenerative conditions, these segments of the LTC population will also continue to grow, thus increasing the need for effective behavior management and mental health services. In general, I anticipate the need to be increasingly flexible and to do more with less.

Daniel Haimowitz, MD, FACP, CMD internist, Levittown, PA:
▶ There has definitely been a trend towards expansion of services out of institutions and toward home- and community-based care. Partly this is due to expectations of baby boomers, but it ties into financial pressures. It certainly provides an opportunity for practitioners outside of the traditional PA/LTC setting (assisted living,PACE, house call practices, etc.).
▶ Financial drivers are always key issues. Medicare and Medicaid are in the midst of potentially very radical changes – bundled payments, ASOs, combined Medicare-Medicaid managed care programs for LTC patients, etc. These are driving real changes in the marketplace. Already, hospitals are making it clear to turn of financial pressures. It certainly provides an opportunity for practitioners outside of the traditional setting.
▶ I hope medical directors will help the nursing homes step up their game and play a major role in helping staff understand and implement the Quality Assurance and Performance Improvement (QAPI) process and INTERACT. Elsewhere, the role of non-physician health care professionals in the PA/LTC world will continue to expand.
▶ I hope that the coming year brings more recognition of the Choosing Wisely campaign, and I think we’ll see more interest in genomic medicine, specifically targeting individuals and their personalized medication use. The concept is interesting, and I believe this issue will continue to expand.

Linda Handy, MS, RD, Commission on Dietetic Registration, San Marcos, CA:
▶ I predict that long-term care will be impacted by the recently completed Centers for Medicare & Medicaid Services Hospital Patient Safety Pilot Initiative that includes detailed surveyor worksheets developed to challenge surveyors as they assess hospitals’ compliance with QAPI and infection control. This impact has already started and will carry over into LTC surveys as surveyors ask for more documentation, and better understand and identify and show how effective corrective actions and staff competency are demonstrated. Facilities also will be expected to show how they demonstrate that the infection control officer designee is involved in preventing foodborne illness. I believe that we would benefit from studying these surveyor worksheets and apply them to long-term care to ensure our own compliance.

Jeffrey Nichols, MD, president, New York Medical Directors Association, New York:
▶ The top issues will be related to finances, as they always are. Although many facilities are dependent on Medicare Part A reimbursement – or managed care equivalents – to cover inadequate Medicaid rates and declining private pay revenues, there will be a acceleration of referring of these referrals. Instead, providers and insurers are increasingly looking at intensive home care as a cheaper alternative to SNF care, especially for many of the standard orthopedics cases that have been the bread and butter of most sub-acute programs. As a result, facilities will need to refocus their rehab programs and align their services to the needs of referral sources and a sicker resident population to survive.
▶ At the same time, 2015 will be the year when electronic health records finally reach many LTC providers. Most systems designed for use in nursing homes perform well on the finance/care planning/ [Minimum Data Set] side but are poorly designed for clinical care or linkage to acute care and home care partners in the care continuum. Progress in this area will depend on whether medical directors and other practitioners are able to unite and insist that these problems are addressed as paper charts disappear.

Dan Osterweil, MD, CMD, professor of medicine and associate director, multicampus program in geriatrics and gerontology, the Borun Center, Sherman Oaks, CA:
▶ The pressures to meet the value-based purchasing propositions will increase both on nursing home providers and hospitals. As a consequence, medical providers will feel this pressure as well.
▶ The demand for quality will spill over to the post-acute space with increased and more stringent oversight of care. This will come out of National Committee for Quality Assurance standards, delineating the responsibilities for post-acute complications between the hospitals and skilled nursing facilities. SNFs may join the crowd and be subject to financial penalties and rewards in this new area.
▶ Last, but not least, the care coordination codes and PA/LTC coordination codes in fee-for-service medicine may shift the burden for care coordination between settings from institutions to practitioners. The next year will provide an opportunity to improve on cross-system coordination. Practitioners will be wise to consider hiring a care coordinator for their facility, especially those practices with more than 200 patients who have two or more chronic conditions and qualify for the per-member-per month fee.

Barbara Resnick, PhD, CRNP, FAAN, FAANP, professor and Sonya Zonkic Gershowitz chair in gerontology, University of Maryland School of Nursing, Baltimore:
▶ There will be a broad separation and differentiation in long-term care between subacute and post-acute care patients and long-stay patients. Increasingly, there will be a growth in specific buildings and units for these different types of patients. In my crystal ball, I see that this will have many positive outcomes. Designated units that focus on rehabilitation and recovery will work on training staff to have the skills to provide rehabilitation nursing and medicine, and will facilitate the discharge in the most cost-effective and efficient manner. I further hope that this rehabilitation philosophy will translate to long-stay patients as well, and we will all begin to incorporate a
function-focused care approach, regardless of setting.

Another prediction (or at least a dream) includes a stronger focus on prevention, with immunizations that go beyond just flu and pneumonia vaccines and include zoster and tetanus-diphtheria-pertussis as routine vaccinations. Likewise, we will focus more on prevention of pressure areas and contractures, even at what is thought of as the end of life (as one never knows what might happen to or with our quite resilient older individuals during this time). Elsewhere, as more individuals live to 100 years or older, we may need to put more emphasis on prevention so that those years can be lived comfortably and with some quality.

Karl Steinberg, MD, CMD, editor in chief, Caring for the Ages, Oceanside, CA: We will see more of a move toward value-based payment and population health in the PA/LTC setting in 2015, and this trend will continue in years to come. With some of the new models, including later generations of accountable care organizations, many of our patients will be able to go directly from emergency department (or doctor’s office) to skilled care in an SNF without a required hospital stay — just as our Medicare+HMO patients have been able to do for decades. That is a very good thing, because the hospital is not a good place to be when patients don’t need to be there (with all due respect to our hospital and hospitalist colleagues). At the same time, it will be possible for a long-term custodial SNF resident to be bumped up to a skilled level without having to go to the hospital, which is also a very positive change.

I also predict that the pilot programs for dual eligibles (Medicare/Medicaid) will be expanded, and we will see a continuing exodus of less functionally impaired SNF residents into residential care (assisted living, board-and-care facilities, etc.). This is another good development and a better way to spend our Medicaid tax dollars.

Meanwhile, as desperately as the assisted living industry tries to cling to the “we are not medical” mantra, we’ll see movement for increasing regulation in this arena — maybe even federal regulations at some point — as the level of chronic illness continues to increase in that setting.

From the clinical side, I think we will continue to see less unnecessary use of antipsychotics, less use of sliding-scale insulin, better antibiotic stewardship (with less checking of urine studies for cloudy or foul-smelling urine, a fall, or mental status changes, and thus less inappropriate treatment of asymptomatic bacteriuria), and more access to palliative care services and appropriate, informed advance care planning in our buildings.

Compiled by senior contributing writer Joanne Kaldy, a freelance writer in Harrisburg, PA, and a communications consultant for AMDA.

Nursing Home
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syndrome, far different from the profile of a typical nursing home resident. Nursing homes with significant hospice or AIDS populations should consider the use of currently available FDA-approved preparations.

The issues presented by legalized recreational possession and use are totally different. Regardless of risks of carcinogens or tars that may be present in marijuana, or the supposed “gateway” nature of its use leading down the slippery slope to addiction, nursing home residents with decisional capacity should have the right to make or repeat the dumb decisions of any other citizen of your state. Because of the risk of fire in an institutional setting, plus the risk of exposure to secondhand smoke for employees and other residents (contact high), it seems reasonable to use all the same restrictions used for tobacco smoking, including complete restriction if necessary. However, oral ingestion using supplies bought and maintained individually for the resident should be accepted. Indeed, perhaps as a tribute to the late Jerry Garcia, you might name one nursing unit Panama Red. Unit birthday parties with brownies should be very mellow.
family was taking him for prostate tests. Dr. Karlawish asked what they were looking for and what they expected to gain from these tests, and discovered the family didn’t really have an answer. “It led to a dialogue about the value of what we propose to do and what will maximize quality of life and dignity for the patient,” he said.

“When people ask for a prognosis, I seek to determine what it is that they want to know, especially in the case of people with dementia.’

