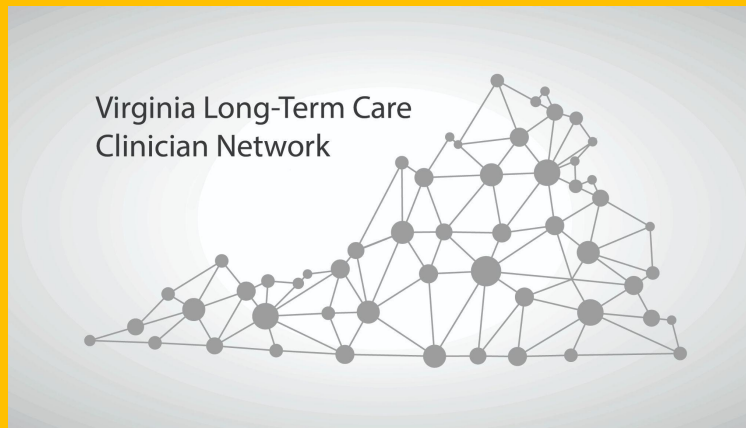


Virginia Long-Term Care Clinician Network

Monthly Forum
October 15, 2025



VCU College of Health
Professions

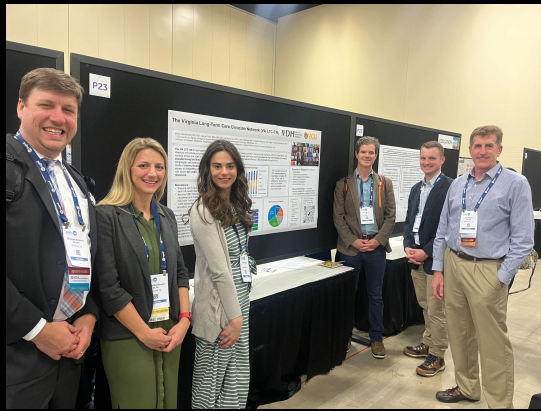
Gerontology and the Virginia Center on Aging



VCU

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WE ARE THE UNCOMMON.



The Virginia Long-Term Care Clinician Network is managed by VCU's Division of Geriatric Medicine, Virginia Center on Aging, and Department of Gerontology.

Welcome!

As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues.



Accreditation

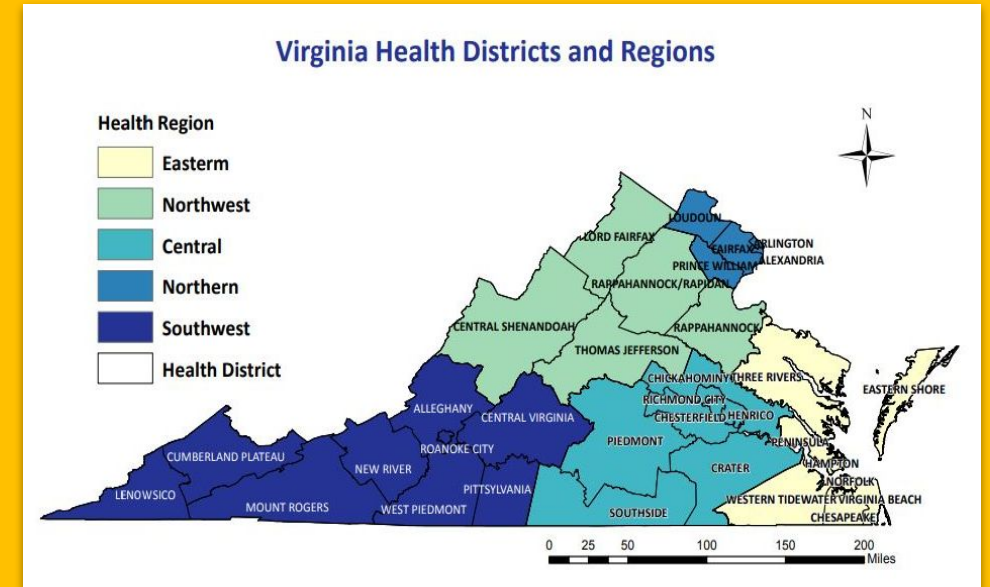
	In support of improving patient care, VCU Health Continuing Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
	VCU Health designates this live activity for a maximum of 1.00 AMA PRA Category 1 Credits™ . Physicians should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education designates this activity for a maximum of 1.00 ANCC contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 1.00 AAPA Category 1 CME credits . PAs should only claim credit commensurate with the extent of their participation.

Welcome new members!

Taylor Tealakh - Central Region

Jodi Gwaltney - Central Region

Alisha Shields - Central Region



There are approximately 287 nursing homes and 580 assisted living facilities operating in Virginia. Within these, there are over 500 clinicians providing care. **We have 320 network members.** The Network provides ongoing learning and communication.

