7th Annual Forum on Post-Acute, Long-Term Care, and Assisted Living Facilities

Program Handouts

Friday, June 2, 2023 | 7:00 AM to 4:30 PM

Itasca Country Club
400 E Orchard St
Itasca, IL 60143

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7th Annual LIVE Forum on Post-Acute, LTC & ALF

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Welcome to the 7th Annual LIVE Forum on Post-Acute, LTC & ALF. Enjoy a day of learning with quality programming, dynamic speakers, and a forum to exchange ideas, share information, and earn 6 free continuing education credits.

Nursing: This program has been approved for six hours of continuing education credit by The Illinois Board of Nursing, an approved sponsor of continuing education by the Illinois Department of Professional Regulation.

Administrators: This program has been approved for six hours of continuing education credit by the National Continuing Education Review Services (NCERS) of the National Association of Long-Term Care Administrator Boards (NAB) – Approval #20240601-6-A94345-IN.

Get your link/QR code for CE before you leave: A QR code will be provided to attendees at the close of the event; use it to submit your CE request. Your license number and a valid email address are required.

Upon successful form submission, an email containing your PDF certificate will be sent within 24 hours to the address provided. Note: if unable to locate in your inbox, please check any spam/junk folders.

The Program

7:00 AM — **REGISTRATION OPENS**

7:30 AM – 8:25 AM — **BREAKFAST, sponsored by Ntiva**

8:30 AM – 9:30 AM — ***Leadership for Today's 5-Generation Workplace***

Thomas Annarella
Valley Hi Nursing & Rehabilitation, Administrator

9:30 AM – 10:30 AM — ***Recruiting & Retaining 5 Generations: A Panel Discussion***

Thomas Annarella
Valley Hi Nursing & Rehabilitation, Administrator

Benjamin Surmi
Koelsch Communities, Director of Education & Culture

Pamela Bryan Kramer
Forum Extended Care Services, Executive Vice President

10:30 AM - 11:00 AM — **BREAK / VENDOR EXHIBITS**

11:00 AM – 12:00 PM — ***Legal Landmines: Risk Management & Liability Mitigation***

Meredith Duncan
Polsinelli, Attorney

12:00 PM – 12:55 PM — **LUNCH PRODUCT THEATER**
sponsored by Neurocrine Biosciences

The Impact of TD in LTC: Recognizing &Treating Tardive Dyskinesia in Long-Term Care

Amita Patel, MD
Geriatric Psychiatrist

1:00 PM – 2:00 PM — ***Immunology Simplified***

Barb Bancroft,
CPP Associates, Inc, Executive Director & President

2:00 PM – 3:00 PM — ***Dementia: Global Innovation***

Benjamin Surmi
Koelsch Communities, Director of Education & Culture

3:00 PM – 3:30 PM — **BREAK / VENDOR EXHIBITS**

3:30 PM – 4:30 PM — ***Diabetes Update & Overview***

Barb Bancroft
CPP Associates, Inc, Executive Director & President

4:30 PM — **CLOSING REMARKS**
DISTRIBUTION OF C.E. LINK
RAFFLE DRAWING

Course Descriptions & Learning Objectives

Leadership for Today's 5-Generation Workplace

Speaker: Thomas Annarella, BS, LNHA; Sara Champion, SHRM

Course Description: Today's leaders have to connect with team members all across the age continuum, collaborating with and leading people with different preferences, norms, and behaviors. Learn methods and tactics to successfully manage a generationally diverse workforce, assuring that teams operate effectively and team members are engaged.

Learning Objectives:

- Learn how culture and a purpose-driven workplace is important in leading multi-generational teams.
- Understand how communication styles differ across generations and how you can succeed as a leader by adapting to each.
- Explore how various workstyles across generations lead to productive teams.

Immunology Simplified

Speaker: Barb Bancroft, RN, MSN, PNP

Course Description: This seminar provides an overview of general immune system principles, the function of the macrophage antigen processing cell, and the presentation of the antigens to the cells of the immune system. Various cytokines will be reviewed including the interleukins, the interferons, and tumor necrosis factor. Drugs that modulate these cytokines will also be discussed as they relate to the immune system and to diseases. The seminar will include how vaccines work, and how long they last. Immunopathology will be discussed according to type. The aging immune system will also be discussed. This session is a robust primer on the immune system and its functions.

Learning Objectives:

- Learn how the three different immunopathology types impact resident care.
- Understand how monoclonal antibodies support the immune system.
- Learn the effectiveness of various vaccines and how they impact the immune system.

Recruiting & Retaining 5 Generations: A Panel Discussion

Speakers: Thomas Annarella, BS, LNHA; Benjamin Surmi, MSG; Pamela Bryan Kramer BA, LPhT

Course Description: Employee retention is an issue all providers are trying to address. Team members want to feel valued and appreciated. Join this panel to learn tactics and tools that go beyond annual bonuses and periodic pizza parties to reach all types and generations of staff. Review methods leaders can use to recruit and retain high performing employees and how building a healthy, positive organization is everyone's responsibility.

Learning Objectives:

- Learn "outside the box" tactics to help increase employee retention.
- Understand how a heathy, positive organization impacts employee recruitment and retention.
- Explore how your organization's leaders can adjust their retention tactics to address multiple generations of employees.

Dementia: Global Innovation

Speaker: Benjamin Surmi, MSG

Course Description: People around the globe are experimenting with fresh ways to help people living with dementia thrive. What can we who work and live in the USA learn from people around the world? From social programs to technology to city planning to engaging the arts in new ways, innovation right now is high. Spark your own creativity. Broaden your knowledge of what's possible. Look beyond our borders for inspiration.

Learning Objectives:

- Learn how technology supports individuals living with dementia in their current setting.
- Compare "outside the box" solutions vs. current tools to support individuals living with dementia.
- Expand knowledge, tools, and solutions for individuals living with dementia.

Legal Landmines: Risk Management & Liability Mitigation

Speaker: Meredith Duncan, BS, JD

Course Description: Senior housing, assisted living, CCRCs, and skilled nursing facilities are constant targets for regulatory and civil liability. As communities fight through the current environment with staffing shortages and higher acuity, the risk of significant legal liability for all organizations is at an all-time high. This session will discuss the nature of liability, the most common sources of liability and how to develop a clear plan for managing and minimizing these risks.

Learning Objectives:

- Explore the most common sources of liability in long-term care.
- Discuss best practices to mitigate your risk.
- Prepare an action plan for incidents and accidents that occur in long-term care settings.

Diabetes Update & Overview

Speaker: Barb Bancroft, RN, MSN, PNP

Course Description: This update on Type 1 and Type 2 diabetes includes a discussion of current thinking on pathophysiology and its clinical manifestations, complications, key lab tests, and the various classes of drugs used to treat this disease and underlying insulin deficiency and/or insulin resistance.

Learning Objectives:

- Learn how current medications are helping individuals living with diabetes live an independent life.
- Understand how lifestyle changes can delay the onset of diabetes and help individuals live with the diagnosis.
- Compare the differences between Type 1 and Type 2 diabetes to help you care for your residents.

Leadership for Today's 5-Generation Workplace

Thomas Annarella, BS, LNHA
Valley HI Nursing & Rehabilitation, Administrator

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A dedicated member of the long-term care profession for more than two decades, Tom served as the Administrator at Arbor of Itasca for nearly 10 years before joining Valley Hi as its Administrator in 2010. Tom holds a Bachelor's degree in Healthcare Administration from Southern Illinois University and has been a member of the Illinois Healthcare Association for most of his career. He was recognized as one of Provider magazine's "20 to Watch" and completed the AHCA/NCAL Future Leaders program. Tom joined the IHCA Board of Directors in 2011 and has served on various IHCA committees. He currently chairs the IHCA Nursing Facility Constituency Steering Committee and Illinois Leaders program.

Learning objectives

- Learn how culture and a purpose-driven workplace is important in leading multi-generational teams
- Understand how communication styles differ across generations and how you can succeed as a leader by adapting to each
- Explore how various workstyles across generations lead to productive teams

Agenda

1. Changes to the health care landscape
2. Staffing challenges
3. Overcoming staffing challenges
4. Organizational health
5. Multigenerational workplace
6. Leadership and accountability

Changes to the health care landscape

55% of nursing home providers are limiting new admissions – AHCA survey 12-2022

55% of SNF's are operating in the red, 48% said that they would not be able to sustain operations at the current pace for more than a year –AHCA survey 12-2022

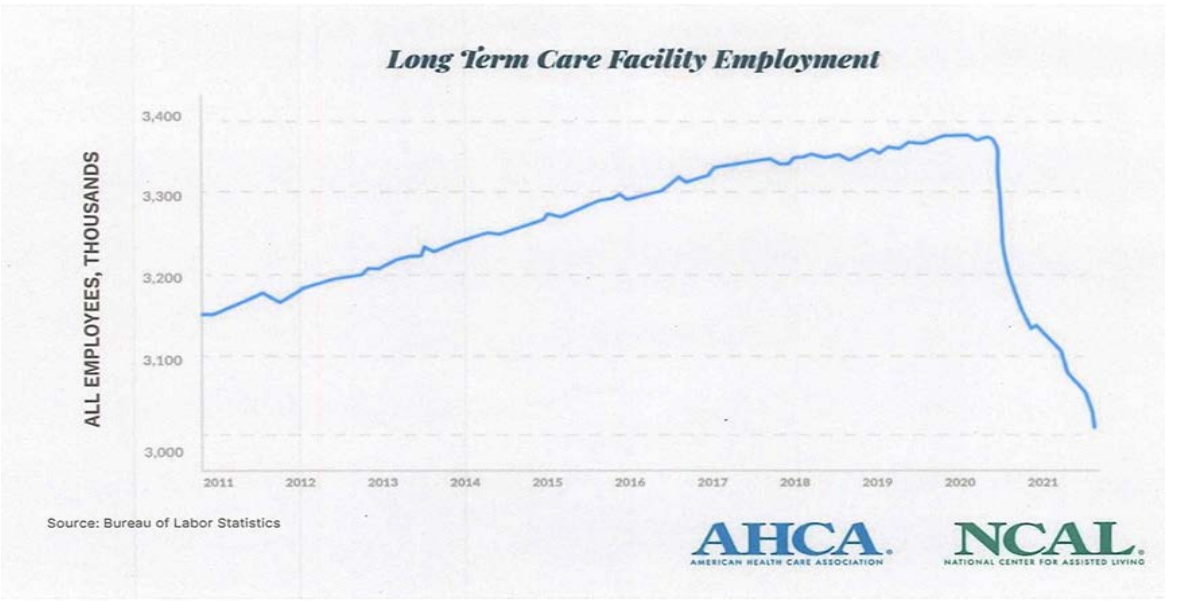
Skilled Nursing News reported on 8-3-2022:

- 7 homes in Montana closed their doors in the last 6 months
- 11 homes in Iowa closed or are in the process of closing since last year
- AHCA / NCAL projects that more than 400 SNFs could close in 2022 nationally, with the nearly 240,000 job openings as the primary driver – mostly rural and underserved areas

In a survey conducted by AHCA in 2022, 87% of facilities reported facing moderate to high staffing challenges and 73% expressed concerns that staffing shortages may force them to close their doors.

Staffing challenges

Where did all the healthcare workers go?



380,000 workers lost since 2020

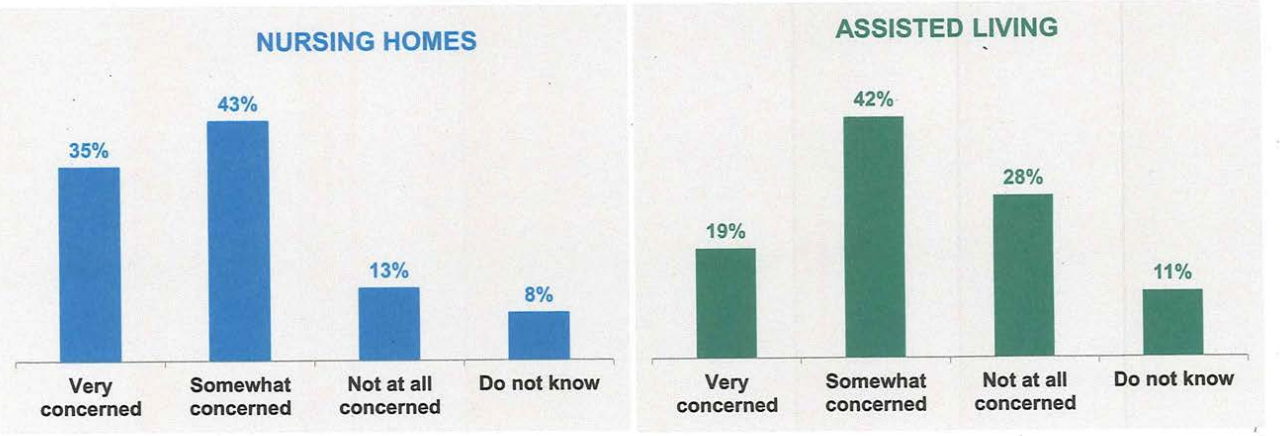
3% of long-term care providers nationally are fully staffed – AHCA survey 12-2022

Staffing challenges

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

78% of nursing homes and 71% of assisted living communities are concerned workforce challenges might force them to close. More than one-third of nursing homes are very concerned about having to shut down their facility(ies).

Q. How concerned are you that if your workforce challenges persist that you may have to close your facility(ies)?



Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

Staffing challenges – those who stayed

- 55% of healthcare workers report burnout (mental and physical exhaustion from chronic workplace stress)
  - The highest rate of burn out 69% is among the youngest staff (age 18 to 29)
- 62% of healthcare workers report some mental health repercussions from the COVID-19 pandemic, including depression, anxiety, and mental distress

Staffing challenges – those who stayed

What does all this amount to?

- Healthcare access issues
- Decrease in quality
- Healthcare worker burnout / moral injury
- Quiet quitting

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Overcoming staffing challenges

We cannot simply fill our shifts with agency and OT anymore

1. Financial impacts
2. Quality impacts
3. Organizational health impacts

Overcoming staffing challenges

Beyond recruitment – what can we do?

Focus on organizational health and ensure your good employees STAY

Organizational health and the importance of team strength

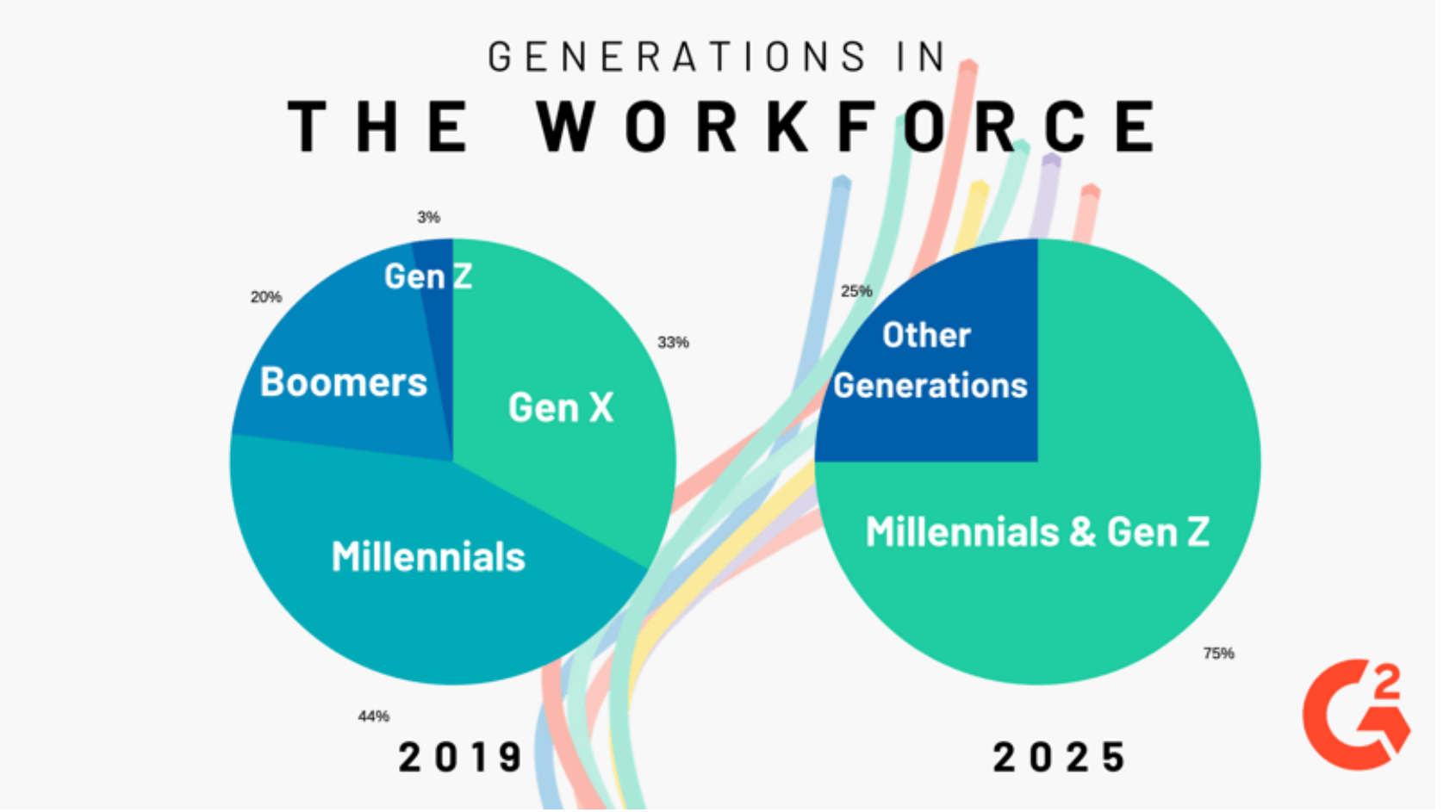
Organizational health assessment – ask yourself the following about your Team:

1. Are meetings compelling? Are the important issues being discussed during meetings?
2. Do team members engage in unguarded debate? Do they honestly confront one another?
3. Do team members apologize if they get out of line or when they are wrong?
4. Do team members pay attention in meetings and when others are talking? Are they distracted?
5. Do team members avoid gossiping about one another?
6. Are there silos, cliques, informal “groups”?

