From Pot to Prescription: The Long, Strange Trip of Medical Marijuana

Joanne Kaldy

When people think of marijuana, they may picture Cheech and Chong, embodying the stereotypical image of stoners high on drugs who are mostly interested in chips and chilling out. However, as medical marijuana has become legal in 29 states and the District of Columbia, practitioners and patients are seeing the health and palliative benefits of controlled forms and dosages of the substance. Nonetheless, even in states where medical marijuana can be used legally, there are still some barriers, questions, and concerns that limit its popularity.

Medical marijuana isn’t for everybody, but it should be easily available and affordable to those who benefit from it.

The two main cannabinoids that are currently of greatest medical use are tetrahydrocannabinol (THC) and cannabidiol (CBD). THC — the compound that creates the “high” feeling associated with marijuana — can increase appetite and reduce nausea, and it also may help decrease pain, inflammation, and muscle control problems. Unlike THC, CBD doesn’t elicit euphoria, but it has been used to reduce pain and inflammation, and control epileptic seizures. CBD may have potential uses for treating mental illness and addictions as well.

Navigating the River of Transitions for a Smoother Journey

Joanne Kaldy

When health care practitioners talk about transitions of care, they are really asking, “Is everyone on the same page?” said Alicia Arbaje, MD, MPH, PhD, associate professor of medicine and director of transitional care research at Johns Hopkins University, at AMDA – the Society for Post-Acute and Long-Term Care Medicine’s Annual Conference. Dr. Arbaje and others talked about successful efforts to bring practitioners along the health care continuum together to improve and streamline transitions in and out of health care facilities.

Numbers Don’t Lie

The numbers tell the tale of why improved care transitions need to be a priority. One in four older adults transitions annually, and one in three older adults transitions two times or more after discharge from the hospital. Fortunately, “we know something about the risk factors for frequent transitions,” said Dr. Arbaje. These include recent hospitalizations, longer hospital lengths of stay, an increased number of chronic medical problems, functional
DEAR DR. JEFF:

One facility has one resident who routinely consumes large quantities of alcohol in his room. Usually his booze is brought in by “friends,” who sometimes drink with him, but at times his brothers bring him his boozes. Once, when no one was available to visit, he called out for a delivery from a local liquor store! Nursing staff is concerned that he will sustain an injury falling drunk and, noting potential negative effects on his chronic medical problems, are concerned that we will receive a deficiency citation. They want to confiscate his bottles and bar any visitor who brings him alcohol. The social worker says that his drinking is his right and we can't interfere. What do you think?

Dr. Jeff responds:

Alcoholic liquids served for pleasurable consumption are often referred to as “legal beverages.” There may be age restrictions on who may consume them and regulations regarding public versus private consumption or which restaurants and stores can sell them, but the point is that they are legal to consume. The phrase was intended to distinguish them from ethanol-containing liquids used for medicinal purposes which can, of course, be prescribed without age limitations and dispensed by pharmacies without a required liquor license. But, assuming that your problem resident is an adult, he is indeed within his legal rights to consume alcoholic beverages within his room, whether alone or with other adults.

Phase 1 of recent revisions to the Requirements of Participation from the Centers for Medicare & Medicaid Services have highlighted a new emphasis on resident rights. New introductory language reinforces a resident’s right to dignity, self-determination, and person-centered care. A new section (§483.10(h) Exercise of Rights) adds new language expanding these concepts with a new right to be supported by the facility in the exercise of these rights. The potential for a deficiency citation would certainly exist if a resident were arbitrarily denied access to a beverage that he could legally access, which would be a violation of self-determination. Alcohol is such a marker of adult status that young adults often celebrate the attainment of legal drinking status as a major life event; denying this resident’s right to drink essentially violates his dignity by treating him as a child. Furthermore, prohibition of an element of the resident’s usual socialization and lifestyle could be characterized as a failure to provide person-centered care.

Resident rights, however, are not unlimited. You describe behavior that is confined to the resident’s room and not disruptive to other residents or interfering with routine care delivery. However, he would have no right to schedule wild parties in the day room or invite other residents to share his liquor cabinet to the detriment of their medical care—or even to become drunk and abusive to other residents or staff.

Facility Prohibitions

Facilities do have the right to create and enforce regulations that potentially limit otherwise legal resident activities. The risks of secondhand smoke and the general public health interest to limit or eliminate tobacco use has allowed increasing numbers of facilities to declare themselves smoke-free. This is quite different from the 1980s and 1990s when state surveyors, at least in New York, routinely told facilities that they needed to make arrangements to accommodate smokers.

Facilities sponsored by religious entities that forbid alcohol consumption could adopt a policy to forbid its use within their facilities. This could include Muslims, Jains, Sikhs, members of the Church of Latter Day Saints, and many Methodists, Baptists, and Pentecostals. Potential residents would need to be informed of such policies prior to admission; they cannot be applied retroactively to those for whom the facility is already home. The Supreme Court decision in the Hobby Lobby case may support this religious exemption to extend to facilities owned by an individual or a closely held, corporately owned facility whose owners hold these religious views.

Many religions incorporate alcohol for sacramental purposes, including, of course, Roman Catholicism usage during Mass and Hinduism’s use of alcohol in Ayurvedic healing. Shintoism and Judaism not only permit the use of alcohol but have religious ceremonies in which some religious authorities endorse drunkenness. Noah was a vintner, and the Book of John reports that Jesus’ first public miracle was the transformation of water to wine when a marriage feast’s supply was depleted. The ancient Greeks and Romans actually had a god of wine (Dionysus or Bacchus), and the Dionysian cults reportedly enjoyed not only overindulging in wine but also the behaviors that typically followed. Although I do not believe that federal code requires your activities department to coordinate Dionysian orgies, reasonable respect for the beliefs of your residents would require a facility to accommodate alcohol use in accordance with religious practices.

But your letter raises concerns regarding the quantities that this resident is consuming and the potential consequences for his health. Moderate consumption of alcohol in general does not seem to pose a health risk. I have worked at religiously sponsored facilities that incorporated a cash bar in the basement. Friends and families were encouraged to drop by after work and socialize just as they had done when the resident lived in the community. Residents from different units could interact socially during happy hour. A glass of dry sherry or other bitter alcoholic beverages such as gin may stimulate the appetite (the evidence, although slightly contradictory, leans in that direction), an effect that seems to correlate with the quantity ingested. A glass of Dubonnet, which was deliberately formulated with quinine, will also help protect you from malaria — better safe than sorry.

The National Institutes of Health recently announced a $100-million study to determine whether moderate alcohol intake will protect against heart disease. The funding comes primarily from alcohol industry corporate donations. There is considerable evidence that moderate alcohol consumers live longer than either chronic alcoholics or total abstainers. Worldwide clusters of extremely long-lived persons include some where alcohol consumption is routine and some communities where complete abstinence is the norm.

Of course, the trick here may be to define “moderate” in terms of alcohol consumption. One wag defined an alcoholic as “someone who drinks more than their doctor.”

What is “Moderate”?

Clearly, what is considered moderate drinking should vary based on age, body size, and metabolism. Although hepatic alcohol dehydrogenase function does not decline significantly with age in the normal liver, its rate might vary, depending on other factors such as drug-drug interactions and underlying liver disease. Because alcohol distributes in total body water, which tends to decline as a proportion of total body mass with aging, the same consumption over a lifetime may produce significantly higher blood alcohol levels in an 80-year-old than when he was in his 20s. The standard two pints at the pub or two martinis before dinner, which might have been described as moderate consumption, may produce dangerous blood alcohol levels with aging. Also, end-organ sensitivity may also increase with medication interactions (particularly warfarin, benzodiazepines, or nonsteroidal anti-inflammatory drugs) or comorbid conditions, particularly balance disorders, cognitive impairment, hypertension, congestive heart failure, and peripheral neuropathy.

In your patient’s case, members of the interdisciplinary team have identified health concerns related to his alcohol consumption. Alcohol consumption is his autonomous right, but this does not mean the facility and the care team can simply ignore it. As with any other potentially risky behavior, the concerns must be addressed in his interdisciplinary care plan.

Alcohol consumption is the resident’s autonomous right, but this does not mean the facility and the care team can simply ignore it. As with any other potentially risky behavior, the concerns must be addressed in his interdisciplinary care plan. This will probably require some attempt to quantify his actual consumption (self-report or marking the levels in bottles could be a measure, as could the number of empties or even blood alcohol level measurements), and to evaluate it within a person-centered plan regarding his individual needs and risks.

Risks in the Nursing Home

Alcohol consumption is associated with falls and other accidents in individuals of all ages, and because the care team has explicitly raised concerns regarding that possible complication, it should be addressed in his care plan. Fall risk may increase with consumption of 14 or more drinks per week (J Am Geriatr Soc 2004;52:1174–1179). Comprehensive evaluation of the overall effects of his behavior should be included within the overall plan for his identified medical, nutritional, social, recreational, and nursing needs.

For example, social alcohol consumption is frequently associated with food consumption. There is extensive anecdotal literature suggesting that foods such as chicken wings and pizza are commonly consumed with beer and other alcoholic beverages. Should he be provided with low-salt or salt-free snacks

2 CARING FOR THE AGES OCTOBER 2017
LOS ANGELES — Endocrinologist Jane Weinreb, MD, has a message for long-term care facilities and clinicians about caring for people with diabetes: help them control their glucose, but don’t overdo it. In fact, a high HbA1C level — even nearly 9% — might actually be just fine, depending on the patient.

“We want to individualize our targets based upon the overall health status of patients and also based on personal and family desires,” said Dr. Weinreb, who spoke at the annual meeting of the California Association of Long-Term Care Medicine. “In some cases, we don’t need to achieve tight goals because no benefit will be derived.”

Dr. Weinreb, the chief of epidemiology of the VA Greater Los Angeles Healthcare System and a clinical professor of medicine at David Geffen School of Medicine at the University of California at Los Angeles, shared tips about care for patients with diabetes.

Be aware of how common diabetes is in this population.

An estimated 26.8% to 34% of nursing home patients have diabetes, and the cost of caring for these patients in U.S. long-term facilities was estimated at $19.6 billion in 2012 (Diabetes Care 2016;39:308–318; Diabetes Care 2013;36:1033–1046).

Consider checking C-peptide levels.

In some cases, a patient with diabetes who takes multiple daily insulin injections may seem to be doing quite well on the blood sugar front, based on his or her levels — but this scenario might be too good to be true, Dr. Weinreb cautioned.

Many patients with diabetes retain the ability to secrete insulin even though they take insulin, she said. “I encourage you to check their C-peptide level,” she said, referring to a test of blood levels of a peptide that provides insight into insulin production. “If it’s greater than 1, they’re making their own insulin and don’t need to consume rather than the salted nuts, potato chips, and pretzels that his friends might also bring! If inadequate dietary intake is a concern, might this provide an opportunity to get some additional nutrition into him?”

Should his interactions with friends from the community be regarded as emotional support and a resident choice of recreational activity? Or do they interfere with his social interactions with other residents and his ability to participate in other desired activities? Assuming that alcohol is not only his pleasure in life, should an attempt be made to schedule his friends’ visits around other events or activities?

Alcohol is a known depressant and can cause mood swings. Is there evidence that his consumption is interfering with his mood (as scored by the Patient Health Questionnaire 9 or through simple observation)? Is the resident also receiving hypnotics, sedatives, or anti-depressants where potentiation would be high? Are there other side effects? Is there evidence to suggest nocturnal alcohol consumption is disrupting his normal sleep patterns? Is his alcohol use being addressed within an overall behavioral care plan?

The team should not assume that the resident is necessarily aware of the health consequences of his habits. Many older drinkers believe that they are not at risk because their consumption has not changed throughout life, particularly if their intake is typical for their family or social circles. The general notion that “drinking is bad for you” is not the same as a careful review with the resident of his problem list and medication list with a frank and informed review of the health risks and benefits of alcohol on each of these — including transparency regarding some mild benefits, or simply no reliable information. The clinical pharmacy consultant must be involved with this process to ensure the resident receives the best current information. Alternatives, including alcohol-free beer, may be considered.