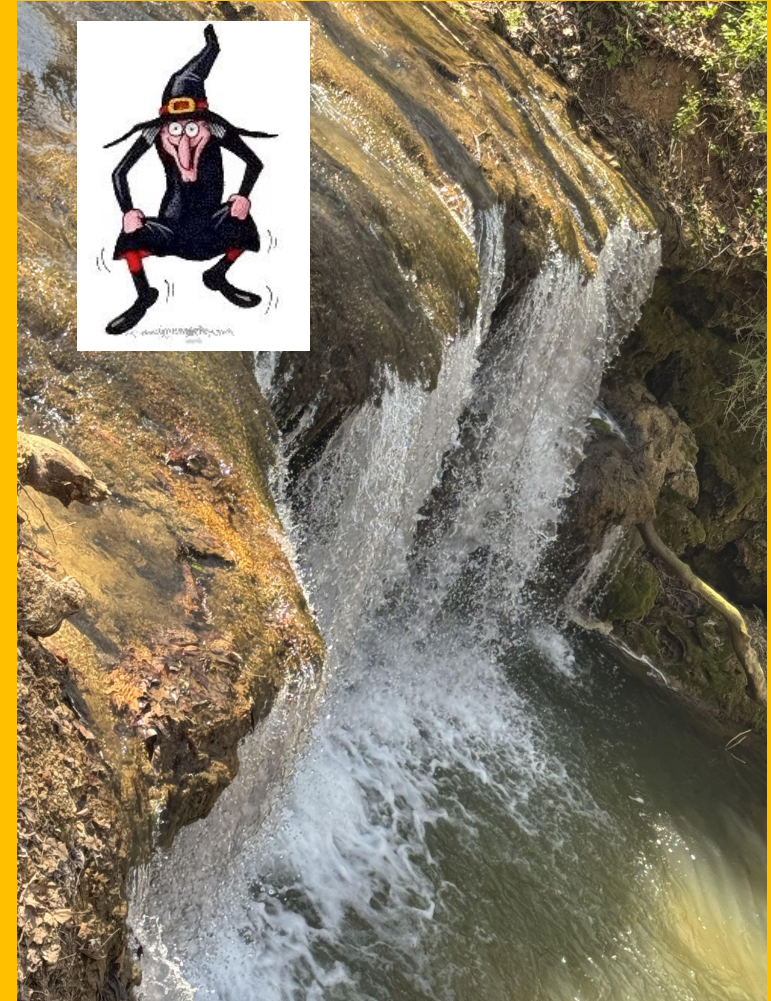
Remind your work colleagues to attend so they can get education, support and CME!

Waterfall Poll

Halloween, do you like it or dread it?

- A. I look forward to Halloween
- B. I have my costume organized and my home is fully haunted.
- C. Turning off the lights and locking the doors.

Foley Mills, Staunton, VA



Disclosure of Financial Relationships

Disclosure of Commercial Support:

We acknowledge that no commercial or in-kind support was provided for this activity.

Rheumatoid Arthritis in Long Term Care

a case presentation and discussion

John Gilstad, MD

Internal Medicine and Geriatrics

Virginia LTC Clinicians Network, 15 Oct 2025

Poll: which of these patients has RA?



A

B



UpToDate photo credits:
bilat hands: Patrick J Venables MD
left hand: OARSI online primer

Poll: which patient has Heberden's nodes?



A

B



UpToDate photo credits:
bilat hands: Patrick J Venables MD
left hand: OARSI online primer

Case vignette part 1 – history of present illness; meds

- 71-year-old woman with seropositive rheumatoid arthritis on maintenance prednisone. Trials of both methotrexate and adalimumab (TNF inhibitor) were stopped after brief trials several years ago due to side effects.
- At initial meeting with me more than a year ago, she had lost contact with her rheumatologist. She told me her RA was stable, and was reluctant to consider rheumatology re-eval, or prednisone taper or other med changes.
- She now presents with increased shoulder and elbow pain, plus elevated ESR/CRP, five months after prednisone discontinuation: the clinical concern is RA exacerbation.
- Her current medications include apixaban, oxycodone, acetaminophen, furosemide, buspirone, fluticasone, cholestyramine, melatonin, multivitamin, potassium chloride, vitamin B12, iron–vitamin C, and topical miconazole.

Case vignette part 2 – past medical and surgical history

- Atrial fibrillation, onset several years ago during hospitalization for wound infection
- Chronic leg edema with stasis dermatitis
- Restless legs syndrome
- Long-term narcotic use for pain
 - in the past, hydrocodone up to 10mg q6h scheduled (40 MME 40 / 24h)
 - presently oxycodone 5mg q8h prn, reported insufficient by patient (22.5 MME / 24h)
- Anxiety and depression
- distant cholecystectomy