The multigenerational workplace

- Why does understanding generational differences matter?
  - We have representation from 4-5 working generations within our organizations, do you suppose there are some differences? Significant?

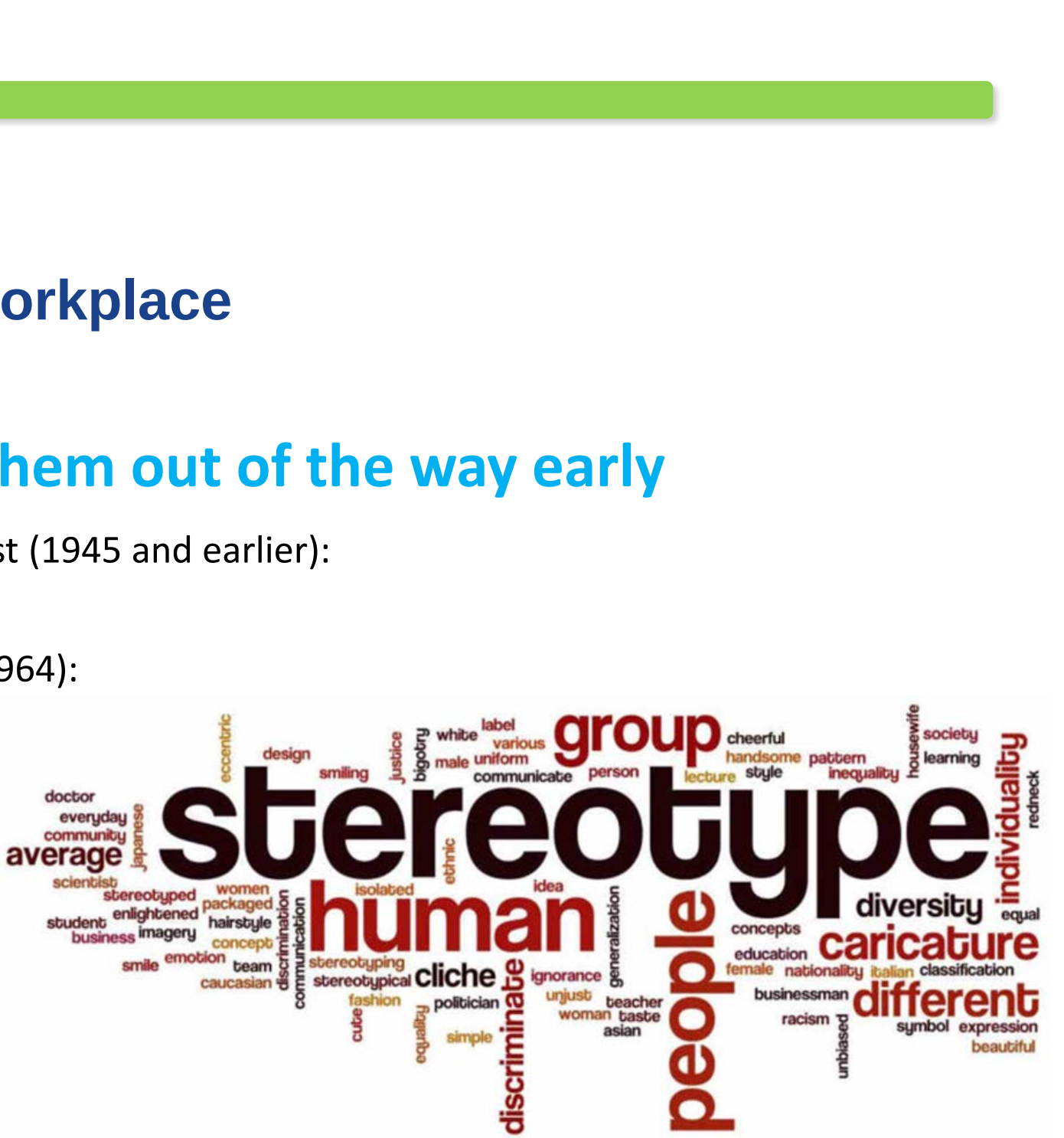
The multigenerational workplace



The multigenerational workplace

Stereotypes – let's get them out of the way early

- The Silent Generation / Traditionalist (1945 and earlier):
  - "Staunch rule followers"
- Baby Boomer Generation (1946 – 1964):
  - "Boomers"
- Generation X (1965-1980):
  - "Last of the great childhoods"
- Millennials (1981 – 2000):
  - "Participation trophy generation"
- Generation Z (2001 – 2015)



The multigenerational workplace

Generation	Defining Moments
Silent Generation / Traditionalist	Economic fragility (Great Depression), 2 World Wars, firm parenting style
Baby Boomer	Post-war, prosperity, Vietnam War, Civil Rights Act 1964
Gen X	Increase in single parenting, first to interact with technology, last generation to hold dear to its culture and education, latch-key children
Millennials	Rapid changing technology, 9-11
Gen Z	Full digital immersion, 2008 recession, “digital natives”

The multigenerational workplace

Generation	Key Traits
Silent Generation / Traditionalist	Loyal, determined, respectful, thrifty
Baby Boomer	Ambitious, goal orientated, competitive Focused and believe in more hours at work Resourceful and team players
Gen X	Work hard, believe in work-life balance Independent minded, flexible and direct Self-reliant, thinkers, embrace feedback, cynical
Millennials	Socially driven, ethically diverse, tech-driven, curious Educated and multi-career based, Financially conscious Poor interpersonal skills, less religious, realism
Gen Z	Tech-savvy, always “on” Poor interpersonal skills, reduced attention span Indoor generation Ethically diverse Set for online social interactions, less religious, personalized learning

The multigenerational workplace

Generation	Communication Preferences
Silent Generation / Traditionalist	Written and formal
Baby Boomer	One-on-one, telephone
Gen X	Direct, email, text messaging
Millennials	Text messaging, social media
Gen Z	Text messaging, social media Hand-held and wearable devices Video

The multigenerational workplace

Generation	Feedback Preferences
Silent Generation / Traditionalist	No news is good news Pride in a job well done Have a desire to lead
Baby Boomer	No keen on feedback Comfortable in leadership / mentoring positions
Gen X	Direct feedback Being a mentor, supporter, and educator boosts engagement / retention
Millennials	Lots of instantaneous feedback and touch points Hate being called Millennials (or any other label)
Gen Z	Bite-sized and instantaneous feedback, reward driven

The multigenerational workplace

Generation	Recruitment and Retention
Silent Generation / Traditionalist	Focus on company history and how they can contribute to it Create a sense of satisfaction for a job well done Rewards are those earned honestly and include monetary and retirement benefits Want responsibility and control over environment or projects
Baby Boomer	Be transparent and inclusive, show respect for experience and allow for questions Feedback is not as desired as recognition, title, acknowledgement, and advancement
Gen X	Be clear about what the organization has to offer and the exact expectations Expect candid communication and a collaborative mindset Loyalty to a leader is more important than to the organization
Millennials	Looking for meaningful work and will want to know exactly what working for your organization will be like Key to retention is providing regular feedback and structure, flexibility and bonuses are important
Gen Z	Emphasize stability and security the organization can offer, focus on benefits Perform best with regular feedback from managers, even as often as 5 minutes several times a week

The multigenerational workplace

Generation	Views on Management
Silent Generation / Traditionalist	Chain of command, follow the rules (top down)
Baby Boomer	Challenge the chain of command Respect authority but don't always trust it
Gen X	What chain of command Not intimidated by authority
Millennials	No chain, we are all in the same boat
Gen Z	Put me in coach, I can run this company, want coaching / mentoring

The multigenerational workplace

What does all this mean?

Why is it important?

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The multigenerational workplace

- **6 strategies for a multi-generational workplace**
  1. Establish a culture of respect
  2. Be flexible and accommodating
  3. Avoid stereotyping
  4. Learn from one another
  5. Tailor your communication and feedback style
  6. Don’t overlook the similarities

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- **Always fall back to your Core Values**

Overcoming staffing challenges

- As leaders we need to understand the perspectives of our teams and how they view the world
- As teammates we need to do the same
- Perspective matters, **but what is more important is intent**

Leadership and accountability

- Recovery is going to take great leadership, presence, and accountability – the three most important things that make the difference from good to great, from 1-star to 3-star (or even better, 5-star)
- We must hold ourselves and our team(s) accountable when we get off track, and quickly recover; there is no room for ego, no time for fighting, and certainly no need to waste time
- Understanding generational differences allows us to gain better perspective on where our teams are coming from and allows us to be more effective leaders

Thank you - Any questions?

Recruiting & Retaining 5 Generations:

A Panel Discussion

Thomas Annarella
Valley Hi Nursing & Rehabilitation
Administrator

Benjamin Surmi
Koelsch Communities
Director of Education & Culture

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Benjamin Surmi, MSG, Social Gerontologist

The focus of Benjamin's work as a social gerontologist is to empower people to thrive, no matter the disability or cognitive disorder they may have. He is passionate about designing powerful user experiences for elders and the people who serve them. Benjamin joined Koelsch Senior Communities in 2016 as the Director of Programs and Training before moving into the Director of Education and Culture in 2018, where he shapes innovative engagement experiences for seniors, as well as specialized programming for people living with dementia. Benjamin also guides person-centered training for over 2,000 employees in 8 states, leads Koelsch Innovation Lab, and coaches 70+ wellness directors and 32+ Executive Directors who support over 1,500 seniors. His passion is imagining the impossible and building alliances that make it possible. Benjamin holds a Bachelor's degree in Communication and Sociology from Biola University and a Master's degree in Gerontology from California State University.

Pamela Bryan Kramer, BA, LPhT

With more than 35 years of experience in the pharmaceutical industry, Pam has created award-winning strategies and educational programs for industry leaders. She is responsible for developing and implementing Forum's mission and vision and optimizes Forum's infrastructure, approach, and services, based on her diverse background and expertise in strategic planning, customer relations, operational process development, and Lean Six Sigma. Pam holds a Bachelor's degree from New York University, is a Licensed Pharmacy Technician, and is proud to be part of a company honored as one of the Best Places to Work in Illinois for three years in a row!

Learning objectives

- Learn “outside the box” tactics to help increase employee retention
- Understand how a heathy, positive organization impacts employee recruitment and retention
- Explore how your organization’s leaders can adjust their retention tactics to address multiple generations of employees

1

How do you hold yourself and your teams accountable?

2

How do you teach that accountability to your next-generation leaders?

3

How have you changed your recruiting efforts to address the different generations or the post-pandemic landscape?

4

What types of conflict have you seen between generations in your workplace and how have you resolved it?

5

If you have encountered cliques, what have you done to address them?

6

What do leaders need to change or incorporate into their communication to accommodate the different generations?

7

Using a single phrase or sentence, what is your key to helping people get along with each other?

8

For your long-tenured employees, what is different about your "secret sauce" that led them to stay? Do you use any tools or specific methods to help you?

9

What do your employees say about why they stay?

Audience questions?

Thank you!

Legal Landmines:

Risk Management and Liability Mitigation

Meredith Duncan
Polsinelli PC
Shareholder

Legal Landmines: Risk Management & Liability Mitigation

Meredith Duncan, BS, JD

A litigator at heart, Meredith Duncan advocates for clients before government regulators, administrative law judges and courtrooms alike. She focuses mainly on the compliance and operational issues facing health care providers, including long-term care providers, senior housing entities and hospitals. From licensing to contracts, to risk management and regulatory compliance, she handles all aspects of a health care provider's practice. Meredith appears regularly before the regulatory agencies that oversee the health care industry, including the Centers for Medicare and Medicaid Services, the Office of the Inspector General, the Department of Healthcare and Family Services, the Illinois Department of Public Health, the Illinois Department of Professional and Financial Regulation, as well as other state and federal governmental agencies on behalf of clients. Meredith also has significant experience with Medicare, Medicaid and Managed Care Organizations. She assists clients in their relationships with payers and with responses to reimbursement disputes, audits, and appeals.

Meredith holds a BS in Business Administration from the University of Missouri-Columbia and earned her JD from Chicago-Kent College of Law at the Illinois Institute of Technology.

Learning objectives

- Explore the most common sources of liability in long-term care
- Discuss best practices to mitigate your risk
- Prepare an action plan for incidents and accidents that occur in long-term care

Agenda

WHERE DOES LIABILITY COME FROM?

THE MOST COMMON LIABILITY RISKS THAT COMMUNITIES FACE

WHAT YOU CAN DO NOW

Liability

Duty (du·ty) *noun*

1. a moral or legal obligation; a responsibility
2. a task or action that someone is required to perform

A duty can be created by

- statute
- promise or representation
- industry standard

And, a duty can be difficult to get rid of……

Liability equation

Duty + Failure to Carry Out Duty = Liability

Meet the reasonable person

The "***reasonable person***" is a *hypothetical* individual who approaches *any situation* with the *appropriate amount of caution* and then *sensibly takes action*.

It is a standard created to provide courts and juries with an *objective test* that can be used in *deciding whether a person's actions constitute negligence*.

The reasonable _____?

- Reasonable ***person***
- Reasonable ***administrator***
- Reasonable ***nurse***
- Reasonable ***care aide***
- Reasonable ***doctor***
- Reasonable ***facility***

What's reasonable?

To comply with your policies

To meet the industry standard (ie, what others do)

To meet the regulatory requirements

And, to do these things consistently

Liability - O - Meter

Low

High

Landlord

Health Care Provider

Keep in mind

Hindsight is always 20/20

If you didn’t document, it wasn’t done

Can’t count on immunity from state or federal authorities

Every dog gets one bite

- Once you know that your dog bites, you need to take action
  - What if you ***know*** that a resident is exhibiting a behavior?
  - What happens if you have ***heard*** that a caregiver has done something wrong?
  - What if you ***suspect*** that staff are using social media to post about the facility and residents?

Standard is what you "**knew or *should have known***"

- There are benefits to a zero-tolerance policy
- You can't ignore a dog that growls all the time

Causes of liability

- Human error
- Failure to follow a care plan/physician orders
- Failure to assess and/or document same
- Failure to document care
- Failure to follow policies / making exceptions
- Failure to address warning signs
- Failing to listen to that “little voice”
- Failure to fire poor staff
- Hiring the wrong staff
- Admitting the wrong resident

Causes of liability

- People
- People
- People
- People

Where claims come from

Where do claims come from?

- The family
- The resident
- Your staff

The basis for these claims come from:

- Your staff
- The care they deliver
- Your policies
- Your response to events/information

- Identify and address risks proactively
- Prevent the bad act from happening
- Minimize the community's liability when the bad thing happens
- Implement lessons learned for further improvement

The power of prevention

Avoiding the risk

- ✓Don’t hire
- ✓Fire
- ✓Don’t admit
- ✓Discharge
- ✓Follow your policies
- ✓Be consistent

Look for smart admissions

Look for the warning signs

- Multiple prior placements
- Difficult family
- Arguments within the family
- Complaints about the prior placement, doctor, hospital care
- Something just doesn't seem right
- Story just doesn't add up

Smart hiring/firing

- Pay attention to warning signs
- Attitude means more than skills
- Do not ignore warning signs
- Do not ignore your gut
- Establish bright lines that can’t be crossed

Mandatory training lessons

No exceptions to bright line rules

If you aren’t sure, ask

If you see anything that makes you uneasy, tell someone

Failure to report is as bad as or even worse than the mistake/ issue itself

If you need help or support, ask

Communication is key

Bright lines with staff

Abuse	Transferring resident correctly	Getting angry with residents
Handling residents roughly	Failure to follow service plans	Failure to communicate (Doctors, other staff, reporting)

Most common problems with documentation

- Non-existent
- The reality / documentation gap
  - Speculation
  - Best case scenario driven
  - “No one will read this, right?”
  - No one does read it

Plaintiffs' attorneys are looking for ***ONE*** thing

What did your community

do or fail to do

that

caused

a resident to be injured or die?

Policies

- Required by law
- Provide guidance to staff
  - Create consistency in practice
  - Communicates expectations
  - Remove the chance for error
  - Promotes compliance
- Rules of the road
- Sets the standard of care you will live up to

Biggest problems with policies

Too elaborate

Too strict

Too many

Contrary to practice

Too secret

Policy Do's

Clear.	One policy for an issue.	To the point – what is the take away?
Easy to carry out. If staff can't tell you the policy when you ask they probably aren't carrying it out.	Shared with residents and families as appropriate.	Known by everyone (or at least everyone who should know).

Common liability risks

- Abuse
- Falls
- Elopement
- Wounds

Top four errors with abuse

1. Staff fail to identify an incident or allegation of abuse.

2. Staff fail to report an allegation of abuse.

3. Once a report has been made, staff are not suspended pending investigation.

4. Failure to conduct a thorough investigation & dig deeper.

Three golden rules

1	2	3
Treat every allegation as if it were true and as if it were abuse.	Treat every allegation as if it were true and as if it were abuse.	Treat every allegation as if it were true and as if it were abuse.

