



MLN Connects™

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services
National Partnership to Improve Dementia Care in Nursing Homes
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today.

I would like to welcome you to this MLN Connects National Provider Call on the National Partnership to Improve Dementia Care in Nursing Homes. MLN Connects calls are part of the Medicare Learning Network.

CMS has developed a national partnership to improve the quality of care provided to individuals with dementia living in nursing homes. This partnership is focused on delivering health care that is person-centered, comprehensive, and interdisciplinary. By improving dementia care through the use of individualized, person-centered care approaches, CMS hopes to continue to reduce the use of unnecessary antipsychotic medications in nursing homes, and eventually, in other care settings as well.

The partnership promotes a systemic process to evaluate each person and identify approaches that are most likely to benefit that individual. While antipsychotic medications are the initial focus of the partnership, CMS recognizes that attention to other potentially harmful medications is also an important part of this initiative.

During this National Provider Call, CMS subject-matter experts will provide a brief overview of the process that has been made so far during the implementation of this national partnership. Additional speakers will be presenting on the CMS Hand in Hand training series. A question-and-answer session will follow the presentation.

You should have received a link to the slide presentation and other materials for today's call in previous registration emails. If you have not already done so, please view or download the presentation and "Ask the Director of Nursing" document from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the webpage, select "National Provider Calls and Events." Then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

At this time, I would like to turn the call over to Michele Laughman, Coordinator of the National Partnership to Improve Dementia Care at CMS.

Presentation

Michele Laughman: Hi. Good afternoon.

On behalf of CMS, we would like to thank you for your participation in today's call, as well as your continued partnership in this endeavor. This initiative demonstrates strong collaborative efforts by a broad array of organizations. And we continue to be amazed by the energy and expertise and the commitment of clinicians, advocates, nursing home providers, caregivers, surveyors, residents, and also, of course families, who are passionate about this issue.

These efforts are ensuring that the voice of individuals with dementia is always heard, and that their needs are never forgotten. CMS continues to embrace a new culture, one that values interdisciplinary and system-focused interventions, and one that is grounded upon evidence and data-guided improvement.

We emphasize a person-centered approach that utilizes non-pharmacologic strategies as part of an ongoing treatment plan that may also include medications in some cases to meet the individualized needs of each person. We must continue to put interventions in place such as staff and prescriber training; team communication; and resident, caregiver, and family engagement.

Together, we continue to improve the comprehensive, person-centered care that we provide for people with dementia living in nursing homes. We appreciate your continued commitment to this mission, your dedication to the initiative, and of course your partnership.

Partnership Update: Responding to Feedback

I'm also going to just provide a little bit of update—some things that have been going on directly with the partnership over the last few months. The CMS team has recently put an increased effort in the areas of both provider outreach and also geriatric psychiatry. And we've received a lot of valuable feedback from many providers and also medical directors and DONs and A-DONs, of course, during these outreach calls.

So we've heard from many providers that by using the technique of reviewing the list of residents with dementia, who are receiving an antipsychotic, one by one and utilizing input from the interdisciplinarian team, and, of course, including CNAs and families, that the providers have really found that many of their residents can be safely tapered off of their antipsychotic medication.

The process should involve the attending physician, the nurse practitioners, and/or the medical directors. And most homes have been able to identify a number of residents who are good candidates for gradual dose reduction. There are a lot of tools on the Advancing Excellence website that can be used to review individual residents and to also conduct effective, gradual dose reductions.

When gradual dose reductions are not effective, the main reason that is given is often that the resident simply got worse. And so the medication was then resumed. It's important to note that when a sedating medication is removed, residents may appear to get worse or have an increase in behaviors for a period of time. And that should be anticipated and staff should receive appropriate training and education about that specific phase in the process.

Non-pharmacological approaches that may help to mitigate the effect should also be put in place. However, the resident may appear somewhat worse—for example, be more active or maybe exhibiting an increase in behaviors even when the non-pharm approaches are instituted for a short period of time. This may not mean that the medication is necessarily – should be restarted, or that the individual clinical decision should be made by the physician, nurse practitioner, and also again, the interdisciplinary team.

However, in many cases, additional time is needed in order for the resident to really respond positively to either the gradual dose reduction and/or the behavioral therapy. So this – and all of this information should certainly be included in the care plan so that all staff members are aware of it.

We've spoken with many directors of nursing and medical directors who have instituted a policy where a floor nurse who may not be as familiar with the resident is not to call an attending physician or a nurse practitioner without first running the particular situation that's going on by the director of nursing.

And this tends to enable conversations so that the nurse is not just asking for a medication without first considering non-pharm approaches. It also engages the nursing home leadership in the dementia care policies and practices within their home. And many providers have found that this has greatly reduced the number of residents with dementia who are prescribed an antipsychotic medication.

