Long Term Care
Oklahoma State Department of Health

LTC Insider Chat

Volume II, Issue V

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Inside this issue:

New Projects Need Your Help

Dorya Huser, Chief of Long Term Care

Hello everyone. I have a very exciting issue of the Insider Chat newsletter for you this quarter. It is dedicated to two very important projects that need your help.

Please pay special attention to all of the information to follow on these pages about reducing unnecessary antipsychotic medications for residents with dementia. This is a new initiative designed to provide a higher quality of life for these residents and to help you in your role. The target is at least 15% reduction by the end of this year. I know you can meet this goal. We have a special day of training planned and we want absolutely everyone who can to attend and hear wonderful speakers help you improve your toolbox for dementia care.

The second item of interest I want you to notice is the wonderful program called Oklahoma Honor Flights that has been launched with the help of Representative Gary Banz to honor our World War II veterans and make a dream come true to travel to Washington to see the World War II Memorial and view the changing of the guard at the Tomb of the Unknowns in Arlington Cemetery. There is no cost to the veteran. See details inside on the last page.

Check it all out and make sure you don't miss the chance to be part of these great projects. Every person can make a difference. Every person can change a life!

save the date

Free dementia training

See pages 9-11

PLEASE POST AND SHARE THIS NEWSLETTER WITH STAFF

CMS NEWS

CMS ANNOUNCES PARTNERSHIP TO IMPROVE DEMENTIA CARE IN NURSING HOMES

Government partnering with providers, caregivers, patients to ensure appropriate use of antipsychotic medications

On May 30, 2012, the Centers for Medicare & Medicaid Services (CMS) Acting Administrator Marilyn Tavenner announced the Partnership to Improve Dementia Care, an initiative to ensure appropriate care and use of antipsychotic medications for nursing home residents. This partnership – among federal and state partners, nursing homes and other providers, advocacy groups and caregivers – has set a national goal of reducing use of unnecessary antipsychotic medications in nursing home residents by 15 percent by the end of 2012.

Unnecessary antipsychotic medication use is a significant challenge in ensuring appropriate dementia care. CMS data show that in 2010 more than 17 percent of nursing home residents had daily doses exceeding recommended levels.

"We want our loved ones with dementia to receive the best care and the highest quality of life possible," said Acting Administrator Marilyn Tavenner. "We are partnering with nursing homes, advocates, and others to improve the quality of care these individuals receive in nursing homes. As part of this effort, our partnership has set an ambitious goal of reducing use of unnecessary antipsychotics in nursing homes by 15 percent by the end of this year." CMS and industry and advocacy partners are taking several steps to achieve this goal of improved care:

Enhanced training: CMS has developed Hand in Hand, a training series for nursing homes that emphasizes person-centered care, prevention of abuse, and high-quality care for residents. CMS is also providing training focused on behavioral health to state and federal surveyors;

Increased transparency: CMS is making data on each nursing home's antipsychotic drug use available on Nursing Home Compare starting in July of this year, and will update this data;

Alternatives to antipsychotic medication: CMS is emphasizing non-pharmacological alternatives for nursing home residents, including potential approaches such as consistent staff assignments, increased exercise or time outdoors, monitoring and managing acute and chronic pain, and planning individualized activities.

"A CMS nursing home resident report found that almost 40 percent of nursing home patients with signs of dementia were receiving antipsychotic drugs at some point in 2010, even though there was no diagnosis of psychosis," said CMS Chief Medical Officer and Director of Clinical Standards and Quality Patrick Conway, M.D. "Managing dementia without relying on medication can help improve the quality of life for these residents. The Partnership to Improve Dementia Care will equip residents, caregivers, and providers with the best tools to make the right decision."

These efforts will help achieve the 15 percent reduction goal by the end of this year. In addition, to address this challenge long-term, CMS is conducting research to better understand the decision to use or not to use antipsychotic drugs in residents with dementia. A study is underway in 20 to 25 nursing homes, evaluating this decision-making process. Findings will be used to target and implement approaches to improve the overall management of residents with dementia, including reducing the use of antipsychotic drugs in this population.