Policy and training foundation

1. You anything that you see or hear about that makes you feel . . . . . .

2. You will something like this . . . . . but ***you will be disciplined if you fail to do so***

Resident abuse by staff

- Make sure that your staff:
  - are trained comprehensively and often on the of residents
  - understand how to
  - that makes them uneasy
  - know that but also know that

Falls

Deviations from the care plan / inappropriate transfer are impossible to defend

After a fall

- Documented investigation / Root Cause Analysis
- New interventions to prevent similar fall (or document that all interventions are in place)
- Anticipate future falls and address in the care plan
- Consider clinical issues and follow-up
- Update the care plan to show that this process was completed after a fall
- Train the staff on any care plan updates
- ***Wash, rinse & repeat for each different fall***

Lost residents / elopement

How do you monitor residents in the building?

If a resident is lost have a checklist:

Head count. **Search team.** **Notification.** **Alarm check.** **Investigation of cause.**

How often do you check your door alarms?

Can door alarms be disabled?

Drills – do staff know what to do?

Medication errors

- Residents are unable to self-identify
- Residents need medication assistance/administration
- Residents may be unable to communicate adverse effect

Wounds

- Train staff to and skin changes
- For each new skin change
- Get a at the outset to discuss the “why”
- Treatment interventions & pressure relief
- On nutrition, medication and other clinical components
- Periodic notes and input from clinicians discussing the “”

Key is to have contemporaneous documentation explaining unavoidable skin breakdown

What you can do now

What you can do now…*to get ready*

- Perform a self-assessment
- Identify areas of risk
- Review your survey performance
- Assess your in-service and training topics
- Look critically at your QA
- Consider pre-emptive audits
- Mock survey

What you can do now…*to respond*

- Gather all documentation
- Preserve documents and materials involved
- Make a timeline
- Review your policies
- Start re-training
- If necessary, notify your insurance carrier & get your legal counsel involved

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Questions?

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mduncan@polsinelli.com

POLSINELLI

Thank you!

Immunology Simplified

Barb Bancroft
CPP Associates, Inc
Executive Director & President

Forum 50 YEARS+
EXTENDED CARE SERVICES

Immunology Simplified

Barb Bancroft, RN, MSN, PNP

Barb is an industry professional with more than 40 years of experience in healthcare as a nurse, author, editor, educator, and speaker. She is a passionate and informative speaker on clinical topics such as pathophysiology, physical assessment, and pharmacology. Barb has taught more than 2,800 continuing education seminars on health-related topics and has served as the keynote speaker for professional associations and corporations, including the American Association of Practitioners for Infection Control, the American Academy of Nurse Practitioners, and the National Association of Orthopedic Nurses. Currently, Barb is the Executive Director and President of CPP Associates, Inc., a continuing education provider. Barb holds a Bachelor's degree in Nursing from East Carolina University and a Master's degree in Nursing from the University of Virginia.

Learning objectives

- Learn how the three different immunopathology types impact resident care
- Understand how monoclonal antibodies support the immune system
- Learn the effectiveness of various vaccines and how they impact the immune system

So how do inflammation and the immune system work together?

- Two systems work as a unit to fight infections and repair tissue trauma
  1) Innate system—is the one you are are born with; innate abilities to fight invading pathogens—barriers such as skin, pH of body fluids, and the inflammatory response
  2) Acquired or adaptive “immune” system—you learn from experience—you meet the pathogen and respond specifically to it, and then when it comes around the second time…you remember it!

So, what is the INNATE RESPONSE? These are present at birth and include barrier defense mechanisms and the acute inflammatory response

- Skin and mucous membranes— herpes lesions, surgical wounds, pricks from a thorn, cuts, bites, burns
- Saliva—dry mouth, halitosis and dental caries
- Gastric pH—2; vaginal pH—4; urine pH – 4.5
- How do we, as HCPs, disrupt the innate system in patients?

We break the barriers!

- Gotta hole? We'll put a tube in it…if you don't have a hole for the tube we're holding—we'll make a new hole for ya'! Urinary catheters, Hickman catheters, J tubes, G tubes, IV tubes, trach tubes, ports, arterial lines, venous lines, surgical sites
- Sadly, every tube we insert increases the risk of infections in hospitalized patients, older patients, and immunocompromised patients

Innate defense: acute inflammation

- We’re born with the ability to become inflamed… “itis”
- Red and hot, swollen and painful
- AND, the arrival of phagocytic cells of inflammation. The neutrophils and the macrophages

But first…can inflammation be a good thing?

- Actually, YES…it is absolutely necessary for the healing process
- Burn your hand, cut your finger, yank off a hangnail or stub your toe and the Inflammatory is at-the-ready to clean up the mess made by the damage to tissues
- The inflammatory response is always on the alert for foreign invading pathogens
- Viruses, yeast, bacteria, parasites
- Pollen, ragweed and animal dander (in some of us)…

Inflammation can also be chronic…and this can be even more damaging to overall health

- A **chronic, low-grade** inflammatory plays a role in many chronic conditions, including:
- Cardiovascular disease, type 2 diabetes, Alzheimer's dementia, and cancer
- Low grade chronic inflammation is commonly found as a precursor to cancer

Examples of low grade, chronic inflammation and malignancy

- Chronic cervicitis (HPV) and cervical cancer
- Chronic esophagitis (Barrett's esophagus secondary to GERD) and the risk of adenocarcinoma of the lower third of the esophagus
- Alcoholic hepatitis, chronic hepatitis (HBV, HCV) and hepatocellular cancer
- Chronic gastritis (*H. pylori)* and gastric cancer
- Chronic ulcerative colitis and colon cancer

Acute AND chronic inflammation can also occur with autoimmune diseases

- When the inflammatory response is “instructed by the immune system” to target healthy tissues, we have a problem…autoimmune disease is characterized by WBC (neutrophil)-induced inflammation
- Example: systemic lupus erythematosus
- Inflammation is responsible for all of the acute “itis’s” observed in patients with lupus—vasculitis (butterfly rash), lupus nephritis and renal failure, pericarditis, pleuritis, myositis, and encephalitis (lupus psychosis)…

- Rheumatoid arthritis…is another autoimmune disease with inflammation as a major component

Four WBCs that play a major role in inflammation and immunity

- The neutrophils (segs, segmented neutrophil)—the first responders causing acute inflammation, the first responders to virulent bacteria, and the first responders to acute necrotic tissue –
- The macrophages—perhaps the most interesting cell of all; cells of acute and chronic inflammation; they clean up after the segs and are the antigen processing cells presenting foreign pathogens to the immune system—the LINK between inflammation and immunity
- The lymphocytes—these are the first responder to viruses; these are also the cells of the immune system (T lymphocytes and B lymphocytes)
- The eosinophils are the first responders to allergens…

The first responders: the NEUTROPHILS (segmented nucleus aka “segs”)…normal function

- Margination, pavementing (stuck to the wall), migration, engulfment, and degranulation—the neutrophil migrates into tissues within 5-10 minutes of tissue damage

Corticosteroids

- Inhibit the ability of the neutrophil to migrate into the tissues and de-granulate
- **Hence the “anti-inflammatory” effects of the corticosteroids**

- Glucocorticoids are used to “stop” inflammation as well and stop the attack on “self” (4.5 hours)
- BUT steroids can also delay wound healing
- It’s the old, “GOOD NEWS, BAD NEWS”…

Other reasons for poor wound healing in patients

- Uncontrolled diabetes with a blood glucose greater than 180 mg/dL (9.99 mmol/L) also inhibits neutrophil migration
- Elderly with decreased migration of neutrophils, increases infection susceptibility
- On the other hand…Fever ***increases*** the migration of neutrophils— is fever good for you? YES!

Neutropenia is a medical emergency

- Usually, two words before it…
- “Life-threatening” neutropenia
- Not enough? Neutropenia…can’t fight bacterial infections—increased risk of sepsis
- Impaired inflammatory response so the usual signs and symptoms (erythema, edema, purulence) are usually not present
- **The patient may have a fever…but nothing else…**

MACROPHAGES—BIG EATER!!

- Macrophages have other names in various tissues just to annoy us--but they all do the same thing--EAT
- Monocytes in blood, microglial cells in the central nervous system, Kupffer cells in the liver, histiocytes in connective tissue, Langerhans cells in the skin

The macrophage—the cell of chronic inflammation and the antigen processing cell

- The macrophage is the antigen processing and presenting cell of the immune system
- Immune cells are “labeled” for identification – using a classification “CD” for cell determinant and given a #
- Macrophages have a CD4 on their cell membrane

The macrophage—big and slow

- The cell of chronic inflammation--these cells respond much slower than the neutrophil (2-4 days vs. 5-10 minutes for the neutrophil, the cell of acute inflammation)
- Chronic inflammatory diseases—”osis”—sarcoidosis, amyloidosis, tuberculosis, halitosis…kiddin’ on the halitosis

Chronic inflammatory diseases and macrophages—TB

- “red snappers”—the tubercle bacillis
- Macrophages circle around the bacteria and “spit” cytokines into the “granuloma” --
- Interferon gamma and TNF-alpha is especially important--**TNF-a keeps TB in check (i.e., dormant)…**

VITAMIN D

- POTENT macrophage booster
- In the old days…*“If you have consumption, go up on the mountain…”*
- Heliotherapy (sun therapy) for TB in 1908 in the Swiss Alps
- **Heliotherapy in 2023** ☺☺☺

The macrophage (CD4+)—is also the link between inflammation and immunity

- The macrophage is the antigen processing and presenting cell
- It engulfs the pathogen
- Chews it up
- Processes it and presents it to the CD4+ helper T lymphocyte (T4 cell) of the immune system
- CD4s “talk” to CD4s!!

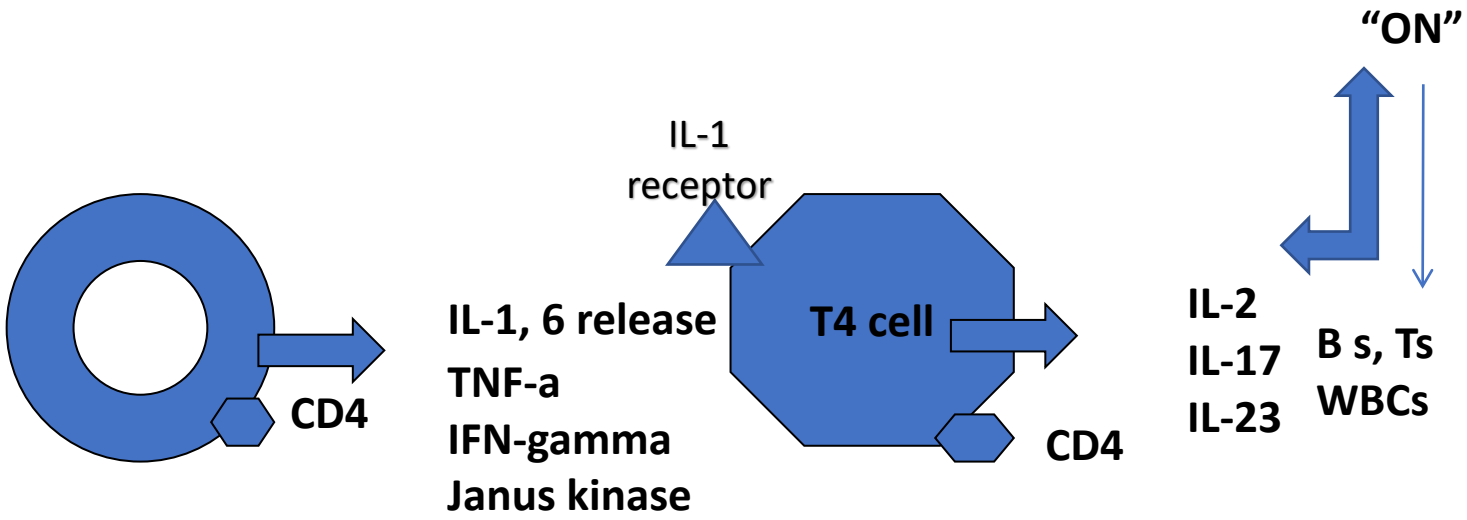
The macrophage releases a myriad of “cytokines” as it engulfs and presents --

- Interleukins— “inter”= between and “leukins”—white blood cells (leukocytes); there are 36 of them… abbreviated IL-1, IL-2, IL-3…get it? Aren’t you happy we won’t be talking about ALL of them?
- Some of the interleukins are “inflammatory” -- IL-6, IL-17, IL-22, IL-23—and others are “anti-inflammatory”...
- Tumor necrosis factor alpha (TNF-a)—a potent inflammatory mediator
- Interferons (IFN)—interferon-gamma is an immune booster (basis for the IGRA test)—interferon gamma release assay for TB
- Janus kinases—inflammatory enzymes

Cells of the immune system—the lymphocytes—quick hit (more in a minute)

- T lymphocytes (all have numbers on them)—T4 and the macrophage (CD4
- B lymphocytes produce antibodies to specific pathogens – we can measure the antibodies

Let’s put it all together: the link between inflammation and immunity…Gulp, chew, process, spit, kick…



macrophage with CD4 receptor

helper T cell with CD4 receptor

How do drugs influence this immune response – many of which are used to treat autoimmune diseases by either inhibiting the immune response or inhibiting WBCs…

- Prednisone inhibits IL-1 (interleukin-1) release—immunosuppressive and also anti-inflammatory.
- Methotrexate--blocks the binding of interleukin-1 to the interleukin 1 receptor; inhibits T cell activation
- Plaquenil (hydroxychloroquine) inhibits macrophage function (didn't work for COVID-19)
- Cyclosporine inhibits IL-2—used to reduce tissue transplant rejection
- Janus kinase inhibitors, IL-6—tofiticinib (Xeljanz) for Rheumatoid Arthritis

Drugs that inhibit TNF-alpha and others

- Excess TNF-alpha is the “culprit” causing severe inflammation in certain diseases such as rheumatoid arthritis, Crohn’s disease, ulcerative colitis, psoriatic arthritis, and ankylosing spondylitis
- Etanercept (Enbrel) binds with excess TNF-a molecules—anti-inflammatory
- Monoclonal antibodies—infliximab (Remicade), adalimumab (Humira), certolizumab (Cimzia), golimumab (Simponi)
- Tofacitinib (Xeljanz) –janus kinase inhibitor for rheumatoid arthritis (also needs TB testing before starting for RA)
- A TB test is mandatory before starting any drug on this page
- Hepatitis B testing should also be performed before administering the above drugs, too

Langerhan's cells and the pro-inflammatory cytokine IL-17

- IL-17 is an inflammatory cytokine released by Langerhan's cells in the skin
- In patients with psoriasis, the signals in the normal healing process of skin due to minor trauma are faulty. The tissue overreacts to an injury in the skin, or the immune system will mobilize for an unknown reason.
- People with psoriasis lesions have 30 times higher amounts of the inflammatory interleukin, IL-17, than people without lesions, (Bagel et al. August 2012 *Practical Dermatology)*
- Studies have clearly demonstrated that blocking IL-17, or reducing it, can help clear psoriasis.
- Secukinumab/Cosyntex – 81% of patients with a 75% improvement in symptoms (commercial—Cindy Lauper)

Kim Kardashian has psoriasis…I haven't seen a single lesion...anyone in this room seen a lesion on KK

- Other drugs that target IL-17
- Approved 2017—brodalumab (Siliq) injection for psoriasis—anti-IL-17 receptor and prevents activation of IL-17
- Ixekizumab (Taltz)—binds to IL-17 (not receptor)

Let’s get back to the T lymphocytes

- T lymphocytes—derived from bone marrow, mature in thymus gland, hence the “T” lymphocytes
- CD4 lymphocytes are also called the helper T lymphocytes or helper T cells;
- CD8 -- cytotoxic “killer” T lymphocytes
- CD25 are regulatory T lymphocytes
- All mature T lymphocytes have CD3

T cell immunity

- Primarily responsible for the specific immune response to virus', parasites, protozoa, fungii, TB, cancer
- 2 types of T cell deficiency syndromes
- Congenital immunodeficiency syndrome is DiGeorge's disease—RARE, no thymus
- Acquired immunodeficiency syndrome is AIDS, caused by HIV

What are the diseases seen in immunosuppressed AIDS patients?

- Viruses—systemic overwhelming herpes viral infections (HSV-1, 2, VZV, EBV, CMV, HHV-8 (Kaposi's sarcoma); HPV
- Fungus'—candida albicans throughout GI/GU tracts
- Protozoa—pneumocystis pneumonia
- Parasites--cryptosporidiosis
- TB
- Cancer—Non-Hodgkin's lymphoma (B cell lymphoma—EBV), Kaposi's sarcoma (HHV-8), squamous cell carcinomas

B lymphocytes

- The B lymphocytes are the 2nd major players of the specific immune response
- When stimulated, B lymphocytes differentiate into plasma cells that make antibodies/immunoglobulins
- This primary response to a pathogen (1st meeting) takes anywhere from 7 to 21 days to make the initial antibodies/immunoglobulins
- This is why it takes 2-3 weeks for vaccines to work…and why we give the flu vaccine before the flu season!!
- Memory antibodies take only moments to be triggered the second time around

B lymphocyte stimulation

- We make 5 types of immunoglobulins (antibodies)
- IgG, IgA, IgM, IgE (allergies), and IgD
- We need about 100 million different types of antibodies to fight all of the infections and bad guys we meet

Immunoglobulins (also known as antibodies)

- IgM—1st formed to a foreign substance and it decays over time
- IgG—2nd formed; the antibody of memory; crosses placenta;
- Antibody testing— “acute vs. convalescent titers” IgM? Or IgG?
- Have you had this disease or vaccine before? IgG testing for memory

Immunoglobulins (antibodies)…

- IgA—barrier antibody; saliva, tears, urine, breast milk

What about IgD?