Case vignette part 3 – physical exam and lab

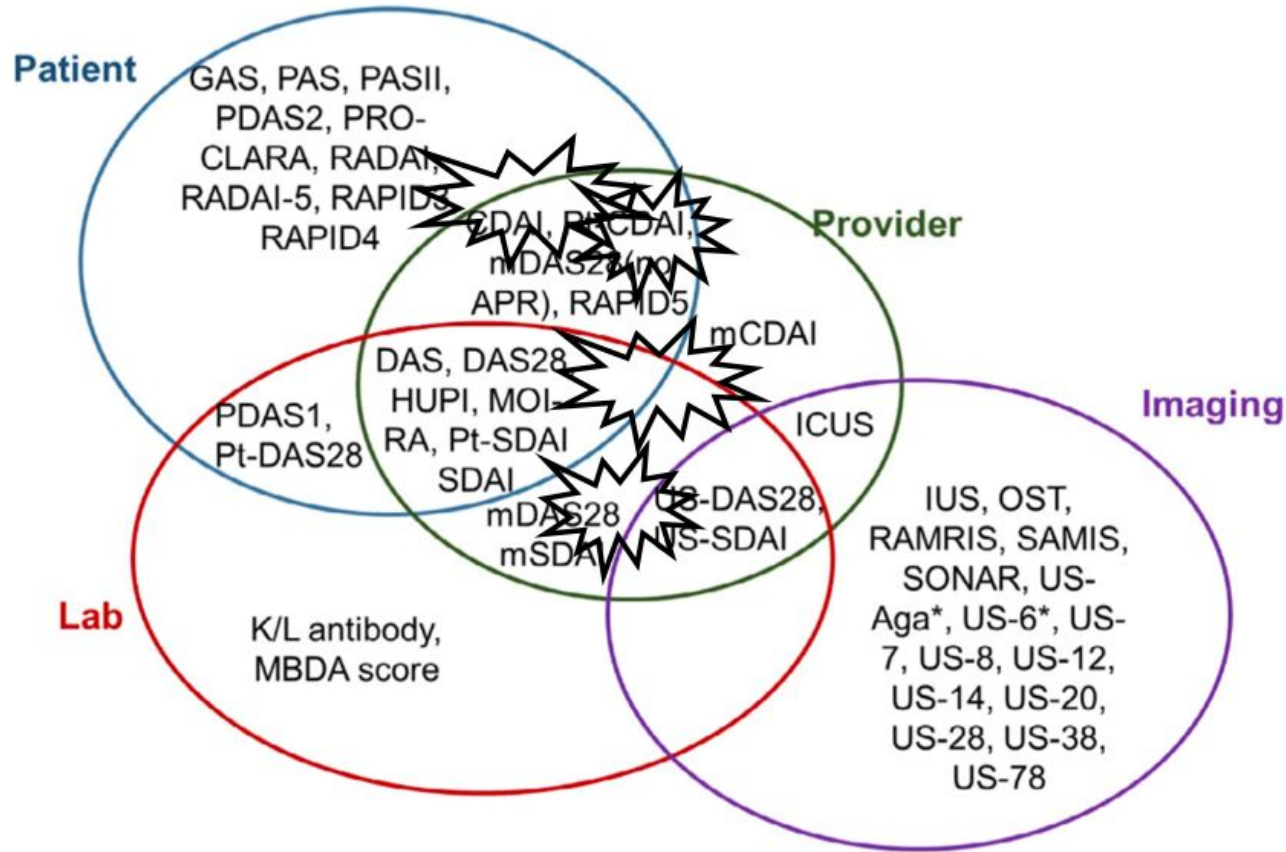
Patient examined as she is sitting in wheelchair in a quiet corner of hallway. She is distressed due to pain in shoulders.

- Shoulders are not swollen or red, patient reports pleasant sensation to gentle palpation, but marked pain with minimal passive movement of abduction or extension on either side.*
- Elbows also nontender, not swollen, but patient reports pain with passive flexion and extension around the range 45 to 135 degrees*
- Right knee mildly tender diffusely, especially joint line medially, some suggestion of effusion anteromedially. Left knee nontender to palpation, no suggestion of effusion. Both knees have passive range of motion on extension out to within 10 degrees of straight, with minimal pain.*
- Heart has regular rate and rhythm, no murmur; lungs have diminished airflow but no wheezing, no rales; abdomen is nontender to gentle palpation; no edema*
- BMI 25.1**
- ESR 67, CRP 3.8; up from 33 and 0.8 last winter.**
- Hgb 7.5, MCV nl, ferritin 67, iron sat 11% (no change after 1 month oral iron suppl)**

Outline of the talk:

- Quick overview of rheumatoid arthritis management recs
 - basic approach
 - application to this case
- The long term care context
 - drop-off in rheumatologic attention with transition to LTC
 - comorbidities and age in RA treatment decision-making
- Discussion:
 - clinical comments? best practices?
 - policy or research agenda?
- If time: brief follow-up on the previously presented case

Assessing RA disease activity: so many options!



CDAI

Clinical Disease Activity Index

* *No lab data used*

SDAI

Simplified Disease Activity Index

* *uses CRP*

RAPID3

Routine Assessment of Patient Index Data 3

* *patient self-assessment only*

DAS28

28-Joint Disease Activity Score

* *uses either ESR or CRP*

*multiple versions

RA disease activity calculators: several online options

UpToDate® rheumatoid arthritis clinical disease activity index CME 500+ Sign out

< Back Calculator: Rheumatoid arthritis Clinical Disease Activity Index (CDAI) in adults

PGA #

EGA #

Tender joint count (TJC)

☐ Shoulder

☐ Elbow

☐ Wrist

Right hand
MCP 1-5
IP 1, PIP 2-5

☐ Knee

☐ Shoulder

☐ Elbow

☐ Wrist

Left hand
MCP 1-5
IP 1, PIP 2-5

☐ Knee

TJC 0

Swollen joint count (SJC)

☐ Shoulder

☐ Elbow

☐ Wrist

Right hand
MCP 1-5
IP 1, PIP 2-5

☐ Knee

☐ Shoulder

☐ Elbow

☐ Wrist

Left hand
MCP 1-5
IP 1, PIP 2-5

☐ Knee

SJC 0

1:57 Search UpToDate

Calculator: Rheumatoid arthritis Clinical Disease Activity Index (CDAI) in adults

Input

PGA #

EGA #

TJC count

SJC count

Result

Important: Inputs must be complete to perform calculation.