CMS Initiative
To ensure appropriate care and reduce unnecessary antipsychotic drug use for residents with dementia in nursing homes

PARTNERSHIP TO IMPROVE DEMENTIA CARE IN NURSING HOMES

Engage leadership team (DON, administrator, medical director, consultant pharmacist)

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Leadership team meets with direct caregivers to conduct facility self-assessment and establish goals

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Leadership team and direct caregivers review current policies and procedures related to dementia care

↓

Use actual care situations to review caregiver and practitioner performance regarding implementation of desired practices
* (see questions to consider on page 7)

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Review data on rates of antipsychotic use in the facility

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Review utilization of antipsychotic medications and other psychopharmacological medications throughout the facility

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Identify residents who could benefit from modification of their current treatment regimen, including (but not limited to) attempted reduction of current antipsychotic medications

↓

Establish ongoing meetings, rounds or other means of continuous staff engagement at all levels on individualized approaches to care

↓

Analyze and trend data regarding both outcomes and underlying processes related to dementia care and to facility-wide systems for review and action

↓

Follow up with State partners to share challenges, successes, resources

Developed under the Partnership to Improve Dementia Care in Nursing Homes

Long Term Care Protective Health Services
Oklahoma State Department of Health

LeadingAge™ Oklahoma

Foundation for Medical Quality Inc. 1979 — IMPROVING HEALTH CARE Improving Lives

alzheimer's association®

OAHCP Oklahoma Association of Health Care Providers

Beadles Nursing Home — A Place for Special Treasures

Description of Antipsychotic Medication Quality Measures on Nursing Home Compare

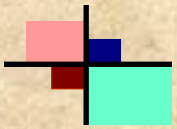
There are two new measures of antipsychotic medications that will be posted on the Nursing Home Compare (NHC) website beginning July 2012. The new measures include an incidence measure that assesses the percentage of short-stay residents that are given an antipsychotic medication after admission to the nursing home, and a prevalence measure that assesses the percentage of long-stay residents that are receiving an antipsychotic medication. The long-stay measure differs from the previous long-stay antipsychotic measure on the CASPER reports.[1]

The specifications for the new measures are below in Figures 1 and 2. The NHC website includes the average value for each quality measure across the most recent three quarters of available data. Data are only posted on NHC if there are at least 30 long-stay residents and 20 short-stay residents included in the denominator for those measures, respectively. These measures will not initially be included in the Five-Star Quality Rating System.

The long-stay measure on NHC will be used to track the progress of the CMS National Partnership to Improve Dementia Care in Nursing Homes, and CMS will be using as a baseline the last three quarters of Calendar Year 2011. This corresponds to the data that will be posted on NHC starting in July 2012. The national average for the percentage of long-stay residents who received an antipsychotic during this time period was 23.9%.

A 15% reduction in that rate would mean a national prevalence of 20.3%. This does not mean that each facility across the country should have a prevalence of 20.3%, but that the national average should not be higher than that. The initial target for the national partnership was to ensure that we made rapid progress and put systems and infrastructure in place to continue to work toward lower antipsychotic medication use. It does not mean that we believe that a rate of 20.3% is acceptable. We will set 2013 goals with our partners toward the end of 2012.

Most importantly, each facility should be working with its medical director, pharmacy vendor, and consultant pharmacist to use facility-level pharmacy data to identify residents on antipsychotic medications. Each resident should be examined by the interdisciplinary team, including the attending physician and pharmacist, to determine whether the dose of the medication could be gradually reduced or discontinued.