The resident may well refuse to change his habits. Nevertheless, the facility response cannot be “It’s your funeral.” Medication adjustments may be available to minimize interactions if the resident continues to insist on self-medicating with alcohol. Other needed care must still be provided.

Beware Overdoing Glucose Control in Elders

Randy Dotinga

The July 2017 issue of Caring included an excellent Legal Issues column by William C. Wilson, Esq., that reviews the legal and risk management issues with a “refusing resident.” First, residents can only be regarded as refusing our care if it is an informed decision by a resident with decision-making capacity. If this occurs, the team must take multiple steps to protect the resident and the facility. And, of course, as with almost everything else in 21st-century medicine, “document, document, document.”

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.

EDITOR’S NOTE

Dr. Weinreb’s advice contains many pearls beyond the well-known recommendation to avoid overly tight glycemic control in most of our nursing home residents. Checking a C-peptide level, and periodically checking midnight or 3 a.m. finger stick glucose levels, are appropriate in patients who have seemingly reassuring A1C levels but high daytime pre- or postprandial finger stick blood sugar (FSBS) glucose levels.

While we are at it, we need to rethink the old-school, knee-jerk order sets — “FSBS before each meal and at bedtime”— which are unnecessary and burdensome for patients with reasonably stable glucose levels; and “Notify physician for FSBS less than 70 or greater than 400”— does that mean “If it’s 396, I don’t need to know?” Personally, I want to know if my patient’s blood sugar is over 200 in most cases — and it doesn’t need to get down to 70 for me to consider a change in therapy. Many facilities seem to have these types of routine orders as part of the admission process for any diabetic resident, and that needs to change. Please help when you admit a new patient and consider both the frequency of blood sugar monitoring and the parameters for notification of abnormal levels.

—Karl Steinberg, MD, CMD, HMDC

Editor in Chief
Psychedelics: Finding a New Groove?

Dr. Steinberg is chief medical officer for Mariner Health Central in California, and a longtime nursing home and hospice medical director. He is editor-in-chief of Caring and chairs the Public Policy Committee for the Society. The views he expresses are his own and not necessarily those of the Society or any other entity. He may be reached at karlsteinberg@MAIL.com and he can be followed on Twitter @karlsteinberg.

I
t late August, the Food and Drug Administration somewhat surprisingly granted “breakthrough” status to a not-so-new drug, methyl-endo-methylamphetamine (MDMA, long used recreationally in the club scene and known as ecstasy, X, or Molly), for the treatment of post-traumatic stress disorder (PTSD). This hallucinogen stimulant has shown considerable promise for this indication, as phase 2 trials have demonstrated a very robust effect on many PTSD sufferers, with complete remission in over two-thirds of the patients at 1 year. Many of these patients had severe PTSD symptoms for 15 to 20 years or longer, despite traditional psychotherapy and the usual medications, including selective serotonin reuptake inhibitors, so these results truly are remarkable.

In case you are wondering, these MDMA studies do not involve the patients taking some unknown dose of ecstasy and then going to a rave or nightclub for all-night dancing and feeling unconditioned love for (and from) strangers. Instead, the protocols typically require preingestion and postingestion psychotherapy in addition to supervision and psychotherapy during each of three doses of MDMA. Researchers refer to this as MDMA-assisted psychotherapy. Because the acute effects of MDMA include feelings of euphoria, connectedness to others, and empathy, it is perhaps not surprising that individuals with PTSD—who are highly mistrustful of their surroundings and always in a state of hyperarousal—would benefit from some respite in which they can feel at ease, joyful, safe, and emotionally close to other humans.

In our cover story, Joanne Kaldy writes about the current status of medical marijuana. While marijuana has been around much longer than MDMA and certainly is much less likely to cause severe psychotropic symptoms or overdose, they are both classed as Schedule I controlled substances by the Drug Enforcement Agency, along with other notorious drugs like heroin and LSD (for context, methamphetamine and fentanyl are Schedule II). Even though medicinal marijuana is now legal in many states, and recreational marijuana use is legal in a few, apparently the DEA thinks marijuana is worse than crystal meth. For those of us who work in nursing homes, this disconnect between federal and state law is a challenge. And with the current political climate, who knows when a bureaucrat may declare that a facility that allows the use of any marijuana will forfeit all federal funding?

What’s even more disturbing is that even cannabidiol (CBD), a marijuana alkaloid that has no abuse potential or psychotropic properties, and has some definite medical indications, has not been explicitly included in the Schedule I classification as of December 2016. Many colleagues of mine have had good success with CBD preparations in their geriatric patients, with no apparent adverse effects. But for most physicians, who tend to be somewhat risk averse, this may rapidly take CBD off the table for treating pain and other symptoms. In our post-acute, long-term, and palliative care arenas, that is unfortunate—because our options are already limited, the evidence for many interventions is weak, and we are often taking a pragmatic, seat-of-our-pants, first-do-no-harm approach to symptom control.

Beyond Marijuana

Caring has reported on several occasions on studies indicating that ketamine, a dissociative agent with hallucinogenic properties that is used for anesthesia (in humans and animals), can be rapidly effective for refractory depression. It also can treat neuropathic pain, presumably via NMDA neurotransmitter pathways. Coincidentally, ketamine is also a club drug (“Special K,” etc.), and it is chemically similar to phencyclidine (PCP). I have prescribed ketamine in oral form for palliative care patients with severe depression, with some success. This is a Schedule III controlled substance, and of course its use for these indications is off-label; it does not come in an oral formulation, so it must be compounded.

There is good literature on dosing and potential side effects available for anyone who is considering prescribing ketamine for their patients. Along these same (psychedelic) lines, there has been a substantial body of research work done on psilocybin, a hallucinogenic alkaloid found in a variety of “magic” mushrooms, in end-of-life patients with severe existential suffering. A single dose of psilocybin seems to hold significant promise in alleviating spiritual and other nonphysical pain; heart-warming and glowing videos of euphoric patients who have undergone apparently transformative spiritual experiences that confer newfound meaning to their lives are readily available on YouTube. The psilocybin studies also involve therapy sessions before and after the ingestion, with a guide present throughout the “trip” and often with the subject wearing a blindfold.

As a child of the 1970s, I had experience with a variety of “recreational” psychoactive substances (yes, I did inhale), although I have had none in at least 30 years. As an undergraduate I studied hallucinogenic plants in graduate-level courses and an individualized tutorial with the eminent ethnobotanist Richard Schultes (https://en.wikipedia.org/wiki/Richard_Evans_Schultes). He was a remarkable man who had done years of field research in Central and South America. I also credit his recommendation letter with getting me into medical school despite a less-than-stellar science GPA, and I’ll always be grateful for his guidance.

I never took any hallucinogens (or other recreational drugs) with Dr. Schultes, but I did have some seemingly very cosmic, meaningful, fascinating, reassuring experiences with these substances in those years. These included periods of euphoria where everything seemed to make sense as the very bright and colorful galaxies, stars, molecules, and atoms went whizzing by, and I felt very much a powerful and loved part of the universe—that everything at that instant was precisely and perfectly as it should be. Of course, when you “come down,” you can’t quite remember exactly how things made so much sense, but it’s reassuring to know that they can.

Mind Expansion

I remember having some conversations with my dad, a psychologist, around this time about my strong belief that “expanding your mind” was a worthwhile and important endeavor. When he was in medical school, they were doing experiments with LSD on medical students, but apparently he had been assigned to the control group. Nonetheless, he did see some people have some very scary and unpleasant bad trips, although they weren’t called that in 1960. Anyway, I’d confront my dad: “Don’t you have any intellectual curiosity?” His reply was along the lines of, “Hey, regular life is plenty interesting enough without a bunch of sensory distortion and loss of contact with reality.” I thought, “What an old fuddy-duddy!” As with so many other things, I eventually had to admit that my dad was right.

Yet when I think back to the profound spiritual and existential insights I experienced thanks to the neurochemical alterations created by hallucinogens, I can see where these could be very powerful tools for patients with a variety of ailments, especially when other measures have failed or when time is short. As a geriatrician, I think less medication is better, but sometimes better living through chemistry is a valuable concept, even though these particular drugs obviously would have a high risk of delirium and perhaps enduring cognitive decline—we just don’t know yet. With the current political climate, it’s hard to know if and where these substances will fit in, but I certainly will consider their use in appropriate patients as they become more available, and I will continue to use ketamine in appropriate cases, with informed consent.

The use of these drugs, if eventually approved, will probably (and appropriately) come with a lot of restrictions and hoops to jump through. I worry that this will create yet another area where health care disparities will rear their ugly head. It’s highly improbable that insurance companies are going to agree to cover this kind of treatment (particularly if it requires at least three to six hour-long psychiatric sessions and a professional to spend 6 hours or more coaching or guiding the patient through the acute intoxication phase). And it’s similarly improbable that most of our indigent, frail, elder nursing home residents who might benefit from these treatment modalities will ever have access to them. I’m an optimist, and I would like to hope that equitable distribution of these resources will become the norm, if they are ever actually approved for general (nonresearch) use. The profound potential good that can come from these substances should not become another (if less superficial) version of Botero or Kybella, with which only the wealthy and privileged will have access to.

Psychedelics and other hallucinogenic drugs, including THC, are largely unavailable today, but that may change in the future. They clearly have shown great promise for some conditions that cause extreme suffering. As always, we must consider the individual patient’s situation and goals of care, as these drugs also bear significant risks of harm. But for our often very ill, sometimes miserable nursing home residents, we should not count out the use of this class of drug for palliative purposes.
**Indication and Usage**
DIFICID is a macrolide antibacterial drug indicated in adults (≥18 years of age) for treatment of *Clostridium difficile*–associated diarrhea (CDAD).

To reduce the development of drug-resistant bacteria and maintain the effectiveness of DIFICID and other antibacterial drugs, DIFICID should be used only to treat infections that are proven or strongly suspected to be caused by *C difficile*.

**Important Safety Information**
- DIFICID is contraindicated in patients with hypersensitivity to fidaxomicin.
- DIFICID should not be used for systemic infections.
- Acute hypersensitivity reactions, including dyspnea, rash pruritus, and angioedema of the mouth, throat, and face have been reported with fidaxomicin. If a severe hypersensitivity reaction occurs, DIFICID should be discontinued and appropriate therapy should be instituted.

Please read the additional Important Safety Information on the following pages and the adjacent Brief Summary.
Clinical response rate (primary end point)

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
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<tbody>
<tr>
<td>DIFICID</td>
<td>vancomycin</td>
</tr>
<tr>
<td>88% (n=289)</td>
<td>87% (n=256)</td>
</tr>
<tr>
<td>(95% CI): 2.6% (2.9%, 8.0%)</td>
<td>1.0% (-4.8%, 6.8%)</td>
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</tbody>
</table>

Patients (%)

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**Important Safety Information (continued)**

- Only use DIFICID for infection proven or strongly suspected to be caused by *C. difficile*. Prescribing DIFICID in the absence of a proven or strongly suspected *C. difficile* infection is unlikely to provide benefit to the patient and increases the risk of development of drug-resistant bacteria.
- The most common adverse reactions reported in clinical trials are nausea (11%), vomiting (7%), abdominal pain (6%), gastrointestinal hemorrhage (4%), anemia (2%), and neutropenia (2%).

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**Study description:** Two phase 3, randomized, double-blind, noninferiority studies (N=1,105) comparing the efficacy and safety of oral DIFICID 200 mg BID vs oral vancomycin 125 mg QID for 10 days in the treatment of adults (aged ≥18 years) with CDAD (defined as >3 unformed bowel movements or >200 mL of unformed stool for subjects having rectal collection devices in the 24 hours before randomization and presence of either *C. difficile* toxin A or B in the stool within 48 hours of randomization).
- The primary end point was clinical response rate at the end of 10-day treatment. Clinical response was defined as improvement in diarrhea or other symptoms, such that further CDAD treatment was not needed.
- An additional efficacy end point was a sustained response 25 days after the end of treatment. Sustained response was evaluated only for patients who were clinical successes at the end of treatment. Sustained response was defined as clinical response at the end of treatment and survival without proven or suspected CDAD recurrence through 25 days beyond the end of treatment.
In the same studies, DIFICID demonstrated superior sustained response rate vs vancomycin through 25 days after end of treatment.