CDAI score

Decimal precision 1

CDAI interpretation

CDAI 52.8: Remission

Bookmark More

2:53 sniv3r2.github.io

Calculator: Rheumatoid arthritis Clinical Disease Activity Index (CDAI) in adults

Calculator: Rheumatoid arthritis Clinical Disease Activity Index (CDAI) in adults

CDAI = SJC + TJC + PGA + EGA

Result:

Input:

CDAI score

PGA #

EGA #

Decimal precision 1

Tender joint count (TJC)

☐ Shoulder

☐ Elbow

☐ Wrist

Right hand
MCP 1-5
IP 1, PIP 2-5

☐ Shoulder

☐ Elbow

☐ Wrist

Left hand
MCP 1-5
IP 1, PIP 2-5

Swollen joint count (SJC)

☐ Shoulder

☐ Elbow

☐ Wrist

Right hand
MCP 1-5
IP 1, PIP 2-5

☐ Shoulder

☐ Elbow

☐ Wrist

Left hand
MCP 1-5
IP 1, PIP 2-5

uptodate.com
sniv3r2.github.io

mdcalc.com
reference.medscape.com

RA treatment in a nutshell

Nonbiologic (traditional; conventional synthetic)

- methotrexate
- hydroxychloroquine
- sulfasalazine
- leflunomide

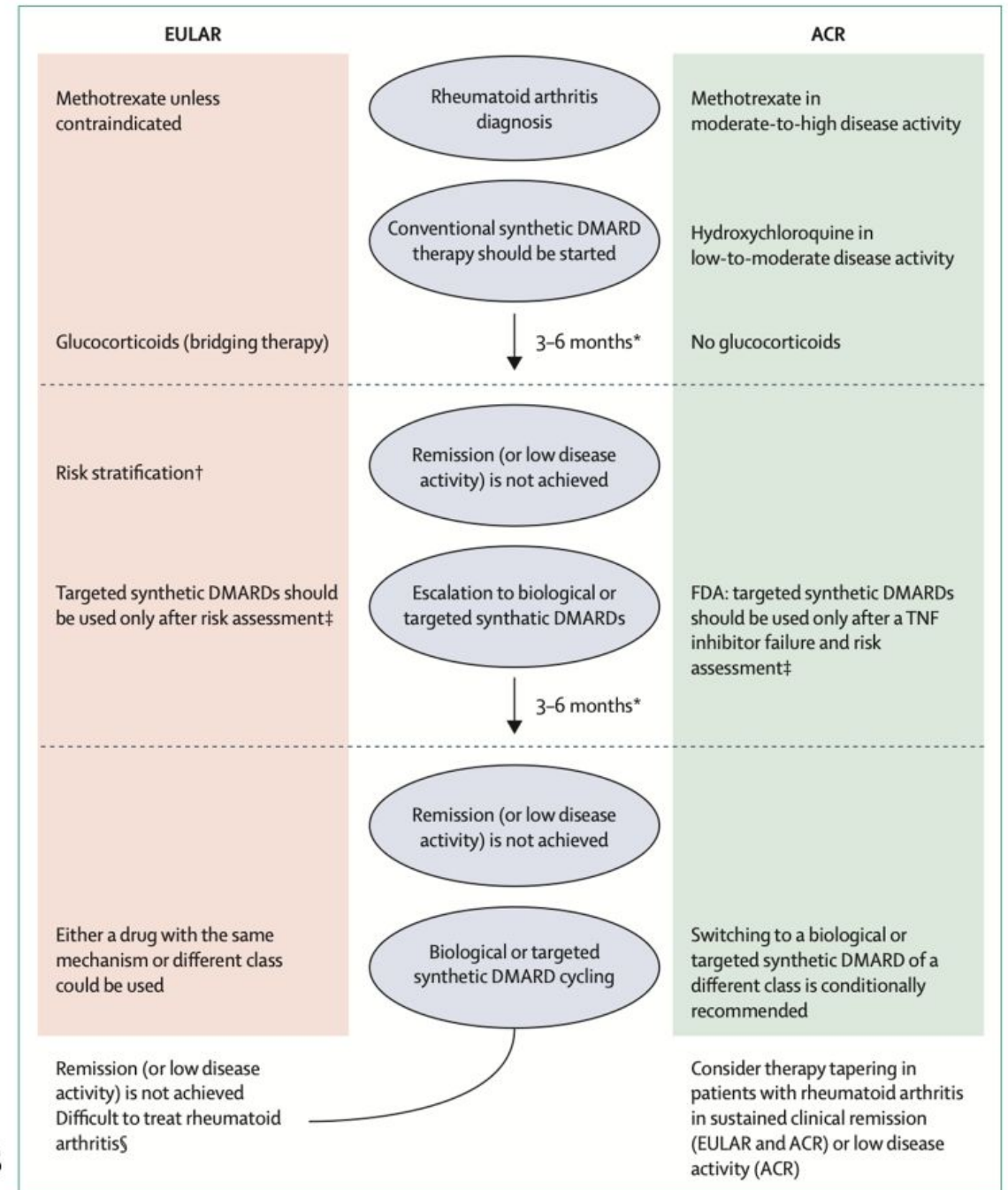
Biologic

- TNF inhibitors (etanercept; infliximab; adalimumab; golimumab; certolizumab pegol)
- IL-6 receptor antagonists (tocilizumab; sarilumab)
- T-cell co-stimulation blocker (abatacept)
- anti-CD20 B-cell depleting monoclonal Ab (rituximab)