- WHO CARES?
- No one knows exactly what it does, so you don’t have to learn it…

IgE—the antibody of allergies

- IgE drills a hole in the mast cells that line the eyes, nose, sinuses, throat, lungs, GI tract
- Mast cells release primary granules full of histamine
- Histamine is responsible for itchy, sneezy, wheezy, coughy, runny…
- Localized histamine release?
- Allergic rhinitis in the nose
- Hives in the skin

Hives…due to IgE triggered release from mast cells

- BUT…not all hives are IgE mediated!
- Morphine directly releases histamine
- Thermal –induced hives
- Exercise induced hives

Systemic histamine release of histamine?
Anaphylactic shock
Lots of causes of anaphylaxis

- Foods—peanuts, tree nuts, fish, shellfish, wheat,, tomatoes, strawberries, maple syrup (all age groups); egg, soy and milk (especially kids)
- Medications—beta-lactam AB (esp. PCN), radiocontrast dyes
- Venom—yellow jackets, hornets, wasps, and fire ants
- Miscellaneous—latex, seminal fluid (WHAT??? More in a moment), gelatin, inhaled allergens (horse dander), exercise (in some people, especially right after ingestion of a particular food), idiopathic (Spettel)
- Carry 2 epi pens! (they're CHEAP! RIIIIIGHT???)

Husbands

- YES!! Some women are anaphylactically allergic to their husband's semen!! YIKES…whaddya do?

Hay fever, asthma, allergic rhinitis—the allergic salute, the allergic “cluck”, shiners

- The one-airway hypothesis—allergic rhinitis and asthma? treat the NOSE first…
- Increased airway reactivity with low vitamin D levels?

What are the triggers?

- Pollen, ragweed and other airborne particles
- Animal dander—cats and dogs
- Roach dander
- Dust mites

What can you do to reduce allergies? Get the pet BEFORE you have the kid…

- Get rid of the pet?
- Stop sleeping with the enemy?
- Give ‘em a bath once a week?

THANK YOU!

Global Innovation:
Thriving with Dementia

Benjamin Surmi
Koelsch Communities
Director of Education & Culture

50 YEARS
Forum
EXTENDED CARE SERVICES

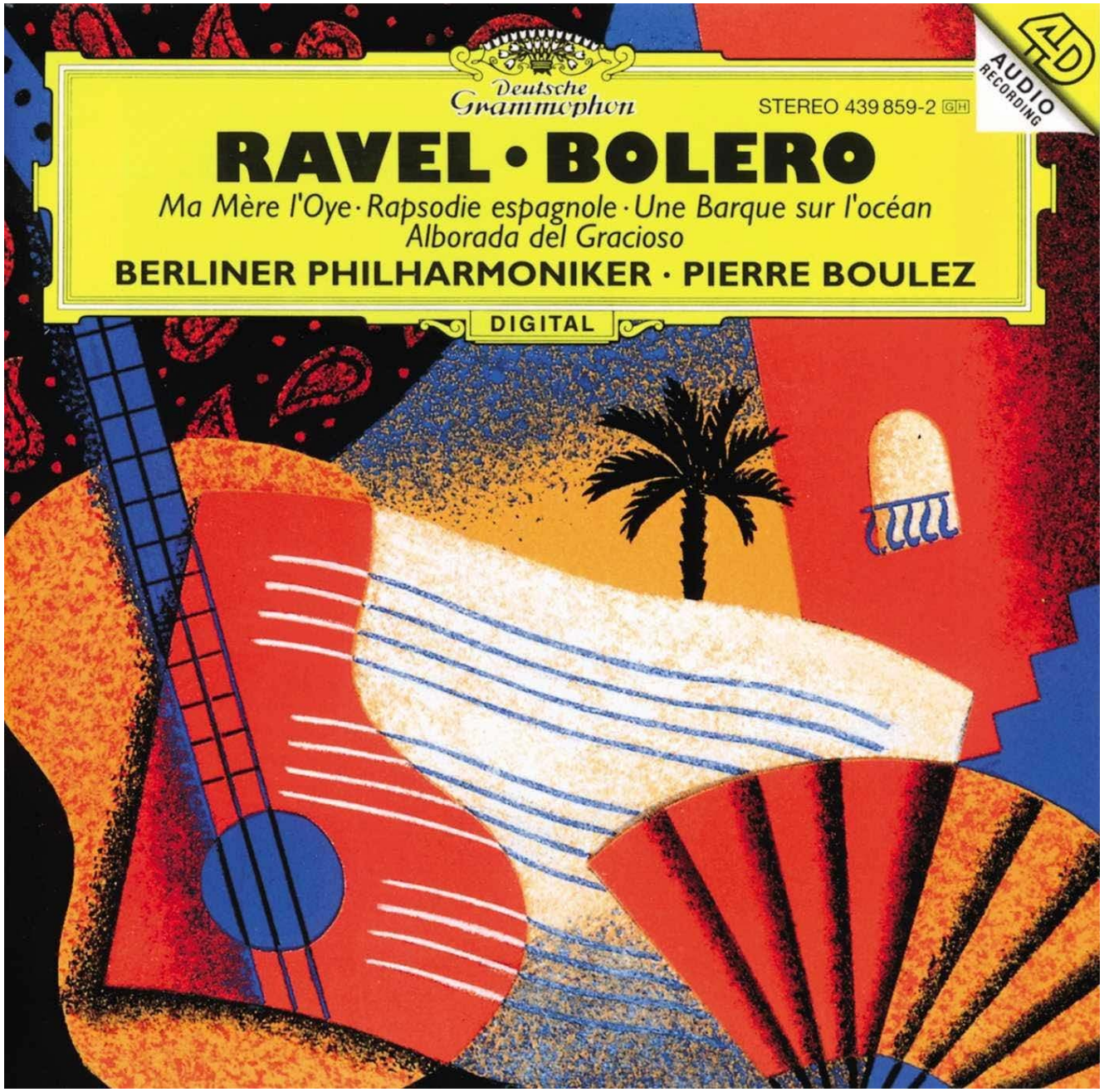
Dementia: Global Innovation

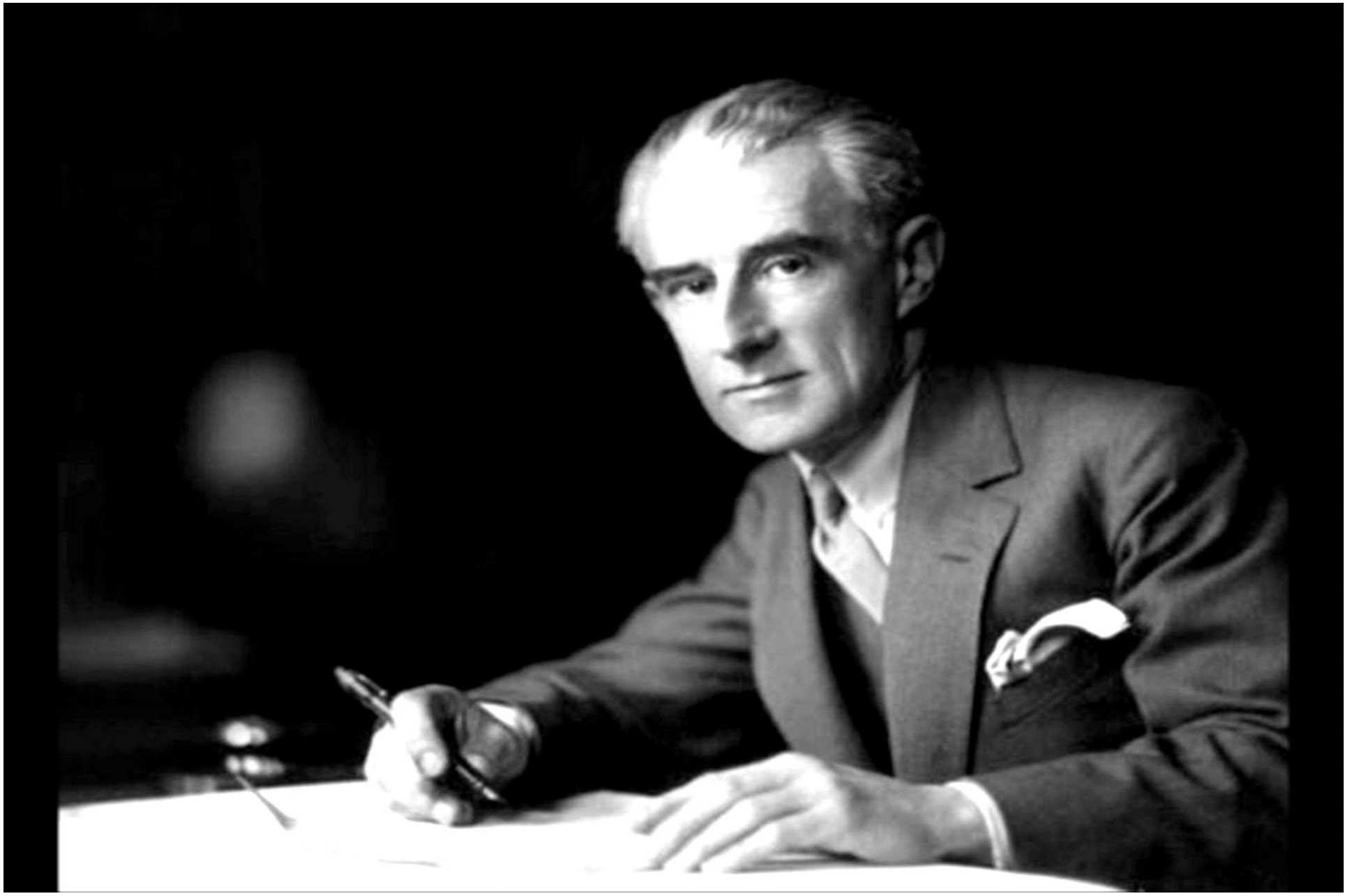
Benjamin Surmi, MSG, Social Gerontologist

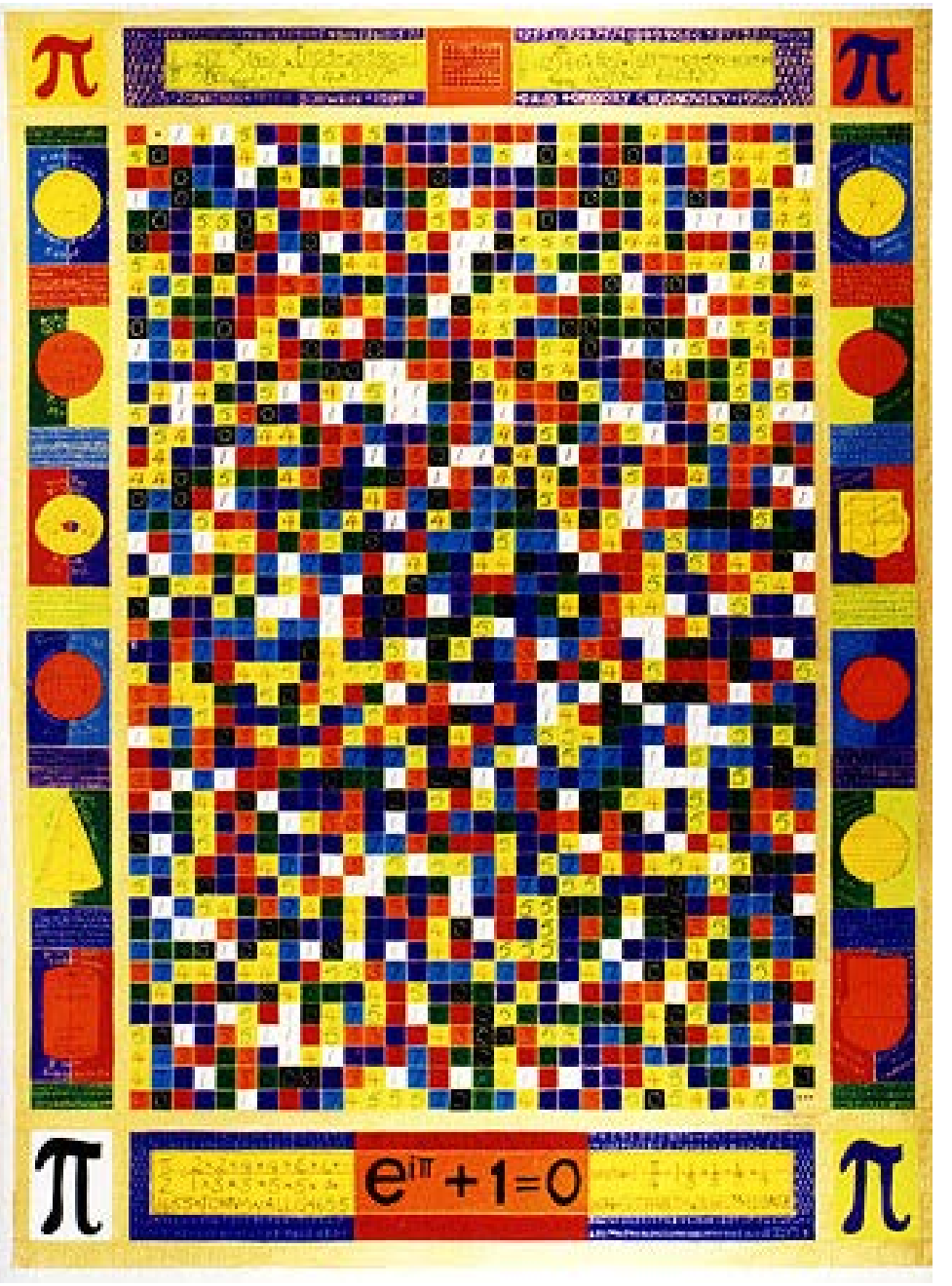
The focus of Benjamin's work as a social gerontologist is to empower people to thrive, no matter the disability or cognitive disorder they may have. He is passionate about designing powerful user experiences for elders and the people who serve them. Benjamin joined Koelsch Senior Communities in 2016 as the Director of Programs and Training before moving into the Director of Education and Culture in 2018, where he shapes innovative engagement experiences for seniors, as well as specialized programming for people living with dementia. Benjamin also guides person-centered training for over 2,000 employees in 8 states, leads Koelsch Innovation Lab, and coaches 70+ wellness directors and 32+ Executive Directors who support over 1,500 seniors. His passion is imagining the impossible and building alliances that make it possible. Benjamin holds a Bachelor's degree in Communication and Sociology from Biola University and a Master's degree in Gerontology from California State University.

Learning objectives

- Learn how technology supports individuals living with dementia in their current setting
- Compare “outside the box” solutions vs. current tools to support individuals living with dementia
- Expand knowledge, tools, and solutions for individuals living with dementia


Deutsche Grammophon
STEREO 439 859-2 GH
AUDIO RECORDING
RAVEL • BOLERO
Ma Mère l'Oye · Rapsodie espagnole · Une Barque sur l'océan
Alborada del Gracioso
BERLINER PHILHARMONIKER · PIERRE BOULEZ
DIGITAL

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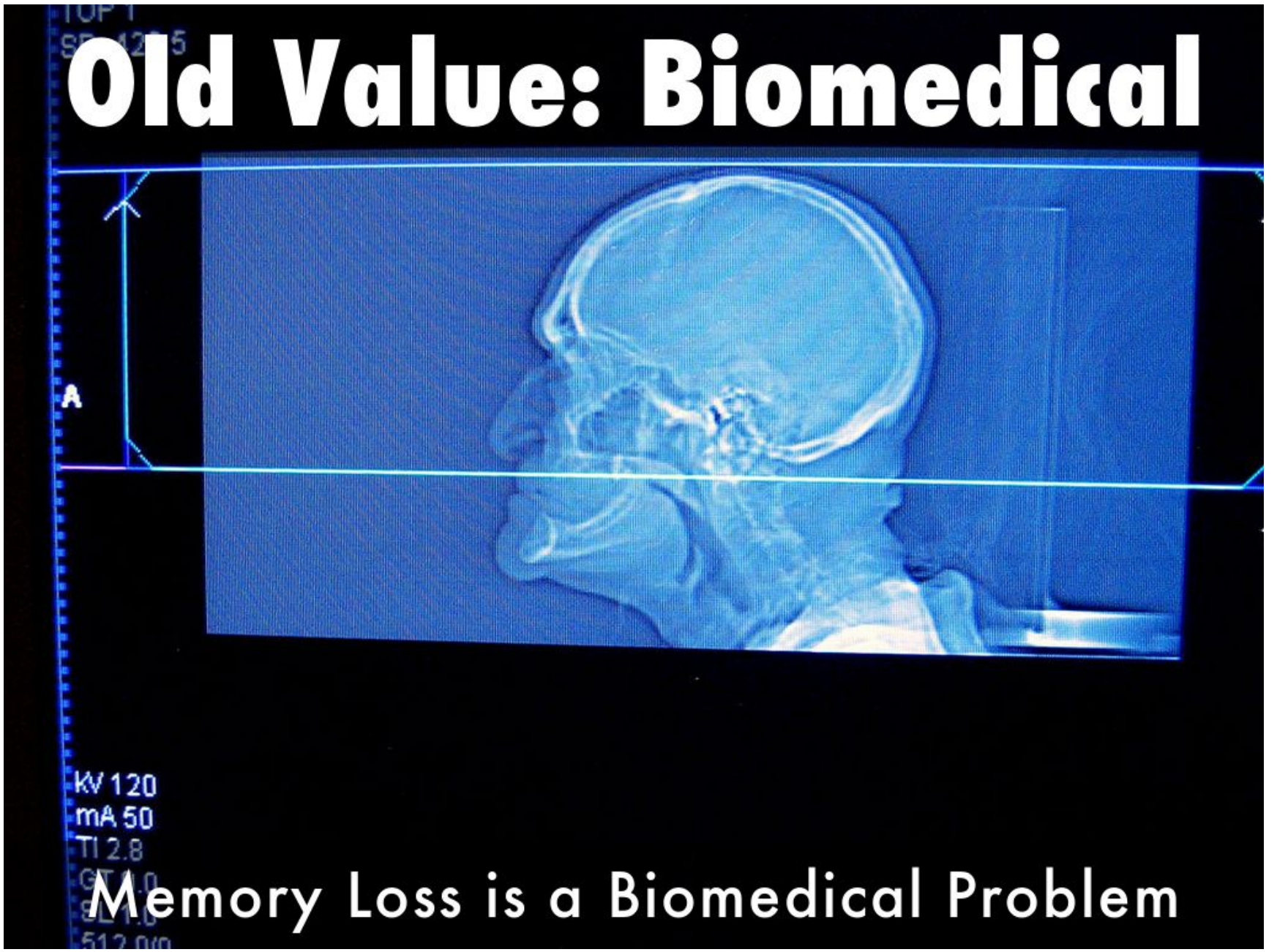
$e^{i\pi}+1=0$