Sustained response rate (secondary end point)

Trial 1
- 70% (n=289)
- DIFICID 200 mg BID
- vancomycin 125 mg QID

Trial 2
- 72% (n=253)

Patients (%)

12.7% difference
(95% CI): 12.7% (4.4%, 20.9%)

14.6% difference
(95% CI): 14.6% (5.8%, 23.3%)

Since clinical success at the end of treatment and mortality rates were similar across treatment arms (approximately 6% in each group), differences in sustained response were due to lower rates of proven or suspected CDAD during the follow-up period in DIFICID patients.

Efficacy in BI isolates

In patients infected with a BI isolate, similar rates of clinical response at the end of treatment and during the follow-up period were seen in fidaxomicin-treated and vancomycin-treated patients. However, DIFICID did not demonstrate superiority in sustained response when compared with vancomycin in these patients.

Network pharmacies can help support your patients prescribed DIFICID

Patient support features include:

- Information and assistance regarding access to therapy (including benefits investigations and reimbursement requirements)
- Product availability
- Next-day delivery of medications
- Disease-related educational materials for patients
- 24-hour patient counseling services

DIFICID is available at pharmacies in and out of the network. Check with your pharmacy to learn what features they offer to patients. Merck does not support the use of any particular pharmacy, and one is not preferred over the others. Merck does not make any warranty as to the features and support offered by any particular pharmacy.

Important Safety Information

- Among patients receiving DIFICID, 33 (6.9%) withdrew from trials as a result of adverse reactions. Vomiting was the primary adverse reaction leading to discontinuation of dosing (incidence of 0.5% for both DIFICID and vancomycin patients).
- The safety and effectiveness of DIFICID in patients <18 years of age have not been established.

Please read the adjacent Brief Summary of the Prescribing Information.
BRIEF SUMMARY OF PRESCRIBING INFORMATION

DIFICID (fidaxomicin) tablets, for oral use

INDICATIONS AND USAGE

To reduce the development of drug-resistant bacteria and maintain the effectiveness of DIFICID® and other antibacterial drugs, DIFICID should be used only to treat infections that are proven or strongly suspected to be caused by Clostridium difficile.

Clostridium difficile-Associated Diarrhea

DIFICID is a macrolide antibacterial drug indicated in adults (≥18 years of age) for treatment of Clostridium difficile-associated diarrhea (CDAD).

CONTRAINDICATIONS

Hypersensitivity to fidaxomicin.

WARNINGS AND PRECAUTIONS

Not for Systemic Infections

Since there is minimal systemic absorption of fidaxomicin, DIFICID is not effective for treatment of systemic infections.

Hypersensitivity Reactions

Acute hypersensitivity reactions, including dyspnea, rash, pruritus, and angioedema of the mouth, throat, and face have been reported with fidaxomicin. If a severe hypersensitivity reaction occurs, DIFICID should be discontinued and appropriate therapy should be instituted.

Some patients with hypersensitivity reactions also reported a history of allergy to other macrolides. Physicians prescribing DIFICID® to patients with a known macrolide allergy should be aware of the possibility of hypersensitivity reactions.

Development of Drug-Resistant Bacteria

Prescribing DIFICID in the absence of a proven or strongly suspected C. difficile infection is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

ADVERSE REACTIONS

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of other drug and may not reflect the rates observed in practice.

The safety of DIFICID 200 mg tablets taken twice a day for 10 days was evaluated in 564 patients with CDAD in two active-comparator controlled trials with 86.7% of patients receiving a full course of treatment.

Thirty-three patients receiving DIFICID (5.9%) withdrew from trials as a result of adverse reactions (AR). The types of AR resulting in withdrawal from the study varied considerably.

Table 1. Selected Adverse Reactions with an Incidence of ≥2% Reported in DIFICID Patients in Controlled Trials

<table>
<thead>
<tr>
<th>System Organ Class Preferred Term</th>
<th>DIFICID (N=564)</th>
<th>Vancomycin (N=583)</th>
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<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Blood and Lymphatic System Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>14 (2%)</td>
<td>12 (2%)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>14 (2%)</td>
<td>6 (1%)</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>62 (11%)</td>
<td>66 (11%)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>41 (7%)</td>
<td>37 (6%)</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>33 (6%)</td>
<td>23 (4%)</td>
</tr>
<tr>
<td>Gastrointestinal Hemorrhage</td>
<td>20 (4%)</td>
<td>12 (2%)</td>
</tr>
</tbody>
</table>

The following adverse reactions were reported in <2% of patients taking DIFICID tablets in controlled trials:

Gastrointestinal Disorders: abdominal distension, abdominal tenderness, dyspepsia, dysphagia, flatulence, intestinal obstruction, megacolon

Investigations: increased blood alkaline phosphatase, decreased blood bicarbonate, increased hepatic enzymes, decreased platelet count

Metabolism and Nutrition Disorders: hyperglycemia, metabolic acidosis

Skin and Subcutaneous Tissue Disorders: drug eruption, pruritus, rash

Post Marketing Experience

Adverse reactions reported in the post marketing setting arise from a population of unknown size and are voluntary in nature. As such, reliability in estimating their frequency or in establishing a causal relationship to drug exposure is not always possible.

Hypersensitivity reactions (dyspnea, angioedema, rash, and pruritus) have been reported.

DRUG INTERACTIONS

Fidaxomicin and its main metabolite, OP-1118, are substrates of the efflux transporter, P-glycoprotein (P-gp), which is expressed in the gastrointestinal tract.

Cyclosporine

Cyclosporine is an inhibitor of multiple transporters, including P-gp. When cyclosporine was co-administered with DIFICID, plasma concentrations of fidaxomicin and OP-1118 were significantly increased but remained in the ng/mL range. Concentrations of fidaxomicin and OP-1118 may also be decreased at the site of action (i.e., gastrointestinal tract) via P-gp inhibition; however, concomitant P-gp inhibitor use had no attributable effect on safety or treatment outcome of fidaxomicin-treated patients in controlled clinical trials. Based on these results, fidaxomicin may be co-administered with P-gp inhibitors and no dose adjustment is recommended.

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Category B. Reproduction studies have been performed in rats and rabbits by the intravenous route at doses up to 12.6 and 7 mg/kg, respectively. The plasma exposures (AUC0-7), at these doses were approximately 200-66-fold that in humans, respectively, and have revealed no evidence of harm to the fetus due to fidaxomicin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers

It is not known whether fidaxomicin is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when DIFICID is administered to a nursing woman.

Pediatric Use

The safety and effectiveness of DIFICID in patients <18 years of age have not been established.

Geriatric Use

Of the total number of patients in controlled trials of DIFICID®, 50% were 65 years of age and over, while 31% were 75 and over. No overall differences in safety or effectiveness of fidaxomicin compared to vancomycin were observed between these subjects and younger subjects.

In controlled trials, elderly patients (≥65 years of age) had higher plasma concentrations of fidaxomicin and its main metabolite, OP-1118, versus non-elderly patients (<65 years of age). However, greater exposures in elderly patients were not considered to be clinically significant. No dose adjustment is recommended for elderly patients.

For more detailed information, please read the Prescribing Information.

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A medical director, I have worked with many dedicated clinical staff. However, passion does not always translate to quality care due to the historical systems that have been put in place across an organization. To see results, leadership must work with staff to evaluate these systems, with the medical director playing a significant role, and they must identify the opportunities for performance improvement. But this process isn’t always easy.

In today’s market, with its onslaught of regulatory and payment changes, care facilities must have a comprehensive understanding of performance systems to realize meaningful improvement. With that being said, how can medical directors work with their centers and staff to build a strong foundation for performance excellence?

The nationally recognized Baldrige Performance Excellence Criteria are a powerful tool for improving quality in post-acute and long-term care settings. This framework for performance excellence focuses on systems in all areas of the organization. The value of applying this method in the health care setting is well documented, and its effectiveness has been cited in many studies throughout the years (including Castle et al., 2016, Schulingkamp and Latham, Qual Manag J 2015;22[3]:6–22; Truven Health Analytics, 2014, https://goo.gl/CDPdrP; Foster and Chenoweth, 2011, http://goo.gl/GVJRWy). Baldrige recipients in long-term care outperform their peers in a number of key metrics: they are 5% lower than the national average for hospital readmissions rates, are 15% lower for off-label antipsychotic use rates, and have higher occupancy and positive operating margins.

There are several recognized programs affiliated with, and based on, the Baldrige criteria, which include the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) National Quality Award Program.

To better understand the role of the medical director in pursuing the Baldrige framework, AHCA interviewed the administrator and medical director at two recent AHCA/NCAL Quality Award recipient organizations: Aftercare Post-Acute Rehabilitation Center (APRC), in Kent, OH, which received its Gold award in 2016; and Kindred Nursing and Rehabilitation Center – Mountain Valley (MV), in Kellogg, ID, which received its Gold award in 2011 and was the first skilled nursing center to be recognized with the Malcolm Baldrige National Quality Award from the Department of Commerce in 2016.

**What prompted your facility to begin the AHCA/NCAL National Quality Award journey?**

**Frederick Haller, MD, medical director, MV:** The workforce at MV always strives to be better and to do better. But the Baldrige framework offered staff additional tools to help them improve quality outcomes. Not just clinical, but customer satisfaction, workforce engagement, and community involvement. All were clear areas that could be impacted by beginning the quality journey.

**As the medical director, what made you interested in being part of this process?**

**Dr. Haller:** Quality care is my priority — my responsibility as attending physician and medical director is to ensure that I am doing everything to drive the best clinical outcomes for our patients/residents. Being part of this process meant that we as an organization would be engaged daily on a journey of quality.

**Hugh O’Neill, MD, medical director, APRC:** As a physician, being part of an organization that focuses on systems and encompasses quality in all aspects of providing care is extremely rewarding. How was the Baldrige journey changed or improved the relationship between the facility and medical director?

**Maryruth Butler, MBA, administrator, MV:** I think the biggest change has been our ability to include other key success factors in our Quality Assurance and Performance Improvement (QAPI) process with Dr. Haller. For example, talking about strategic objectives relating to customer satisfaction (residents/patients) and key drivers of workforce engagement normally are not discussed with the medical director. We involve him in our strategic planning process, particularly in areas of development for new health care services.

**Dr. Haller:** I would agree with Maryruth’s comments here — through this process I have expanded my involvement to include other areas outside of clinical areas that are equally important key drivers to the outcomes of our residents.

**Dr. O’Neill:** The Baldrige criteria facilitate an integrated approach where the medical director, facility administrator, director of nursing, nursing staff and therapists can communicate openly and freely. This approach to communication is critical to achieving high quality care. Please share one or two things that occurred during the Quality Award journey. What was the impact?

**Dr. Haller:** Because we had developed a systematic succession plan, when our director of nursing services of 25 years retired, her successor was able to easily transition into that position. I have experienced many succession plans in my career and most are not well done. However, this one was the most systematic, organized, and successful transition that I have experienced. In fact, the new director of nursing services was so prepared that 2 months after her promotion, MV received a deficiency-free survey.

**Erin K. Fromwiller, administrator, APRC:** The staff realized how the processes and systems of the organization impact every department and, as a result, how each department impacts the overall quality of care a patient receives. To establish a high performing culture, organizations must achieve a high level of customer service and employee satisfaction.

**How have the changes at your facility prompted by the Quality Award journey impacted your practice as medical director?**

**Dr. Haller:** In today’s post-acute care environment we get them sicker and quicker. MV’s systematic approach to workforce development and quality outcomes gives me the confidence to refer my patients to the center as well as to promote them to our community medical clinic, acute care hospital, and area physicians.

**Dr. O’Neill:** My practice has improved by the systematic approach to problem solving that results in allowing the staff to confidently assess and report conditions to physicians and then act on that information to prevent hospitalizations and improve how patients function. I was extremely satisfied before and continue to be extremely satisfied by an organization that strives to improve quality and that believes in the approach that doing good is never good enough.