We've also been hearing a lot of story sharing, you know, success stories that providers have been making us aware of that are pertaining to the outreach efforts with their hospital partners. And they've been engaging with hospital chief medical officers, emergency room directors, pharmacy and therapeutic committees, or other senior leadership to request that older adults who are discharged back into the nursing home are not continued on an antipsychotic medication unless there is a clear, ongoing clinical indication for that medication.

And these efforts have resulted in conversations, policy changes, and better communication across the care settings. We strongly encourage that providers think about these types of relationships as a way to reduce the number of residents who are admitted to their home on an antipsychotic medication without a clear clinical, ongoing indication.

We've also heard a lot from surveyors and survey agency directors in many States. And surveyors are really looking closely at F329 and F309. They're talking with more direct

care staff, more physicians, as well as medical directors. And we expect that this increased focus by surveyors is just going to continue.

So now I'm going to turn it over to Alice Bonner, who is a contractor with CMS and also an associate professor at Northeastern University, and she's going to speak on a few more points about the partnership and some ongoing things that have been going on right now.

Alice Bonner: Terrific. Well, thank you very much, Michele, and good afternoon, everyone. We're so glad that you could join us today.

And I just wanted to echo what Michele said in the beginning about how grateful we are for all the work that you're doing. Clearly, the points that Michele was able to talk about with you today are things that we've heard from many of you, many of you who are on the phone with us. This is work that is going on in the field actively by people all over the country and it is really hard work. It is very challenging to transform the way we deliver dementia care in nursing homes in so many different ways. So thank you very much for the work that you're doing.

I wanted to just very briefly add to the things that Michele already mentioned, to talk about some of the feedback that we've gotten from you about specific areas that you have found to be helpful. And the two that we think are really important are the assessment of pain and the assessment and treatment of sleep and sleep disorders.

In terms of pain, we've heard from many of you that you're already assessing pain in all of your residents. But some of the directors of nursing and staff developers and other nursing leadership, along with therapists and activities professionals and social workers, have said, "When we really made pain assessment in people with dementia a significant priority, and we re-educated staff and we talked about it at change of shift, and we talked about it on interdisciplinary rounds and with our consultant pharmacists, we saw a significant decline in behaviors associated with dementia."

So we would encourage you to do what some of your colleagues have done already, if you're not doing it already, which is to really refocus staff efforts and family engagement around the issue of pain. It's much more difficult to detect pain in people with dementia. And if you have a comprehensive pain program in your facility already, it's just a way to really be thinking about folks with dementia and the impact that consistent, comprehensive pain assessment can have on reducing behaviors.

And again, very similarly with sleep, people have said that by looking at sleep hygiene, particularly with the folks who are up at night, wandering at night, and then sleeping a lot during the day, they've been able to do work with light during the day, with reducing nap and sleep time during the day, in some cases talking to families about sleep hygiene—making sure the room is extremely dark, for example, and that there's limited or no interruptions at night, if that's what the person was used to—so that the patterns of sleep hygiene can be maintained.

So those are just a few specific areas to consider. I want to go back to pain for one more minute, to mention one website that is available. And this is not a CMS official website or endorsed by CMS in any way, but it is a website that's by a national nursing organization that has a number of possible assessment tools for your consideration, along with other resources you may want to look at. And that's a website that's www.geriatricpain.org.

So again, one resource – we have not put anything yet on the Advancing Excellence website because many of you already have something that you're using for pain assessment. But if you do not, that's a place you may want to explore some of the tools out there.

In addition to what Michele said about the directors of nursing and other nurse leaders being involved in the calls that go out to physicians and nurse practitioners about a request for an intervention of some kind, it – the feedback that we're getting is that it helps nurses who are on the floors, who are there in the direct – you know, directly working with patients, to feel supported. So it's really a good example of leadership engagement with staff that is one of the elements of quality assurance performance improvement, or QAPI.

And there is a new resource that is posted on the Advancing Excellence website by one of the directors of nurses who's been working on this specific issue. And her name is Kate Lynch, and she's with Genesis. And she and her administrator and their team at Genesis put together a little statement about how they went about this process of supporting the nurses who are in a position of trying to do the right thing with each resident and individualizing for each resident every time. So that's on the Advancing Excellence website, and you may want to take a look at that.

And then finally, to think about with all of this, the importance of activities and activity programs and exercise, that to withdraw or reduce the use of medications requires that something else is in place.

And the other piece of feedback that we've heard quite consistently is that when facilities have enhanced activity programs—more activities offered more days of the week, not only on days but evenings, off-shifts, on the weekends—it's made a significant improvement and reduced the behaviors that are seen in those facilities.

So the last item is that there is going to be, very soon, a new toolkit that will be on the Advancing Excellence website in about a week. And it's in response to something we've heard from many of you over the last 18 months—that you would like something that gives a review of non-pharmacologic interventions for dementia care that's easy to use so you can match a particular behavior with a particular approach that may be effective with that behavior.