[1]The previous long-stay measure (sometimes referred to as the "surveyor QI") that is available in the CASPER reports also assesses the percentage of long-stay residents receiving an antipsychotic medication. It excludes from the denominator residents with Schizophrenia, Tourette's syndrome, Huntington's disease, Manic Depression (Bipolar disease), hallucinations, and delusions, while the new measure only excludes residents with Schizophrenia, Tourette's syndrome, and Huntington's disease. The CASPER report measure (as well as data provided by the QIOs or other organizations) may generate slightly different results than the new long-stay measure, based on different reference ranges, exclusions or methodologies. The CASPER report measure will continue to be available, in parallel with the NHC measures, until CMS can replace it with the new long-stay prevalence measure.

Figure 1. Long-stay measure of antipsychotic

Measure name	Prevalence of antipsychotic Medication Use—3 exclusions (Long Stay)
Numerator	Long stay residents with a selected target assessment where the following condition is true: antipsychotic medications received. This condition is defined as follows: • For assessments with target dates on or before 03/31/2012: N0400A = [1]. • For assessments with target dates on or after 04/01/2012: N0410A = [1, 2, 3, 4, 5, 6, 7].
Denominator	All long stay residents with a selected target assessment, except those with exclusions.
Exclusions	1. The resident did not qualify for the numerator and any of the following is true: 1.1 For assessments with target dates on or before 03/31/2012: N0400A = [-]. 1.2 For assessments with target dates on or after 04/01/2012: N0410A = [-]. 2. ***Any*** of the following related conditions are present on the target assessment (unless otherwise indicated): 2.1 Schizophrenia (I6000 = [1]). 2.2 Tourette's Syndrome (I5350 = [1]). 2.3 Tourette's Syndrome (I5350 = [1]) on the prior assessment if this item is not active on the target assessment and if a prior assessment is available. 2.4 Huntington's Disease (I5250 = [1]).

Figure 2. Short-stay resident measure of antipsychotic incidence

Measure name	Incidence of Psychoactive Medication Use—3 exclusions (Short Stay)
Numerator	Short stay residents with one or more assessments between the initial assessment and the target assessment that indicate an antipsychotic medication was received: • For assessments with target dates on or before 03/31/2012: N0400A = [1]. • For assessments with target dates on or after 04/01/2012: N0410A = [1, 2, 3, 4, 5, 6, 7].
Denominator	All short stay residents with one or more assessments between the initial assessment and the target assessment, except those with exclusions.
Exclusions	1. The resident did not qualify for the numerator and the following is true: • For assessments with target dates on or before 03/31/2012: N0400A = [-]. • For assessments with target dates on or after 04/01/2012: N0410A = [-]. 2. Any of the following related conditions are present on ***any*** of the assessments: a. Schizophrenia (I6000 = [1]). b. Tourette's Syndrome (I5350 = [1]). c. Huntington's Disease (I5250 = [1]). 3. Any resident without initial assessment. 4. Any resident with initial assessment indicating antipsychotic drug use: • For assessments with target dates on or before 03/31/2012: N0400A = [1]. • For assessments with target dates on or after 04/01/2012: N0410A = [1, 2, 3, 4, 5, 6, 7].

Partnership to Improve Dementia Care in Nursing Homes
Suggestions for provider Checklist

% of residents in facility on atypical antipsychotics: ___ Quality Measure State Percentile Rank antipsychotics: ___