**How have the changes at your facility affected the practice of staff you work with?**

**Dr. Haller:** The reduction in turnover and increase in staff retention, particularly among the nursing staff, affected me the most. As part of our workforce capability and capacity system, all nurses are trained using the same competencies relating to resident care and assessments. Their systematic process of developing workforce with competencies to match residents and then managing to meet the daily clinical needs for each patient ensures higher quality.

**How have the changes impacted your satisfaction as medical director?**

**Dr. O’Neill:** Open the lines of communication with staff. Create a system and culture that allow all members of the care team to come directly to the physicians. Avoid the pitfalls of a hierarchy in which therapists and aides must go through nursing to transmit information to the providers.

For more information about the Baldrige Foundation and the Baldrige Performance Excellence Criteria, visit http://baldrigefoundation.org/. To find out more about the AHCA Quality Initiative Recognition Program, visit www.ahcanal.org/quality_improvement/qualityinitiative/Pages/RecognitionProgram.aspx.

**Dr. Gifford** is the senior vice president of quality, research and regulatory affairs at the American Health Care Association, the largest association in the country representing long-term and post-acute care centers. A board-certified geriatrician, Dr. Gifford also serves on the board of the Advancing Excellence in America’s Nursing Homes campaign and the Baldrige Foundation Board. He is a clinical associate professor of medicine at Brown University and a former director of the Rhode Island State Department of Health. Special thanks to Courtney Bishnoi, AHCA senior associate professor of medicine at Brown University and a former director of the Rhode Island State Department of Health. Special thanks to Courtney Bishnoi, AHCA senior director of quality, for her contribution to this article.

**Baldrige Criteria Illuminate the Steps to Achieve Quality Care**

**David Gifford, MD, MPH**
It is imperative for SNF medical directors that the admitting department ask the hospital before placement whether the stay was OBS or hospital inpatient, and find out how many days of each.

Dr. Donovan: A unique combination of hospitallist and palliative care specialist at Lawrence & Memorial Hospital in New London, CT. He has been a popular and well-received speaker at the Transitions of Care Committee Symposia at AMDA – the Society for Post-Acute and Long-Term Care Medicine Annual Meetings. The difference between OBS and hospital inpatient admission is clinically invisible to patients and families. Do you address the OBS status upon admission; that is, do you, during the admission process, specifically state that the patient is being admitted to OBS and not a hospital patient?

Dr. Donovan: It is imperative for SNF medical directors that the admitting department ask the hospital before placement whether the stay was OBS or hospital inpatient, and find out how many days of each. Issuance of a MOON notice is evidence of an OBS stay, which should trigger examination of how many days are true hospital inpatient as opposed to OBS.

In your hospital, the hospitallist cares for OBS patients. Is this typical across the country? Who determines whether a patient is to be admitted to OBS vs. hospital inpatient status? And can the hospitallist change or reverse the emergency department (ED) physician’s decision on admission?

Dr. Donovan: In many hospitals, hospitallists care for all OBS patients. However, we are also seeing a developing trend of ED doctors managing “observation units.” The “attending” physician ultimately determines the patient’s status (so yes, the hospitallist can reverse the ED doctor’s decision), but typically this decision is now made in collaboration with a team of utilization review clinicians (including physicians) who have more expert knowledge of the process.

Dr. Lett: SNF medical directors must be aware of OBS policies at referring hospitals. Do hospitallists or ED physicians admit, care for, and discharge OBS patients? Where do OBS patients receive care: in the ED, in the hospital, or in a special unit? Is there a specific discharge planer — or planners — involved in transitions? Regarding the paperwork process in OBS stays, does it mirror that of inpatients? Is there a historical and physical, daily progress notes, and a discharge summary performed?

Dr. Donovan: In my hospital, all the paperwork is exactly the same. This may not be the case everywhere.

Dr. Lett: This response warms the heart of any SNF clinician! Do not forget to thank the hospitallist, and be equally vigilant in calling and submitting similar information to the hospitallist on patients sent to the hospital ED. Is there a difference in how the hospitallist, care for, and discharge OBS patients vs. a hospital inpatient?

Dr. Donovan: Same care, same amount of work, same degree of testing, and so on. Despite the identical care, the reimbursement to the physician and hospital is significantly less.

Dr. Lett: For me, this engenders a great deal of respect for our hospital colleagues.

Education for OBS patients and families has become mandatory through the Notice of Observation, Treatment and Implication for Care Eligibility (NOTICE) Act (which the Society actively advocated for on Capitol Hill) requiring that a hospital must, within 36 hours of admission, tell a Medicare enrollee of their outpatient status and that OBS does not count toward potential Medicare eligibility. Are patients/families being informed, in your experience? If so, who is performing the informing and educating? How is the hospitallist involved in this effort?

Dr. Donovan: See my answer to question 1.

Dr. Lett: It is clear that SNF personnel must be respectful of, and engaged with hospital case management to best serve our patients.

Haven you as a hospitallist received pushback from patients or SNFs regarding an OBS stay preventing the patient from accumulating the necessary 3-day hospital stay to trigger the SNF stay benefits?

Dr. Donovan: Yes! At least once or twice a week, we must have this difficult and uncomfortable conversation with patients and families.

Dr. Lett: The regularity with which this occurs with hospitallists should forewarn those of us on the SNF side of care to be prepared and alert to issues of whether an adequate qualifying hospital stay has taken place.
What advice would you provide the SNF physician receiving a patient from OBS status at the hospital to improve the transition to the SNF and reduce the chances of hospital readmission?

Dr. Donovan: I think the key for the SNF physician is simply knowing that the patient is coming after an observation stay. Consequently, for many of these patients, the cost of the SNF stay will not be covered by Medicare. And this may change significantly the dynamic with the patient and family, so expectations will need to be set very early regarding the plan of care, duration of physical or occupational therapy, and anticipated discharge. A warm handoff from your hospitalist colleague certainly would be beneficial for these patients.

Dr. Lett: One more reminder that the gold standard for information transfer is direct clinician-to-clinician discussion. Despite institution of the NOTICE Act notifying a Medicare enrollee in writing that they are an outpatient under observation, and the MOON now issued to all patients on observation status, OBS remains very much the “medical twilight zone.” Inadequate transitions can result in loss of crucial information, jeopardize Medicare coverage for post-acute care, and precipitate poor patient outcomes. Post-acute care clinicians will need to work with their facilities to investigate for OBS in all new and returning residents from the hospital and ED.

Dr. Saltsman is the section chief of geriatrics and transitional care for Lahey Health, Burlington, MA. He is the chair of the Society’s Transitions of Care Committee and this column’s editor. Dr. Lett is a Society past president, past chair of the Society’s Transitions of Care Committee and previous editor of this column.

EDITOR’S NOTE
We can see from this interchange between Drs. Lett and Donovan that there are ongoing frustrations regarding the hospital classification of patient care status that extends across the team and disposition levels, with the “loser” in this process far too often being the patient and the family. Post-acute facilities, in the primary service areas for my institutions, are now offering alternative pricing and are trying to think outside the box in order to help make needed — but not Medicare A reimbursed — SNF care available and affordable. Optimizing communication and education for providers and families is key, and we see the necessity for continued collaboration between the SNFist and the hospitalist as we all maneuver through the observation “twilight zone.”

—Wayne Saltsman, MD, PhD, CMD

Approaching Submission Deadlines
The Society Annual Meeting is in March — only a few short months away. Now is the time to submit your poster and awards proposals, and apply for the Foundation Futures program. Don’t put it off!

October 26, 2017
2018 Annual Conference Poster Abstract Deadline
Web: https://amda2018.abstractcentral.com/
November 10, 2017
Foundation Futures program Application Deadline
Web: http://paltcfoundation.org/index.php/our-work/futures

November 17, 2017
Excellence Awards Deadline
http://paltcfoundation.org/index.php/our-work/recognize-awards
November 17, 2017
Quality Improvement Awards Deadline
http://paltcfoundation.org/index.php/our-work/recognize-awards
Marijuana
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Cannabinoids can be administered in a variety of forms. The patch form is not recommended for dementia patients, as they are more likely to peel them off; for those patients, the lotion or oil forms can be rubbed on the skin. There also are vape juices and edibles such as cookies, candies, and brownies, as well as oils that can be added to food or drinks.

Although more study on the clinical benefits of medical marijuana is needed, for now there is a general consensus that medical marijuana may be helpful in treating some medical issues. In 1999, for instance, the Institute of Medicine concluded that marijuana may produce positive outcomes. One recent study found that opioid overdose death rates were an average of about 25% lower in states where medical marijuana was legal, compared with states that hadn’t legalized the substance (JAMA Intern Med 2014;174:1668–1673). The significance of this statistic is unknown, though.

Practitioners are starting to see benefits of medical cannabis with geriatric patients, including lower levels of anxiety and improved sleep. According to Cari Levy, MD, PhD, CMD, associate professor of medicine at the University of Colorado School of Medicine, “Many argue that marijuana is safer than opioids. It’s nearly impossible to overdose. It would require a dose of 15 grams or more, which is much higher than even heavy users consume in a day. Patients might get ‘goopy,’ but we won’t see any respiratory depression.”

One study, although only conducted in mice to date, suggests that marijuana also may be good for memory, especially in the elderly, and may actually prevent brain aging and restore learning ability (Nat Med 2017;23:782–787). Other recent animal studies have shown that marijuana extracts may help kill certain cancer cells and reduce the size of others. The research isn’t all good news for marijuana users, however. Recently, results from a study on respondents to the 2005 U.S. National Health and Nutrition Examination Survey suggested that marijuana users had a threefold increase in the risk of death from hypertension compared with nonusers (J Eur J Prev Cardiol, Aug. 8, 2017; doi:10.1177/2047487317723212). Although there remain many barriers and ambiguities to medical marijuana use that are likely to prevent its growth, at least in the short term. However, Mr. Horowitz noted that the U.S. government is trying to move from “ locking up” states that hadn’t legalized the substance, and the increasing body of scientific evidence of the efficacy of CBD, as well as the expanding number of states that have legalized it, the Department of Justice issued an official memo in 2011 to all U.S. attorneys suggesting prosecutorial discretion,” Mr. Horowitz said.

This memo provided some clarification and support for the 2009 Ogden Memo,” named after former deputy U.S. Attorney General David W. Ogden, which provided guidance to federal prosecutors in states that authorized the legal use of marijuana. That memo started out ominously by clarifying the DOJ’s determination that “marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime that provides a significant source of revenue to large scale criminal enterprises, gangs, and cartels.”

Specific to medical marijuana, the 2011 memo stated, "The Department's view of the efficient use of limited federal resources as articulated in the Ogden Memorandum has not changed. There has, however, been an increase in the scope of … commercial cultivation, sale, distribution and use of marijuana for purported medical purposes … Persons who are not the owners of cultivation premises, growing or distributing marijuana, and those who knowingly facilitate such activities, are in violation of the Controlled Substances Act, regardless of state law. Consistent with resource constraints and the discretion you may exercise in your district, such persons are subject to federal enforcement action, including potential prosecution.”

However, the memo also acknowledged that, while “prosecution of significant traffickers of illegal drugs, including medical marijuana, remains a core priority, it is likely not an efficient use of federal resources to focus on enforcement efforts on individuals with cancer or other serious illnesses who use marijuana as part of a recommended and treatment regimen consistent with applicable state law, or their caregivers.”

In August 2016, the Ninth Circuit Court of Appeals ruled that the DOJ “cannot spend money to prosecute federal marijuana cases if the defendants comply with state guidelines that permit the drug’s use, and Congress barred the use of federal funds for this purpose. However, Senior U.S. Circuit Judge Diarmuid O’Scannlain cautioned against overconfidence, saying, “Congress could restore funding tomorrow, a year from now, or 4 years from now … the government could then prosecute individuals who committed offenses while the government lacked funding.”