Prognosis and Life Expectancy

Prognosis and life expectancy should inform how elders live and the interventions practitioners recommend for them. “We should be recommending whether or not to pursue tests or treatments based on meaningful future risk,” said Dr. Karlawish. “We should be recommending them based on meaningful future risk, and they want a prognosis.” However, he added, “When people ask for a prognosis, I seek to determine what it is that they want to know, especially in the case of people with dementia. It’s presumptuous to think that they mean life expectancy.” For example, he said, they may want to know how long it will be before a loved one doesn’t recognize them or until he or she is no longer able to live alone.

If the family actually wants to know how long someone will live, said Dr. Karlawish, “I talk about how surprised – or not – I would be to hear in a year that the person had died. That is a more meaningful qualitative response than a number that may or may not be accurate.”

Mining for Gold in Conversations

Practitioners should take full advantage of opportunities to communicate with family members and to learn from these interactions. “A useful conversation is to say, ‘Tell me how things have gone for your family member? How has he gotten to this place in his life? What does he – and you – see for the future?’ Ask the family to share what they see as the person declines and what they expect to happen in the future,” Dr. Karlawish said. He explained that these narratives can uncover interesting and even surprising information.

For example, “They may see the disease differently than you do,” he said. “Or they may have a narrative that is full of conflict and emotion and views that reflect this. You may discover that they don’t trust the health care system or that they have guilt or anger because they don’t think a loved one has been cared for adequately.”

He recalled, “I remember one incident where my perspective was that the patient had advanced dementia, while the family’s view was that the cognitive impairment was only a recent development. My perspective of advanced dementia with limited time left was different than their view.” Once the practitioner knows the family’s perspective, he or she can seek to find some common ground. “Once you have a common understanding, you have some reasonable grounds to make plans to care for the patient,” Dr. Karlawish said.

Dr. Karlawish stressed that AMDA members and other post-acute/long-term care practitioners play a key role in creating and perpetuating “pleasure panels” for their patients. “They are on the front lines of caring for people who are among the most vulnerable in our society,” he said. “In this unique position, they are the keepers of the culture and values that will shape what society does and does not do – for these people.”

Dr. Karlawish said that he is looking forward to speaking at the AMDA annual conference. His presentation at the AMDA annual conference, “How Are We Going To Live with Alzheimer’s Disease,” is scheduled for Friday, March 20, from 8:00-10:30 a.m.

Balancing Bedside Manner With Desktop Medicine

In 2010, Dr. Karlawish coined the term “desktop medicine,” describing a model of care in which computer networks and big databases transform medical practice. In this model, disease is defined based on risk, and practitioners and patients alike seek information about these diseases and their treatment, and they share information with others.

Desktop medicine is transforming health care, including post-acute/long-term care, a setting where technology is traditionally underutilized. “Many practitioners pursue work in this setting because they want to care for sick people, and long-term care is seen as the last bastion of bedside medicine. These patients are sick; they have a number of problems and need personalized attention,” said Dr. Karlawish.

Nonetheless, there is a role for desktop medicine in this care setting. “Long-term care patients are loaded with risks, and desktop medicine can be thought of as an actuarial exercise. We can use technology to help assess patients, to communicate to them and to families, and to devise and communicate a coherent, effective, real-time care plan,” he said.

Although technology has advantages for the PA/LTC practitioner, one challenge for these individuals will be taking advantage of it without losing the art of bedside manner. Dr. Karlawish cautioned against using technology, such as electronic health records (EHRs), as an “endless data dump.” He shared the story of a physician who had a serious injury and, on recovery, reviewed his records. “He determined that the notes in the record were useless with little attention (given) to anything anyone was saying, particularly him.”

“EHRs discourage writing,” Dr. Karlawish said. “Instead, there are ‘drop downs’ and check boxes for complaints, symptoms, concerns, and so on. These aren’t in the patient’s words. It’s not information about what the patient says or feels.” He added that certain aspects of EHRs, such as the ability to easily transfer information, are good if they are integrated effectively and organically in a way that practitioners don’t have to ‘flip through endless data’ to find the information they need.

To supplement data input into the EHR, Dr. Karlawish uses voice recognition technology to dictate his notes and capture his conversations. “This helps me document what is really happening with the patient – what the typical day.”

For more information about desktop medicine, see Dr. Karlawish’s original article (JAMA 2010;304:2061-2).

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More Fuel from page 1

sodium excretion of 3-5 g per day, and the next largest segment, 44%, had a sodium excretion of more than 5 g per day.

“This suggests that, at present, human consumption of extremely low amounts of sodium for prolonged periods is rare,” the investigators noted.

The investigators found, after multivariate adjustment, that for each 1-g increment in sodium excretion, there was an increment of 2.11 mm Hg in systolic BP and 0.78 mm Hg in diastolic BP (P < .001 for both) for all areas of the globe.

However, this correlation was non-linear. The association between sodium and BP was weak in the largest subset of participants who had an excretion of 3-5 g per day, and was nonsignificant in those who had an excretion of less than 3 g per day.

The association between sodium intake and BP was stronger in people who had an excretion of more than 5 g per day and in those who already had hypertension at baseline. It also increased with increasing patient age.

Taken together, these findings indicate that sodium’s effect on BP is nonuniform and depends on the background diet of the population as well as the individual’s age and hypertension status, Dr. Mente and his associates said (N Engl J Med 2014;371:612-23).

The findings from both of these PURE substudies allow us to call those assumptions into question.

Sodium and Cardiovascular Mortality: NUTRICODE

The third report was a review of the literature regarding sodium intake’s effect on CV mortality worldwide; the gathered data then served as the basis for a complex statistical model that estimated how many deaths could be attributed to sodium consumption in excess of a reference level of 2.0 g per day. This study was performed by the Global Burden of Diseases, Nutrition, and Chronic Diseases Expert Group (NUTRICODE) and was headed by Dariush Mozaffarian, MD, PhD, MPH, a cardiologist and epidemiologist with Tufts University and the Harvard School of Public Health, both in Boston.

These investigators quantified sodium intake in 66 countries (accounting for 74% of adults throughout the world) by age, sex, and country of residence, and correlated these data with findings from their meta-analysis of 107 randomized trials of interventions to curb sodium intake and then with the results of two large international trials linking the effects of various BP levels on CV mortality.

They estimated that the mean level of sodium intake worldwide is 3.95 g per day and that those mean levels varied by geographic region from a low of 2.18 g to a high of 5.51 g. “Overall, 181 of 187 countries – 99.2% of the adult population of the world – had estimated mean levels of sodium intake exceeding the World Health Organization recommendation of 2.0 g/day,” Dr. Mozaffarian and his associates said.

Contrary to the findings of the two PURE analyses, these data showed “strong evidence of a linear dose-response relationship” between sodium intake and BP such that each reduction of 2.30 g per day of sodium was significantly linked with a reduction of 3.82 mm Hg in systolic BP, as well as a direct correlation between increasing BP and increasing CV mortality.

Extrapolating from these data, “we found that 1.65 million deaths from CV causes worldwide in 2010 were attributable to sodium consumption above the reference level” of 2 g per day. “Globally, 40.4% of these deaths occurred prematurely, i.e. in persons younger than 70 years of age,” Dr. Mozaffarian and his associates said (N Engl J Med 2014;371:624-34).

“In sum, approximately [one] of every 10 deaths from CV causes worldwide and nearly [one] of every [five] premature deaths from CV causes were attributed to sodium consumption above the reference level,” they said.

In an editorial accompanying this report, Suzanne Oparil, MD, MD, said, “The NUTRICODE investigators should be applauded for a herculean effort in synthesizing a large body of data regarding the potential harm of excess salt consumption” (N Engl J Med 2014;371:677-9).

“However, given the numerous assumptions necessitated by the lack of high-quality data [in the literature], caution should be taken in interpreting the findings of this study,” said Dr. Oparil, of the vascular biology and hypertension program, University of Alabama at Birmingham.

The PURE studies were supported by the Heart and Stroke Foundation of Ontario, the Population Health Research Institute, the Canadian Institutes of Health Research, several pharmaceutical companies, and various national or local organizations in 18 participating countries. These funders played no role in the design or conduct of the studies, in collection or analysis of data, or in preparing the manuscript. Dr. O’Donnell reported ties to Boehringer Ingelheim, Bayer, Bristol-Myers Squibb, and Pfizer, and his associates reported ties to Sanofi-Aventis, AstraZeneca, and Cadila. The NUTRICODE study was funded by the Bill and Melinda Gates Foundation.