Targeting synthetic

- JAK inhibitors (tofacitinib; baricitinib; upadacitinib; filgotinib; peficitinib)

UpToDate; Fraenkel 2021; Di Matteo 2023



Our patient

Disease activity:

- CDAI=26 (>22 “high”)
- SDAI=29.8 (>26 “high”)
- DAS28-ESR=5.1 (>5.1 “high”)
- DAS28-CRP=3.7 (>3.2, ≤5.1 “moderate”)

A proposed management plan

⇒ ⇒ ⇒

1. Resume prednisone at 10mg daily now, begin very gentle taper as soon as sx improve (use disease activity measures!)
2. Try to get that rheumatology consult
3. If rheum input will be super delayed or looks impossible: options to discuss with patient include:
 - a) try hydroxychloroquine (best safety profile)
 - b) add sulfasalazine and then leflunomide if needed
 - c) goal is disease control without prednisone
4. If rheum input is possible, read up on abatacept (T-cell co-stimulation inhibitor) and IL-6 inhibitors (tocilizumab, sarilumab) which are appropriate next-line options; check costs; aim to participate in shared decision-making with patient and rheum as the patient’s primary care clinician.
5. “Treat to target” = q3mo followup with activity measure reassessment, and intervention if disease activity isn’t responding

Our patient

Rx	WAC 30
hydroxychloroquine 200-400mg daily	\$36.80
sulfasalazine 500-2000mg daily	\$31.10
leflunomide 20mg daily	\$1360.70
abatacept 500mg mg IV month or 125mg subQ weekly	\$2456.90 \$4850.50

Med Lett 2021
UpToDate

Monitoring strategies for drug treatment of rheumatoid arthritis

Drugs	Ongoing monitoring via system review and physical examination *	Ongoing laboratory monitoring and other testing ^{1A}
Salicylates, NSAIDs	Dyspepsia, nausea/vomiting, abdominal pain, edema, blood pressure	CBC and complete metabolic panel (electrolytes, creatinine, albumin, transaminases) every 6 months.
Glucocorticoids	Mood, weight gain, visual changes, weakness, polyuria, polydipsia, edema, infection, blood pressure	Diabetes screening, lipids, bone mineral density testing.
Hydroxychloroquine	Visual change, skin color change, paresthesia [◇]	Ophthalmologic evaluation for retinal toxicity. [◇]
Sulfasalazine	Headache, nausea, diarrhea, photosensitivity, symptoms of myelosuppression, hepatotoxicity, rash	CBC, aminotransferases, and creatinine every 2 to 4 weeks for the first 3 months or after increasing the dose, every 8 to 12 weeks for months 3 to 6, then every 12 weeks.
Methotrexate [§]	Stomatitis, alopecia, diarrhea, nausea/vomiting, flu-like symptoms, shortness of breath, symptoms of myelosuppression, hepatotoxicity, infection, lymph node swelling, pregnancy	CBC, aminotransferases, and creatinine every 2 to 4 weeks for the first 3 months or after increasing the dose, every 8 to 12 weeks for months 3 to 6, then every 12 weeks.
Leflunomide [§]	Nausea/vomiting, diarrhea, shortness of breath, paresthesia, hepatotoxicity, weight loss, blood pressure, pregnancy	CBC, aminotransferases, and creatinine every 2 to 4 weeks for the first 3 months or after increasing the dose, every 8 to 12 weeks for months 3 to 6, then every 12 weeks.
Minocycline	Hyperpigmentation, dizziness, falls	None after baseline.
Azathioprine	Diarrhea, nausea/vomiting, symptoms of myelosuppression, infection	CBC and platelet count every 1 to 2 weeks with changes in dose, every 1 to 3 months thereafter.
TNF inhibitors (eg, etanercept, infliximab, adalimumab, certolizumab pegol, and golimumab)	Infection, malignancy, demyelination, congestive heart failure, autoimmune phenomenon	No routine laboratory monitoring (unless also receiving a concurrent conventional DMARD).
IL-6 inhibitors (eg, tocilizumab and sarilumab)	Infection, symptoms of myelosuppression (PMNs and platelets), demyelination, hepatotoxicity, gastrointestinal perforations	CBC with differential (neutrophils) and LFTs every 4 to 8 weeks until stable, then every 3 months. Lipids 4 to 8 weeks after starting therapy, then every 6 months.
Rituximab	Infection, PML, symptoms of neutropenia	CBC every 2 to 4 months.
Abatacept	Infection, COPD exacerbation, malignancy	No routine laboratory monitoring (unless also receiving a concurrent conventional DMARD).
JAK inhibitors (eg, tofacitinib, baricitinib, and upadacitinib)	Infection, zoster, symptoms of myelosuppression, hepatotoxicity, malignancy, gastrointestinal perforation	CBC with differential, creatinine, LFTs (transaminases, albumin, bilirubin) every month for 3 months, then every 3 months; lipids 6 to 8 weeks after drug start.