	YES	NO
Staff in all departments, are trained in person-centered care and how to respond effectively to behaviors (access sample training programs on Advancing Excellence website; Hand in Hand).		
In addition to medical and psychiatric history, recent changes in behavior or cognition and other standard clinical evaluations, at admission information is obtained from the resident, family, and/or caregivers on the resident's preferences, routines, pre-dementia personality, social patterns, responses to stress and effective interventions.		
The information obtained during the admission process is conveyed to direct caregivers.		
This admission information is integrated into the care plan and may be revised over time as the resident's condition and needs change.		
Interviews with staff demonstrate that they have implemented and are following the care plan, continue to seek input from family members or caregivers for unresolved issues, and communicate with practitioners regarding change in condition or new or persistent symptoms.		
If a resident is placed on an antipsychotic medication, there is documentation in the record that the resident or appropriate legal representative was involved in the decision.		
Facility has consistent staff assignments (same Certified Nursing Assistant to same resident 5 days/week).		
Certified Nursing Assistant to Resident Ratio 1st shift/2nd shift/3rd shift		
Senior leadership (Nursing Home Administrator, Director of Nursing, Medical Director) attend care plan meetings periodically for residents with unresolved behavioral or psychological symptoms of dementia.		
Interdisciplinary team seeks input at care plan meetings from the Medical Director, Consultant Pharmacist and Certified Nursing Assistants for residents with behavioral or psychological symptoms.		
Providers conduct outreach and education to the resident's family and strongly encourage their participation in care plan meetings (offering to flex the schedule or use conference calls when the family cannot physically be in attendance).		
Nursing Home Administrators and Directors of Nursing review quality measures (e.g., monthly) and use the Quality Measures report to identify residents who may need alternative interventions and oversee their implementation.		
Each month, Nursing Home Administrators and Directors of Nursing review Quality Measures report, along with the Pharmacy Consultant report, to identify residents appropriate for possible reduction/elimination of antipsychotics. The review of aggregate data should be combined with real-time, case-based information and input from practitioners.		
Nursing Home Administrators and Directors of Nursing review Pharmacy Consultant's report quarterly with Consultant Pharmacist and Medical Director to track and trend data.		
Direct caregivers (Certified Nursing Assistants), together with the family and care plan team, is involved in the process of developing and implementing effective, person-specific interventions to address behavioral symptoms.		
If any resident is admitted on an antipsychotic or is started on an antipsychotic after admission, the Consultant Pharmacist, along with the practitioner, reviews that resident's care plan, including all medications, within 24-48 hours.		
A documented process is in place and is utilized when initiating an antipsychotic prescription (e.g., standard order set, decision support algorithm, routine monitoring recommendations, etc.).		

"Yes" answers require supporting documentation and visual confirmation by quality improvement personnel

PARTNERSHIP TO IMPROVE DEMENTIA CARE IN NURSING HOMES

*Questions to Consider in Interdisciplinary Team Review of Individual Dementia Care Cases

• If the behavioral symptoms represent a change or worsening, was a medical work up performed to rule out underlying medical or physical causes of the behaviors, if appropriate?

• Were current medications considered as potential causes of the behaviors (i.e., those with significant anticholinergic or other side effects)?

• If a medical cause (e.g., UTI) was identified, was treatment (if indicated) initiated in a timely manner?

• If medical causes were ruled out, did the staff attempt to establish the root causes of the behaviors, using a careful and systematic process and individualized knowledge about the resident when possible? Were family caregivers or others who knew the resident prior to his/her dementia consulted about prior life patterns, responses to stress, etc.?

• Was the initial clinical indication for the medication valid?

• Were non-pharmacologic, person-centered interventions tried before medications (other than in an emergency)? Were the results documented?

• Were specific target behaviors identified and desired outcomes related to those behaviors documented? Were caregivers aware of the target behaviors and desired results of the medication?

• Was the resident or appropriate legal representative consulted about the decision to use an antipsychotic medication and was that discussion documented?

• If a drug is continued for more than a few weeks, is the original clinical indication still valid (are the behaviors still present)?

• Is appropriate monitoring in place and is the team aware of the potential side effects?

• If new symptoms or changes in condition occurred after an antipsychotic medication was started, was medication use considered as a potential cause of a change or symptom?

• If on a medication, did the pharmacist perform a medication regimen review and identify related signs and symptoms, or did the staff inform the pharmacist if symptoms occurred after the last pharmacist visit?

Hand in Hand:

A Training Series for Nursing Homes

...to give better care to persons with dementia.
...to understand and prevent abuse.
...to give person-centered care to all residents.
...to make nurse aides' jobs more fulfilling through tools, knowledge, and shared learning.