And so an interdisciplinary group of nurses and psychologists and dementia experts have come together and worked over the last year to develop that. And it will be available on the website very soon. So we wanted to bring your attention to that as well.

So Leah, I will turn it back to you.

Keypad Polling

Leah Nguyen: Thank you, Alice.

At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results.

Victoria, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Thank you. I would now like to turn the call back over to Ms. Leah Nguyen.

Leah Nguyen: Thank you, Victoria. I'm going to turn it back over to Michele.

Presentation Continued

Michele Laughman: OK. I want to introduce our guest speakers. We have Sonya Barsness and Karen Stobbe, who will be presenting using Hand in Hand to improve dementia care.

Sonya is a gerontologist with a passion for research, education, and putting it all into practice. Karen is a family caregiver with a passion for facilitating creativity and helping it all makes sense. Both Karen and Sonya were a part of the Hand in Hand development team.

And I will turn it over to Sonya and Karen.

Sonya Barsness: Thank you, Michele. This is Sonya Barsness. And thank you so much for having us today with all of you. We are looking forward to this opportunity to share

what we know and then hopefully, at the end of our presentation, having a chance to hear from all of you.

As Michele had said, I'm a gerontologist and one of the co-creators of the Hand in Hand training program. And in my role as a consultant, I work with organizations like nursing homes and assisted living communities to live person-centered care. And I believe in living person-centered care so that we can think and act differently, especially with people living with dementia. So the CMS partnership to improve dementia care is right up my alley. And Karen?

Karen Stobbe: Karen Stobbe. And we were contracted through Pioneer Network, that worked under CMS, to work on this Hand in Hand project. And ironically, I just realized today that it is, I believe, the year anniversary, just about, of it coming out and was distributed a year ago around this time, right around Thanksgiving.

And I have been a family caregiver of two parents. My mom currently lives with us, and my father passed away from Alzheimer's disease. I've also worked in health care communities. So my passion is very personal. Both Sonya and I have the same beliefs but come at it from different approaches.

And we're pleased – one thing I was sharing with Alice Bonner before the call started was that when we've been traveling around doing presentations, either about Hand in Hand or other presentations, we've realized that it's about 5 percent in the audience that have actually cracked open that box. And those who have say they like the content. And some of them weren't quite sure how to dig in. And then the other folks don't even know that they received it or they don't know where it is.

So one of our hopes is that if you haven't opened the box or you don't know where it is, you might go look for it, and open that box up, because we don't want it to just sit there and collect dust on the shelves and – because we think there's some valuable tools in there.

Sonya Barsness: Absolutely. And in fact, what we would like to do this afternoon is to sort of help unpack that box and to go through the Hand in Hand toolkit. But larger than that, what we really wanted to do today was to connect the dots between the Hand in Hand toolkit with the CMS partnership to improve dementia care, and to connect this with the overall philosophy and practice of person-centered care.

So what we'll be doing throughout this presentation is finding different ways to show how all of these things really work together, and how Hand in Hand is really about person-centered dementia care.

Karen Stobbe: And I just wanted to share, too, is that the title also of the whole toolkit, Hand in Hand, is because it is hands-on. It's not meant to pick out the clips and to slip them in and have staff – but it's meant to be very hands-on and interactive and instructor-led.

And there was very clean approaches that CMS wanted to have taken. And one of them was this whole hands-on, interactive mode of teaching. And so we really hope that that will project you into opening that box even more, because it is something for not just you to share with CNAs, but to share with everyone so that it can be shared throughout your whole community.

Hand in Hand Overview: What Is Person-Centered Care?

So here's a little overview. There's four modules that pertain to dementia care. There are six modules total: Four of the modules, dementia, two on the prevention of abuse for all residents. The abuse modules are on module 2 and 5.

Now, the abuse modules really do connect to the dementia care modules. What we realized and what we know is that so many times in any kind of abuse situation, that it's connected to the behavior, the approach, the communication style of the staff, of all the staff, of any of the staff, or even of the family members. And so intersected in the abuse modules are very good teaching moments about your approach, about how you're looking at the so-called behavior, the actions/reactions of the person with dementia.

So we, although are going to be focusing a little bit more on the dementia, the abuse ones we feel are just as important, and in some places even more so, but they do connect and it all has this really nice thread. And the main thread that we feel, whether it's spoken or not, is one of person-centered care. And it's throughout each and every one of the modules.

And when we think of person-centered care, too, it's not just about a person, about the resident, about the elder. It's about how we're treating everyone, everyone who walks through those doors. And everyone – including how we're training. And so we tried to put together the training in a way that was person-centered, in fact.