Mary Ann Moons is a Frontline Medical News freelance reporter based in Clarkesburg, MD.
Facilities at Risk When CPR Isn’t Implemented

Post-acute care facilities, including some skilled nursing facilities, continue to struggle with consistent initiation of cardiopulmonary resuscitation for residents who have chosen to elect CPR in the event of cardiac arrest. The failure of SNPs to appropriately implement CPR continues to result in an immediate jeopardy citation by state survey agencies and in civil money penalties and other sanctions for facilities receiving citations. Facility management, including the physicians and medical directors, should review the policies and procedures related to CPR to ensure that their facility is well-prepared to implement a CPR intervention determined by the physician orders and the applicable legal requirements.

Nursing facilities have a responsibility to have and implement policies that provide for immediate CPR intervention for residents who do not have a current DNR order in place.

Despite the fact that the effectiveness of CPR is reduced for individuals outside of the acute care setting, and also reduced as individuals age, the decision regarding whether or not CPR is appropriate, even for residents with end-stage renal disease of 80 years and older, who did not show signs of irreversible death and did not have a do-not-resuscitate (DNR) order in the medical record. The facility was cited for immediate jeopardy and received a civil money penalty ($5,570 per day for 23 days) for placing this resident and other residents at risk of death or serious harm for failing to implement timely resuscitative measures. The facility argued that its policy was supported by the Kentucky Board of Nursing advisory opinion statement. This advisory opinion statement indicates that CPR is inappropriate, even when the resident had no DNR order, when a person exhibits obvious signs of irreversible death. However, the DAB found that the resident did not show signs of irreversible death when the resident was found cool to the touch and without vital signs. The DAB case discussion indicated that the signs of irreversible death listed by the Kentucky Board of Nursing include lividity, rigor mortis, and algor mortis, and that the resident, according to the facility’s own nursing notes, did not display these signs prior to the pronouncement of death. After the fact, handwritten statements by several nurses were determined by the court to be self-serving and unreliable evidence.

A Michigan facility was cited in May 2012 with multiple immediate jeopardy and actual harm citations by failing to resuscitate a full code resident. The resident had a recent change of condition related to pneumonia and was having increasing respiratory distress. When a licensed practical nurse found the resident without a pulse or respiration, she tried to arouse the resident and performed “sternal percussions.” The facility did not undertake appropriate resuscitation efforts or summon EMS personnel, and the resident died at the facility without receiving CPR. The citations included failure to appropriately notify the physician with all the pertinent information; failure to follow appropriate standards of nursing care by failing to implement CPR and summon EMS; and failure to provide necessary care and services by not assessing, monitoring, and providing prompt intervention for an acute condition change. The citations resulted in a fine of $101,000 and the imposition of other sanctions.

These cases illustrate that following the facility’s policies and understanding the state laws related to resuscitation are key components of a successful CPR policy. Staff must know how to determine resident code status, and how and how CPR is indicated for residents who are full code status. A clear and well-communicated CPR policy can prevent serious state survey citations and, most importantly, ensures that resident preferences at the end of life are appropriately addressed and honored.

Clear documentation in the resident’s medical record of the advance directive related to resuscitation that complies with state law and federal certification requirements. Clear identification of the resident’s code status per the facility’s policy.

Periodic review of the resident’s advance directive with the resident or the resident’s legal decision-maker, as resident choices may change over time.

Periodic quality assurance audits of the accuracy of documentation related to identification of facility residents’ code status.

Nursing facilities have a responsibility to have and implement policies that provide for immediate CPR intervention for residents who do not have a current DNR order in place (i.e., indicating no CPR). Staff education and training are key components of a successful CPR policy. Facilities must ensure that all residents have accurate, up-to-date code status documentation according to policy. Staff must know how to determine resident code status, and when and how CPR is indicated for residents who are full code status. A clear and well-communicated CPR policy can prevent serious state survey citations and, most importantly, ensures that resident preferences at the end of life are appropriately addressed and honored.
Combination Drug Quells Anxiety, Aggression

BY MICHELE G. SULLIVAN

PHILADELPHIA – A combination drug of dextromethorphan and quinidine significantly reduced aggression and agitation in patients with Alzheimer’s disease. Associated with those improvements were significant reductions in measures of caregiver strain and distress. Erik Pioro, MD, said at the Clinical Trials Conference on Alzheimer’s Disease.

“These were very clear, stable, and statistically and clinically meaningful differences,” when compared with patients who received placebo, said Dr. Pioro, director of the Section of Amyotrophic Lateral Sclerosis and Related Disorders at the Cleveland Clinic.

The drug, Nuedexta, is already approved for pseudobulbar affect and is being investigated as AVP-923 for several other indications, including depression, migraine, neuropathic pain, autism, and Parkinson’s disease dyskinesia.

This phase II trial comprised 220 patients with moderate Alzheimer’s who displayed clinically significant agitation or aggression as measured by the Neuropsychiatric Inventory (NPI) and the Clinical Global Impressions Scale.

Most (87%) were living at home, about 5% were in nursing homes, and the remainder were in assisted living facilities. At baseline, 74% were taking cholinesterase inhibitors; 50%, memantine; 56%, an antidepressant (including trazodone); 21%, an antipsychotic; and 8%, a benzodiazepine.

As measured by scores on the NPI, 92% displayed clinically significant agitation; 70%, irritability/lability; 52%, apathy/indifference; and 47%, anxiety and aberrant motor behaviors. About a third of the group had nighttime behavioral disorders, depression, dysphoria, delusions, disinhibition, elation, and hallucinations.

Both patients and their caregivers benefited from the combination drug.

They were randomized to dextromethorphan hydrobromide and quinidine sulfate (20 mg/10 mg) or placebo for 10 weeks. Patients in the active group stayed on the study drug for the entire time. Those in the placebo group were assessed for response; 30 of these had improved on placebo. These were rerandomized to active and placebo groups.

Placebo nonresponders were also rerandomized to the drug or placebo.

By the end of the first 5-week phase, patients in the active group experienced a mean improvement of 3.3 points on the NPI aggression subscale, which was significantly better than the 1.7-point improvement seen among those taking placebo.

After the placebo nonresponders had been rerandomized and treated for another 5 weeks, those taking the study drug had a mean 2-point improvement, compared with a 0.8-point improvement among those taking placebo.

In the group that been on their originally assigned treatment for the entire 10 weeks, those taking the study drug again fared significantly better (a mean improvement of about 4.5 points vs. 1.5 points with placebo).

In all randomization schemes, the clinical and physicians’ global impression improved significantly more in the active group than in the placebo group.

The total NPI score improved significantly more in the active group (13.5 vs. 8.5 points for those who had been on the same treatments for 10 weeks). NPI symptom clusters showed the same pattern of improvement favoring the study drug.

Measurements of caregiver response based on the Caregivers Strain Index and the NPI Caregiver Distress Score significantly improved for caregivers of patients taking the study drug for 10 weeks.

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Editor’s Note

Many of us have already tried dextromethorphan/quinidine off-label for our agitated dementia patients, and in my experience it works sometimes, maybe a little better in people with vascular dementia. It’s great to see that there is now actual research showing statistically significant improvement in a well-designed, if small, phase II study. This drug is generally well tolerated – certainly with less significant adverse effects than antipsychotics – and I think we will all welcome more options to treat agitated behavior in challenging patients with dementia.

—Karl Steinberg, MD, CMD
Editor in Chief

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Use your clinical skills from your home!
We continue with our series exploring long-term care provider organizations that serve people in facility-based settings and home- and community-based settings. This month, we’ll look at Golden Living through the eyes of its chief medical officer, Michael Yao, MD, CMD.

Golden Living, headquartered in Plano, TX, is one of the largest providers of rehabilitation and skilled nursing care in the country, with just under 300 facilities in 21 states. This family of companies includes Golden LivingCenters, Aegis Therapies (third largest provider of therapy services in the United States), 360 Staffing, Ceres Purchasing Solutions (a purchasing, contract service company), and AseraCare Hospice. Golden LivingCenters alone serve more than 26,000 patients, with a collective staff of more than 40,000.

Most of its services and individuals served are in facility-based settings, except for AseraCare and Aegis Therapies. Between 50% and 60% of its hospice services and its palliative medicine program, PRIME, are provided in the patient’s home.