The drop-off in rheumatoid arthritis care after arrival into LTC

- Cohort: members of a German health insurance fund (6M, 8% of German population) who transitioned to NH between 2010 and 2014
- Comparison: four quarters prior to placement, vs four quarters following placement.
- 127,227 members underwent NH placement, of which 4+4 quarters of data were available for 75,697
- Of these members, 2485 (3.3%) were identified as having RA in the year leading up to NH placement

	Year prior to LTC n (%)	1st year of LTC n (%)
≥1 rheum appt	437 (17.6)	226 (9.1)
≥1 Rx csDMARD	559 (22.5)	409 (16.5)
≥1 Rx bDMARD	51 (2.1)	36 (1.5)
≥1 Rx steroid	1180 (47.5)	1082 (43.5)
≥1 Rx NSAID	1179 (47.4)	956 (38.5)

[1997 U.S. National Nursing Home Survey (8138 residents sampled from 1406 NH, representing an estimated 1.6M NH residents) showed that only 3% had a primary dx of arthritis, and 19% had any dx arthritis; concurrent arthritis 65+ community prevalence = 50%]. Abell 2004

Age and comorbidities in RA de

- Meta-analysis: “older” patients as defined by study (usually 65+)
 - lower remission rates (OR 0.76)
 - more adverse events (OR 1.33)
 - In both cases, CIs cross 1.00)
- RISE cohort: greater multimorbidity (RxRisk index)
 - no impact on decision to use DMARDs (OR 1.00)
 - lower response (OR 0.9)

age & comorbidities + busy days + lack of rheumatology expertise } *clinical inertia?*

Truijen 2025, England 2023

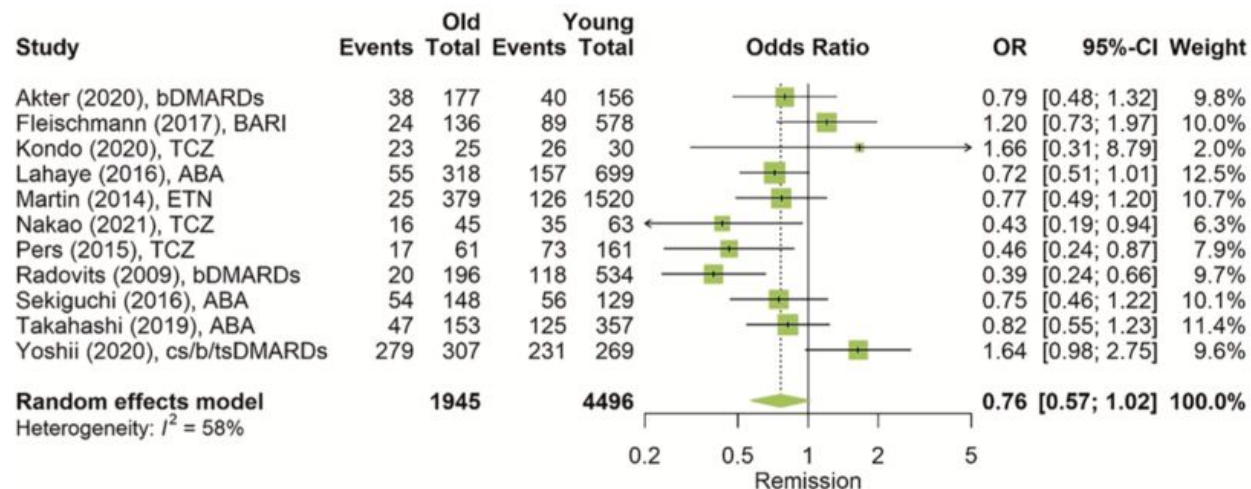


Fig. 3A. Forest plot representing the pooled OR of reaching remission between old(er) and young(er) patients with RA six to 12 months after DMARD initiation (11 studies) [22,26–35]..