Sonya Barsness: Thanks. And something, I think, that is really important to recognize is that what Hand in Hand does is it's not just about identifying alternatives to caring for people with dementia. It's actually also very much about looking at everything differently, which I think is very in tune with the CMS partnership to improve dementia care, which we wanted to pause and talk about that just for a few moments. Because I know that we all fondly refer to the partnership as the antipsychotic initiative, primarily because it's been a primary goal in terms of the reduction of medications.

But I think, you know, clearly CMS recognizes, we all recognize that reducing antipsychotics in and of itself is not really the solution. That really, what we are talking about is caring for people with dementia in a different way, in a person-centered care way. And this is exactly where Hand in Hand comes in, because this is what gives your staff and what – everyone working in long-term care and nursing homes the tools to be able to think about dementia differently and for different approaches with people with dementia.

So although Hand in Hand provides specific approaches that will hopefully result in reducing unnecessary antipsychotics, really, you know, another very important goal is meeting the needs of people with dementia. And I would say, even larger than that, to making their lives better. It's seeking to change the thinking about people with dementia so that staff can determine their own approaches to meet the unique needs of their residents.

Karen Stobbe: Right. I – yes. That's a very good point.

And I would like to say that the other thing that you just touched on, too, Sonya, was that the perspective of the person—that, you know, too often we don't look at or ask what they want, or look at things from their point of view. And it's something that I've learned through the years. And it's one of the reasons why we call the modules “Being with the Person with Dementia.” Too often that we do *for*, and we don't take that time to really be *with* them and look at things from their point of view, and what does person-centered care mean for that particular individual.

There's a great quote from our friends at the Best Friend Approach, that says, “We must think about the experience of Alzheimer's disease and the impact it has on the person. This is the starting point for learning to provide the best quality of care for the person with Alzheimer's disease.”

And I have a lot of family members, when I have the honor to speak to them, that kind of give me a funny look when I say, “You got to get to know the person that you're helping to care for.” Because in all honesty, I've heard stories but I didn't know who my mom was before I was born. And that's who she pretty much is right now, is more in her teenage years, in her young 20s, is the memories and the things she wants to talk about. And so even for family members, so for *everybody*, we've got to get to know who the person is right now in the world that they're in right now.

And the other word that I like a lot is – Sonya uses it a lot, is “normalizing.” What is normal? What is normal for where they are right now? What is – in their world, how can we make it more normal for them, to have an everyday normal life?

You know, we don't think about sometimes how we – at times, we'll just walk in a door. And, you know, there's the great piece from Tom Kitwood's book, putting the person first. And how would you feel if someone just walked in your room and started undressing you and getting you ready for a bath? Now, albeit, you know, unless that person was, you know, Brad Pitt or George Clooney, or whomever you wish.

But how would that make you feel, if someone just came in and said it was time to get up? How would that make you feel? And it's not normal to behave to another human being in that way. So it's also really about – to us, when we were looking at the modules on dementia, is how do we change our own behavior?

And we had to make sure that we were able to put into this training ways that the aides – because it was made for aides, to train aides, but the materials are for anyone and they can be across the board. But we had to make sure that if the aides had to go back on the floor and they weren't seeing it modeled or they weren't doing this reinforced, could they change on their own? And so we wanted to make sure that all of this can be changed on their own, that the behavior – the way that they approach a person with dementia, they could do it, and they could make some of their own changes.

Sonya Barsness: Absolutely. And you reminded me, Karen, too, of a quote from Dr. Al Power, who is also in the Hand in Hand training, where he says that we have to move from saying that people are confused, people with dementia are confused, to *we're* confused because we don't understand what they're telling us. And I think that is, in many ways, the essence of person-centered care.

And so when we look at Hand in Hand, when we look at this whole training kit, we do want to sort of point out, you know, what is the thread throughout this entire training? What are the things that really make this unique and that bring it all together?

And it really is person-centered care. It's the idea and the practice that is throughout every module in this training and that we tried to infiltrate in many ways, through the video clips and the discussion questions and all the various exercises that are throughout the training, in that we really do believe that person-centered care is the prescription to better dementia care.

You know, we talk about, again, all these different approaches that we need to do with people with dementia. But really, person-centered care is the prescription because it makes people's lives better.

The Language of Person-Centered Care

Karen Stobbe: And I am moving forward to – for those of you who are following, we, just like in any training, may be a little flexible with our slides and where we're going. So I wanted to just talk a little bit, too, about some of the language we decided to use in the training.

One of the things that we both noticed was, when you ask or even if you were to think about right now, we were to say the word “behavior.” Anybody that I've asked across the country about that, we heard very negative – everything negative, and especially the words “problem” and “appropriate,” “bad,” “manage,” “difficult.” Or if you ask for specifics, you hear they're a – they need to be fed, they're a wanderer, they're agitated, they hit out, they spit, they kick. You hear negative.