Bipartisan Support
In Congress, there has been broad bipartisan support for medical marijuana. The Compassionate Access, Research Expansion, and Respect States Act of 2015 (S. 683) was designed to amend the Controlled Substances Act to provide that control and enforcement provisions related to marijuana “shall not apply to any person acting in compliance with state law relating to the production, possession, distribution, dispensation, administration, laboratory testing, or delivery of medical marijuana.” It also would move marijuana from Schedule I to Schedule II (with no current accepted medical use) to Schedule II (substances with medical indications, but with a high potential for abuse). Unfortunately, when the bill was introduced in March 2015, it stalled. This bill was reworked and rechristened as the Compassionate Access, Research Expansion, and Respect States Act of 2017 (S. 1374/H.R. 2920). This bill would protect medical marijuana patients who comply with state laws from federal prosecution, enable access to medical marijuana for veterans, remove cannabidiol from the list of controlled substances, and expand opportunity for medical and scientific research on the uses and effects of medical marijuana. Another promising bipartisan bill introduced by Dianne Feinstein (D-CA) in 2017 but not yet passed is the Cannabinoid Research Expansion Act (S. 1276), which would reduce the regulatory barriers associated with conducting research on the potential benefits of substances that are derived from marijuana, such as cannabidiol. The bill was referred to the House Judiciary Committee in May.

Additionally, Sen. Orrin Hatch (R-UT) very recently introduced bipartisan legislation aimed at expanding cannabis research, called the Marijuana Effective Drug Study (MEDS) Act of 2017.

Feds Threaten Bipartisan Efforts
Recent actions by U.S. Attorney General Jeff Sessions suggest that the government...
might be taking a step backward. In a May 2017 letter, Sessions asked Congress to undo the protections outlined in the Rohrabacher–Farr amendment, which precludes the DOJ from prosecuting any grower, distributor, retailer, or user of medical marijuana so long as they comply with state laws. In the letter, Mr. Sessions said, “I believe it would be unwise for Congress to restrict the discretion of the Department to fund particular prosecutions, particularly in the midst of an historic drug epidemic and potentially long-term uptick in violent crime. The Department must be in a position to use all laws available to contact the transnational drug organizations and dangerous drug traffickers who threaten American lives.”

After this rather unexpected move by Mr. Sessions, in late July, lawmakers upheld the Rohrabacher–Farr amendment, legislation first introduced in 2003 by Rep. Dana Rohrabacher (R-CA), and former Reps. Sam Farr (D-CA) and Maurice Hinchey (D-NY), which prohibits the DOJ from spending funds to interfere with the implementation of state medical marijuana laws or to prosecute legal medical marijuana operations. The amendment had passed the House in May 2014 and became law in December 2014, although it requires annual renewal. The Senate Appropriations Committee approved the inclusion of the Rohrabacher–Farr amendment (also known as the Rohrabacher–Blumenauer amendment, renamed after Rep. Earl Blumenauer [D-OR], who in 2017 became a lead cosponsor) in the Commerce, Justice, Science, and Related Agencies appropriations bill for fiscal year 2018.

As a presidential candidate, Donald Trump had said in a televised interview that he supports medical cannabis “100%,” and that the issue should be left up to the states. However, the Trump administration has sent signals to imagine growing support across the country, even in the face of a potential federal crackdown.

Beyond the federal confusion, the state laws vary. In most states, nurses can’t administer medical marijuana, and facilities can’t store it. In some states, physicians can recommend it, but they can’t prescribe it.

There also is the question of resident rights. For example, if a patient is in severe pain and medical marijuana is the only thing that helps, can the family demand that the person be allowed to use it? If not, can they hold the facility legally responsible for withholding care that provides comfort and relief? These kinds of questions are yet to be definitively answered. The good news is that the scientific evidence supporting the benefits of medical marijuana is increasing. “This, along with Congressional and public support, is likely to open up the use for this treatment option moving forward,” Mr. Horowitz said.

Senior contributing writer Joanne Kaldy is a freelance writer and communications consultant in Harrisburg, PA.

Popularity? No Contest
In addition to strong bipartisan agreement on this issue, medical marijuana also is very popular with voters. A recent Quinnipiac poll found that 94% of respondents said they support the legal use of medical marijuana.

And the people who use it vouch for its effectiveness: a representative health survey of 7,525 California adults produced by the Public Health Institute in partnership with the Centers for Disease Control and Prevention found that 92% of medical marijuana users said it “alleviates symptoms of their serious medical conditions” (Drug Alcohol Rev 2015;34:141–146).

In supporting the medicinal use of marijuana by an estimated 2.5 million individuals in the United States, the marijuana industry is positioned to put almost $70 billion yearly into the U.S. economy by 2021. So it’s not difficult to imagine growing support across the country, even in the face of a potential federal crackdown.

Colorado legalized medical cannabis in 2000, but the modern dispensary system didn’t start until 2009. Patients must get a medical license to qualify for medical marijuana, although recreational use became legal there in 2014. The qualifying conditions for medical use vary by state, but in Colorado they include cancer, glaucoma, fibromyalgia, HIV/AIDS wasting disorders, chronic disabling pain/muscle spasms/neuropathy, seizures, chronic nausea, inflammatory bowel disease, multiple sclerosis, migraine/chronic headache, and post-traumatic stress disorder/war combat injury or illness.

To get a license for use in Colorado, a patient must obtain a statement from a licensed physician that documents the qualifying condition(s), then must go to a certified medical cannabis physician to purchase a temporary license. The person then can buy medical marijuana.

WHEN IN COLORADO …
Colorado legalized medical cannabis in 2000, but the modern dispensary system didn’t start until 2009. Patients must get a medical license to qualify for medical marijuana, although recreational use became legal there in 2014. The qualifying conditions for medical use vary by state, but in Colorado they include cancer, glaucoma, fibromyalgia, HIV/AIDS wasting disorders, chronic disabling pain/muscle spasms/neuropathy, seizures, chronic nausea, inflammatory bowel disease, multiple sclerosis, migraine/chronic headache, and post-traumatic stress disorder/war combat injury or illness.

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TRENDING NOW: #Post-Acute & Long-Term Care Careers

Applications now being accepted for THE FOUNDATION’S FUTURES PROGRAM

The Foundation for Post-Acute and Long-Term Care Medicine is pleased to announce an exciting opportunity for residents, fellows or advanced care practitioners interested in post-acute & long-term care medicine — the Futures Program. Held during AMDA–The Society for Post-Acute and Long-Term Care Medicine Annual Conference 2018, this intensive one-day learning experience is designed to expose participants to the numerous career opportunities available in post-acute & long-term medicine.

Participants selected for the Futures Program will receive the following benefits:
- 3-Day registration to AMDA’s 2018 Annual Conference in Grapevine, TX
- One year of AMDA membership (now including FREE webinars)
- Access to dedicated mentors
- Expanded benefits for 5 years to encourage professional development

For program agenda details, visit our website at www.paltcfoundation.org

Application Deadline: November 17, 2017
A MDA – the Society for Post-Acute and Long-Term Care Medicine’s Board of Directors has entrusted the Innovations Platform Advisory Committee (IPAC) to lead the creation of an innovations infrastructure for the Society. IPAC comprises key health care innovators from the United States and Canada who have diverse experience in innovations, academia, and entrepreneurship. In this month’s column, Bianca Stern, a member of IPAC, discusses her perspectives on innovation and how it can help the Society evolve.

Ms. Stern is the executive director for the Centre for Aging & Brain Health Innovation at Baycrest Health Sciences in Toronto, Canada.

Organizations need to adapt to the changes around them to survive. Without new perspectives and the continuous infusion of novelty and innovation, organizations can experience a slow but definite loss of resilience.

Why are you interested in innovation in health care?

Ms. Stern: We cannot solve all the complex problems of today with the conventional approaches and ways of thinking that were useful in the past. Changing health care systems, increasing patient complexity, and newly emerging technologies are some of the factors that challenge us to do things differently. Organizations need to adapt to the changes around them to survive. Without new perspectives and the continuous infusion of novelty and innovation, organizations can experience a slow but definite loss of resilience.

Resilience is about avoiding the traps that prevent an organization from evolving. It often means stopping or reimagining something that we have done for years, and releasing some of the resources of time, energy, money, and skill locked up in our current routines. Otherwise, it can be hard to create anything new or look at things from a different perspective.

Could you provide an overview of the initiative you are helping to lead?

Ms. Stern: The Centre for Aging & Brain Health is a solution accelerator funded by the Canadian federal and provincial governments. Our objective is to accelerate the development of innovations to meet the urgent needs of an aging population, evaluate these solutions in real-world settings, and drive adoption of the proven products, services, and processes to patients, care partners, and health care providers. We have competitive funding programs targeted to a wide variety of innovators, such as point-of-care care providers, industry, researchers, and others. We provide project oversight and resource supports through our Innovation Office. We also run showcases, design sprints, and collaboration events aimed at cross-pollinating ideas, designing solutions, and facilitating a culture of innovation in the sector.

How do you define innovation?

Ms. Stern: We can define innovation as a process or as an outcome. Innovation is a process of proactively identifying new opportunities, finding new approaches to solving existing complex problems, and discovering, combining, and arranging insights, ideas, tactics and methods in new ways. An innovation process includes a diversity of perspectives and the use of design thinking tools to define, ideate, prototype, and test solutions. Innovation, as an outcome, is a product, process, or service that is better than what exists, has widespread appeal to users because it makes life easier or solves a pressing need, and can have promise of economic benefit or systemwide impact. Examples of current innovations are the array of technologies focused on monitoring and managing health conditions.

What is the difference between quality improvement and innovation?

Ms. Stern: Quality improvement is aimed at doing things better. It involves primarily analytical thinking to solve complicated but predictable problems. The focus is on reducing costs, optimizing efficiencies, improving safety, and enhancing satisfaction. Quality improvement activities often have incremental impact.

Innovation is doing things differently. It involves combining multiple ideas in new ways to solve a complex and ambiguous problem that has minimal precedent. Its impact can be disruptive or transformative. For example, the innovation of telemedicine has had a transformative impact on the quality of health service delivery to rural villages, beyond the improvement of local health service delivery practices. Both innovation and quality improvement approaches are important and serve different purposes.

Why is a culture of continuous learning important to an organization that strives to be innovative?

Ms. Stern: Organizations with cultures of innovation view information and knowledge as essential resources that are willingly shared. Knowledge is the foundation for new ideas, and the learning that produces knowledge is what keeps brains malleable to create innovative and disruptive solutions. A culture of continuous learning consciously builds capacity and applies strategic tactics for knowledge dissemination and knowledge implementation.

Employees who are learning new technologies and solutions are the employees who will help solve the problems an organization doesn’t yet know it has. Knowledgeable employees make an organization flexible. In such a culture, people understand that their ideas are valued, trust that it is safe to express those ideas, and oversee risk collectively, together with their managers. Such an environment can be more effective than monetary incentives in sustaining innovation.

Organizations must be able to adapt, pivot, and grow into new market spaces if they hope to survive. In order to do so, an innovation culture allows people to experiment. Failure is a necessary part of the innovation process, because from failure comes learning, iteration, adaptation, and the building of new conceptual and physical models through an iterative learning process. Almost all innovations are the result of prior learning from failures. Organizations fostering a culture of innovation must be prepared to fail in order to innovate.

Where are the pain points that require an innovation approach in our post-acute sector?

Ms. Stern: This is a big topic, but I will highlight two important issues that require innovative solutions: aging at home, and care navigation and coordination — especially for the growing number of individuals with dementia.

The future holds challenges in both affording and accessing institutional solutions for a growing number of older people, a significant proportion of whom have some degree of cognitive impairment. Although some people will spend time in hospital, nursing home, or residential care, many people with dementia live at home in their communities, alone or supported by family and other caregivers. Maximizing the quality of life at advanced ages and ensuring people can stay in the community will be a major challenge of the 21st century.

People with dementia have higher hospitalization rates, use more home health and nursing home care, experience more care transitions, and have higher health care expenditures. The quality of care they receive is often suboptimal, with significant rates of potentially avoidable hospitalizations and emergency department visits. The current health care system is not well suited to meeting the complex needs of people with dementia. Health care providers lack the time and often the training to manage the ongoing care of patients with multiple chronic health conditions, including dementia.