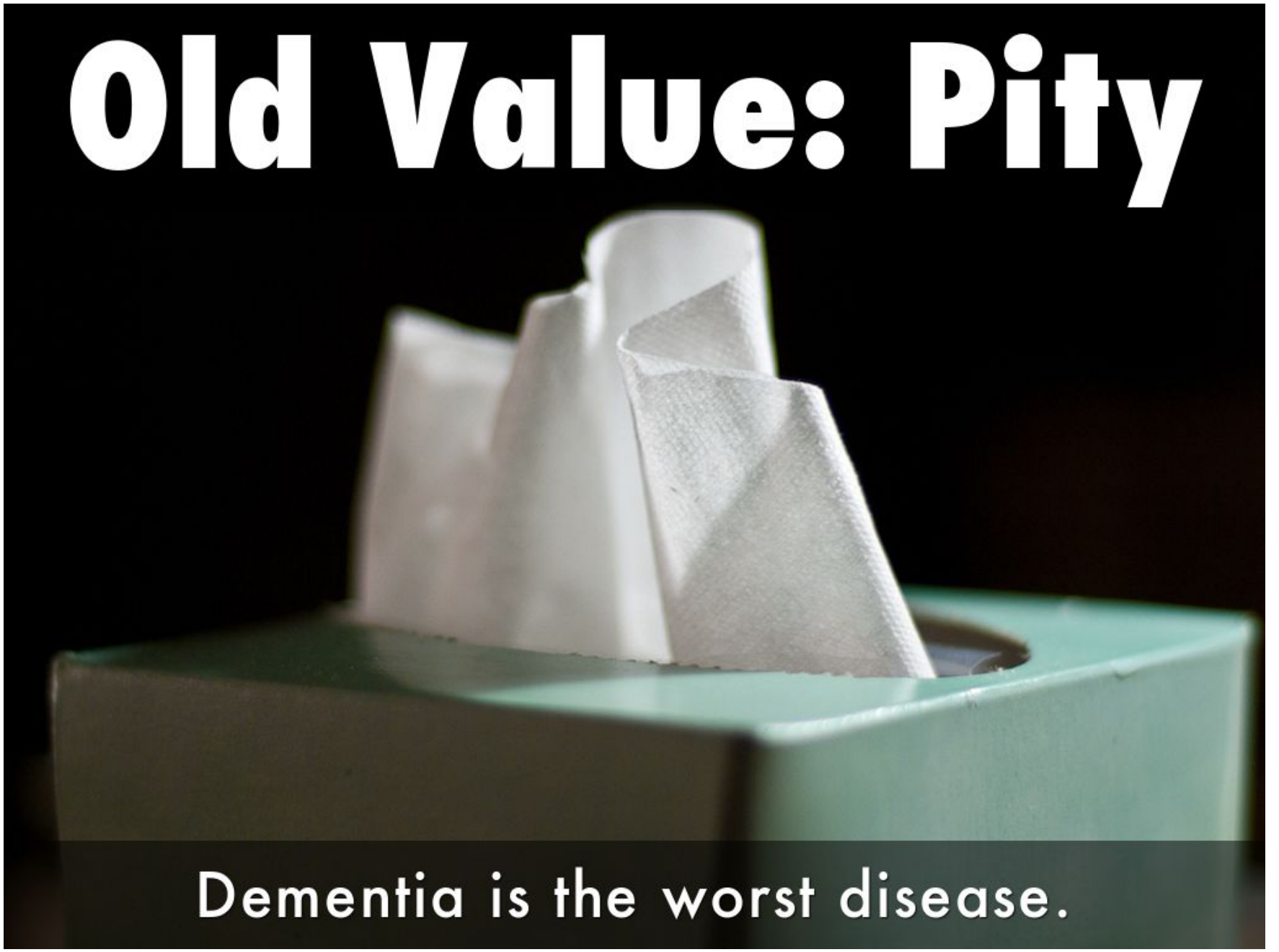

Values
Near/Future Values

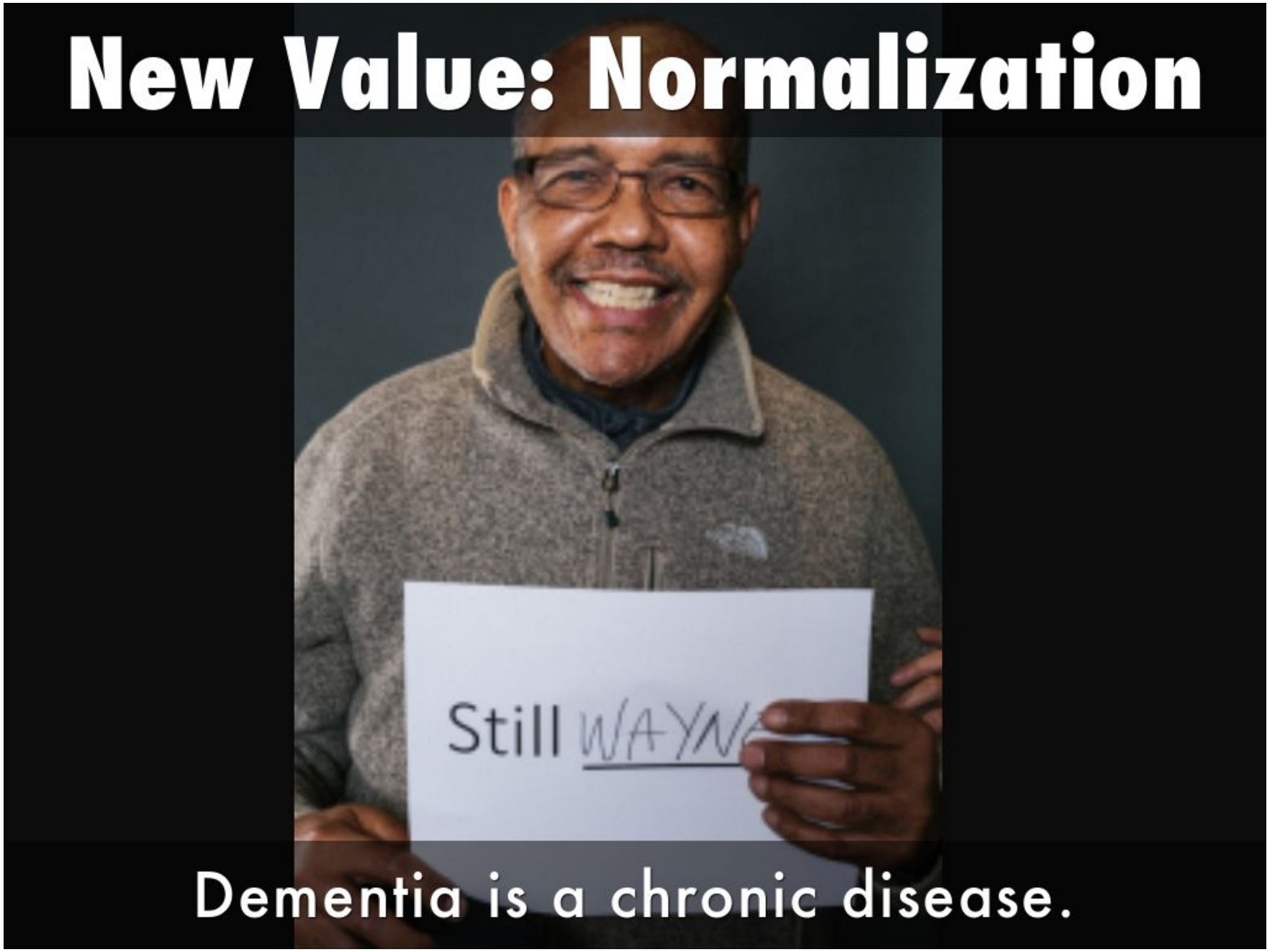

Old Value: Decline
Helping Aging be Less Bad


New Value: Growth
We grow until we no longer breathe.


Old Value: Biomedical
A
KV 120
mA 50
TI 2.8
Memory Loss is a Biomedical Problem


New Value: Experiential
Memory Loss is an Experience

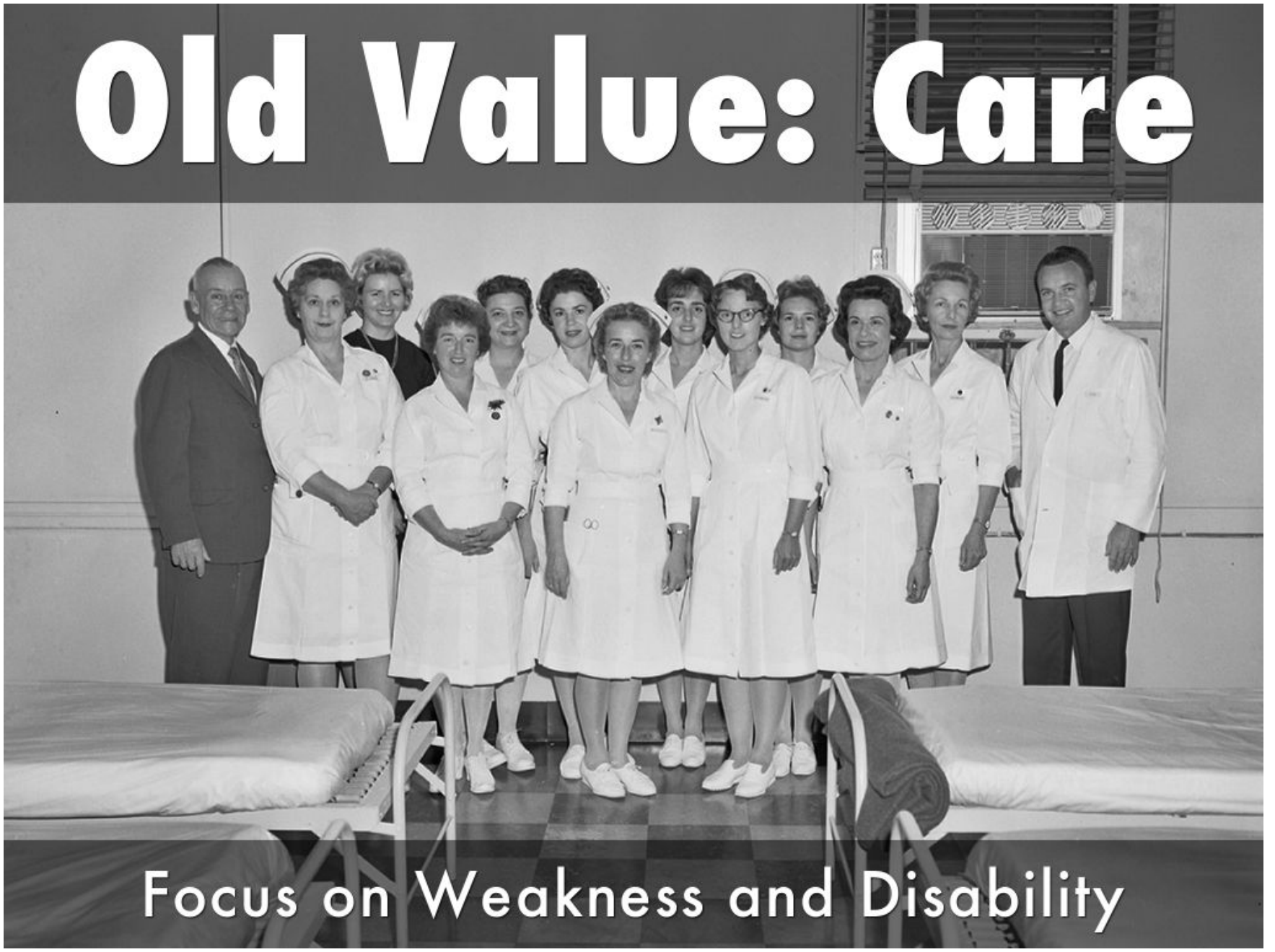

Old Value: Pity
Dementia is the worst disease.


New Value: Normalization
Still WAYNE
Dementia is a chronic disease.


Old Value: Sameness
Isolation and segregation.

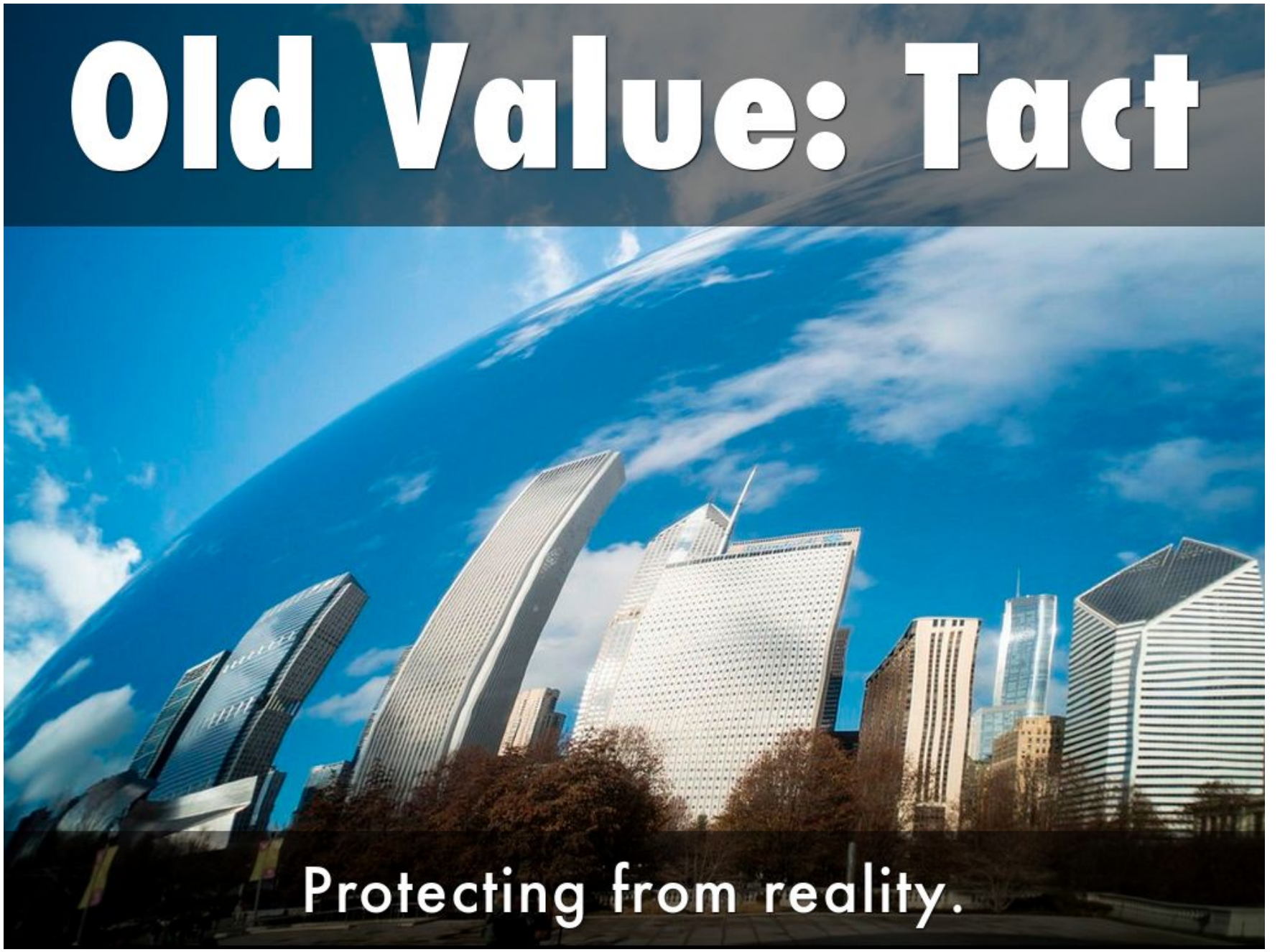
New Value: Integration

Old Value: Care



Focus on Weakness and Disability


New Value: Wellbeing
Focus on Whole Person and Strengths


Old Value: Tact
Protecting from reality.