Empowering Nurse Aides

The Opportunity

Dementia in America has risen dramatically over the last several years. The current number of five million people with dementia is expected to triple by 2050. We will need person-centered approaches so that professional caregivers can help promote the highest quality of life for people with dementia.

About the Project

Section 6121 of the Affordable Care Act, signed into law on March 23, 2010, contains a provision that nursing homes must provide training to nurse aides. The Centers for Medicare & Medicaid Services (CMS) has developed training products as one option for nursing homes to use in training nurse aides on the topics of:

- Abuse prevention.
- Care for persons with dementia.

Person-Centered Care

Person-centered care approaches seek to promote quality of care and life for people with dementia. Person-centered care may prevent possible abuse by encouraging relationships between caregivers and residents and by helping caregivers to understand behavior and to prevent aggressive reactions.

Nurse Aide Training

As part of the Affordable Care Act, CMS is creating a person-centered care training program for the increasing number of nurse aides who will be providing direct care to residents with dementia in long term care facilities. This training will empower nurse aides by providing the tools they need to understand and to care for people with dementia.

To learn more, contact:
ICP Systems, 240 Nat Turner Blvd, Newport News, VA 23606
CRGT, 804 Middle Ground Blvd, Newport News, VA 23606
Department of Health & Human Services Centers for Medicare & Medicaid Services (CMS), 7500 Security Boulevard C2-21-16, Baltimore, MD 21244

"Partnership to Improve Dementia Care in Nursing Homes" *Free Training Conference*

October 10, 2012
Moore-Norman Technology Center, OKC

***Attention:* RNs, LPNs, CNAs, CMAs, Activity/Social Service staff, physicians, medical directors, consultant pharmacists, administrators**

In conjunction with the Centers for Medicare and Medicaid Services (CMS) initiative to ensure appropriate care and reduce unnecessary antipsychotic drug use for residents with dementia in nursing homes, the Oklahoma State Department of Health, Long Term Care Service (OSDH/LTC) and the Oklahoma Coalition to Improve Dementia Care partners are proud to announce the *"Partnership to Improve Dementia Care in Nursing Homes"* conference. This ***free*** training will be conducted on October 10, 2012, at Moore Norman Technology Center, South Penn Campus Conference Center, 13301 S. Pennsylvania Avenue, Oklahoma City.

The Oklahoma Coalition to Improve Dementia Care partners include the Oklahoma Foundation for Medical Quality, Leading Age Oklahoma, the Oklahoma Association of Health Care Providers, the Alzheimer's Association, Beadles Nursing Home, the Oklahoma Department of Human Services Long Term Care Ombudsman Program, consultant pharmacists, medical directors and a variety of nursing home supporters.

The goal of the partnership conference is to educate nursing facility staff to manage dementia without relying on medication in order to improve the quality of life for these residents and to reduce the use of antipsychotic medications by 15% by the end of 2012.

The objectives of the conference are to:

- Improve knowledge of risks and benefits associated with the use of antipsychotic medications for residents with dementia;
- Learn alternatives to antipsychotic medications in the treatment and management of dementia;
- Improve communication among the interdisciplinary team to provide appropriate care to the resident with dementia without the use of antipsychotic medications;
- Learn skills to assist residents with dementia with their activities of daily living;
- Learn how to reduce antipsychotic medication through the professional experience of a director of nursing, medical director and pharmacist; and
- Obtain tools to aid in evaluating and reducing antipsychotic use for residents with dementia.

Registration forms are available on the OSDH website at:

http://www.ok.gov/health/Protective_Health/Long_Term_Care_Service/Long_Term_Care_Meetings_&_Events/index.html

Although we believe you would benefit from all the presentations, we realize nursing facility staff are busy. If you are unable to attend all sessions, please come and go as your schedule permits. We do ask that you pre-register for the entire conference, so we will have a seat for you. CEUs will not be offered for this program.

Thank you to the following expert professionals for your time and commitment to this conference and the initiative!