Care coordination has the potential to help older adults with chronic illness, including those with dementia, by addressing sources of fragmentation and inefficiency in health care systems, improving care quality and health outcomes for people with dementia and their caregivers, and limiting health care costs. Evidence to date suggests that care coordination for older people can improve quality of care and quality of life. Factors that can impact effective care coordination and navigation can include substantial and regular interaction between the coordinator and the primary care provider, manageable caseloads and routine monitoring, and appropriate technology that facilitates communication among team members and enables real-time updates, decision support, and analytics.

Why are you excited about IPAC?

Ms. Stern: IPAC affords an amazing opportunity to network with key change-makers interested in and influencing innovation across North America. It allows us to bring our collective wisdom towards strategically building a culture of innovation in the long-term care and post-acute sector. I am looking forward to seeing what we can accomplish together!

This column is sponsored by AMDA – the Society for Post-Acute and Long-Term Care Medicine’s Innovation and Implementation Workgroup. Dr. Nazir is the chief medical officer for Signature HealthCare and president for SHC Medical Partners. He is treasurer for the Society, chair of the Society’s Innovation and Implementation Workgroup, and editor of this column.

Dr. Levy is a geriatrician board-certified in hospice and palliative medicine, and is associate director of the Denver-Seattle Center for Veteran-Centric and Value-Driven Care. She is currently vice president of the Society.

INNOVATIONS IN PA/LTC

Bianca Stern, a member of IPAC, discusses her perspectives on innovation and how it can help the Society evolve.

Ms. Stern: The Centre for Aging & Brain Health is a solution accelerator funded by the Canadian federal and provincial governments. Our objective is to accelerate the development of innovations to meet the urgent needs of an aging population, evaluate these solutions in real-world settings, and drive adoption of the proven products, services, and processes to patients, care partners, and health care providers. We have competitive funding programs targeted to a wide variety of innovators, such as point-of-care care providers, industry, researchers, and others. We provide project oversight and resource supports through our Innovation Office. We also run showcases, design sprints, and collaboration events aimed at cross-pollinating ideas, designing solutions, and facilitating a culture of innovation in the sector.

How do you define innovation?

Ms. Stern: We can define innovation as a process or an outcome. Innovation is a process of proactively identifying new opportunities, finding new approaches to solving existing complex problems, and discovering, combining, and arranging insights, ideas, tactics and methods in new ways. An innovation process includes a diversity of perspectives and the use of design thinking tools to define, ideate, prototype, and test solutions. Innovation, as an outcome, is a product, process, or service that is better than what exists, has widespread appeal to users because it makes life easier or solves a pressing need, and can have promise of economic benefit or systemwide impact. Examples of current innovations are the array of technologies focused on monitoring and managing health conditions.

What is the difference between quality improvement and innovation?

Ms. Stern: Quality improvement is aimed at doing things better. It involves primarily analytical thinking to solve complicated but predictable problems. The focus is on reducing costs, optimizing efficiencies, improving safety, and enhancing satisfaction. Quality improvement activities often have incremental impact.

Innovation is doing things differently. It involves combining multiple ideas in new ways to solve a complex and ambiguous problem that has minimal precedent. Its impact can be disruptive or transformative. For example, the innovation of telemedicine has had a transformative impact on the quality of health service delivery to rural villages, beyond the improvement of local health service delivery practices. Both innovation and quality improvement approaches are important and serve different purposes.
Active Listening Key to Quality Palliative Care

Christine Kilgore

Nursing home residents want to know the staff who care for them and to be known in return. Such reciprocal relationships are central to palliative care and, more broadly, to person-directed living, but they often don’t happen without concerted efforts to prepare and support staff for these relationships, said Anna Ortigara, RN, MS, FAAN, at the annual conference of AMDA—the Society for Post-Acute and Long-Term Care Medicine.

The better the relationships caregivers have with residents, the better able they are to “kick-start [the] start button that gets broken early in the disease process,” said Ms. Ortigara. Residents with dementia, of course, communicate their comfort and discomfort “through their actions as well as whatever words they have,” and staff have to trust that each individual with dementia is an expert on his or her own personal comfort. The better the relationships caregivers have with residents, the better able they are to “kick-start [the] start button that gets broken early in the disease process,” said Ms. Ortigara. Residents with dementia, of course, communicate their comfort and discomfort “through their actions as well as whatever words they have,” and staff have to trust that each individual with dementia is an expert on his or her own personal comfort.

Ms. Ortigara added, “It’s so important that we support staff in being able to ask questions and have such conversations,” said Ms. Ortigara, who has been an active board member of the Pioneer Network for years.

“The best of intentions, we often go straight to advising residents,” jumping in with suggestions for how to solve problems before residents have the chance to express what’s really troubling them or what they really want, she said during a panel discussion on palliative care and culture change.

Another common listening block involves platingac, when “you are pleasant and supportive without really taking in what the other person is saying,” she said. “In this mode, we can be patronizing. We certainly do that with children, and engage residents in things that make sense for them, she noted.

It is important to remember, Ms. Alonzo said, “that ‘the part of the brain responsible for feelings … remains essentially intact in most dementias, so how people feel is important.”

Throughout the panel discussion, experts emphasized that embedding palliative care strategies into nursing home care increases the quality of care for all residents, and it was noted that palliative care may best be achieved when looked at through a “dementia lens.”

Christine Kilgore is a freelance writer in Falls Church, VA.
Transitions from page 1

Nurse practitioners and physician assistants have a key role in improving transitions from the SNF to the community, said Debra Bakerjian, PhD, associate adjunct professor in the Betty Irene Moore School of Nursing at the University of California, Davis. “NPs and PAs can manage most care transitions,” said Dr. Bakerjian. However, she added, it is best to have a systematic approach to maximize their utility in this role.

She referred to paradigms such as Naylor’s Transitional Care Model, which uses NPs with skills in a particular area to enhance care coordination and improve outcomes in patients discharged from the hospital. “NPs can function as a transitional care nurse, particularly when residents are discharged to a lower level of care,” said Dr. Bakerjian. “Both NPs and PAs can use this model to ensure comprehensive transitional care services provided.”

For successful care transitions, “one of the first things that needs to happen is screening. You want to make sure that the resident is medically stable and ready for the transition,” Dr. Bakerjian said. This involves performing the discharge exam, working with the facility staff to prepare the patient for discharge, ordering home evaluations by a physical or occupational therapist, and ensuring caregivers are identified and engaged. This is a perfect role for the NP or PA, she said.

Dr. Bakerjian said that the NP or PA also can help engage both the elder and caregiver to ensure that they understand the care that must be provided. Additionally, the NP or PA can help “empower the patient and caregiver to share concerns and needs … and evaluate the caregiver’s readiness to provide care.” Visiting the patient in his or her home is useful, she said. “If the practitioner can spend some time in that environment, it’s easier to establish trust and ensure that the necessary steps are being taken to keep the patient safe.”

Managing risk and symptoms is another appropriate role for the NP or PA and is key to keeping the patient from going back to the hospital. “NPs particularly are well suited to help patients and caregivers understand symptom management,” Dr. Bakerjian said. This involves reviewing key symptoms with the patient and caregivers, providing guidance on symptom management, eliciting and addressing concerns and questions, anticipating and addressing potential problems, and offering explicit instructions about when to call for help.

Collaboration is another role for NPs and PAs. Specifically, they can directly collaborate with the interdisciplinary team on discharge planning and communicate closely with physician partners and external players. “Accountability for care continues until the resident transitions to the new level of care and successfully interacts with the new provider,” said Dr. Bakerjian. And the NP or PA can assist with a warm handoff. “He or she can call the resident’s PCP to report the discharge and summarize care that has been provided, the person’s condition, what current medications or treatments the resident is receiving, and ask when the PCP wants to see the resident,” she said.

Dr. Bakerjian referred to the concept of “teaming,” popularized in Amy Edmondson’s Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy (San Francisco: Jossey-Bass, 2012). Teaming, Dr. Bakerjian said, “is teamwork on the fly — coordinating and collaborating across boundaries without the luxury of stable team structures.” When NPs and PAs can participate in teaming, they bring great value to the process, which “is especially needed when work is complex and unpredictable,” she said.

Joanne Kaldy

NPs, PAs Have Starring Role in Care Transitions

The physician’s job doesn’t stop at the SNF doors, said Alicia Arbaje: They need to understand the culture and safety of a patient’s transition environment.

When patients can answer “yes” to these questions and they and their families are clear about what they need to do and why, “it reduces fears and 911 calls. It also increases their confidence to handle situations and enables patients to feel safe at home,” Dr. Arbaje said.

Home Sweet Home

Even if the hospital or nursing facility does everything right before the patient is discharged to his or her home, the journey doesn’t end there. We’re sending people to various environments. We need to understand the culture of where we’re sending the patient,” said Dr. Arbaje. The home might already be fairly neat, clean, and safe, or it might be a cluttered mess where nothing has been thrown away for years. The facility needs to know this in advance and address it accordingly. “You also have to consider family issues,” she added, such as relationships with a spouse or adult children, financial dependence, and unresolved feelings such as grief or anger. Connecting with home health agencies and community programs (such as Meals on Wheels, neighborhood senior centers, or adult day care) can help ensure the patient has access to the support services they need to stay safe and healthy in their home.

Flowing Downstream … and Backward

Lee Lindquist, MD, MPH, MBA, CMD, associate professor and chief of geriatrics at Northwestern University Feinberg School of Medicine in Chicago, said that transitioning the patient from the nursing home to the primary care practitioner (PCP) is like moving down a river — only you have to think of it as flowing backward. “You have to consider the challenges for the primary care physician after the patient leaves the skilled nursing facility,” she said. She noted that the PCP often doesn’t even know that the patient has been in a facility. Of even greater concern, the practitioner may not even know about a new illness or condition change, or what medications the patient is now taking.

Don’t assume the PCP will be able to get all the answers he or she needs from the patient or family. Dr. Lindquist said that, as a PCP herself, she has heard some interesting comments from patients when she has talked to them about their stay in the skilled nursing facility (SNF). Among these:

“I never saw anyone medical at the SNF.”

“They kept giving me bacon when I asked for it. It was salty, but tasty.”

“They gave me my meds at the wrong time. I usually take them at 10 a.m., not 8 a.m.”

“They never got my dad out of bed, but he did go to therapy.”

“The food was OK, but the ceviche should have been served on Bibb lettuce.”

To the PCP, these comments might be amusing, confusing, or even alarming. And, without communication from the nursing home, the PCP may make some pretty tough judgments. For example, Dr. Lindquist said, “They might be thinking, ‘Wow, that is crazy to give bacon to a patient with congestive heart failure. Why can’t they control what people are eating?’”

Some of these issues can be resolved by improving communication with the patient and the family on admission to the facility. “Speak directly to the patient or family. Find out what doctor the person has been seeing and who you will need to follow up with,” Dr. Lindquist suggested. If the patient doesn’t have a PCP, let them know that staff can help identify a potential practitioner.

Disability, and unmet functional needs. Demographics also provide a clue: male gender, older age, racial or ethnic minority, unmarried status, and low income contribute to readmissions. At the system level, the risk is increased by failure to implement plans of care, high admission rates, and lack of discharge education.

A key to successful transitions, said Dr. Arbaje, “is communicating information to the next site of care.” This may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too often there are gaps, lapses, and inaccuracies that may seem obvious, but too 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Congratulations to Our newest Rising Stars!

GAPNA is proud to salute our newest Rising Stars! It’s with great pleasure that we recognize outstanding members who are up and coming in their specialty and in leadership. Rising Stars are the future of our organization. Thank you for your excellent work and commitment to the care of older adults!

Donna Hamill
DNP, AGPCNP

Jennifer Kim
DNP, GNP-BC, FNAP

Megan Simmons
DNP, PMHNP-BC

Lacey Stevens
ANP-C

If you serve as the attending physician while the patient is in the facility, Dr. Lindquist said, don’t assume that the person and family know who you are. “Often, they don’t remember their nursing home physician. Reintroduce yourself every time you visit,” he said. That way, the patients know that they saw a physician, and this establishes a stronger patient–practitioner relationship. This relationship will be important because it will make follow-up easier after the patient is discharged back to the community.