Dr. Yao has been with Golden Living in a variety of roles for the past 10 years. For the past 2 years, he has served as chief medical officer for Golden Living and is responsible for overseeing and supporting the medical directors and attending physicians working within Golden Living Centers and AseraCare agencies. He also assists in the evaluation of leading-edge, evidence-based medical practices through the development and expansion of clinical specialty programs, according to the Golden Living website. Dr. Yao is board certified in family medicine and geriatric medicine, and has more than 20 years of experience in long-term care.

Care Across the Continuum

The rise of vertically connected organizations, such as accountable care organizations, is affecting service delivery across the health care industry. Fragmentation in health care delivery is well-known. There are more than 15,000 nursing facilities and approximately 16,000 licensed home health and hospice agencies in the United States, and that does not include private duty agencies and the vast amount of informal in-home caregivers. An emphasis on connection, coordination, and integration across providers is only natural and makes sense.

So how does Golden Living balance the unique opportunities and challenges of facility-based care with community- or home-based care and services? For Dr. Yao, the health care delivery environment for facility-based and home-based care is similar. Whether you work in a skilled nursing facility or in home- and community-based services, the desired goal is the same: to deliver quality care to the patient over time. “If you’re rounding on a patient in an SNF setting, you have to think about how care is delivered postdischarge,” Dr. Yao said. It is a growing challenge to view the patient holistically and over time. With the increasing number of hospitalists, SNF specialists, and office-only physicians, mitigating this challenge will become greater and take intentionality to overcome.

Is there a different skill set for the attending physician who follows patients in a facility-based setting rather than in a home-based setting? Dr. Yao would say that it’s not so much a matter of skill set as it is attitude. Home-based care requires the physician to be overtly intent on listening and paying attention to what on-site caregivers report. The physician has to listen closely to what visiting nurses and other staff identify because they see the patient more often than the physician. And that takes time, which is at a premium for physicians across the board. Although the importance and legitimacy of special providers like hospitalists and SNF specialists should not be overlooked, Dr. Yao’s experience is that physicians who do the best with home-based care are those who also follow patients in their facility-based care as well.

Golden Living anticipates growth in vertically integrated organizations, perhaps sooner in metropolitan areas than in rural settings. Increasingly, this includes not just provider networks but also insurance companies. Golden Living is actively participating in Centers for Medicare & Medicaid Services bundled payment projects, in which provider partnerships are key.

Physicians as Employees

A concurrent development is the changing nature of physician employment status. More and more, physicians are employees of provider networks, rather than being solely independent practitioners. At least conceptually, this should simplify the development process for vertically connected organizations because it streamlines the number of parties involved in the negotiations.

Support and communication are essential parts of Golden Living’s corporate strategy to prepare its physicians for the future. In addition to Dr. Yao being at the helm, four regional medical directors interface directly with facility medical directors, who, in turn, interface with local attending physicians. A dedicated newsletter targeted to medical directors and attending physicians covers topics that may range from facility operations to those of specific clinical focus, such as infection control and medication stewardship. Golden Living also actively encourages its physicians to pursue a medical director certification and promotes attendance at the annual AMDA conference.

Golden Living will continue to explore ways that leverage technology to support physicians and other caregivers. Two things of growing importance to the company: centering dialog about quality of care and quality of life around metrics of care, and how to increase active involvement of physicians in quality assurance and performance improvement.

The transition from primary care physician and educator to a 100% administrative role has been a significant change for Dr. Yao. The challenges are many: working daily to improve care and systems of care in the face of reimbursement, regulation, and increasingly complex care issues. However, Dr. Yao said, “In the end, it still comes down to quality of care and having a heart for the populations we serve.”

Surely Dr. Yao, his work, and his leadership at Golden Living, are a great example for others to model and admire.

Mr. Kubat is director of mission integration for the Evangelical Lutheran Good Samaritan Society. He is an editorial advisor for Carrying For The Ages and coordinates the work of various authors for this column. You can comment on this and other columns at www.caringfortheages.com, under “Views.”

Community LTC, Golden Living, and Michael Yao

By Bill Kubat, LNHA

Michael Yao, MD, CMD

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DIGITELLE
Stroke Guidelines Worthwhile

BY A. MARIA HESTER, MD

A
n estimated 690,000-plus adults in the United States suffer an ischemic stroke annually, and an additional 240,000 experience a transient ischemic attack. The good news is that the current estimated annual rate of future stroke (3%-4%) is historically low, thanks to preventive measures, according to the new “Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack: A Guideline for Healthcare Professionals.” The updated guideline (Stroke 2014;45:2160-236), gives evidence-based recommendations on secondary stroke prevention as well as primary prevention in those who have suffered a TIA. In the guideline, the American Heart Association and the American Stroke Association address scenarios ranging from general risk factor modification to specific circumstances, such as myocardial infarction and thrombus, cardiomyopathy, and arterial dissection.

One recommendation is to consider adding clopidogrel 75 mg/day to aspirin for 90 days in patients with a recent (within 30 days) stroke or TIA attributable to high-grade stenosis (70%-99%) of a major intracranial artery, an alternative therapy to statins and antiplatelet therapy. Other new recommendations stress nutrition. One item suggests performing a nutritional assessment for patients with a history of ischemic stroke or TIA. After having experienced an acute neurologic event, many patients and their families are highly motivated to make whatever changes are necessary to prevent a future, potentially catastrophic stroke. Reduction of sodium from 3.3 g/day to 2.5 g/day or less is reasonable, according to the guidelines, although lowering intake to less than 1.5 g/day will lower blood pressure even further. The new guideline also suggests counseling patients to follow a Mediterranean-type diet – emphasizing whole grains, fruits, vegetables, nuts, olive oil, legumes, fish, poultry, and even low-fat dairy products – instead of the traditional low fat diet.

A. Maria Hester, MD, is a hospitalist with Baltimore-Washington Medical Center.

Less-Than-Severe Sepsis Not Recognized in Time

BY M. ALEXANDER OTTO

SAN DIEGO – Although doctors in recent years have done a good job catching severe sepsis, lesser cases are falling through the cracks and ultimately proving fatal, according to a retrospective database study.

That’s probably the main reason investigators at Kaiser Permanente Northern California found that up to half of hospital deaths are sepsis-related. Of 14,206 adult inpatient deaths at KPNC hospitals between 2010 and 2012, 36.9% had sepsis-related codes. When the team included patients without sepsis codes but with evidence of both infection and acute organ failure – implying sepsis – the number rose to 55.9%.

There is a role for ... education efforts to make the public aware of sepsis and the need for early intervention, similar to what’s been done for stroke.

Sepsis could have been the final common pathway in already-ill patients, but the numbers hint that, at least in some cases, sepsis that could have been extinguished early got out of hand before it was recognized.

The Surviving Sepsis Campaign and other efforts “have had a huge impact on how we treat the most severely ill sepsis patients. We’ve seen about a halving of mortality in the past 15 years. Now we need to broaden our perspective to focus intervention on the less severely ill, who tend to be less severe up front and under identified,” said lead investigator Vincent Liu, MD, with the KPNC division of research, Oakland, CA.

Based on the results, KPNC has started applying its sepsis bundle to patients with intermediate-lactate levels, “but there is very limited data about the benefit of bundle care in less severe sepsis patients, so we are still tracking our outcomes,” he said. There’s also a culture shift involved, which includes heightening clinician awareness, updating communication protocols, and other measures, Dr. Liu said, in presenting the results at an international conference of the American Thoracic Society.

There is a role for more research dollars as well, and education efforts to make the public aware of sepsis and the need for early intervention, similar to what’s been done for stroke, he said.

The work was funded by the Kaiser Foundation, the Department of Veterans Affairs, and others. One author disclosed personal fees from Pfizer, MedImmune, Eli Lilly, Ferring Pharmaceuticals, and Roche Diagnostics. Dr. Liu and the other authors said they had no financial disclosures.

M. Alexander Otto is with the Seattle bureau of Frontline Medical News.

Editor’s Note

This 50-plus-page set of guidelines is very comprehensive and does add a lot of practical, nuts-and-bolts guidance for those of us who look after stroke and TIA patients. But I would reiterate that the most important guideline in nursing homes is to be sure that acute neurological symptoms are considered an emergency – by all staff and all clinicians.