New Value: Authenticity
Get real.


Old Value: Person-Centered
Focus on person - not organization.


New Value: Empowerment
BRINKLEY'S
Elders choosing – even with dementia


THRIVING
WITH
DEMENTIA
GLOBAL
INNOVATION


GREENGROCERS
FRESH EGGS
FRESH BREAD
COOKED MEATS
CHEESE
FISH ORDERS
CONFECTIONARY
PRESERVES
POST OFFIC


THE GREATEST SHOW ON EARTH
GLENNER PARK
AT TOWN SQUARE
Alois'
NEWSSTAND


CEDAR CREEK


EXIT


Jack's Cabin


Sophie's
ICE CREAM
IS
always
A
GOOD
IDEA
It's a
GREAT
DAY FOR
Sophie's
ICE CREAM!
MUSIC
OPEN
Sophie's
ICE CREAM PARLOR

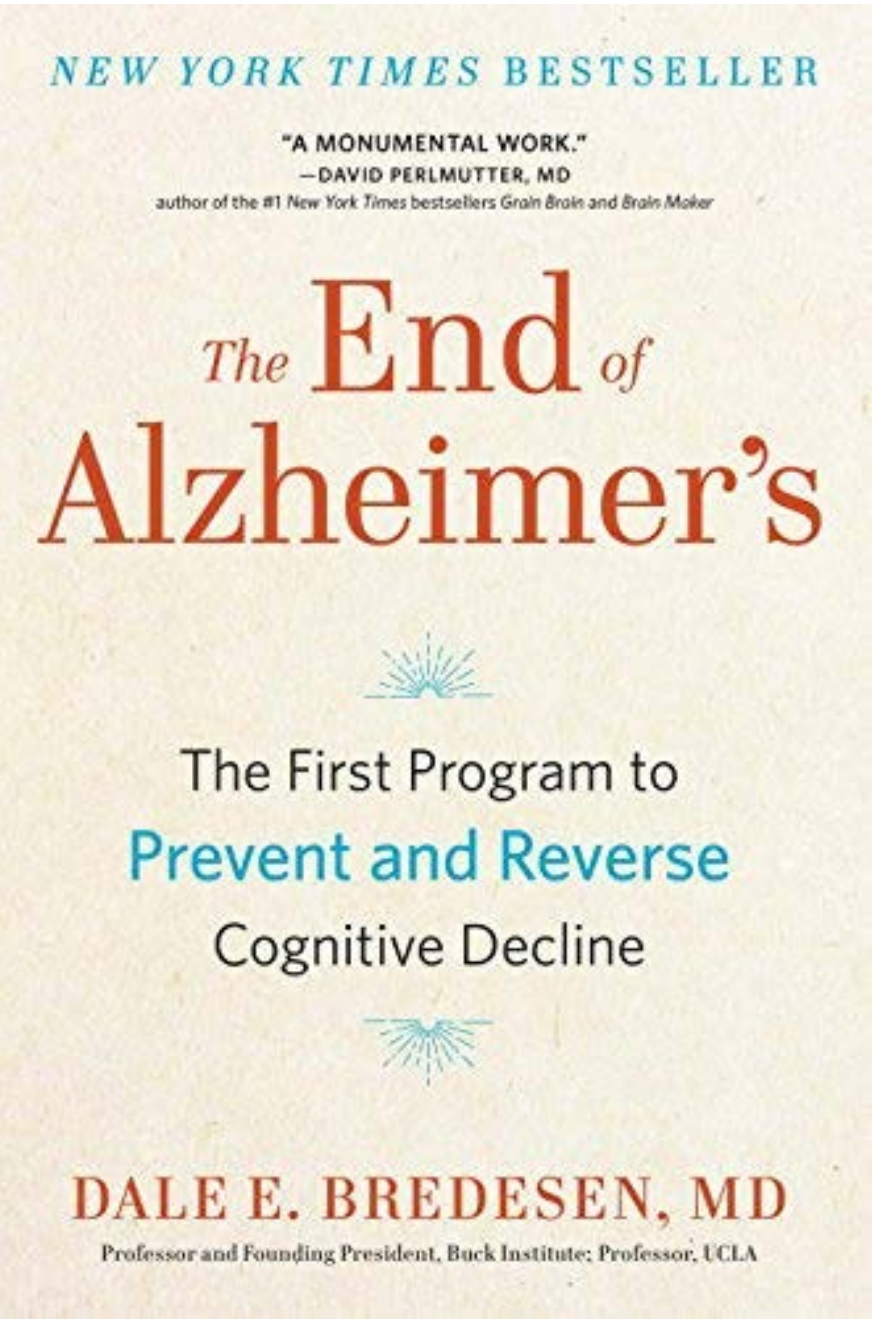

Alice's
GENERAL
STORE
OPEN
AMERICA


EMMETT'S GARAGE
EXIT
QUAKER STATE
MOTOR OIL
J&K
REPAIR
GAS
STP
SPECIALIZED LUBRICATION


CIVIL SOCIETY


イラスト
家族も安心
認知症ケア
やさしい
住まい・暮らし
の工夫
大島千帆

子晚报讯（记者 张毕荣）为激励子女经常到护理院探望父母长辈，苏州一家护理院别出心裁地推出了“奖孝金”管理制度。这项制度规定：子女两个月内到护理院探望父母长辈超过30次，就可获2
孝金”现金抵用券，可以在缴纳老人相关费用时抵用。

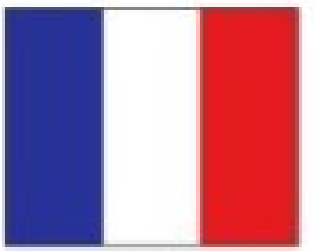

NEW YORK TIMES BESTSELLER
"A MONUMENTAL WORK."
—DAVID PERLMUTTER, MD
author of the #1 New York Times bestsellers Grain Brain and Brain Maker
The End of Alzheimer's
The First Program to
Prevent and Reverse
Cognitive Decline
DALE E. BREDESEN, MD
Professor and Founding President, Buck Institute; Professor, UCLA

BRAIN U online

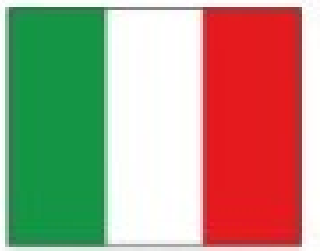
Dashboard Help

Unit 2 - Memory

1. Have a look at these flags and remember the letter assigned to each
2. When ready, click the next button to test your memory



A



B

C

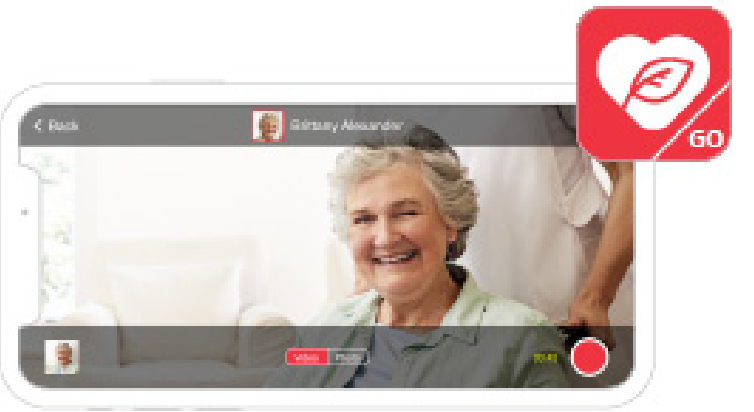
D

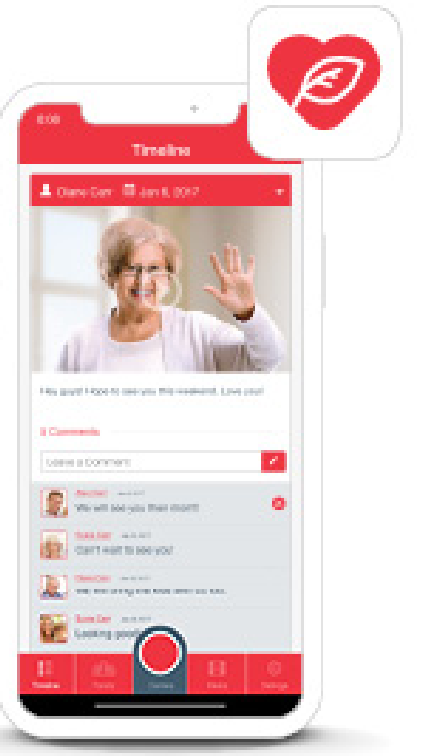
Next →

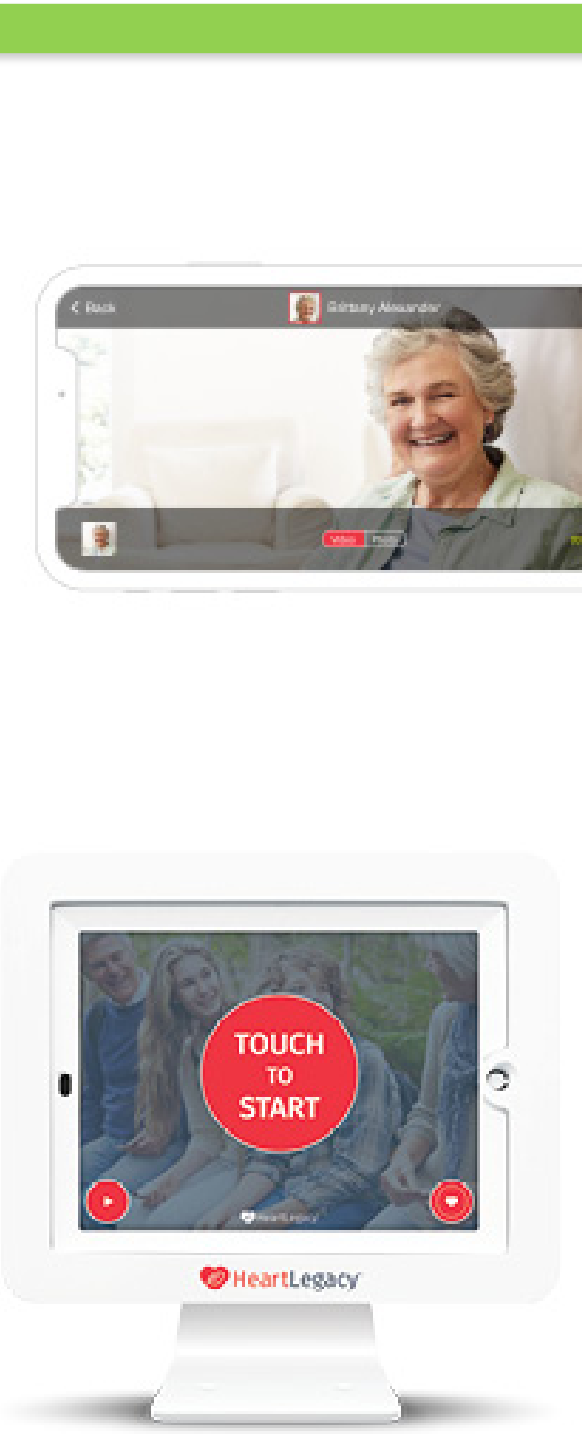

jDome

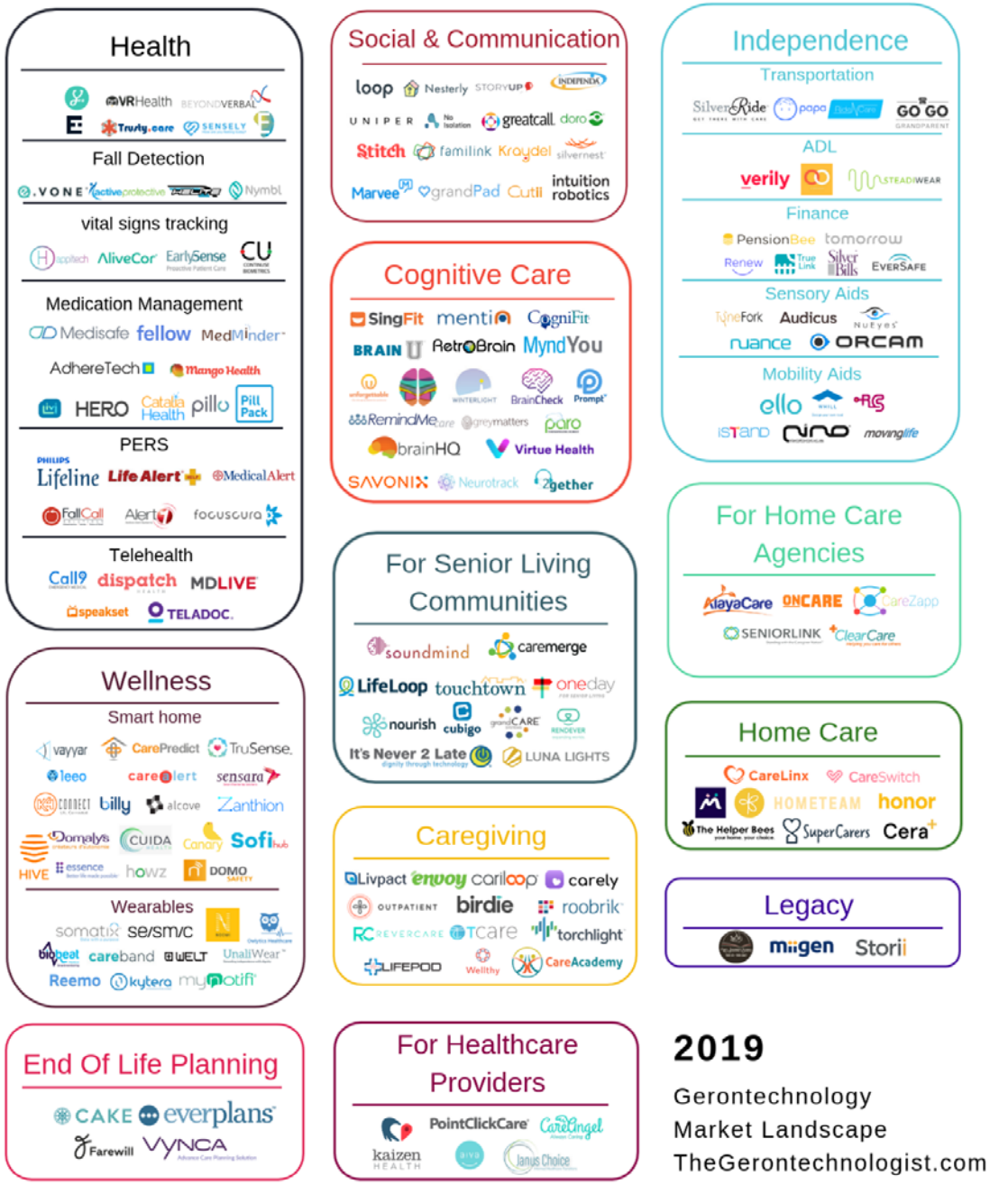

eversound


TOUCH
TO
START


Back
Brittany Alexander
GO


Timeline


TOUCH
TO
START
HeartLegacy



2019

Gerontechnology
Market Landscape
TheGerontechnologist.com


Close
10:09
It looks like you've taken a hard fall.
SOS
EMERGENCY SOS
I'm OK


pillo
DINNER


Ecare.coach

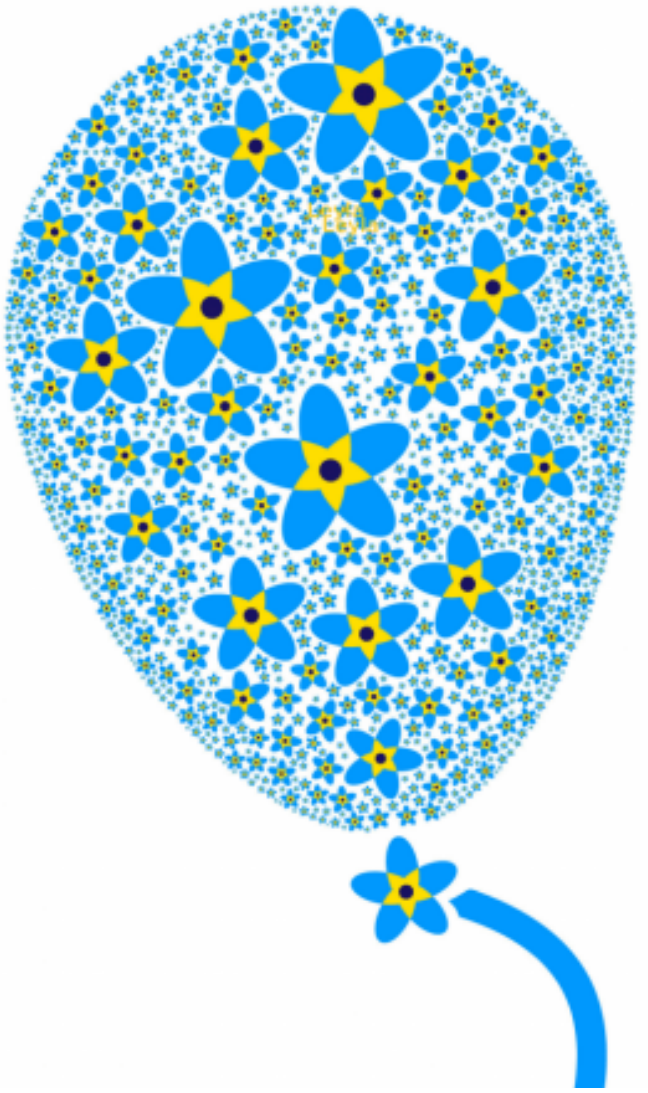

捜索


足元注意


MEN'S SHED


TimeSlips
Creative Storytelling
Her name might be
Gloria Jean.
She looks happy.