We never hear that they are playful, that they are very creative, they like to paint—that the word “behavior” seems to have gotten this pretty bad rap. And that we thought that it's almost impossible when it's so spread like that to change that mindset, that if we change the word and actually look at what is the cause, because so many times, the actual behavior is just a reaction to *our* confused or inappropriate behavior.

And so really they're reacting to our actions. And then what happens is sometimes a spiral approach. And so if we're waking someone up and they reach out and almost smack us in the face, it's just a reaction to our action of an improper approach to someone, especially someone with dementia, who's not sure who we are, maybe not sure where they are.

I shared with Sonya a couple of months ago that my mom – I was checking on her when she was waking up, and I kept checking in to say, "Mom, you doing OK?" She can get dressed on her own still. And she was sitting and she was completely dressed, her shoes on and sitting in her chair by her dresser, just sitting there looking at the ground. And I said, "Mom, are you OK?" And she looked at me and she slowly said, "I don't know what I'm supposed to do next. What am I supposed to do?"

And the first thought in my mind is, "Here's one person and – that we're checking on constantly. And how many people – how many people are sitting in nursing homes across the country that have that same lost feeling?" And we just need to be aware of our behavior, our approach when we're approaching people. And I think that can really make a huge difference, which we talk about quite a bit in the module, too.

So that's one of the reasons why we decided to really look at changing that language and think about actions and reactions. We believe that behaviors are truly a form of communication. Just like it was said at the top of the call, we believe it's communicating something to us, believe that it's an expression of a need. We believe, like I said, that it's a response to sometimes our own poor behavior.

Modeling Person-Centered Care

I'm going to just share another quick story with you about a friend of mine named Pat. And Pat has Down syndrome, and he also was developing Alzheimer's disease. And he would go to an adult – he lived in a group home. And during the day, he would go to an adult day center.

And I was teaching a workshop in this adult day center, which was just off what they called the great room and really near the front doors. And it had a big glass window. So when I was teaching, I could see into the great room but all the participants in the workshop couldn't see through the window. They were looking at me.

And when you walked in, Pat – what he really wanted to be was a Walmart greeter. So Pat would stand at the door and greet everybody that walked in: "Hi, how you doing?" "Hi. My name's Pat. Nice to see you."

And the staff went as far as to buy him a vest with a nice big name tag and lots of patches and buttons. And that was his purpose. That was his job. That's why he came there. It was because that's what he wanted to do every day.

And so when I was doing the training, Pat would run between the door to greet people and the glass window on the training door and be peering inside. And I would give him a thumbs-up now and then and wave at him. And he was just curious and watching what was going on.

And at one point, I could see this CNA from behind Pat see him looking in the window at us. And the class was at that time doing something at the table, so they were busy. And I could see this very nice, well-meaning CNA – the thought process, almost in her head, thinking, “He’s bugging them.” And I saw her walking up from behind and she placed her hand on his shoulder, and he immediately took his fist and just went “pow!” behind him.

And then all I saw was her go down, him turn around, freak out, shake a little bit, then turn back to the window, and forget completely all about it and looking back at me. And then the next thing I just saw was the staff pulling her away and pulling him in the other direction.

And about 15 minutes later, when I got out of the workshop, they were sitting in a little conference room. And I wish I could ask you all, but they were already discussing, they were already to the point of discussing about Pat two things: One, taking away his purpose because they said, “Oh my gosh. We have to take this – his job away, because if we don’t, he could hit somebody just walking in. It’s very dangerous. He can’t be greeting people.” And number two, they were already discussing meds.

That’s fast, and it was all because of her approach. And it was this form of communication that he was scared, he was startled, he was in his own world watching what was going on in the window in the workshop. And if he was just approached in a different manner, it would have made a completely different story.

Now, the ending was fine and dandy because I told my whole side of the story. But it’s just another way – reason to look at actions and reactions. His was just a normal reaction for where he was in his world to this action.

Sonya?

Sonya Barsness: Mm-hmm, absolutely. And I think, Karen – I mean, I think that also feeds very well into need and as an expression of need. When we think of quote/unquote “behavior” of actions and reactions and expression of need, because in that story, Pat had a need. He had purpose. And his quote/unquote “behavior” was a result of the environment, then, not supporting him in that need.

And I think what has been interesting to me is that this is not necessarily a new idea in that behavior is an expression of unmet need. That actually, there has been research, even, on this idea. And that when we’ve looked at research about quote/unquote “behavior problems” that there is evidence to support this, that what we have labeled as

behavior problems are actually an incongruence between the needs of people who suffer from dementia and the degree to which their environment fulfills those needs.

And specifically, a study from Jiska Cohen-Mansfield and others—and many other studies of theirs have identified this—but what they really are pointing to is that – the extreme importance of us trying to understand what the need is of the person with dementia as we are responding to them, as we are addressing their actions and reactions.