Unless your patient is definitely not a candidate for thrombolysis, the 911 system should be activated immediately. This is one situation where it’s not acceptable to wait 20 minutes for a doctor to call back. We should educate and remind our personnel about the importance of time in a “brain attack” and empower them to use whatever avenues are necessary to ensure prompt attention in a stroke-protocol emergency department.

—Karl Steinberg, MD, CMD Editor in Chief

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Caring for the Aged
BY A. MARIA HESTER, MD

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The good news is that the current estimated annual rate of future stroke (3%-4%) is historically low, thanks to preventive measures, according to the new “Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack: A Guideline for Healthcare Professionals.” The updated guideline (Stroke 2014;45:2160-236), gives evidence-based recommendations on secondary stroke prevention as well as primary prevention in those who have suffered a TIA.

In the guideline, the American Heart Association and the American Stroke Association address scenarios ranging from general risk factor modification to specific circumstances, such as myocardial infarction and thrombus, cardiomyopathy, and arterial dissection.

One recommendation is to consider adding clopidogrel 75 mg/day to aspirin for 90 days in patients with a recent (within 30 days) stroke or TIA attributable to high-grade stenosis (70%-99%) of a major intracranial artery, an alternative therapy to statins and antiplatelet therapy. Other new recommendations stress nutrition. One item suggests performing a nutritional assessment for patients with a history of ischemic stroke or TIA.

After having experienced an acute neurologic event, many patients and their families are highly motivated to make whatever changes are necessary to prevent a future, potentially catastrophic stroke. Reduction of sodium from 3.3 g/day to 2.5 g/day or less is reasonable, according to the guidelines, although lowering intake to less than 1.5 g/day will lower blood pressure even further.

The new guideline also suggests counseling patients to follow a Mediterranean-type diet – emphasizing whole grains, fruits, vegetables, nuts, olive oil, legumes, fish, poultry, and even low-fat dairy products – instead of the traditional low fat diet.

A. Maria Hester, MD, is a hospitalist with Baltimore-Washington Medical Center.

Editor’s Note

This 50-plus-page set of guidelines is very comprehensive and does add a lot of practical, nuts-and-bolts guidance for those of us who look after stroke and TIA patients. But I would reiterate that the most important guideline in nursing homes is to be sure that acute neurological symptoms are considered an emergency – by all staff and all clinicians.

Unless your patient is definitely not a candidate for thrombolysis, the 911 system should be activated immediately. This is one situation where it’s not acceptable to wait 20 minutes for a doctor to call back. We should educate and remind our personnel about the importance of time in a “brain attack” and empower them to use whatever avenues are necessary to ensure prompt attention in a stroke-protocol emergency department.

—Karl Steinberg, MD, CMD Editor in Chief
Chronic Kidney Disease Linked to Cognitive Impairment

BY BRUCE JANCIN

Vascular dementia, which is much more common than Alzheimer’s disease in patients with chronic kidney disease, impairs executive function and is associated with anatomic white matter brain disease. Executive function is the cognitive domain concerned with attention, processing speed, reasoning, planning, and problem solving. Clinicians tend to miss the presence of cognitive impairment in patients with CKD because they typically rely upon the Mini-Mental State Examination (MMSE) to screen for impaired cognition. And the MMSE focuses on memory difficulties, which are more common in Alzheimer’s disease, rather than the more subtle domain of executive function, he explained.

“We’re trying to teach (CKD patients) about complex topics such as fluid restriction, medication management, and salt intake, and you wonder if it just goes in one ear and out the other because they’re not able to process these complex issues,” observed Daniel Weiner, MD, a nephrologist at Tufts University, Boston. Dr. Weiner was co-author of a recent cross-sectional cohort study in which 314 hemodialysis patients at six Boston-area hemodialysis units completed a comprehensive battery of neuropsychological tests assessing memory and executive function. The patients scored markedly worse than general population norms on executive function, but not on memory performance. Moreover, impaired executive function was highly prevalent even in patients with a normal MMSE of 24 or more. The take-home message: be cautious in using an MMSE score of less than 24 to screen for cognitive impairment in dialysis patients (Neurology 2013;80:471-80).

Executive function impairment is also prevalent even in patients with a normal MMSE of 24 or more. The take-home message: be cautious in using an MMSE score of less than 24 to screen for cognitive impairment in dialysis patients (Neurology 2013;80:471-80).

Old Standby Valproic Acid Effective Against Hyperactive Delirium

BY NEIL OSTERWELL

NEW YORK – Valproic acid might be effective for treating hyperactive delirium, results of a small, retrospective study suggest.

Among 16 patients with hyperactive delirium, 13 had complete resolution of delirium according to the DSM-IV-TR criteria, reported Yelizaveta I. Sher, MD, an instructor in psychiatry and behavioral science at Stanford University, CA. You should definitely consider this medication where antipsychotics are ineffective or there are concerns about side effects from antipsychotics, and you need rapid control of agitation,” Dr. Sher said at the annual meeting of the American Psychiatric Association.

Antipsychotic agents are usually first-line pharmacological therapies for delirium, but these agents are associated with adverse events such as prolongation of the QT interval, extrapyramidal side effects such as akathisia, tremors, and, less frequently, the neuroleptic malignant syndrome. Dr. Sher said. Antipsychotics also are less-than-ideal agents for treatment of agitation associated with acute delirium after traumatic brain injury or from alcohol withdrawal, she added.

Valproic acid is approved in the United States for seizures, migraine prophylaxis, and acute manic or mixed bipolar episodes. It often is used off-label for treatment of agitation, neuropsychiatric pain, and personality disorder, according to Dr. Sher. In addition, its use has been explored in agitated patients with dementia, acute myocardial infarction, traumatic brain injury, and corticosteroid-induced mana.

The use of valproic acid has been associated with mild blood dyscrasias, abnormal liver function tests, and, in patients with urea-cycle enzyme deficiencies, symptomatic hyperammonemia. Medication interactions with valproic acid include a decrease in blood levels of up to 80% when it is used with meropenem, and an increase in warfarin levels when valproic acid is used with the anticoagulant. Valproic acid also can decrease clearance of carbamazepine, lamotrigine, nortriptyline, and amitriptyline.

Dr. Sher and her colleagues conducted a retrospective study of charts for patients with episodes of hyperactive delirium who were treated with adjunct valproic acid by a consulting or liaison psychiatrist on the psychosomatic medicine service at their center from Aug. 1, 2011, through Aug. 31, 2012. All the patients had hyperactive or mixed delirium as defined by Dr. Benjamin Liptzin’s criteria (Am. J. Psychiatry 1991;148:454-7).

Dr. Sher and her associates reviewed daily notes from the primary intensive care unit team; daily mental status examination results; daily medication use and doses of psychotropic medications, sedatives, and related medications; daily lab data; descriptions of agitation; and important clinical events such as the use of restraints and extubation.

They identified 16 patients (14 men and two women) treated for hyperactive delirium, all but three of whom were treated in the ICU. Of this group, 15 patients had received multiple drug treatments for delirium and/or agitation prior to valproic acid use. Ten patients received a dose of valproic acid used on days 2-5 was 1,131-1,258 mg per 24 hours in divided daily doses.

Thirteen patients had complete resolution of delirium, at an average of 7.2 days from the start of valproic acid. Two patients had resolution of delirium within 2 days, four within 3 days, two within 4 days, one within 5 days, and the remaining four patients at 10, 12 (two patients), and 31 days.

In all patients, agitation was marked reduced need for sedatives.

The effect of delirium itself upon cognition is a matter of continuing controversy. Although some nephrologists posit that a more intensive dialysis regimen would result in improved cognitive performance, that hasn’t been borne out in analyses to date (Kidney International 2011;79:14-22).

“This suggests that the cognitive impairment we see in dialysis patients isn’t related to the dialysis dose. It’s not related to retained solutes, but is more related to the – for lack of a better word – bad humors patients have been exposed to for many years and which have put them into a situation where they require dialysis,” according to Dr. Weiner.

“We have patients that drop their systolic blood pressure by 20, 30, 40, even unfortunately 80 mm Hg during dialysis. You can’t imagine that this is good for you. We’re inducing transient microvascular ischemia, which is ultimately manifest structurally: in the kidney we get fibrosis, in the brain we get white matter disease,” he said.