Diana Sturdevant, MS, GCNS-BC, APRN Diana received a Bachelor of Science in Nursing from Oklahoma Wesleyan University and a Master of Science in Nursing from the University of Oklahoma College of Nursing. She is a board certified gerontological nurse specialist and is currently a D.W. Reynolds predoctoral scholar at the University of Oklahoma College of Nursing. Diana has worked in long term care for 30 years and has been a Director of Nursing for 16 years. Diana serves on the Governor's Long Term Care Facility Advisory Board, The Advancing Excellence Expert Workgroup to decrease antipsychotic medication use in nursing homes, is a member of the Oklahoma Culture Change Network Steering Committee and is President of the Oklahoma Gerontological Nursing Association. Diana currently works as the Director of Nursing Service at Mitchell Manor Convalescent Home in McAlester, OK.

Richard Taylor, PhD Nine years ago, a noted neurologist told Richard Taylor, "You have dementia, probably of the Alzheimer's type."
Four years ago, he discovered that thinking, speaking, and writing about what it was like for him to live with this condition had quite unexpectedly brought him a new sense of purpose to his life.

Today he speaks of his experiences living with Alzheimer's from the inside out for two important reasons. First, in the hopes that his presentation will convince folks not living with dementia that folks who are living with dementia are and will always be whole and complete human beings. Still possessing all the needs and wants everyone who does not have dementia possesses. And second he hopes that his witness will encourage others living with the disabilities associated with dementia to stand up and speak out. After all, if folks living with the symptoms don't speak out, how will anyone really know what it is like live with dementia?

He has literally traveled around the world, many times - standing up and speaking out; meeting with kindred spirits and supporting care partners: sharing his belief that people living with dementia are not fading away, and the diagnosis of probable Alzheimer's does not signal the start of the long goodbye. He sees everyone as being neither half empty, nor half full. It's the wrong question to ask, the wrong way to look at folks, especially those folks living with the symptoms of dementia.

He promotes what he terms humanizing dementia care. A transactional approach to care giving that humanizes the giver and the receiver, both at the same time.
His words are poignant, sometimes blunt, and occasionally reflective of the humor attached even to this unwanted and unpleasant human condition. He is engaged in creating purpose, joy, and love in his own life. And he seeks to convince his listeners, especially those living with cognitive disabilities that the quality of any one life is determined from the inside out.

Carrie Ciro, PhD, OTR/L Carrie received a Bachelor of Science in Occupational Therapy from OU in 1990 with a practice emphasis in adult recovery from neurologic and orthopedic injuries. In 2000, she received a Master of Health Science degree in Occupational Therapy from the University of Indianapolis where her emphasis shifted to working with older adults with chronic conditions, including cognitive dysfunction. She completed a PhD in Preventative Medicine and Community Health from the University of Texas Medical Branch in Galveston, Texas with a research emphasis on depression and function in older adults. Currently, she is an assistant professor in the Department of Rehabilitation Sciences in the College of Allied Health where her research agenda is focused on improving functional performance in people with dementia.

Peter Winn, MD, CMD Dr. Winn is a Professor at the University of Oklahoma Department of Family Medicine in Oklahoma City. He is Board Certified in Family Medicine in the United States and Canada with qualifications in geriatrics and hospice and palliative medicine through the American Board of Family Medicine. Dr. Winn is a Certified Medical Director in long term care through the American Medical Directors Association (AMDA), is the current President of the Oklahoma Chapter of AMDA and is a National Board member of the AMDA Foundation.

Keith A. Swanson, Pharm.D., CGP Dr. Keith Swanson is an Associate Professor of Pharmacy Practice at the University of Oklahoma College of Pharmacy. He also holds an adjunct appointment in the Department of Geriatric Medicine in the College of Medicine at the University of Oklahoma Health Sciences Center. As a Certified Geriatric Pharmacist (CGP), his practice is based in long term care facilities in the Oklahoma City area where he provides pharmacotherapy care services within a multidisciplinary team of physicians, physician assistants, nurses, and social workers. His academic activities focus on geriatric topics and self-care topics.