And this is particularly important when we think about the use of medications or even non-pharmacological approaches, because perhaps a drug or even a non-pharmacological approach may stop someone from yelling. But will it be addressing the underlying cause of why that person is yelling? Is it meeting their need?

And I think that is the type of thinking that we need to be having. And that we're thinking about what it is that – why people are acting in the way that they are, and what we can do to meet that need. So when we think of it that way, we realize that, you know, antipsychotics may just address quote/unquote “the symptoms,” but that there's these underlying things that we still need to be looking at.

Mrs. Caputo

So I'm going to tell you a little bit about another example that we use in Hand in Hand of an individual who is a theme throughout Hand in Hand. So we have a number of different, I guess, quote/unquote “characters” throughout Hand in Hand that we developed. And Mrs. Caputo is someone that is throughout Hand in Hand and teaches us a lot about living with dementia.

Mrs. Caputo is a woman who lives in a nursing home. And one of her frequent expressions is she needs to go home. And she tells this to people all the time: “I want to go home.” And I'm sure almost everyone on this call can identify with this in terms of people with dementia expressing that they need to go home.

So in one particular clip that I'm thinking of, which is first in the abuse module, module 2, Mrs. Caputo we see needing to go home. And what we do in the training is try to stimulate conversation with participants about what does home mean to you? What is the meaning of home?

You know, for some people, home means an actual physical address. For some people, home might mean security—their husband, their pets. For some people, home means heaven or after death. So when people say, “I want to go home,” what is the need that they are expressing? And what does home mean to them?

Karen Stobbe: And so we talk about looking at the why behind any of the actions.

When any of these occur – and so if we take for the example of Mrs. Caputo and “I want to go home,” and we look at it and we think about, could it be because of a health condition? No matter what kind of health condition. But even if we say it's because of

acute pain, where do *you* want to go when *you* are in pain? Where do you want to go when you don't feel good, when you have a stomachache? We all want to go home in our own bed.

It could be because of communication. It could be that they overheard someone saying they're going home and see someone getting their jacket. It could be because of the environment. It could be that it's because of the task at hand, that perhaps maybe they're having a cooking class and they're washing berries. And this is something that she always did with her mother. And it just brings it that she needs to go home and be with her mother and bring those berries there.

It could be because she doesn't feel safe in the place she is and that it's an unmet need of feeling safe and secure. And that that's where we feel safe. I do. I feel the safest always in my own – my own house, in that I can go around and lock all the doors.

I thought about that one time recently that I had – someone asked me that they have a gentleman that goes around and they think he's trying – they thought for a long time that he was trying to get out when in actuality he was looking for locks to try and lock all the doors. Because every night, that's what he did at home. He went around and locked all the doors in his house.

It could be part of their life story that she needs to get home, because I thought back to my own mom. We had dinner on the table exactly 5:30 every weekday. My dad got home. He sat. He rested. And dinner was on the table 15 minutes later. And maybe at that 5:30 time, she needs to get home, she needs to make – maybe she needs to go home and pick up her kids at the bus stop.

And then there's something that we don't think about all the time. We bring it up a little bit in Hand in Hand in a couple of places, that it could be you, as the caregiver. "I want to go home" because you remind her of her daughter, her child. You remind her of the bus driver from – that takes her kids home. You remind her of someone. She overhears something you've said.

So we need to look at the reasons, the what, the causes behind. Using aromatherapy, using different types of cooking activities, they all are great. But what is causing it? If we find out the cause, then we might be able to look at the root reason and think about how we prevent it, or we prepare for it if there's nothing that we can prevent. And what do we do in the present?

Sonya Barsness: Absolutely. And as Karen's explaining, you know, this process – I mean this is exactly the brainstorming process that we are trying to model in Hand in Hand.

So again, you know, although we do give ideas of specific approaches, which we'll talk about in a bit, we also really are just modeling the brainstorming process and the need to – as a team, to come together and to talk about the reasons behind actions and reactions.

And with that, for the very important next step, then, of identifying ways to respond. Because when we can understand or try to understand the reasons behind actions and reactions, then we can identify specific individualized approaches that would meet the needs of the person and help them to live well.

Ways to Respond: Prepare, Prevent, Present

So in Hand in Hand, one of the ways that we have conceptualized this is by saying that ways to respond – we might break it down into three different ways: prepare, prevent, and present. So using the example of Mrs. Caputo and wanting to go home, we do, in the training, then, give examples of three different ways that we may prepare, prevent, and be present.

So, you know, for example, in preparing, when we try to understand what Mrs. Caputo is thinking and feeling, why she wants to go home, what are all the reasons why she can be communicating this and what it might mean, we're starting to prepare ourselves to respond.

Preparation also involves working with the specific caregivers that are going to be with Mrs. Caputo at the times in which she is expressing these needs. So for example, if Mrs. Caputo was saying she wants to go home at 3 o'clock every day, preparation also involves, at that time, and who's going to be present, and who's going to be responding to her, and where Mrs. Caputo is going to be. So it is really being very proactive in terms of trying to identify how this is going to work and your response to Mrs. Caputo.