Cognitive dysfunction is associated with both poor memory and mortality risk even in CKD patients who are not dialysis dependent. In an analysis of National Health and Nutrition Examination Survey III data, non-dialysis dependent CKD patients in the lowest quartile in terms of cognitive score had a twofold increased risk of mortality, compared with those in the highest quartile (Am J Nephrol 2013;39:97).

Chronic kidney disease as defined by an estimated glomerular filtration rate below 60 ml/min/1.73 m is also a cardiovascular disease risk equivalent for stroke. Dr. Weiner and coworkers showed that the stroke rate in patients with CKD but no known CVD is elevated to roughly the same extent as in patients with known CVD but no CKD (Am J Kidney Dis 2013;61:271).

More recently, Dr. Weiner and his colleagues showed in a brain MRI study that hemodialysis patients not only have far more white matter disease and cerebral atrophy than controls without kidney disease, they also have a high prevalence of previously unrecognized strokes. The cross-sectional study involved 45 hemodialysis patients and 67 controls, all without a history of stroke. Impressively, 18% of the hemodialysis patients had evidence of a small-vessel infarct on brain MRI. One patient had a large-vessel infarction (Am J Kidney Dis 2011;61:271-8).

The high rate of often subtle cognitive impairment among dialysis patients points to the need for alternative prevention strategies. In order to reinforce his educational messages, Dr. Weiner makes an effort to convey the same extensive information to family members and other primary care-givers that he provides to the patients themselves.

He reported having no financial conflicts.

B R U C E J A N C I N  i s  w i t h  t h e  D e n v e r  b u r e a u  o f Frontline Medical News.

Editor’s Note

Although this was a tiny, retrospective study in which it’s not clear why valproate was used in place of other antipsychotics (the standard treatment for delirium) in the first place, it is very intriguing. We all know that delirium is really bad, and most of us aren’t fond of antipsychotics, so it’s certainly worth considering valproic acid (or divalproex) for agitated delirium as we await the results of larger and better-designed studies.

The drug is available in intravenous as well as oral formulations. It is pretty sedating in the elderly, and many of us have used it in the past for dementia-related agitation (a use that has no real evidence to support it and has fallen out of favor). But delirium is a different animal, and it would be great to have something quick, easy, and inexpensive in our armamentarium. Better yet would be if it were also evidence-based. —Karl Steinberg, MD, CMD  Editor in Chief

Neil Osterweil is a Frentline Medical News freelance writer based in Boston.
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INTERACTing With the Electronic Medical Record

By James Lett II, MD, CMD

Improving care transitions has long been a priority for PA/LTC practitioners, as they have sought to enhance communication between care settings and support patients and families as individuals move through the care continuum. AMDA has several tools, developed by interdisciplinary teams and based on clinical evidence, to support care teams and facilities as they improve care transitions.

Tools for Transitions

Improving care transitions has long been a priority for PA/LTC practitioners, as they have sought to enhance communication between care settings and support patients and families as individuals move through the care continuum. AMDA has several tools, developed by interdisciplinary teams and based on clinical evidence, to support care teams and facilities as they improve care transitions.

- **Tools for Transitions**

  **Acute Change of Condition Clinical Practice Guideline.** This document describes a person-centered approach to recognition, assessment, treatment, and monitoring of acute condition changes designed to result in better management of these events and fewer transfers to hospitals and other acute-care settings. For more information, go to www.amda.com/tools/guidelines.cfm/acoc.

  **Transitions of Care Clinical Practice Guideline.** This guideline offers an array of steps, tools, and resources to enable smooth and effective care transitions as patients move from setting to setting. This guideline is available as a free download. More information, go to www.amda.com/tools/guidelines.cfm/toct.

  **The Know-It-All Series** includes several tools to encourage communication, documentation, and support that improve transitions and care as patients move between the PA/LTC facility and the hospital, home, or other setting. Included in the series are: Caregiver’s Communication Guide – Caring for the Older Adult in the Community; Know-It-All Series: Tools to Reduce Unnecessary Transfers to Hospitals; Know-It-All Before You Call Data Collection System; Know-It-All When You’re Called Diagnostic System; and Know-It-All Set (includes both data cards and diagnosing system). For more information, go to www.amda.com/tools/kia.cfm.

  **When You’re Called Diagnosing System; and Know-It-All Set (includes both data cards and diagnosing system). For more information, go to www.amda.com/tools/kia.cfm.

- **A** substantial reduction in hospitalization rates has been associated with implementation of the INTERACT quality improvement program using the paper-based clinical practice tools (INTERACT 3.0). There is a compelling opportunity to further increase the impact of INTERACT by embedding INTERACT 3.0 tools into nursing home health information technology (HIT) via standalone or integrated clinical decision support systems. This article highlights the process of embedding INTERACT 3.0 tools from paper to nursing home HIT.

**INTERACT** is an example of a quality improvement intervention designed to support clinical decision making, as well as to facilitate the identification, evaluation, documentation, and communication about changes in resident status. This is accomplished by collecting information about baseline care plan goals and condition-specific clinical information when a change in status occurs. The INTERACT 3.0 (originally II) care paths and other tools, incorporate information from various sources including best practices, clinical practice guidelines, and input from front line nursing home providers and national experts in long-term care.

**Saves Time, Streamlines Processes**

Many LTC facilities using electronic health records have already obtained a license agreement with Florida Atlantic University to embed INTERACT within their HIT. Some of the reported challenges associated with using paper-based INTERACT 3.0 tools may be improved when these tools are incorporated into nursing home HIT. Use of an electronic format will enable staff to spend less time updating data, provide greater access to automated information, reduce the time needed to track down information from different sources, minimize the time spent performing manual calculations, and keep tasks on track through reminders or prompts noting when specific actions should be taken. Simply put, it will make it easier for front line staff to do the right thing at the right time when a patient’s clinical condition has changed.

Translating INTERACT 3.0 clinical decision support tools from paper to HIT in the nursing home has spotlighted the potential to enhance the detection, management, and communication of acute change in condition among nursing home residents. For example, unlike standalone paper-based tools that rely on employees to follow proper policy when notifying the clinician about a subtle change in condition, INTERACT automatically sends an alert to the nurse when a subtle change has been detected by a nursing assistant, which prompts the nurse to react to that alert within the system.

Developing INTERACT 3.0 clinical decision support tools in an interoperable format that would enable widespread dissemination and integration into various nursing home HIT products, could lead to sustainable improvement in resident and clinician process and outcome measures, including a reduction in unplanned transfers and potentially avoidable hospital admissions.

For information on how to obtain a license for INTERACT please visit the website at http://interact.fau.edu/.
Gaining Control Over Fecal Incontinence

BY JON O. EBBERT, MD

Fecal incontinence is a devastating and isolating condition. Sales of adult diapers are a $7 billion global market and the fastest-growing household products business. Which is where a lot of our patients with this condition remain— at home.

Fecal incontinence (FI) is characterized by continuous or recurrent uncontrolled passage of fecal material. The prevalence may be as high as 15%. Risk factors include physical disabilities, dementia, diabetes, urinary incontinence, chronic diarrhea, and multiparity. One-third of patients will talk to us about it. Which for some of us may be suitable, given our inability to offer good treatments.

If patients do mention it, evaluation involves taking a good history. We need to differentiate incontinence from fecal urgency and frequency. Anorectal examination should look for a bilateral anal wink (absence suggests nerve damage). Some form of endoscopic examination should be performed in most patients. Further evaluation and referral will be based upon findings.

Treatment includes improving stool consistency (e.g., fiber for loose stool) and reducing frequency (e.g., loperamide for diarrhea). Hyoscyamine may be helpful for post-meal leakage. Scheduled defecation and amitriptyline may be of benefit to some patients. However, significant anticholinergic effects may limit the utility of these medications in the geriatric population.

Henri Damon, MD, of Hospices Civils de Lyon, France, and colleagues conducted a multicenter study of perineal retraining for FI (Dig Liver Dis 2014;46:237-42). The standardized intervention included perineal retraining and biofeedback. The protocol was based upon 20 sessions of 30 minutes performed within a 4-month period. Eighty patients were included in the control group, with 77 in the biofeedback group.

The success rate was significantly higher in the biofeedback group (57% vs. 37%; P < .021). Stool frequency, leakage, and urgency significantly decreased.