Scripted-IMPROV™
An evidence-based
Drama Club experience



2.5 million
Dementia Friends

Visit dementiafriends.org.uk to get involved

Performances

We warmly welcome anyone with an interest in dementia to *Every Third Minute*, including people living with dementia. Our dedicated staff and volunteer team are committed to making your visit as enjoyable and stress-free as possible. If you have any questions about the suitability of events for your specific needs please contact **Maggie De Ruyck** on **0113 213 7296** or **maggie.deruyck@wyp.org.uk**

Friday 9 February - Saturday 3 March, 7.45pm plus matinees, Courtyard Theatre, from £13.50

The performance is followed by a **Post Show Discussion** on 20 Feb.

Associate Production Sponsor SKIPTON BUILDING SOCIETY

Still Alice

A West Yorkshire Playhouse production in association with Michael Park for The Infinite Group

Adapted by **Christine Mary Dunford**
Based on the best-selling novel by **Lisa Genova**
Alice Howland (portrayed by **Sharon Small**) is a professional at the top of her game. But, diagnosed with early-onset Alzheimer's, she is compelled to confront her new reality.
Uncompromising and truthful, yet tender.

DF Our Dementia Friendly performances of *Still Alice* are on Wed 21 Feb, 7.45pm, and Thur 22 Feb, 2pm.
To book tickets contact the Box Office on **0113 213 7700**.

Access Partner IM irwinmitchell solicitors

Friday 23 February, 1.30pm, Barber Studio, £3

Maggie May (Rehearsed Reading)

A West Yorkshire Playhouse production

By **Frances Poet**
Maggie wants everything to be perfect when Michael brings his new girlfriend to meet the parents for the first time, but is she also trying to hide something?
A brand new commission full of songs, laughs and pathos for and about people living well with dementia.

Monday 26 February , 7pm, Barber Studio, £12.50

The Purple List

By **Ian Baxter and Libby Pearson**
This short one-man play, is a touching, poignant, yet often funny, insight into the lives of two gay men as they navigate their way through the dementia care system and the changes in their personal relationship.

The performance is followed by a **Post Show Discussion**.

Tuesday 27 February, 1.30pm, Barber Studio, £3

This Is Us

A West Yorkshire Playhouse production

A performance platform showcasing new work by artists living with dementia in a supportive environment.
This celebration of the creativity encourages audience members to give feedback. Short performances of poetry, drama, puppetry, music and song, featuring **Wendy Mitchell**, **Cognitive Shift**, **Our Time** & **Doing Dementia Differently Intergenerational Choir**.

Wednesday 28 February , 4pm & 7pm, Barber Studio, £12.50

Blank Tiles

By **Dylan Cole**
World Scrabble Champion Austin Michaels used to know over 200,000 words, then he was diagnosed with Alzheimer's Disease.
Since his diagnosis, Austin has been in a race against time to document his memories, before they fade.

Training & Workshops

Tickets can be booked for training & workshops through the box office on **0113 213 7700**, or contact **Nicky** or **Maggie** for further information on **0113 213 7296**.

Monday 12 February, 10.30am - 11.30am, Congreve Room, FREE

Dementia Friends
An Alzheimer's Society initiative
Information Session

Dementia Friends family session

During this half-term break we invite families - including children - to take part in this participatory information session to become Dementia Friends. **Alzheimer's Society's Dementia Friends** programme is the biggest ever initiative to change people's perceptions of dementia. It aims to transform the way the nation thinks, acts and talks about the condition. Dementia Friends is about learning more about dementia and the small ways you can help.

Thursday 15 February, 10.15am - 12.15pm, Priestley Room,
£10 per family (up to 3 people inc. a person living with dementia)

Create your Digital Life Story

What makes you, YOU? We will be recording all aspects of your story, including your voice, visuals, story and text. Artist **Claire Ford** welcomes people living with dementia accompanied by up to two friends or family members in this intergenerational session.

Please bring along any photographs, precious objects or special mementos that you have collected during your life to create your digital life story.

Thursday 15 February, 1.15pm - 3.15pm, Priestley Room, £5

Learn to Create Digital Life Stories – training session for supporters of people living with dementia

Learn to use sound, text, photographs, drawings, music and colour to collate those important and poignant moments in life to form a digital book. Artist **Claire Ford** teaches new digital skills to use to engage with a person living with dementia at home.
Please bring along a selection of photographs and memorabilia that you can digitalise on the day.

Thursday 22 February, 10am - 4pm, Congreve Room , £50 Access Partner irwinmitchell solicitors

An introduction to dementia friendly theatre performances, by Nicky Taylor

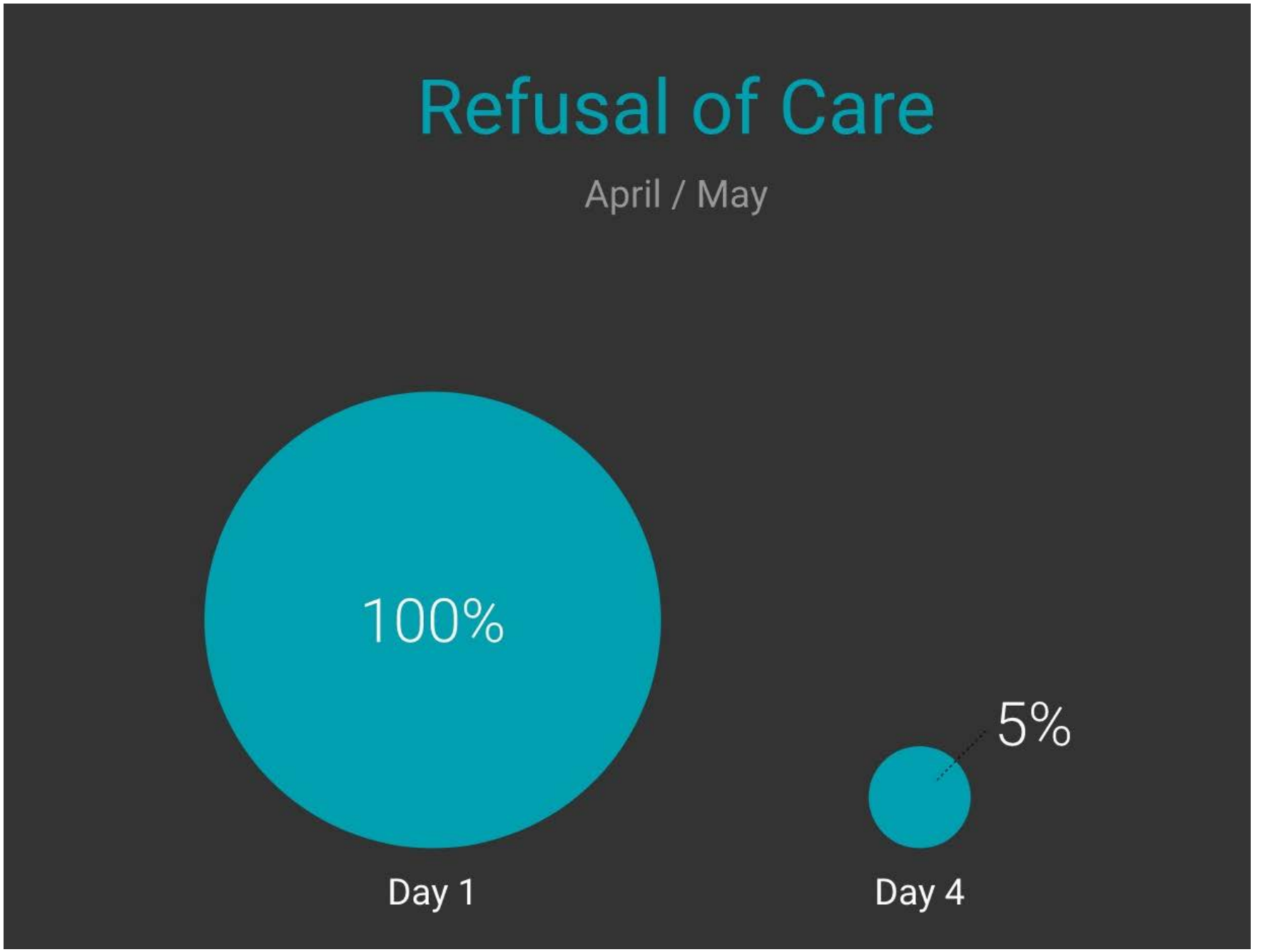
This workshop for theatre and creative industries professionals introduces the process of planning and delivering a dementia friendly performance. Practical and interactive, the session encourages theatres and arts centres to take their first steps in welcoming audiences living with dementia, and includes an opportunity to shadow the West Yorkshire Playhouse team during a dementia friendly performance of *Still Alice*.

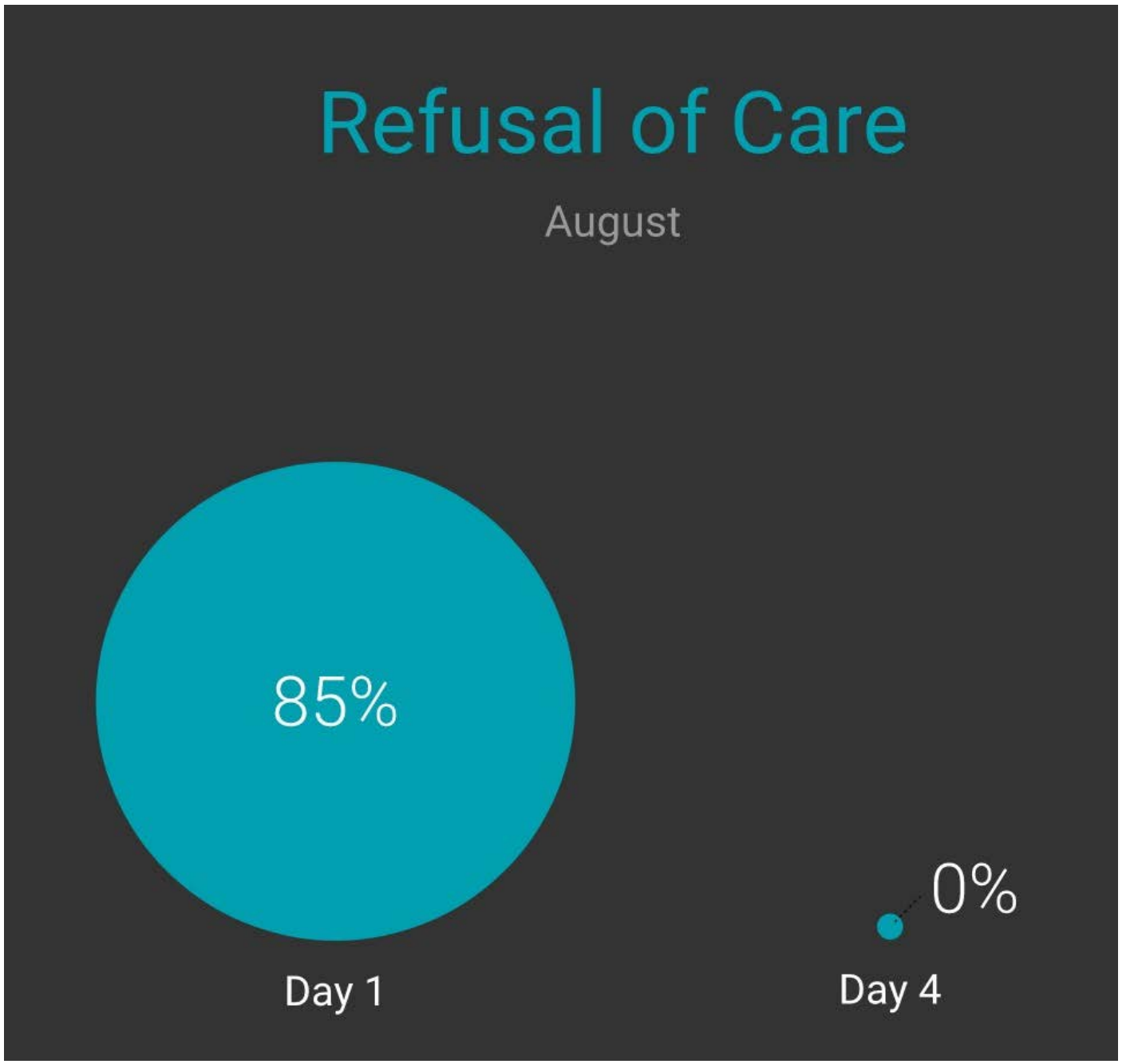
Saturday 3 March, 11am - 1pm, Rehearsal Room 3, FREE

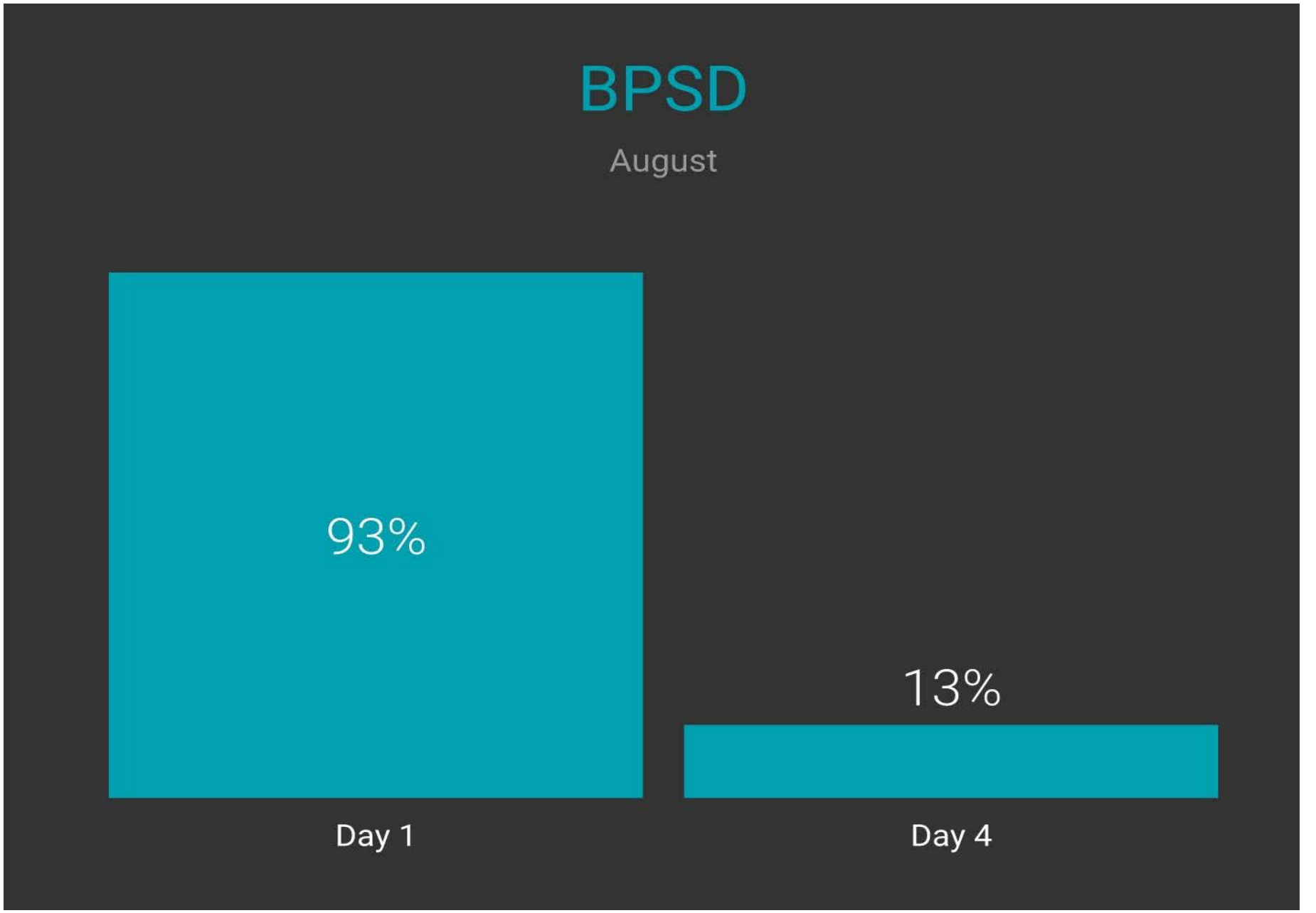
Performing Our Lives - Theatre-making workshop for people living with dementia

The Performance Ensemble, in collaboration with West Yorkshire Playhouse, present a theatre-making workshop for six people living with dementia who are interested in performing their own stories. Using storytelling and movement techniques developed with older performers in the recent *Anniversary* project, we aim to build performers' confidence, develop connections and value unique life experiences.

There will be a pre-workshop meeting for anyone interested to find out more. Please contact **Nicky** or **Maggie** on **0113 213 7296** to register interest.


Refusal of Care
April / May
100%
5%
Day 1
Day 4


Refusal of Care
August
85%
0%
Day 1
Day 4


BPSD
August
93%
13%
Day 1
Day 4

Questions?