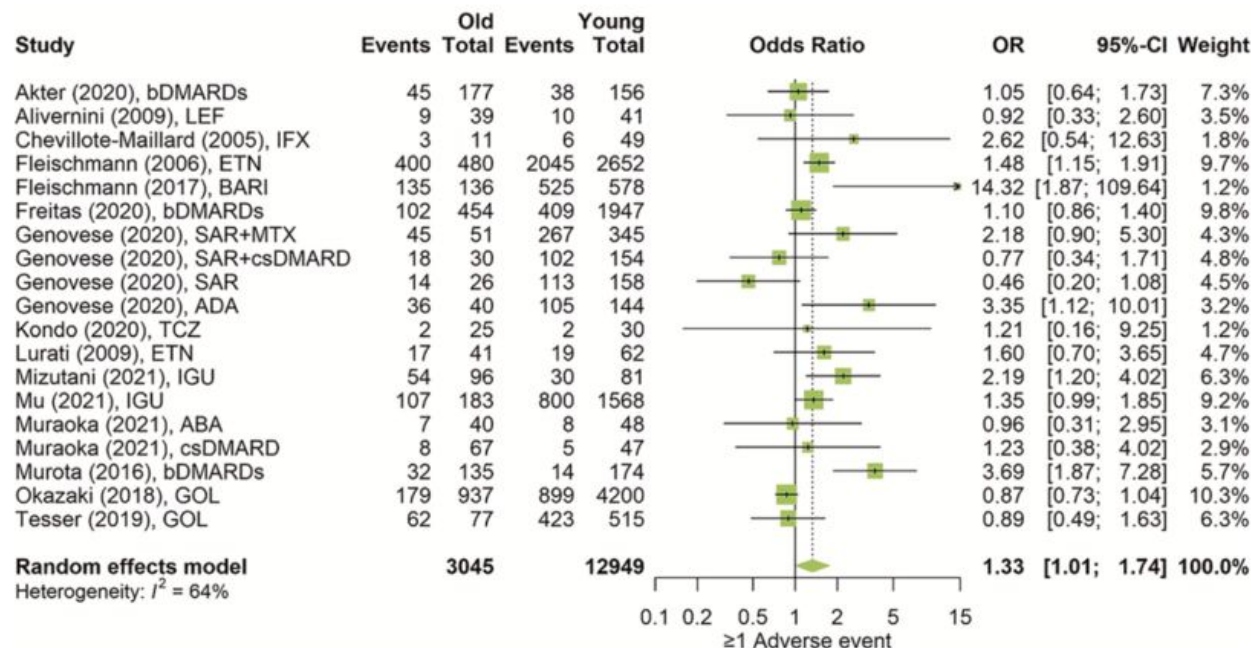


Fig. 3B. Forest plot representing the pooled OR of experiencing ≥ 1 AE between old(er) and young(er) patients with RA at any time point after DMARD initiation (19 studies) [26–28,36–46]..

Outline of the talk:

- Quick overview of rheumatoid arthritis management recs ✓

- guideline basics
- application to this case

- The long term care context ✓

- drop-off in rheumatologic attention with transition to LTC
- comorbidities and age in RA treatment decision-making

- Discussion:

- clinical comments? best practices?
- policy or research agenda?

- If time: brief follow-up on the previously presented case

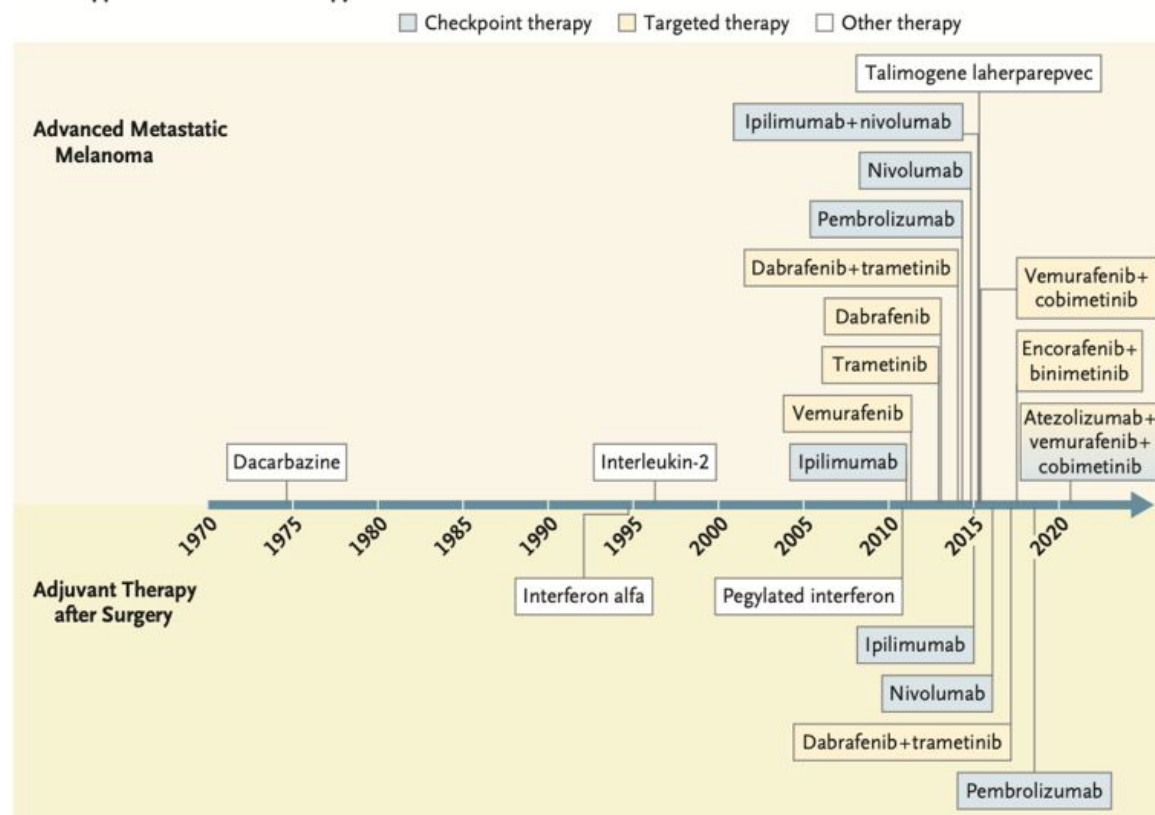
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The immunotherapy era in melanoma