PA/LTC Perspective

"Many staff and caregivers think fecal incontinence is just a result of aging, which is incorrect," said T.S. Dharmarajan, MD, vice chair of the department of medicine at Montefiore Medical Center’s Wakefield Campus and clinical director of the division of geriatrics of Montefiore in New York. "The older the patient and the longer the stay in the nursing home, the more likely the prevalence of fecal incontinence is," he told Caring for the Ages.

He emphasized the need for staff to be aware of and knowledgeable about risk factors. "They also must understand the importance of the ability to transfer between bed and chair (and the toilet), as data suggests that the inability to transfer correlated with occurrence of more fecal incontinence," he said.

Dr. Dharmarajan added that prompted defecation helps as a conservative approach in ambulatory and responsive residents. "While dietary modification, such as increased fiber and fluids intake, as well as increased activity, are the best means of addressing chronic constipation, these measures are less effective in [the frail elders] in long-term care," he said.

Ultimately, he said, "The best means to address the issue are to assess every resident individually using a multifactorial and interdisciplinary approach including assessing mental and physical capacity and [to] initiate a care plan to address the predisposing factors in each individual."

For more information, see Dr. Dharmarajan’s AMDA webinar, "A Practical Approach to Incontinence and Constipation" at AMDAs e-University. Visit www.amda.com/cmedirect/#web.

Perineal retraining was significantly associated with a higher chance of self-rated improvement.

[Perineal training] combined with improved perianal skin hygiene, bowel habit ritualization, and the addition of fiber and loperamide is an effective option.

The take-home message is that perineal retraining is an effective component of FI treatment. Combining it with improved perianal skin hygiene, bowel habit ritualization, and the addition of fiber as a bulking agent and loperamide for diarrhea offers the best hope for patients with this challenging condition.

Jon O. Ebbert, MD, is professor of medicine, a general internist at the Mayo Clinic in Rochester, MN, and a diplomate of the American Board of Addiction Medicine. The opinions expressed are those of the author. The opinions expressed in this article should not be used to diagnose or treat any medical condition.

AMDA Foundation’s 2015 Caring Canines Calendar is here!

Our 12-month, full-color calendar features dogs and other furry friends with their human friends selected from long-term care facilities from across the country. It’s a perfect holiday gift and a great way to support the Foundation’s long-term care research and education projects.

Find out more at www.amdafoundation.org/canines
CNA Scope of Practice
Certified nurse aides (CNAs) in nursing homes have an expanded scope of practice in 11 states, according to a study led by Tara L. McMullen, MPH, of the University of Maryland in Baltimore. Researchers looked at state-by-state differences in tasks that nurses may delegate to CNAs.

“By law, some of what is required must be currently performed by a nurse (LPN or RN). With the increasing complexity of care needs of older adults, there will not be a sufficient number of registered nurses to provide one-on-one care, nor is that practical,” said fellow researcher Barbara Resnick, PhD, CRNP, FAAN, FAANP, of the university’s school of nursing.

Using data from all 50 states’ regulatory offices or health care services agencies, the researchers compared the tasks each state allows CNAs to perform against the Code of Federal Regulations (42 CFR § 483). The code lists tasks that CNAs may perform in nine areas: personal care skills, safety/emergency procedures, basic nursing skills, infection control, communication and interpersonal skills, care of cognitively impaired residents, basic restorative care, mental health and social service needs, and residents’ rights.

All states allowed CNAs to perform the nine basic nursing care tasks from the 42 CFR § 483, whereas 11 states allowed for what could be considered expanded scope of practice for CNAs, the researchers found. Specifically:

- Two states let CNAs participate in medication management, such as documenting a resident taking medications, and assisting with the placement of pills and medication into the resident’s mouth.
- Nine allowed CNAs to manage wound care and to reposition residents to facilitate wound care and healing.
- Nine allowed CNAs to manage catheter care tasks and catheter and tube care, such as cleaning and replacing catheters.
- Three allowed CNAs to manage medical information, such as communicating medical history, with another provider or to a family member.

“there is no reason to believe patients are in jeopardy and that is exactly what we were trying to demonstrate; in states in which expanded care is provided there is no evidence of harm,” Dr. Resnick said.

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Frailty Costs
A 12-month multifactorial intervention in frail individuals provided better value for its cost than usual care, especially for those who were very frail, according to a cost-effectiveness study.

Using data from the Frailty Intervention Trial (FIT), Nicola Fairhall, PhD, of the University of Sydney, Australia, and colleagues compared the cost effectiveness of an interdisciplinary intervention with usual care in community-dwelling individuals aged 70 years and older who met the Cardiovascular Health Study (CHS) frailty criteria. Dr. Fairhall and her colleagues found that such an approach reduced degree of frailty and decreased disability in older people.

The researchers randomized participants to receive usual care, or a 12-month intervention in which professionals from different health disciplines treated various components of frailty. Among the 216 individuals who completed the study, the prevalence of frailty was 14.7% lower in the intervention group vs. the control group at 12 months. The team found that there was a 30% probability that the intervention was both cost-saving and effective in all groups, and a 63% probability in the very frail subgroup.

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<th>Economic Evaluation of a Multifactorial, Interdisciplinary Intervention Versus Usual Care in Older People – Fairhall N, et al.</th>
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Jeffrey S. Eisenberg, a freelance writer in the Philadelphia area, compiled this report.
Automated Support Eases Patient, Caregiver Burden

BY NEIL OSTERWEIL

BOSTON – An automated system for monitoring the symptoms of patients in home hospice and supporting their caregivers in coaching can both improve patient comfort and relieve at least some of the stress on the caregiver, said investigators in a pilot program.

In a prospective, randomized controlled trial, caregivers assigned to symptom care by phone, in which they received automated coaching tailored to the specific situation, had better overall vitality, and the patients they cared for had less fatigue and anxiety than caregiver-patient pairs assigned to usual care, reported Kathi Mooney, RN, PhD, professor of nursing at the University of Utah College of Nursing, Salt Lake City.

“The family inclusion in hospice care, the philosophy around that, offers the opportunity to extend PROs [patient-reported outcomes] to FCRs [family caregiver reported outcomes]. We call that an opportunity to use electronic monitoring to monitor a family,” she said at the Palliative Care in Oncology Symposium.

Dr. Mooney and her colleagues have previously reported on the use of automated symptom monitoring for support of patients undergoing ambulatory chemotherapy. In the current study, she described its application in home-based end-of-life care to support both the patient and the caregiver.

The investigators recruited 319 cancer patient/caregiver dyads from 12 hospices in Illinois, Massachusetts, Oregon, and Utah. The mean age of the patients was 72 years, and the mean age of caregivers was 59 years.

The caregivers were randomly assigned either to the symptom care by phone (SCP) system or to usual care. The SCP system is an automated system in which caregivers phone in to report the patient’s symptoms and their own level of distress about the symptoms. The nurses were instructed to log that they had seen the alert and what their planned action was, which was left to their professional judgment.

The average length of the calls was 7 minutes, 4 seconds for the usual care group and 7 minutes, 59 seconds for the intervention group. Control group caregivers completed 59% of expected calls and those in the intervention group completed 64%.

Reported symptoms present in more than 50% of patients included fatigue (88.8%), pain (66.2%), eating/drinking problems (76.6%), difficulty thinking (69.6%), anxiety (67.6%), negative mood (67.3%), bowel problems (61%), and trouble sleeping (58.3%). Among caregivers, 73.3% reported fatigue, 66.7% anxiety, 61% trouble sleeping, and 57.1% negative mood.

In a mixed-effects model looking at caregiver vitality – a composite of caregiver symptoms – the authors found that the severity of symptoms in the usual care group increased steadily over the course of hospice care, out to at least 91 days. In contrast, the severity of symptoms among caregivers in the SCP group rose only slightly. The between-group difference was significant (P < .001).

Similarly, among patients the overall symptom severity scores were lower for those in the intervention group than for controls (P = .03). Additionally, the onset of benefit, defined as time to the first symptom-free day, was significantly earlier among patients in the SCP group (P < .02).

Patterns of patient fatigue during the last 8 weeks of life also favored the symptom-care intervention, Dr. Mooney noted.

The symposium was cosponsored by the American Academy of Hospice and Palliative Medicine, American Society of Clinical Oncology, American Society for Radiation Oncology, and Multinational Association of Supportive Care in Cancer.