360.601.4959

bms@koelschsenior.com

medium.com/rethinking-dementia

Diabetes Update & Overview

Barb Bancroft
CPP Associates, Inc
Executive Director & President

50 YEARS
Forum
EXTENDED CARE SERVICES

Diabetes Update & Overview

Barb Bancroft RN, MSN, PNP

Barb is an industry professional with more than 40 years of experience in healthcare as a nurse, author, editor, educator, and speaker. She is a passionate and informative speaker on clinical topics such as pathophysiology, physical assessment, and pharmacology. Barb has taught more than 2,800 continuing education seminars on health-related topics and has served as the keynote speaker for professional associations and corporations, including the American Association of Practitioners for Infection Control, the American Academy of Nurse Practitioners, and the National Association of Orthopedic Nurses. Currently, Barb is the Executive Director and President of CPP Associates, Inc., a continuing education provider. Barb holds a Bachelor's degree in Nursing from East Carolina University and a Master's degree in Nursing from the University of Virginia.

Learning objectives

- Learn how current medications are helping individuals living with diabetes live an independent life
- Understand how lifestyle changes can delay the onset of diabetes and help individuals live with the diagnosis
- Compare the differences between Type 1 and Type 2 diabetes to help you care for your residents

Toss out what you learned years ago about Type 2 Diabetes

Type 2 has 8 basic defects going on…“the Ominous Eight”

1) Insulin resistance in peripheral tissues—muscle, liver, fat cells—

- Insulin resistance is when the myocytes, adipocytes, and hepatocytes, “resist” the ability of insulin to move glucose into the cells for energy. “Thinking” it can help, the pancreas pumps out more insulin to overcome the resistance. Eventually the resistance wins, and hyperglycemia ensues.
- What causes insulin resistance?
- GENETICS – family history
- Sedentary lifestyle?
- The lack of sleep
- Weighty issues – especially fat around the middle (visceral fat)

……The epidemic of diabetes has paralleled the weight gain in the U.S. over the last 40+ years

Weight issues in the U.S. (women @ 5’4”, men @ 5’9”)

1980

- Average weight of a 5’4” adult female: 144.2 pounds (BMI = 24.7)
- Average weight of a 5’9” adult male: 172.2 (BMI =25.4)

38 years later: 2018

- Average weight of adult women: 170.5 pounds (BMI = 29.3)
- Average weight of adult men: 197.9 (BMI = 29.6)

(Fryer C et al. National Weight and Health Statistics Reports, December 20, 2018)

This “weighty risk factor” doesn’t seem to be mitigated by anything we have tried so far…

- There are 100 million Americans living with obesity as defined as a BMI $\geq$ 30
- Over 40% of the U.S. adult population fits into the above category…
- OUCH. It’s no wonder insulin resistance, pre-diabetes, and diabetes numbers have risen exponentially in the Southeast
- HealthLeadersMedia.com (3/20/23)

Weight gain is A MAJOR RISK FACTOR for Type 2 Diabetes

- ~87% are of our Type 2 diabetics are overweight or obese
- Women with a body mass index (BMI) of 30 kg/m^2 have a 28 times greater risk of developing diabetes than do women of normal weight. The risk of diabetes is 93 times greater if the BMI is 35 kg/m^2

BTW…it doesn't help when we give drugs to diabetics that INCREASE their weight gain

- Sulfonylureas (5 pounds) (glipizide (Glucotrol and Glucotrol XL), glyburide (Diabeta, Micronase, and Glynase PresTab), and glimepiride ; insulin (4-11 pounds in the first year)
- Anti-depressants—SSRIs (~10 pounds ++)
  - paroxetine (Paxil, Pexeva, Brisdelle)—most weight gain
  - sertraline (Zoloft)
  - fluoxetine (Prozac)
  - citalopram (Celexa)
- Atypical anti-depressant--Mirtazapine (Remeron)—8 pounds over 6 weeks, up to 30 pounds?

(Gafoor R et al. Antidepressant utilization and incidence of weight gain during 10 year's follow-up. *BJM* 2018 May 23;361:k1951; Serretti A and Porcelli S. Antidepressant-induced weight gain. *BMJ* 2018 May 23;361:k2151)

The smarter thing to do: Substitute another anti-depressant that doesn't have the dreaded weight gain as a side effect…

- escitalopram (Lexapro, Cipralex)
- duloxetine (Cymbalta)
- venlafaxine (Effexor) and venlafaxine ER (Effexor XR)
- bupropion (Wellbutrin, Forfivo, and Aplenzin)
- vilazodone (Viibryd)
- vortioxetine (Trintellix)

Weight gain and the second-generation anti-psychotics (SGAs)

- Weight gain (abdominal) from SGAs is primarily in first 6 months; It's not dose-related; the likelihood and the amount of weight varies from person to person.
- Clozapine (Clozaril)—High (15–30-pound average weight gain after 1 year)
- Olanzapine (Zyprexa)—High (up to 40%; 10–30-pound weight gain after 1 year)
- Risperidone (Risperdal)—Medium
- Quetiapine (Seroquel)—Medium
- Paliperidone (Invega)—Medium
- Aripiprazole (Abilify)—Low (significant weight gain in some patients, kids especially.)
- Lurasidone (Latruda)—Low
- Ziprasidone (Geoden)—Low
- (Haddad P. Antipsychotic Medications and Weight Gain. Brit Assoc Psychopharm, March 31, 2017)(Medication Fact Book for Psychiatric Practice, 5th edition. Carlat Publishing)

Corticosteroids of SIDM

- Can worsen hyperglycemia in the diabetic, increase weight gain & trigger steroid-induced diabetes mellitus in non-diabetics; ~40 - 56% of all inpatient hospital consults to the Endocrinology service are for new onset steroid-induced hyperglycemia/diabetes or for T2DM exacerbated by steroid use.
- **The larger the dose, the greater the risk**
- Low dose: less than 7.5 mg/d – no risk
- Moderate dose: between 7.5 mg/d and 40 mg /d – increasing risk
- High dose: 40 mg/d to 60 mg/d – more risk
- Really high doses: > 60 mg/d – YIKES risk!!
- The odds ratio for patients receiving the equivalent of 50 mg, 100 mg, and greater than 120 mg of hydrocortisone daily are: 3.02, 5.82, and 10.35 for developing SIDM respectively when compared to a control group.
  (Gurwitz JH et al. Glucocorticoids and the risk for initiation of hypoglycemic therapy. *Arch Intern Med.* 1994; 154:97-101)

What decreases insulin resistance?

- Lose the belly fat! Exercise and light-weight lifting—both make the receptors more “receptive” to insulin
- Metformin … insulin-stimulated glucose uptake into skeletal muscle is enhanced by metformin.
- Pioglitazone (Actos) helps decrease insulin resistance but causes fluid retention—not good in HF patients!!
- The GLP-1 receptor agonists induce weight loss and decrease insulin resistance – GLP-1 receptor antagonists (“tides” such as dulaglutide (Trulicity), liraglutide (Victoza), lixisenatide (Adlyxin), exanatide (Byetta) (2005), exanatide ER (Bydureon), semaglutide (Ozempic), tirzepatide (Mounjaro)

2) Pancreatic beta cell dysfunction

- Abnormal release of insulin in response to a glucose load—the beta cells are “sleeping”—they are not dead…what wakes them up?
- Weight loss and exercise

3) Increased hepatic glucose production

- Increasing fasting blood sugars, especially overnight glycogenolysis with an early morning hyperglycemia —
- Basal insulin helps maintain normal glycemia during fasting (insulin glargine and insulin detemir),
- Metformin – metformin reduces the overall rate of glycogenolysis in the liver by decreasing the activity of the hepatic enzyme, glucose-6-phosphatase

4) Accelerated lipolysis in the fat cells

- Resulting in high triglycerides = small, dense LDLs (even though the LDL# with traditional testing can be normal); What does this mean? LDL partical size is important—LDLs come in 2 sizes—small/dense (pattern B) vs. Large/loose (pattern A)

*REFRESHER: Pattern B, small, dense LDLs are packed in the arteries faster than any other size of LDLs

This is WHY so many diabetics are in CCUs, ICUs, and stroke units,—ACS, TIAs, Strokes, Peripheral vascular disease...

The “Statins” for lowering cholesterol and as anti-inflammatory drugs

- Use a statin for **primary prevention** for most diabetes patients 40 years of age and older.
- **AHA/ACC**:
  - Statins are indicated for adults 40 to 75 years of age with diabetes and an LDL ≥70 mg/dL
  - In adults 20 to 39 years of age with diabetes that is longstanding (≥10 years for type 2 or ≥20 years for type 1), albuminuria (≥30 mcg/mg creatinine), eGFR <60 mL/min/1.73 m^2, ABI <0.9, retinopathy, or neuropathy, starting a statin may be reasonable.
  - In patients >75 years of age with diabetes, continuing or even starting a statin may be reasonable after a risk/benefit discussion.

(Grundy, Anderson)

Statin therapy

--Ariel Green, MD, MPH, PhD,

"Statin therapy should be individualized to weigh benefits, noncardiac risks, and other considerations."

Her research provides evidence for "deprescribing statins", with a focus on those with a life expectancy of less than a year--increases the quality of life without increasing cardiovascular events or death when statins were deprescribed.

- **Green AR**, Wolff JL, Echavarria DM, Chapman M, Phung A, Smith D, Boyd CM. How Clinicians Discuss Medications During Primary Care Encounters Among Older Adults with Cognitive Impairment. *J Gen Intern Med*. 2020 Jan;35(1):237-246; Green AR, Boyd CM, Gleason KS, Wright L, Kraus CR, Bedoy R, Sanchez B, Norton J, Sheehan OC, Wolff JL, Reeve E, Maciejewski ML, Weffald LA, Bayliss EA. Perspectives on Deprescribing Communication in Primary Care. J Gen Intern Med. 2021 Apr;36(4):1122. doi: 10.1007/s11606-020-06377-x. PMID: 33432430; PMCID: PMC8042063.

In addition to statins, what other drugs have cardiovascular benefits?

- Liraglutide use in patients with high CV risk or CV disease for about four years may reduce death from CV causes and death from any cause (Marso) SP, Daniels GH, Brown-Frandsen K, et al. Liraglutide and cardiovascular outcomes in type 2 diabetes. N Engl J Med 2016;375:311-22
- Semaglutide (Ozempic) use in patients with CV disease, chronic kidney disease, or CV risk factors for about two years may reduce the combined endpoint of CV death, nonfatal MI, or nonfatal stroke.
- In patients who need more than one or two diabetes meds, combination therapy with basal insulin and a GLP-1 agonist is an emerging strategy

NOTE: Drugs that reduce the risk of CV

- Empagliflozin (Jardiance) use in patients with CVD for about three years may reduce hospitalizations due to heart failure, cardiovascular deaths, and overall death. Empagliflozin use has NOT been shown to reduce individual rates of MI or stroke (Zinman)
- CANVAS (CANagliflozin cardioVascular Assessment Study found canagliflozin use for about 3.5 years when added to standard glucose-lowering therapy in patients with type 2 diabetes and very high CV risk (>70% of patients had atherosclerotic CV disease), may reduce the combined endpoint of CV mortality, nonfatal MI, or nonfatal stroke (NNT=224).
- Metformin—may reduce CV mortality, especially in obese patients; lowers LDL-cholesterol, increases HDL-cholesterol

Caution: drugs that can increase the risk of HF or worsen symptoms of HF

- DPP-4 inhibitors: saxagliptin (Onglyza) and alogliptin (Nesina)
- TZD: pioglitazone (Actos)

5) Incretin resistance/deficiency in the small intestine—

- WTFudge are incretins? Released from the duodenum after a meal – responsible for 60% of the post-meal insulin secretion—abnormal incretin response? HUNGRY, weight gain
- The action of the incretins is impaired in diabetics -- only 36% post-prandial incretin secretion in patients w/ T2DM vs. 73% post-prandial incretin secretion in patient's w/o T2DM)
- Could the abnormal incretin action be responsible for the increased hunger and weight gain observed in 87% of Type 2 diabetics?

GLP-1 agonists (“incretin mimetics”)—1% to 1.5% reduction in HbA1C

- Exenatide (Byetta) (2005)
- Exenatide ER (Bydureon)
- Dulaglutide (Trulicity)
- Liraglutide (Victoza for Type 2 DM); Saxenda for weight loss
- Semaglutide (Ozempic for T2 DM)(Wegovy for weight loss)
- **Do not use** if the diabetic patient has gastroparesis as these drugs slow down gastrointestinal motility

GLP-1 agonist + GIP-receptor agonist

- Tirzepatide (Mounjaro)– a dual glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide-1 (GLP-1) receptor agonist. Mounjaro is the first medication in the GIP/GLP-1 receptor agonist drug class.

- GIP is a peptide that also boosts insulin secretion after a meal

The oral DDP-4 inhibitors—the “gliptins”

- Inhibit the enzyme that breaks down the incretins in the small intestine therefore increasing availability to increase post-prandial glucose excursions
- “the gliptans”--Sitagliptin (Januvia); Saxagliptin (Onglyza); Linagliptin (Tradjenta); Alogliptin (Nesina)
- This class of drugs is weight neutral
- Best used as “ad on’s” to metformin for the best HbA1C reduction

6) Hyperglucagonemia

- Increasing hyperglycemia—Glucagon secretion is substantially elevated in the fasting state and is not suppressed during the postabsorptive phase in patients with both prediabetes and clinically apparent diabetes
- Patients with T2DM appear to be hypersensitive to glucagon stimulation further promoting hyperglycemia and insulin resistance
- Rx: the basal insulins—levemir (Detemir), glargine (Lantus, Toujeo, Basaglar)

7) Increased glucose absorption by the proximal convoluted tubule of the kidney

- Increasing hyperglycemia
- SGLT-2 inhibitors—the “flozins”-- canagliflozin (Invokana), dapagliflozin (Farxiga) and empagliflozin (Jardiance)--Reduce renal glucose reabsorption and increase urinary glucose excretion with osmotic diuresis—up to 1 gram of glucose per day in urine
- Be careful with older patients-- hypovolemia/hypotension (especially elderly, patients already taking diuretics, and anyone with an unstable intravascular volume status); Keep an eye on **K+** and serum creatinine—hyperkalemia and increased serum creatinine – important with patients on ACE inhibitors and other K+ sparing drugs
- Yeast infections due to SGLT2 inhibitors (females greater than males will (1 in 19 women and 1 in 39 men) (Medical Letter December 21, 2015)
- Increased risk of hypoglycemia with insulin (may need to reduce the dose of insulin)

8) Insulin resistance in the brain

- Insulin has two important functions in the brain: controlling food intake and regulating cognitive functions, particularly memory. Insulin resistance may damage the cognitive system and lead to dementia state such as dementia of the Alzheimer's type (DAT).
- Insulin receptors are expressed in the hypothalamus at high density, and insulin resistance can impair signaling resulting in excessive caloric/carbohydrate intake and high fat diets.
- Exercise can enhance brain and hypothalamic insulin sensitivity, but it is the option least preferred and/or continuously practiced by the general population. (Cetinkalp S, Simsir IY, Ertek S. Insulin resistance in brain and possible therapeutic approaches. Curr Vasc Pharmacol. 2014;12(4):553-64)

Anything else?

- PLUS…diabetes is a proinflammatory, prothrombotic, and an accelerated pro-aging disease! So be PRO-active in DX and RX!
- Aspirin
- Stents? Clopidogrel (Plavix), tacagrelor (Brilinta)
- Which leads us to ONE LAST PEARL

The use of aspirin in diabetics

- Give aspirin 81 mg/day for SECONDARY prevention... patients who've had an MI or stroke, angina, or peripheral artery disease. CV benefits clearly outweigh bleeding risks.
- Aspirin is not routinely recommended for primary prevention for patients with diabetes or multiple CV risks

The final PARTING PEARL:

- The diabetic patient with TACHYCARDIA may have an autonomic neuropathy due to the loss of the vagus nerve. This results in unexplained tachycardia;
- If their arteries are full of fat, the tachycardia can increase the workload of the myocardium and trigger an acute coronary syndrome (ACS)
- SO, what's the problem? (Besides an ACS?)
- The loss of the vagus nerve results in the inability to FEEL chest pain…in other words, diabetics can have silent ischemia during an angina episode or myocardial infarction…YIKES!! (hypotension, diaphoresis, and a feeling of impending doom may be symptoms—but NO CHEST PAIN)
- The clue that the vagus nerve is GONE? Unexplained tachycardia...
- Beta blockers to the rescue

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Estimated average glucose—a calculated conversion of A1c

- eAG = 28.7 x A1c – 46.7

A1c (%)	eAG (mg/dL)
5.5	97
6	126 (7 mmol)
7	154
8	183
9	212 (11 mmol)
10	240
11	269
12	298

eAG is a running average over the past 3 months of all glucose fluctuations; used to help patients correlate their numbers with A1c.

Hypoglycemic syndromes

Mild	Moderate	Severe
Hunger Shakiness Weakness Paleness Anxiety Irritability Dizziness Sweating Drowsiness Personality change Inability to concentrate	Headache Behavior changes Poor coordination Blurry vision Slurred speech Confusion	Loss of consciousness Seizure Inability to swallow

Symptoms of hyperglycemia

Mild	Moderate	Severe
Thirst Frequent urination Fatigue/sleepiness Increased hunger Blurred vision Weight loss Stomach pains Flushing of skin Lack of concentration Sweet, fruity breath Headache	Mild symptoms, plus: Dry mouth Nausea Stomach cramps Vomiting Dizziness Dehydration	Mild + moderate symptoms, plus: Labored breathing Very weak Confused Unconscious

THANK YOU, FORUM, FOR MANY YEARS OF PRESENTING FOR YOU!

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