He is the immediate-past president of the Oklahoma Chapter of the American Society of Consultant Pharmacists and outgoing chair of the Geriatrics Special Interest Group of the American Association of Colleges of Pharmacy. He is also a member of the CGP Certification Exam Development Committee for the Certification Council for Geriatric Pharmacy.

Conference Agenda

7:45 – 8:30 *Registration*

8:30—8:45
Opening Remarks
Dorya Huser,
Chief, LTC, OSDH

8:45—9:45
"Best Practices for Dementia Care in the Nursing Home"
Diana Sturdevant,
MS, GCNS-BC, APRN

9:45—10:00 *Break*

10:00—11:30
"Dementia without Drugs, An Insider's Perspective"
Richard Taylor, PhD

11:30—12:30
Lunch (on your own)

12:30—1:45
"Maximizing Life Skills in People with Dementia"
Carrie Ciro, PhD, OTR/L

1:45—2:00 *Break*

2:00—3:15
"Reducing Psychotropic Drug Use for Residents with Dementia"
Peter Winn, MD, CMD

3:15—4:30
"Evidence-based Evaluation of Psychotropic Use in Dementia: Risk vs. Benefit"
Keith A. Swanson, Pharm.D, CGP

4:30 *Adjourn*

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For suggestions, comments, or questions, e-mail us at: ltc@health.ok.gov

LTC is on the web! Visit us at: www.health.ok.gov

Oklahoma Honor Flights (OHF) sponsor trip for WWII Veterans

Oklahoma State Representative Gary W. Banz, District 101

Oklahoma Honor Flights (OHF), assisted by volunteer committees in Lawton, Oklahoma City, and Tulsa, is a 501 c 3 not-for-profit partner "hub" organization of Honor Flight Network located in Springfield, Ohio. Currently 37 states have hub organizations that are dedicated to flying World War II veterans to Washington, D.C. to see the World War II Memorial and others built to honor veterans. Top priority is given to the World War II veterans, along with those who may be terminally ill.

Each Oklahoma Honor Flights event attempts to take at least 100 World War II veterans by charter flight to Washington, D.C. for a one-day trip that highlights a visit to the World War II Memorial and viewing of the changing of the guard at the Tomb of the Unknowns in Arlington Cemetery. Each veteran is assigned a volunteer Guardian who provides assistance and supervision during the flight. Guardians make a donation to OHF that covers their expenses. There is no cost to the veteran.

We need your assistance to help us find World War II veterans who can still travel and would enjoy making one of these flights. Oklahoma Honor Flights took its first flight in May 2010. At the end of the 2012 flying season OHF is proud to announce the completion of 11 flights that served more than 1100 World War II veterans from across Oklahoma. Some of those veterans were on a waiting list more than a year. Generous financial support of our mission has allowed us to shift our focus from fund raising to finding more World War II veterans. Finding these heroes and getting their applications on file so we can honor them on a 2013 flight is now our top priority. Application forms can be found on our web site at www.oklahomahonorflights.org.

We are contacting you to help us reach those veterans who would be able to handle this physically demanding trip. It is a long day as we spend about eight hours on the ground in Washington, D.C. We load and unload the charter aircraft twice and ground transportation (buses) five times. We normally take at least 50 wheelchairs for use on the trip because it allows us to move the group more quickly through the airports and it allows the veterans to save their strength and stamina for viewing the memorials. Each flight has medical professionals who serve as Guardians who can assist with medical issues as they arise. Veterans with oxygen issues may travel with us but must supply their own equipment and it must be FAA approved.

Additional information, pictures of previous flights, and contact information for OHF is on our web site listed above. Thank you for your helping us reach these World War II veterans and their families.

This publication was issued by the Oklahoma State Department of Health (OSDH) as authorized by Terry L. Cline, Ph.D., Commissioner of Health. 1000 copies were printed by OSDH at a cost of $1,740.00. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.