The study was supported by the National Cancer Institute. Dr. Mooney reported having no relevant disclosures.

NEIL OSTERWEIL is a Frontline Medical News freelance writer based in Boston.
AMDA's Choosing Wisely recommendations were featured prominently in a recent Consumer Reports health special publication, “Advice for Caregivers: Treatments and Tests for Seniors,” a roundup of medical issues and tips to help patients and families make decisions about health care.

The report stated, “If you are caring for an aging relative or friend, you want to help all you can. You may urge the doctors to try every possible treatment. But the experts who care for older adults say you should be cautious.” In addition to AMDA’s Choosing Wisely recommendations, the report highlights other groups’ suggestions of interest to seniors and their family caregivers.

Access the Consumer Reports special publication at http://consumerhealthchoices.org/wp-content/uploads/2014/10/ChoosingWiselyCaregiversRoundup-ER.pdf. AMDA partnered with the ABIM Foundation in 2013 to participate in the Choosing Wisely campaign to encourage conversations among physicians, patients, and other health care stakeholders about medical tests and procedures that may be unnecessary and could be harmful. AMDA has produced a list of five items (www.amda.com/tools/ChoosingWisely_5Things.pdf), including associated tools and resources.

Leave Your Literary Legacy Through the Foundation

Two General Session speakers at AMDA’s 2015 annual conference are talented authors whose books have received rave reviews. Conference participants will have the opportunity to obtain signed books by keynote speaker Jason Karlawish, MD, and Anne-Marie Filkin lecturer Louise Aronson, MD, MFA, as part of the AMDA Foundation’s book auction. However, the Foundation needs you to ensure the auction’s success. If you have signed or rare volumes or other interesting or unique books, please consider donating them to the Foundation for the auction. Other items, including works of art, toys and games, and DVDs, are also welcome. To arrange your donation, contact the AMDA Foundation at amdafoundation@amda.com or 410-992-3134.

Countdown to AMDA Annual Conference

The countdown to AMDA’s 2015 annual conference is on, and March 19-22 is quickly approaching. The 2015 program features leading experts and hot topics, including: Jason Karlawish, MD, will deliver the keynote address on Friday, March 20, entitled “How Are We Going to Live with Alzheimer’s Disease?” Dr. Karlawish is professor of medicine, medical ethics and health policy at the University of Pennsylvania and director of Penn’s Neurodegenerative Disease Ethics and Policy Program and associate director of the Penn Memory Center. Physician and author Louise Aronson, MD, MFA, will deliver the Anne-Marie Filkin Lecture on Sunday, March 22. She will discuss and demonstrate how stories and data can be used for narrative advocacy, bearing witness, teaching, and improving PA/LTC. She will provide examples and offer simple tips to help participants translate their expertise and experience into stories that inspire and persuade. Saturday’s General Session will focus on AMDA’s top policy issues for 2015. The program will also feature an update on AMDA’s competencies for attending physicians and a presentation about the impact of health care reform on post-acute/long-term care.

The acclaimed day-long program, "Navigating Mood and Behavior Challenges in Long-Term Care Strategies for Optimal Outcomes" is scheduled for Thursday, March 19. Program Chair Eric Tangelos, MD, CMD, will lead a panel of experts who will discuss evidence-based approaches to effective behavioral interventions and professional strategies and solutions to navigate mental health challenges in this care setting. (A 4-day registration and additional $55 pre-registration fee are required for participation.) Nationally known speaker and author Pratap Chand, MD, DM, FRCP, professor and director of movement disorders in the department of neurology and psychiatry at the St. Louis University School of Medicine in Missouri, will address “Movement Disorders in the Older Adult” at the Meet the Expert Breakfast Session. The program is set for Saturday, March 21, 6:00-7:45 a.m.

For more information about the online core program, visit www.amda.com/cmedirect/core-part-1.cfm.
It's Not Too Late To Inspire Young Practitioners

There is still time to support the 2015 AMDA Foundation Futures Program. Individuals who receive a scholarship to participate in this program not only gain insights into career opportunities in PA/LTC medicine but also make friends and career opportunities in PA/LTC program not only gain insights into Program. Individuals who receive

"amazing," Dr. Konchilja said, adding

wants to do research and practice medi-

thinking that primary care physicians can’t

interesting to me because people often

arose from a request by her organiza-

noting that the idea for this webinar

restrict area in recent months," she said,

noting that the idea for this webinar

A great deal has been happening in the infection con-

programs for managing infections in the PA/LTC setting.

Dr. Leible perhaps understands

the challenges of addressing infec-

tious disease better than many, as

she was on the forefront of treating

patients with AIDS and HIV back in the early ‘80s, when these illnesses

were largely unknown. “I was a nurse at Mass General when we got the

first AIDS patients. We used drac-

nian precautions, such as the use of
gowns, masks, and strict isolation.

We learned over time not only how
to treat AIDS and other infectious
diseases but also how to provide per-
sion-centered care for the people with

these conditions.” She noted, “We

have to realize in post-acute and long-
term care that our patients’ rooms

are their homes. We need a better

way than just isolate them there

when they get sick or show signs of

an infectious disease.”

For more information about the

program or to register, go to http://


Sign Up for Infection Control Webinar: Get Member Discount

In response to member feedback and a

commitment to provide affordable,
cutting-edge, and convenient

education, AMDA has announced a

2015 member discount for webinar

programs. Single webinars for AMDA

members will be discounted to $55 –
amostly a 50% savings.

You can take advantage of this
discount to register for the webinar

on infection control, presented by

AMDA past-president Karyn Leible,

RN, MD, CMD. “A great deal has been

happening in the infection control area in recent months,” she said,

noting that the idea for this webinar

arose from a request by her organiza-
tion to develop policies and proce-
dures to address Ebola. The program

will present an update on infection

control and infectious diseases includ-
ing the various organisms practitio-
ners need to be aware of, what is

known and what the literature says

about treatment and prevention, and

misconceptions on the part of staff

and others. For example, she said,

“People often think that drug-resis-
tant organisms make people sicker.

In fact, they don’t, but they are more
difficult to treat.” Dr. Leible also will
discuss challenges regarding the over-

use of antibiotics and their implications

for managing infections in the

PA/LTC setting.

Dr. Leible perhaps understands

the challenges of addressing infec-
tious disease better than many, as

she was on the forefront of treating

patients with AIDS and HIV back in the early ‘80s, when these illnesses

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an infectious disease.”

For more information about the

program or to register, go to http://


Don’t Miss These Events

January 5-March 2, 2015
AMDA Online Core Curriculum on Medical Direction in Long-Term Care: Part I Session 1
Contact: AMDA Registrar
Phone: 410-992-3116
Email: registration@amda.com
Website: www.amda.com/cmedirect/#web.

March 21, 2015
Meet the Expert Breakfast Session: Movement Disorders in the Older Adult
Louisville, KY
Contact: AMDA Registrar
Phone: 410-992-3116
Email: registration@amda.com
Website: http://bit.ly/meetexperts

March 27-28, 2015
GAPNA: Contemporary Pharmacology and Prescribing in Older Adults
Philadelphia, PA
Contact: Jill Bretz
Phone: 866-355-1392
Email: gapna@ajj.com
Website: www.gapna.org

April 1, 2015
AMDA CMD Initial and Recertification Deadline
Contact: AMDCP Program Manager
Phone: 410-992-3117
Email: cmd@amda.com
Website: www.amda.com/certification/overview.cfm

April 4-June 1, 2015
AMDA Online Core Curriculum on Medical Direction in Long-Term Care: Part I Session 2
Contact: AMDA Registrar
Phone: 410-992-3116
Email: registration@amda.com
Website: www.amda.com/cmedirect/#web.

April 24-25, 2015
2015 CALTCM Annual Meeting
Los Angeles, CA
Contact: Barbara Hulz
Phone: 888-332-3299
Email: bhulz@caltcm.org
Website: www.caltcm.org

May 15-17, 2015
American Geriatrics Society 2015 Annual Scientific Meeting
National Harbor, MD
Website: www.americangeriatrics.org/annual_meeting/
Contemporary Pharmacology and Prescribing in Older Adults

March 27-28, 2015 • Sheraton Philadelphia Downtown • Philadelphia, PA

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4 hours on Prescribing Controlled Substances