This follow-up is essential to help prevent readmissions. Even if the patient resists, Dr. Lindquist said, it’s essential to ensure that they see a practitioner within 7 to 10 days after they return home. This is especially important if the person has a different or new medication regimen or needs supports, assistive devices, or services that they didn’t have before they entered the hospital or nursing home.

The PCP needs the patient’s discharge information to ensure continuing care. Whether this is delivered via fax, secured electronic health record, or handed off in person by the family or caregiver, this should be done promptly. Sometimes, a warm handoff is necessary, said Dr. Lindquist. “For patients who are medically complex, I will call the PCP myself, provide a verbal report, and answer any questions,” she said. When a practitioner reaches out personally to a PCP, it not only contributes to quality care and prevents readmissions, but it also “is a good marketing tool for the facility,” she said. “After you talk to the PCP, they will feel better about the facility and the practitioners caring for patients there.” Ultimately, she concluded, “We need to look downstream and think about how we can support and communicate with the PCP, with the goal of improving care for patients as they transition.”

Senior contributing writer Joanne Kaldy is a freelance writer in Harrisburg, PA, and a communications consultant for the Society and other organizations.

CMS Proposes Changes to Payment Models

The Centers for Medicare & Medicaid Services announced a proposed rule to reduce the number of mandatory geographic areas participating in the Center for Medicare and Medicaid Innovation’s (Innovation Center) Comprehensive Care for Joint Replacement (CJR) model from 67 to 34. In addition, CMS proposed to allow CJR participants in the remaining areas to participate on a voluntary basis. In this rule, CMS also proposed to make participation in the CJR model voluntary for all low volume and rural hospitals in all of the CJR geographic areas.

CMS also has proposed through this rule to cancel the Episode Payment Models (EPMs) and the Cardiac Rehabilitation (CR) incentive payment model, which were scheduled to begin on Jan. 1, 2018. Eliminating these models would give CMS greater flexibility to design and test innovations that will improve quality and care coordination across the in-patient and post-acute-care spectrum.

“Changing the scope of these models allows CMS to test and evaluate improvements in care processes that will improve quality, reduce costs, and ease burdens on hospitals,” CMS Administrator Seema Verma said in a press statement. “Stakeholders have asked for more input on the design of these models. These changes make this possible and give CMS maximum flexibility to test other episode-based models that will bring about innovation and provide better care for Medicare beneficiaries.”

Moving forward, CMS expects to increase opportunities for providers to participate in voluntary initiatives rather than large mandatory episode payment model efforts. The changes in the proposed rule would allow the agency to engage providers in future voluntary efforts, including additional voluntary episode-based payment models.

For more information on the CJR model, visit: https://innovation.cms.gov/initiatives/cjr. For more information on the EPM and CR models proposed for rescission, please visit: https://innovation.cms.gov/initiatives/epm
How Depression Hides and What to Do About It
Randy Dotinga

LOS ANGELES — Depression can be a chameleon in the elderly. It may manifest through symptoms like low appetite and apathy, but it can also cause overeating and oversleeping. And even to the trained eye, depression may appear to be extended grief at the loss of a loved one.

Or depression might hitchhike with a more obvious condition, such as fibromyalgia, neuropathic pain, or insomnia. “More commonly than not, depression does not ride alone,” said Glen Xiong, MD, CMD, an associate clinical professor at the University of California at Davis and medical director of mental health at Doctor on Demand. He is chief medical officer at On Lok, a care program for the elderly, and a clinical professor at the University of California at San Francisco.

The good news is that even hidden depression is detectable and treatable. That’s the word from Dr. Xiong and Jay Luxenberg, MD, who spoke to colleagues at the annual meeting of the California Association of Long-Term Care Medicine (CALTCM).

According to a 2013 report from the Centers for Disease Control and Prevention, an estimated 49% of nursing home residents suffer from depression, the highest percentage found among five types of long-term care services. That makes depression as common as dementia.

The report says the percentages of patients with depression for the other four categories (adult day health care center, home health agency, hospice, and residential care community) are significantly lower, ranging from 22% to 34% (Vital Health Stat 3 2013;37:1–107).

According to Dr. Luxenberg, diagnosing depression in the elderly can be especially challenging on a variety of fronts. For one thing, he said, common symptoms in aging such as loss of energy, low appetite, and poor sleep can be signs of depression, concomitant medical conditions, or something else.

“In many settings where patients are losing weight, they don’t have a great appetite,” he said. “That can be a sign of depression or other things, like the food in our institution may not be that palatable.”

Sensory and cognitive deficits can also interfere with an accurate diagnosis of depression, he said. He explained that sensory and cognitive deficits may be other complications such as substance abuse, which can trigger depression, and vice versa. And dementia can cause reactive depression, while depression can cause symptoms of dementia.

Grief is another factor to consider when diagnosing depression in the elderly. Uncomplicated grief — bereavement — can cause people to act like they have major depression, but patients should be at baseline mood or moving toward it at 1 year, Dr. Luxenberg said.

He noted that under the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria, patients can now be diagnosed with major depression whether or not they’ve recently suffered a major loss. “That’s helpful to us because loss is so common in our population,” Dr. Luxenberg said. “Their daughter has cancer or their son died last year, and we don’t get aggressive enough with treatment.”

Dr. Luxenberg recommended an annual 15-minute depression screening, which Medicare covers without requiring copayment/coinsurance or deductible. Commonly used depression screening tools include the Patient Health Questionnaire 9 (PHQ-9, part of every Minimum Data Set [MDS] form in nursing homes), the Hospital Anxiety and Depression Scale, and the Geriatric Depression Scale. If a patient cannot communicate easily, he recommended trying the Staff Assessment of Resident Mood (PHQ-9-OV).

As for treatment with antidepressants, Dr. Xiong emphasized that it’s important to not “set-it-and-forget it” — too often patients are left endlessly taking an antidepressant without proper monitoring about whether the dose should be increased, decreased or maintained.

“While you should start slow and go slow, it’s also important to go all the way when needed,” he said.

Dr. Xiong noted that certain antidepressants may be especially efficacious in patients with comorbid conditions. For example, he said, duloxetine and venlafaxine may help a patient with neuropathic pain, whereas mirtazapine might be appropriate for a patient with insomnia or anorexia. Duloxetine may help depressed patients with fibromyalgia and chronic fatigue syndrome. He also pointed out that in some cases prescribing antidepressants in a liquid form may be helpful if patients have difficulty taking pills.
Defining Your Conflict Management Style
Christine Kilgore

Are you skilled at arguing and debating, at standing your ground, and at using your rank, position, or influence when dealing with conflict? Or are you better in conflict situations with forgiving your desires, yielding to others, and acting with selflessness?

According to the Thomas-Kilmann Conflict Mode Instrument (TKI), your conflict-handling style would be either “competing” or “accommodating,” respectively. And if you had certain other dominant skills, your most natural conflict-handling style would be either “competing” or “accommodating,” “compromising,” or “avoiding.”

No one of the five conflict-handling styles is necessarily good or bad, said Yuya Hagiwara, MD, at AMDA – the Society for Post-Acute and Long-Term Care Medicine’s Annual Conference. “All are good if used appropriately,” he said. The point is that conflict management skills are essential for the interdisciplinary practice of post-acute and long-term care, and we want to be more aware of our own intrinsic conflict management preferences and be able to assess what’s appropriate in each situation,” he said. Dr. Hagiwara explained.

A “competing” style might be appropriate when you need to take quick action, make unpopular decisions, stand up for vital issues, or protect yourself. “Like when you need to send someone to the nursing home … and with hospice,” she said. Developing effective conflict resolution skills is important “for getting results across different settings, getting everyone on the same page, and trying to stay person-centered.”

Christine Kilgore is a freelance writer in Falls Church, VA.

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Call for Posters

2018 ANNUAL CONFERENCE
AMDA – THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

MARCH 22-25, 2018
Gaylord Texan Resort & Convention Center · Grapevine, TX


The Annual Conference Program Planning Subcommittee invites you to submit abstract proposals for AMDA – The Society for Post-Acute and Long-Term Care Medicine Annual Conference 2018, March 22-25, 2018 in Grapevine, Texas.

TARGET AUDIENCE
The program is designed for medical directors, attending physicians, nurses, administrators, consultant pharmacists and other professionals practicing in the post-acute and long-term care (PA/LTC) continuum. Medical students, interns, residents and fellows planning a career in geriatrics are also encouraged to attend.

SUGGESTED TOPICS
The Society welcomes submissions on all topics pertinent to PA/LTC medicine and medical direction. Emerging clinical information, best practices in management and medical direction, research, innovation in PA/LTC, and updates on approaches to regulatory compliance, are areas of interest. The Society also seeks skill-based proposals that incorporate interactive learning strategies and provide attendees with resources to implement upon return to practice.

HOW TO SUBMIT
To submit an abstract for the 2018 Annual Conference or for more information, please go to https://amda2018.abstractcentral.com. All abstracts must be submitted via the abstract submission site. The deadline to submit a poster abstract is October 26, 2017.

QUESTIONS?
Contact the Society’s Professional Development/Meetings Department at education@paltc.org.
Purpose in Life May Lead to Better Sleep
Joanne Kaldy

Results from a study out of Northwestern University’s Feinberg School of Medicine suggest that elders who believe they have a purpose in life may sleep better.

“The beauty of what we’re finding is that purpose in life is an eternal thing,” said Arlener D. Turner, PhD, a post-doctoral fellow at the Feinberg School of Medicine and the lead author of a study published in the July issue of Sleep Science and Practice [doi: 10.1186/s16067-016-0015-6].

The researchers used a sample pooled from the Minority Aging Research Study (MARS) and the Rush Memory and Aging Project (MAP), two ongoing epidemiological cohort studies on aging and cognition. Purpose in life was assessed at baseline employing a 10-item measure modified from existing scales of psychological well-being. Participants rated their agreement with each of the 10 items, such as “I feel good when I think of what I’ve done in the past and what I hope to do in the future.” Sleep quality and the possibility of existing sleep disorders were assessed via a 32-item questionnaire adapted from the Pittsburgh Sleep Quality Index, the Berlin Questionnaire, and the Mayo Sleep Questionnaire.

Over three-quarters of the 825 survey respondents were female, just over half were black, and all were between 60 and 100 years of age. None had a diagnosis of dementia. They had an average of 15 years of education. At baseline, most participants had slightly disturbed sleep quality, whereas 42% were at high risk for sleep apnea, and about one-fourth had symptoms of restless leg syndrome.

The researchers found that greater purpose in life predicted better sleep quality. People who reported that their lives have meaning and who found purpose in waking activities seemed to sleep well at night. Overall, said Dr. Turner, “The emerging data indicate the benefits of positive psychology on sleep health.”

“We believe that we can reduce the incidence of sleep disorders in this population . . . We can start by identifying individuals with sleep problems or complaints on admission.”

Studies such as this one could help practitioners identify creative, effective non-pharmacologic means of preventing and managing some sleep disorders in their elderly patients. Other studies have looked at the possible use of mindfulness-based cognitive therapy (MBCT) to address sleep disorders, particularly insomnia. MBCT, originally devised as a relapse-prevention depression therapy, partners cognitive-behavioral therapy methods with Eastern psychological strategies such as mindfulness meditation, which focuses on awareness and acceptance of all incoming thoughts and feelings, but discourages reacting to or embracing them.

“The next step is looking into these kinds of treatments with different parameters of sleep and working to improve purpose in life for patients,” Dr. Turner said. She stressed that it’s not too late for elders to find or identify a purpose in life.
“We can help them find their purpose by encouraging them to think back on their lives and identifying what events and activities inspired them and brought them joy and pride,” she said. “We can’t just ask them what their purpose in life is — it’s not that simple. It’s hard to wake up and say, ‘This is my purpose.’”

The promise of better sleep may not clarify purpose for many elders, Dr. Turner said. “You want to give them time to think about it and help them identify their purpose. You don’t want to push them and have them stressing about it.”

Although Dr. Turner and her colleagues studied dementia-free individuals, she suggested that similar techniques could be used with patients who have cognitive issues.

“I don’t know of any studies like this with dementia patients. However, you can use information from family members and other clues from their past to uncover what might be meaningful for these individuals. This is a good starting point. We need more research involving individuals with cognitive issues,” she said.

Purpose in life goes beyond improving sleep, Dr. Turner said. “People who have a purpose in life tend to be healthier in general and have less disability. If you cultivate purpose in life, it can enhance health a bit overall, and this can lower costs as well as improve outcomes.”

Dr. Turner said many people who have sleep disorders don’t talk about them. “They think this is a normal part of aging or they don’t realize that they aren’t getting quality sleep,” she said. However, as practitioners and facilities increasingly seek to improve outcomes while reducing costs and preventing readmissions, effective nonpharmacologic interventions to address common problems are worth pursuing.

“Elders have a much higher rate of sleep disorders than the younger patient population. We don’t know if [identifying life purpose] is enough, but we believe it will help. We believe there is a connection here. And we believe that we can reduce the incidence of sleep disorders in this population,” she said. “We can start by identifying individuals with sleep problems or complaints on admission.”

She urged the use of including questionnaires designed to assess sleep quality as part of the intake process.

Kindred Healthcare has completed the closing for 54 skilled nursing facilities in 10 states, the company announced in a statement. The closing is related to Kindred’s agreement with BM Eagle Holdings, LLC, a joint venture led by affiliates of BlueMountain Capital Management, LLC to sell Kindred’s skilled nursing facility business for $700 million in cash.

Sale proceeds from the closing were approximately $519 million.

“We are pleased that we have completed the initial sale of a majority of the nursing facilities held for sale and look forward to completing the remainder of the closings by year end,” Benjamin A. Breier, president and chief executive officer of Kindred, said in a press statement.

“We believe that the sale of our nursing facility operations will significantly enhance shareholder value, focus our attention to our higher margin and faster growing businesses, and advance our efforts to transform Kindred’s strategy.”

The sale includes a total of 89 nursing centers and seven assisted living facilities, which collectively have approximately 11,500 employees in 18 states. Kindred expects that the remainder of the closings will occur in phases as regulatory and other approvals are received. Kindred expects that all of the closings will be completed by year end.

“On behalf of the Kindred Board of Directors and management team, I thank all of our caregivers for their hard work to facilitate a smooth transfer process. We appreciate and respect their dedication to our patients, residents and their families,” Mr. Breier said.
Sensor Systems

Sensors that can alert nursing staff to changes in health or falls (or increased risk of falling) allow for early interventions in individuals who show signs of illness or functional decline, according to a prospective intervention study in Missouri.

Led by Marilyn Rantz, RN, PhD, Helen E. Nahm Chair, University Hospitals and Clinics professor of nursing at the University of Missouri, researchers conducted a prospective intervention study in which they randomized 171 residents from 13 assisted living communities to receive their usual assessments (control group) or have environmentally embedded sensors in their homes (intervention group). These sensors included:

• Motion sensors that monitor individuals as they go about their daily activities.
• Bed sensors placed under the mattress to collect data about pulse, breathing, and restlessness while the individual sleeps.
• A gait depth sensor (GAITRite) that constantly monitors and measures velocity, stride length, and step length to identify increased fall risk. “We’ve found that the gait measures are particularly sensitive to being able monitor people’s well-being and their functional status,” Dr. Rantz told Caring.

Earlier pilot studies found the sensors detected changes in chronic diseases or acute illnesses an average 10 days to 2 weeks before usual assessment methods or self-reports of illness. That means patients can receive treatment earlier “and prevent that marked decline that happens when people get really sick and are hospitalized, or get really sick and stay in bed for a week,” Dr. Rantz said.

In this study, the control group declined more rapidly than the intervention group, as measured by walking speed, velocity, and other measures from GAITRite, the researchers found. For example, walking speed increased by 0.80 seconds in the control group (worsened) vs. 0.04 seconds in the intervention group (improved). Velocity also remained more stable in the intervention group, declining 0.027 meters per second vs. a larger (worse) decline of 0.073 meters per second for the control group.

This research team, a combination of nursing, engineering, social work and medical faculty, is part of the Aging in Place Project, designed to help elderly individuals maintain their independence and avoid — or at least delay — the need to move to a nursing home. That includes coordinated nursing care and use of the system.

“We wanted to move to a nursing home. That includes coordinated nursing care and use of the system.

“…We also knew that technology potentially held a lot of the answers.”

“We also knew that technology potentially held a lot of the answers,” Dr. Rantz said.

Data from the sensors goes into a computer, and automated algorithms establish norms for each individual. The sensor system alerts nursing staff to changes that may suggest illness or functional decline. For example, a noted increase in bathroom activity might serve as an early warning sign of a urinary tract infection, Dr. Rantz said. An individual with a developing case of flu might show less activity than normal. And, by detecting falls, the sensors alert staff so individuals get help earlier.

Other published research has shown that coordinated nursing care can increase the length of stay in independent senior housing an average of almost 1 year, and sensor technology can add an average of almost 2 years. “So, 2.5 to 3 years additional length of stay makes a big difference for people who want to live in these places as well as for the owners who want to keep the housing development full,” Dr. Rantz said.

Dr. Rantz said the sensor technology, besides being used in assisted living, has potential applications in nursing homes, especially for fall detection and prevention, and early illness detection.


Protein Supplements

Whey protein drinks can help increase total energy intake in elderly individuals whether patients consume them immediately before or as much as 3 hours before a meal, according to results from a single-blind randomized study in Australia.

Led by Caroline Giesenaaar, MSc, of the University of Adelaide, researchers had 16 elderly men (average age of 76) consume 30 g whey protein drinks on five separate occasions anywhere from immediately before or at 1, 2, or 3 hours before a buffet meal. They received the whey protein drink 3 to 14 days apart and an isocaloric, noncaloric drink on those in-between days.

Energy intake (kcal), which included the intake at the buffet meal and the energy content of the whey protein drink, was an average 82 kcal higher on the days the individuals received the whey protein drink. There was no difference in how far before the meal individuals consumed the drink and their reported perceptions of appetite and gastrointestinal symptoms, nor was there any difference in energy intake.

The findings support the use of these supplements to increase protein and energy intake in older individuals at risk of being undernourished, the researchers said.


Companion Robot

Sessions with a companion robot can enhance affective and social outcomes for individuals with dementia, according to a pilot block randomized controlled trial in New Zealand.

Led by Amy Lang, MHlthPyc, of the University of Auckland, researchers randomized 30 dyads (individuals with dementia and their caregivers) at a dementia day care center to receive 2 to 3 weekly sessions for 6 weeks with Paro, a companion robot resembling a Canadian baby harp seal, or standard activities. The researchers monitored them for 12 weeks.

Individuals who received sessions with Paro showed significantly more positive facial expressions and talked more to staff and researchers vs. those who did typical activities; moreover, they exhibited low amounts of agitated behavior. There were no significant differences in care recipient dementia symptoms nor physiological measures between the intervention and control group.


Jeffrey S. Eisenberg, a freelance writer in the Philadelphia area, compiled this report.

JOURNAL HIGHLIGHTS
From the October issue of JAMDA

The Journal of Post-Acute and Long-Term Care Medicine
Panoramic View Gives Futures Participants 20/20 Vision of Their Future

When Soheir Boshra, MD, became a residency program director it was no surprise that she enthusiasti-

cally promoted the program to her students.

Years earlier, “My knowledge about post-acute and long-term care (PA/LTC) was very limited,” she told Caring. Then she participated in the Foundation’s Futures program. “It enriched my knowledge tremendously. It was set up in a way to provide a panoramic view of the field — clinical, regulatory, adminis-
trative, and more. I learned everything I needed to know,” she recalled.

During her 9 years as a program director, about 15 of her students par-
ticipated in Futures and, of those, the majority pursued PA/LTC careers. Each and every one of those students came back from Futures with positive feed-
back. “They were so impressed with the program and the amount of knowledge they acquired from it,” she said.

“The Futures program definitely helped influence them,” she said. “They’ve had nothing but praise for the program. They get their questions answered. They met people who are in the same boat as them, as well as those who have been there and moved on to successful, satisfying careers.”

The financial support — from sources including state chapters, physician prac-
tices, facility chains, individuals, and others — makes a tremendous differ-
ence for students and residency pro-
grams with limited budgets. “To get the support to participate is so import-
ant, and it enabled us to build a rela-
tionship with the Futures program,” Dr. Boshra said.

She urged organizations and individu-
als alike to support the Futures program, an opportunity that has a significant

return on investment. “Geriatrics will be expanding, and there will be greater

opportunities and submit posters on

various topics. “I learned about wound care — something that I had very little

knowledge about before the program. This was one of the most powerful

aspects of the Futures for me.”

There is still time to contribute to the 2018 Futures program and support one or more participant from your state, organization, medical school, or region. Visit www.paltc.org/core

October 12–15, 2017
Best Care Practices in the Post-

Acute & Long-Term Care Continuum
Lake Buena Vista, FL
Contact: Ian L Cordes
Phone: 561-689-6321
Email: icordes6@bellsouth.net
Website: www.bestcarepractices.org/

October 13–15, 2017
Ohio Medical Directors Association
Annual Conference
Dublin, OH
Contact: Liz Culp
Email: ohioomda@gmail.com
Website: http://ohiomda.org/

October 17, 2017
Fall Core Synthesis
Late Registration Deadline
Website: www.paltc.org/core

November 1, 2017
Live Webinar: Please, Don’t Say THAT to a Family!
What to Say Instead
Website: www.paltc.org/webinars
Contact: Society Registrar - Phone: 410-392-3116
Email: registration@paltc.org

June 29–30, 2017
PCORI Workshop – Excellence in
Research in Long-Term Care
Sunriver, OR

Phone: 856-256-2333
Website: www.amda2018.abstract-central.com

October 4–7, 2017
Gerontological Advanced
Practice Nurses Association
(GAPNA) Annual Conference
Nashville, TN
Contact: Jill Brett
Phone: 856-256-2333
Website: www.gapna.org/events/
annual-conference

October 6–8, 2017
Oregon Geriatrics Conference &
Oregon Medical Directors Meeting
Sunriver, OR
Contact: Mary Olhausen
Phone: 360-892-1814
Email: omary52@comcast.net
Website: www.oregongeriatricsonline.org/

October 12–15, 2017
Geriatric Critical Care - Excellence in
Directors Association Symposium
Lake Buena Vista, FL
Contact: Ian L Cordes
Phone: 561-689-6321
Email: icordes6@bellsouth.net
Website: www.bestcarepractices.org/

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Email: registration@paltc.org

October 26–27, 2017
Minnesota Medical
Directors Association
Fall Conference
Roseville, MN
Website: www.minnesotaogeriatrics.org/fallconference/mmda.html

October 27–29, 2017
Caring in the Carolinas 2017
Concord, NC
Contact: Lexi Surface
Phone: 336-847-9405
Email: lexi@randylongmd.com
Website: http://cpaltc.org

October 28, 2017
2017 Virginia Medical Directors Association Annual Conference – Excellence in Long-Term Care
Richmond, VA
Contact: Angel Rivera
Phone: 757-889-4383
Email: ARivera@LongTermCareVA.com

October 31, 2017
Fall Core Synthesis
Late Registration Deadline
Website: www.paltc.org/core

November 1, 2017
Live Webinar: Please, Don’t Say THAT to a Family!
What to Say Instead
Website: www.paltc.org/webinars
Contact: Society Registrar - Phone: 410-392-3116
Email: registration@paltc.org

October 20–21, 2017
25th Annual Pennsylvania Medical
Directors Association Symposium
Hershey, PA
Email: pmda@pamedsoc.org
Website: http://pamd.org/category/events/

October 26, 2017
2018 Annual Conference
Poster Abstract Deadline
Website: https://amda2018.abstract-central.com/
Contemporary Pharmacology & Prescribing in Older Adults

SAVE the DATE

March 16-17, 2018
Boston Park Plaza
Boston, MA

GAPNA
Gerontological Advanced Practice Nurses Association