The second part of this is preventing, that there are – there may be times that an action or reaction can be prevented. And so what are we going to do?

In the Hand in Hand training, one of the examples we give, and this is a video clip, actually – we show an aide inviting Mrs. Caputo to a cooking class. So what's important about this is the aide, the way in which she invites Mrs. Caputo is by asking for her help and telling her that she needs Mrs. Caputo to show others how to cook. Cooking is something that's extremely important to Mrs. Caputo.

So to Karen's point that the approaches have to be appropriate to the person, if she would have invited Mrs. Caputo to a wood building class, Mrs. Caputo might not have had that interest. But she loves cooking, so this is something that was important to her.

And when she realized that – when we look at Mrs. Caputo and why she might be saying, "I want to go home," underlying that might be a need for purpose. And so by inviting her to participate in something and to show us her skill set is actually giving her purpose. So it's meeting her need and also preventing an undesirable action or reaction, which might be leaving the building unsupervised.

The third way is being present. Sometimes we can try to prepare, we can try to prevent, and that's just not going to work. So what we have to also be prepared to do is to be present with someone with dementia. How do we respond to them in the moment?

And so we give some ideas in the training about how to do this. One in particular, we say that sometimes we just have to go with Mrs. Caputo outside the building and walk with her. Sometimes we have to be with her where she wants to be, which is outside.

And so all three of these, we try to show in different ways of how to brainstorm these various responses. And one of the things that we definitely talk about in the training as well is, all these responses do not work all the time. They don't work for the same person. They don't work every day. And that's why we constantly have to be sort of brainstorming about different ways to approach someone.

The second piece of this, too, is that when we're doing this brainstorming process, we also have to be, you know, really asking ourselves, is this – do we even need to do anything about this action or reaction? Is this really a matter of health or safety? Or is this something that, you know, we can live with, and it's just Mrs. Caputo expressing her need?

Non-Pharmacological Approaches

I wanted to just say a couple of things at this point about non-pharmacological approaches. Because I think that with this increased emphasis on non-pharmacological approaches, thanks to the CMS partnership and thanks to recent awareness of some of the negative effects of antipsychotics, there's a real opportunity for us to think more broadly about non-pharmacological approaches.

I think that we clearly have seen the benefit of non-pharmacological approaches. And when I use that term, I mean we're talking about aromatherapy, reminiscence therapy, cognitive therapies, exercise, activities, all these different things, but I think one of the things that can happen with non-pharm approaches is we can sometimes, I think, take them to be something that's very brief and applied after the fact. So sometimes non-pharmacol approaches have the danger of not being individualized, but they also – you know, one of the dangers could also be that it's not actually transforming the underlying experience or environment for the person, or maybe not even meeting their need.

So an example I give a lot when I'm out talking to people, is I say, you know, if I have dementia, and I'm living in a nursing home and I'm looking for my husband, and I'm looking all over the home for him and asking, "Where is my husband?" And someone tells me that we're going to do aromatherapy, that may or may not be helpful to me at that moment because what I'm expressing to people is my fear and my insecurity and my need to be with someone. And that might be the approach that is the most effective.

So it's a real opportunity for us to think more broadly than specific non-pharmacological approaches, but to think about how we're changing the paradigm of react – interacting with people with dementia. If we're – how we're changing this paradigm – just really try to understand what the needs of people with dementia are and that these individualized approaches are really the key.

And something I like to say is that, you know, moving from intervention to prevention and invention. And really, just thinking about how this is so much more of a bigger opportunity for us to really improve the lives of people with dementia.

Karen Stobbe: Oops. Had to get off mute.

I want to just go back for just one second about Sonya saying, is it a matter of health or safety? Is there anything that we really need to do?

I think that sometimes – though, of course, there are many, many times that there are actions and reactions that we do need to think about because of different reasons. But a lot of times, and especially when I'm speaking to family members, is – the action of the person is actually just bugging us.

The action is not who they were; that we think the action is inappropriate. And it can be as – something as simple as, for a short period of time, my dad would shred napkins. And it drove my mother insane and she wanted him to stop it. And of course a fight would ensue until she just let him alone and let him shred napkins around the house.

And so once she was able to let it go and just let him be, and we found it purposeful because what we found out was that he actually used to go and be at a farm in the summers when he lived in Germany. And that the action that he was actually doing looked like he was taking the napkins and throwing them out like feeding chickens.

And once my mom was able to let it go and let it be, he would run out of napkins and then turn around and see the mess and see it literally as napkins, and start to clean it all up. But it was so bothersome to her that it would drive her almost to this panic point, wanting to clean it behind him and make him stop, and sometimes we need to step into their world and just not worry about how *we* think the action or reaction is, and see it, perhaps, is purposeful to them.

