Long-Term Care Toolkit Helpful Information

DEATH CERTIFICATES - Contact Vital Statistics of BC, by email: hlth.vsstock@gov.bc.ca and they will send you a packet of death certificates. If you need one urgently explain this in the email, and they will fax you one. The long-term care homes do not keep death certificates on hand. Visit the link below to access a handbook for filling our death certificates entitled: *Medical Certification of Death and Stillbirth – A Handbook for Physicians, Nurse Practitioners and Coroners*.
https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/vsa051.pdf

CORONER - Call the switchboard at Royal Inland Hospital to get connected to the coroner on call.

MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) - Visit the link below to access patient focused MOST resources housed on the Interior Health website.
https://www.interiorhealth.ca/YourCare/PalliativeCare/ToughDecisions/Pages/Medical-Orders-for-Scope-of-Treatment-(MOST).aspx

MEDICAL ASSISTANCE IN DYING (MAID)
The Interior Health website offers valuable patient and provider MAiD resources. Visit the link below to access physician related resources focused on education/training, credentialing/privileging, documentation and forms.
https://www.interiorhealth.ca/AboutUs/Physicians/PhysMAiD/Pages/default.aspx

PATHWAYS - Members and associate members of the Division have access to Pathways — an online referral resource tool used by providers and their healthcare team to facilitate patient referrals by optimizing the specialist and clinic referral process. If you are interested in Pathways, please reach out to the Division to gain access.

CHARTING IN LONG-TERM CARE - All of the Kamloops-based long-term care homes have implemented PointClickCare, an electronic charting platform. The charting platform allows for charting to take place either on site or off site. Overlander and Ponderosa utilize Meditech as well as paper charts for progress notes and physician orders.

PROFESSIONAL DEVELOPMENT OPPORTUNITIES - The Residential Care Initiative allocates funds for professional development opportunities related to long-term care. A popular opportunity amongst our Division members is the Long-term Care update Conference held at Predator Ridge. The Division reimburses travel expenses and the registration costs.

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Inspiring Minds

Thompson Region Division of Family Practice
A GPSC initiative

GPSC General Practice Services Committee

Invoice for Physician Services

GPSC Long-term Care Initiative

Billing Period: (please check appropriate period)

Current date: _____

Q1 APRIL - JUNE ☐ Q 3 OCTOBER - DECEMBER ☐

Q2 JULY - SEPTEMBER ☐ Q4 JANUARY - MARCH ☐

REQUIRED:

Personal Information			
Name:		MSP #	
Payable to (if incorporated):			
Address:			
City:			
Province:	Postal Code:		

Striving to achieve the best practices:	Unit	Rate	Amount
Quarterly proactive visits (**$65.00 per patient per quarter**)		$ 65.00	$
Quarterly participation in 24/7 coverage, case conferences, medication reviews and documentation ($1000 per year or $250 per quarter)	1.00	$ 250.00	$ 250.00
		Total	

OPTIONAL:

Please tell us how you are doing with attaining the five best practices.				
	Very Good	Good	Poor	Very Poor
Ability to provide 24/7 coverage and onsite attendance, when required				
Ability to provide proactive visits to residents				
Ability to provide meaningful medication reviews				
Ability to complete end of life plan for residents (shared care plans, advance care plans or medical summaries)				
Ability to attend case conferences				

Do you have any suggestions on how we can help improve your experience for you and your patients in long-term care?

Claimant Signature

Division Lead Signature

FOR OFFICE USE ONLY			
GL	DEPT	PROJECT	AMOUNT

Please fax to 250-372-1610 or email thompsonregion@divisionsbc.ca.

Treating Asymptomatic Bacteriuria: All harm, No Benefit

Asymptomatic bacteriuria is common

- In many elderly people, the bladder is colonized with bacteria
- A positive urinalysis or urine culture in the absence of symptoms suggests colonization
- Treatment of asymptomatic bacteriuria is NOT indicated in the elderly

Urine cultures should not be obtained without an indication or physician order

- Obtaining urine cultures when there are no localizing urinary tract symptoms drives the unnecessary prescription of antibiotics

Over prescribing antibiotics results in many adverse events

- Drug-drug interactions
- Renal & other complications
- *C. difficile* infection
- Multi-drug resistant bacteria

Asymptomatic bacteriuria (ASB) is a common condition in which bacteria are present in the urine but there are no symptoms of a urinary tract infection

Challenges	Strategies for practice change
The resident's family wants urine test and antibiotic treatment in the setting of asymptomatic bacteriuria	Educate the family about the prevalence of asymptomatic bacteriuria, and tell them you do not suspect UTI on clinical grounds. Emphasize the dangers of antibiotic overuse.
We've always ordered urine cultures when there is a baseline mental status change (either confusion or change in behavior)	DELIRIUM or CONFUSION ≠ UTI A change in mental status or delirium is non-specific and may accompany conditions such as dehydration or adverse drug effect. Diagnosing and treating UTIs based on non-localizing symptoms often results in inappropriate antibiotic use. More importantly, you may miss the complete clinical picture. Observe and problem solve for other causes of delirium using PRISME (found on the Delirium Care and Monitoring worksheet)
It is okay to give an antibiotic even if it may not be needed. Better safe than sorry.	Antibiotics can cause adverse drug reactions, *C.difficile* infection, and promote the emergence of multi-drug resistant organisms. Inappropriate antibiotic use now may cause future issues for your client.
It is hard to ignore a positive urine test even when done for no clearly apparent reason.	Residents in long-term care frequently have positive urine cultures, even when they are well.

Urinary tract infections – diagnostic toolkit

Criteria for Urine Testing

Resident *without* Indwelling Catheter

•Fever (37.9 ºC)+ at least one of the symptoms below (new or increased) OR

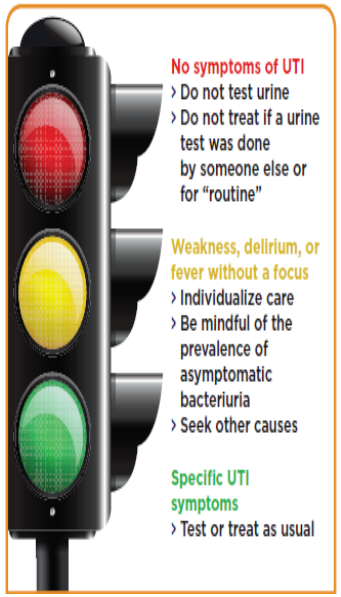
•If no fever, at least two of the following symptoms:

- Acute Dysuria
- Gross hematuria
- Urinary Incontinence
- Urinary Urgency/hesitancy
- Suprapubic pain
- Flank pain
- Urinary Frequency

Resident *with* Indwelling Catheter

•At least one of the following symptoms below (new or increased)

- Fever
- Pelvic Discomfort
- Flank pain (back, side pain)
- Malaise or lethargy with no other cause
- Costovertebral angle (CVA) tenderness
- Rigors (shaking chills)
- Delirium
- Gross hematuria



Adapted from Massachusetts Infection Prevention Partnership Asymptomatic Bacteriuria clinician handout

Diabetes Guidelines for the Frail Elderly

Intended for those with severe or very severe frailty according to the Clinical Frailty Scale. The guidelines advocate for more lenient blood glucose targets with frailty and make recommendations to avoid excessive blood glucose testing.

BLOOD GLUCOSE TARGETS, mmol/L	ACTION
Less than 7	Decrease diabetes treatment
7.0 – 9.9	May be acceptable. There is a risk for hypoglycemia with oral diabetes agents or insulin. If there is hypoglycemia, decrease treatment.
10 – 20	This range is acceptable if there are no reversible symptoms
Frequent Values Greater than 20	Increase treatment

HgbA1c TARGETS, %	ACTION
Less than 8	Decrease diabetes treatment
> 8 and < 12	Acceptable, if asymptomatic
More than 12	Increase treatment

Routine blood glucose testing is usually not necessary for those with stable BG measures that are within target range when using oral agents or stable doses of basal insulin without regular/rapid insulin.

CLINICAL PEARLS

- Consider that most oral medications decrease A1C by ≈1% when deciding whether and which medications can be stopped.
- Use NPH as basal insulin instead of long-acting insulin analogues such as glargine (Lantus™) or detemir (Levemir™), as NPH is less expensive with similar outcomes.
- Basal insulin alone (without regular or rapid insulin) may be preferable due to variations in oral intake that can lead to hypoglycemia.
- With consistent BG measures between 16 – 20mmol/L, an increase in treatment may be indicated.
- Do not stop insulin with type 1 diabetes.

Developed by the Diabetes Care Program of Nova Scotia [http://cme.medicine.dal.ca/ADS.htm] with the Palliative and Therapeutic Harmonization (PATH) Program [www.pathclinic.ca]. For rational behind guideline: see Mallery LH. J Am Med Dir Assoc. 2013 Nov;14(11):801–8.

over 20 yrs Partnerships, Quality, and Innovation (since 1991) Diabetes Care Program of Nova Scotia NOVA SCOTIA

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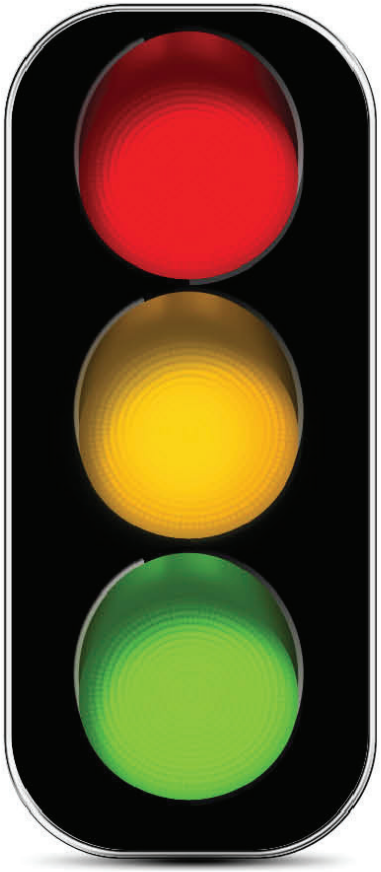
Treating Hypertension in Frailty



STOP

Taper and discontinue antihypertensives if sitting SBP is < 140 mmHg, but:

- It is not certain whether to discontinue treatment with a history of previous stroke (see full guideline)
- Before stopping, consider whether the medication is treating additional conditions such as atrial fibrillation or symptomatic heart failure

START

- Consider treatment when SBP is > 160 mmHg
- Aim for sitting SBP of 140 to 160 mmHg
  - Use seated (not supine) blood pressure to make treatment decisions
  - If there is symptomatic orthostasis or if standing SBP is < 140 mmHg, the seated SBP may need to be adjusted upwards
- In the severely frail nearing the end of life, a target SBP of 160 to 190 mmHg is reasonable
- In general, use no more than 2 medications

Intended for individuals who are severely frail, with a Clinical Frailty Scale score of 7 or higher—who require assistance performing basic ADLs, such as bathing or dressing

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DEANS DRUG EVALUATION ALLIANCE OF NOVA SCOTIA

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Treating Hyperlipidemia in Severe and Very Severe Frailty

These recommendations consider the significant impact and decreased life expectancy of severe and very severe frailty according to the Clinical Frailty Scale[1]

CLINICAL SCENARIO	RECOMMENDATION	THE DETAILS
PRIMARY PREVENTION: no history of stroke or ischemic heart disease	Do not start or continue statins	It is unlikely that statins provide benefit in applicable outcomes.
SECONDARY PREVENTION: prior history of stroke or ischemic heart disease	Probably not necessary to start or continue statins There may be extenuating circumstances that shift the risk/benefit ratio.	With severe frailty there is: • uncertainty about whether statin trial outcomes are clinically meaningful; • uncertainty about the magnitude of benefit conferred, partly because of the decreased life expectancy in severe frailty; • increased potential for adverse events. For the frail elderly, an important outcome is non-fatal stroke leading to disability. In some statin studies, the outcome of non-fatal stroke sometimes includes mild strokes and TIAs and the number of strokes leading to disability is not reported separately. In some studies, CHD events include those with asymptomatic heart disease such as silent MIs.
Patients with Congestive Heart Failure (CHF) only	Do not start or continue statins	There is evidence that statins are ineffective in improving clinical outcomes for older adults with CHF.
Patients on Ezetimibe	Stop Ezetimibe	There is no evidence that ezetimibe reduces cardiovascular events or mortality either alone or with statins.
Patients on combination lipid lowering therapy	Use statin only	There is no evidence of added benefit in clinical outcomes for combination therapies for either primary or secondary prevention.

We suggest doses no higher than at right and possibly lower; 2/3 of the lipid-lowering effect is realized at the starting dose. Consider a trial of statin discontinuation if there is concern about myalgias or other adverse effects.

Atorvastatin 10 mg	Rosuvastatin 10mg	Fluvastatin 80mg
Simvastatin 20 mg	Pravastatin 40mg	

Developed by Dalhousie University Academic Detailing Service [http://cme.medicine.dal.ca/ADS.htm] and the Palliative and Therapeutic Harmonization (PATH) Program [www.pathclinic.ca]

1. Rockwood, 2005 CMAJ, Aug 30;173(5):489-495.

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DEANS

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Thompson Region
Division of Family Practice
A GPSC Initiative

GPSC
General Practice Services Committee

Invoice for New Long-term Care Patient Attachment Incentive Reporting

Billing Period: (please check appropriate period)

Q1 APRIL - JUNE
Q2 JULY - SEPTEMBER
Q3 OCTOBER - DECEMBER
Q4 JANUARY - MARCH

Current date: _____

Personal Information

Name: MSP #:

Payable to (if incorporated):

Address:

City:

Province: Postal Code:

Striving to achieve the best practice:	Unit	Rate	Amount
Number of Patients attached in this period		$200.00	

Required: Information regarding your newly attached patient(s)

Explanations:

Patient ID: PHN number of Patient
Option 1: Continuing care of existing patient into LTC
Option 2: Patient was unattached and required an MRP
Option 3: Patient attached as a lateral transfer

Patient ID (PHN#)	Attachment Date	Name of Long Term Care Home	Option 1	Option 2	Option 3

Claimant Signature

Division Lead Signature

FOR OFFICE USE ONLY			
GL	DEPT	PROJECT	AMOUNT

Please fax to 250-372-1610 or email thompsonregion@divisionsbc.ca