Clinical Follow-up
Feb → Aug 2025

A FDA-Approved Melanoma Therapy



Curti 2021

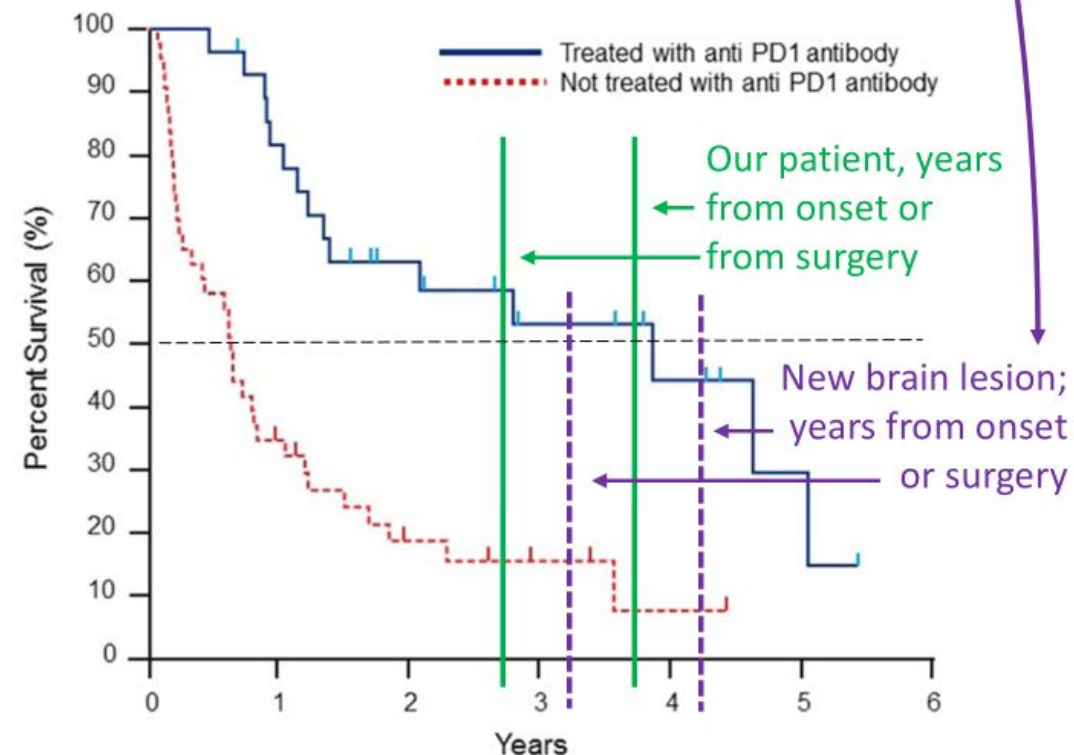


Fig. 2 Kaplan-Meier curves of overall survival by presence or absence of anti-PD-1 antibody therapy (*pts with brain metastases*)

Vosoughi 2018

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Open Forum

Any questions or
ideas from the
talk?

Today's CE
Code is #####



Resources/Research & Education Opportunities

Study Invitation: Moral Distress in Nursing Home Medical Directors

You are invited to participate in a brief **research study** exploring the experiences of moral distress among Medical Directors and physicians working in nursing homes.

This qualitative study involves a one-time, private interview conducted virtually (via HIPAA-compliant Zoom) and lasting approximately 45–60 minutes. The goal is to understand better how Medical directors utilize their voice in leadership roles and navigate ethical challenges within long-term care environments.

If you have any questions, concerns, or complaints about this study now or in the future, please get in touch with Annie Rhodes, rhodesas2@vcu.edu. To schedule an interview or learn more, [click here](#) or contact Catherine MacDonald at macdonaldcs@vcu.edu.



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PALTmed Releases Recommendations for COVID-19 Vaccine in PALTC

PALTmed's Infection Advisory Committee has developed [recommendations](#) for the 2025–2026 COVID-19 vaccine to guide clinicians and administrators in post-acute and long-term care (PALTC) settings. While the Centers for Disease Control and Prevention (CDC) provides national guidance, these recommendations address the specific risks and needs of PALTC residents and staff. The recommendations will be published in JAMDA.



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Thank you for joining us!

Updates and News - See News Updates via email and newsletter

Next Monthly Forum:

- **Nov. 19 - Chronic Kidney Disease Updates from Rachel Khan, PharmD, BCPS**
- **Dec. 17 we will take a forum holiday**
- **Jan. 21, 2026 - Osteoporosis Treatment: prescription and non prescription prevention and treatment as well as deprescribing**

Your Calendar Link - In the Zoom Registration Confirmation email you received today, there's a calendar link to update your calendar for future meetings.

On your way out of our meeting today, kindly answer a brief feedback survey.

Stay in touch! Email us at lfinch@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu