infected by Streptococcus pyogenes that is certainly an uncommon pathogen for IE. It has not been reported to cause IE in our hospital for over ten years. The incidence of severe infectious complications caused by Streptococcus pyogenes has been increasing over recent years, most likely due to immunosuppression and HIV. It is associated with a high mortality rate similar to Staphylococcus aureus IE. Acute septic arthritis may be the first clue to the presence of infective endocarditis in a small percentage of patients. It is well to point out that IE can present with the manifestation of infection at a distant site which dominates the presenting clinical picture. We believe that as mentioned in literature; elderly patients with IE show a higher rate of in-hospital death, and efforts should be made to improve outcomes in this major subgroup of patients. To conclude, physicians should always be aware of unusual presentations and uncommon pathogens in IE to lessen the mortality and morbidity of the disease.

Disclosures: All authors have stated there are no disclosures to be made that are pertinent to this abstract.

Beyond the Medical Model: The Culture Change Revolution in Long Term Care

E. Foy White-Chu, MD, Geriatric Fellow, Hebrew Senior Life/Beth Israel Deaconess Medical Center/Harvard Medical School; Alice Bonner PhD, RN, Executive Director, Massachusetts Senior Care Foundation

Introduction/Objective: Culture change in long-term care facilities involves a shift in the overall philosophy away from the focus on safety and uniformity and toward resident-directed, consumer-driven care and quality of life. Fundamental to this attitudinal shift is a focus on the importance of the relationship between the resident and direct care staff. This review addresses the history of culture change; the key elements of small scale living, workforce redesign, person-centered care, and resident choice; leadership; the implementation process; and evaluation methods. A case report will put a personal face on the steps by which a facility can move away from the medical model.

Design/Methodology: Review of the Literature and Illustrative Case Report.

Results: Elements of culture change; steps in implementation; and measures of outcomes will be presented.

Conclusion/Discussion: At the 2008 Pioneer Network Conference on Culture Change, there were over 1000 participants but only approximately 15 were physicians. This presents a tremendous opportunity for AMDA to play a leadership role in educating physicians and other providers about culture change, and to promote this model of improved quality of care and quality of life for frail, older adults.

Disclosures: All authors have stated there are no disclosures to be made that are pertinent to this abstract.

Cadeoxemr Iodine Gel and 6 Month Mortality, Is there a Risk?

Lester J. Kieome, PA, Mayo Clinic

Author(s): Lester J. Kieome, PA; Stephen S. Cha, MS; Paul Y. Takahashi, MD

Introduction/Objective: Introduction: Cadexomer iodine gel is commonly used to help with debridement of non-healing ulcers. Cadexomer also can provide an antiseptic environment for infected wounds or wounds at high risk for infection. Thus, providers often use cadexomer gel in high risk patients with severe ulcers. However, many providers and nursing staff worry that this may have a detrimental effect upon the long term care resident. Aim: The aim was to determine the association between cadexomer iodine gel and 6 month mortality in residents in long term care.

Design/Methodology: Subjects: Nursing home residents seen from 1998-2007 with an ongoing chronic ulcer (primarily ischemic). All residents were seen by the nursing home wound care consultative service for ongoing management and included the treatment with cadexomer iodine gel. Methods: This was a retrospective cohort study from 9 different nursing facilities in Olmsted County, Minnesota. Data was manually abstracted for each LTC resident. 6-month mortality was collected as the primary outcome and was verified by two methods. The primary predictor variable was the use of cadexomer gel versus standard wound care. Statistical comparisons were made using Fisher’s exact test for univariable analysis and using logistic regression for multivariable analysis with adjustment for age and gender.

Results: 373 residents with wound information were seen with an age of 77 years +/- 12 years. 206 residents were female (55%). Of those 373 residents, 87 died within 6 months (23.3%). 128 residents used cadexomer gel of which 31 died (24%). This compares to 56 deaths in 250 residents (22%) who did not use cadexomer gel and this was not significant (p = 0.70). After adjustment for age and gender, there was still no association (p = 0.72).

Conclusion/Discussion: The use of cadexomer iodine gel does not appear to be associated with increased mortality. There have been two primary concerns with cadexomer iodine gel. First, there are concerns that iodine may slow wound healing; thus, increasing the potential for mortality from infection. Second, use of cadexomer iodine may be a surrogate for potential poor underlying physical condition (like severe peripheral vascular disease or malnutrition). This study refuted both assumptions and cadexomer gel appears safe to use in nursing home residents. Cadexomer gel should be used when debridement might be important.

Disclosures: All authors have stated there are no disclosures to be made that are pertinent to this abstract.

Comparison of Nursing Home Quality and Physician Quality Between Closed and Open Medical Staff Models

John J. Mast, MD, Lancaster General Hospital

Author(s): John J. Mast; MD; J. Kenneth Bruhaker, MD, CMD; Matthew J. Beelen, MD, Vicki L. Gillmore, RN, PhD, NHA; Michael A. Horst, PhD, MS

Introduction/Objective: Complexity of nursing home care is exploding. Co-morbidities confound the normal aging process and yet life expectancy increases. With each new pharmaceutical breakthrough standards of medical care morph. Consumer expectations are rising. In this environment, it is critical that the medical team work together to optimize resident care. Competence and communication are critical components of this care. Limited studies so far imply that closed staff nursing facilities are positively associated with quality measures. The purpose of this study is to compare subjective physician quality measures and quality outcomes in open and closed medical staff nursing facilities. This study only evaluates the staff model with respect to the primary care physician. For this study, open staff facilities will be defined as allowing any credentialed licensed physician to visit, assess, prescribe medical care, and follow a resident in a nursing facility. Closed staff facilities have a rigorous credentialing/re-credentialing process (a process that has denied or revoked privileges for at least one physician) or have an employed, salaried, or contracted relationship with the nursing facility and provide primary care to at least 95% of the residents that receive primary care inside the facility.

Design/Methodology: A descriptive-comparative study design will be used to compare quality measures between the open medical staff model and the closed medical staff model. The data collection tool consists of 2 parts. The first part (Quality Physician) is a likert scale questionnaire asking the Director of Nursing to respond to a series of 13 questions related to physicians that provide highest quality, average and lowest quality care. Rankings on the scale are Excellent, Good, Fair, Poor, and Unacceptable. The second part of the tool (quality facility) compares the facility % and the comparison percentile of the most recent CMS quality measures analysis of: prevalence of depressive symptoms without antidepressant therapy, prevalence of fecal impaction, presence of urinary tract infection, prevalence of tube feeding, prevalence of anti-psychotic use in the absence of psychotic or related conditions, and prevalence of anti-anxiety/hypnotic use. Additional survey questions will address potential confounding factors related to nursing facility quality: for profit or not for profit status, percentage of beds filled with long term care residents and with short term rehab residents, facility size, physician training or certification, facility requirements for frequency of visits for long term and short stay residents, physician - facility relationship; salaried/employed, contracted, or neither.

Results: Not available yet; preliminary data will be available by date of the AMDA meeting.

Conclusion/Discussion: Preliminary conclusions will be available by date of the AMDA meeting.