Reducing Antipsychotic Meds: Mr. Haynes

There's a clip that we put in, and it's called "Mr. Haynes," the name of the clip. It's in module 4 and it's clip number 8. And it's actually the longest clip that's in the entire training.

And one thing I'd like to say – we'll talk about a little bit more, but what's really nice is that you can take these clips, and most of them are 3 to 5 minutes, some shorter. This one's the longest one. And you could have a 15-minute training by watching just the clip and then having a talk about it. And then going and doing the whole training at another time, or reinforcing with watching it again after you do a whole hour in-service.

So this clip is called "Mr. Haynes." And we really wanted to show quite a bit of different things. And so all of the clips, I feel, are very layered. There's a lot happening in that we

want to show not just the – how – the purpose of the video and the behavior of the person or what you can do, but we wanted to show – to look at the environment, to look at the actions of the staff, to look and think about what else is happening.

And so just a quick overview of this clip is that Mr. Haynes has been having some particular different actions that have been very disruptive. And we witness, during an exercise class, that we hear an overhead pager talking about a cupcake sale. And Mr. Haynes reacts to the overhead page in a manner that he needs to get out of there. And he goes over to another person and wants to get them out of there, too.

Well, long story short is we wanted to show that if we allow and provide time, opportunities for staff to be able to talk, and especially interdisciplinary staff, that most of the time they have the answers. They have to be able to share with one another and be comfortable with talking to one another and thinking out loud and really problem-solving, and taught the act of problem-solving and brainstorming together, that they do have some answers.

And so we did a split-screen kind of thing, of going back and forth between a doctor and a nurse talking about the same gentleman, Mr. Haynes, and a small group of staff, two CNAs and an activity director.

But in the same room, fixing the TV, was the maintenance engineer. And basically what happens is that the maintenance engineer overhears the conversation and he's actually the one that comes up with the answers because he's developed a friendship with Mr. Haynes.

And what it turns out is Mr. Haynes was in Vietnam and he was a medic. And this overhead paging, he believes it's paging to say that a helicopter is coming in or an ambulance is coming in; you need to go, we need to go. We need to go and get to the pad or we need to go and help the ambulance.

And a lot of his other actions, when they sit down and look at them all together, make sense – how he salutes the Boy Scouts. And he – they were never told that he was a medic. And they had to dig a little deeper into his background and really figure it out. And it also, we – you know, then you also have that opportunity to think and talk about overhead paging. So like I said, there are layers to this.

And so when we think about – oh, I have to share with you if you guys have seen that clip or if you do watch it. When we've shown it, so many people say, "Oh, I really thought that that guy in the background, listening in, why is that maintenance guy listening in to their conversation? And he seems kind of weird." And then when he sits down to ask permission and sit with the group and share a thought, they're like, "I love him! We want him to come work for us." But he's a really great actor who played that role and did that part.

But it really shows how, at the same time that's going on, that a nurse is talking to the doctor about "What else can we do?" "Have you tried this?" she says, the doctor. "Have you tried this?" They go through all these different ideas that they've tried, and that they're prescribing the medication at the same time that the staff is figuring out what to do and to step into his world, when this happens.

And how do they start getting rid of their overhead paging? And how disruptive, perhaps, it is to others? That the two intersect and they stop the prescription for the antipsychotic medication. And they figure out a different approach of how to help Mr. Haynes.

And so that, I believe, is really just a perfect example of what we hope – that we hope that people can learn to brainstorm and problem-solve, listen to one another. But like, there – it is deep; it is very individual. But that is one of the clips that are in the training.

Sonya Barsness: Thanks, Karen.

Karen Stobbe: Sonya, did you have something to say about that one?

Sonya Barsness: No, actually I was going to – I was actually going to close the loop a little bit to bring that back. Because I think, you know, that clip is a great example of what we have tried to do throughout the training, which is to balance these kind of specific concrete approaches with some of, like, the broader, I guess, values of person-centered care, which are – you know, both of them are equally important. And that's why we have both of them throughout the training.

And, you know, what I mean kind of specifically about the values is, you know, when we're talking about – we say throughout the training, we try to bring this up in many different ways. But this – the whole title, "Being with Persons with Dementia," is actually something that we explain in every module what we mean by that.

And we're very – and we try to clearly say that what we're talking about are things like understanding things from the perspective of the person. You know, seeing people as whole individuals, being with them where they are, you know, building on their strengths and validating them as human being, and recognizing that sometimes the best way we can support them is to be with them.

And so, I think, the Mr. Haynes clip is a great example of how that is kind of operationalized. And I think it clarifies sort of what we mean by that in terms of the values.

So – and like Karen had said, I mean, I think it's something that is great to just even use independently for just a 15-minute in-service and to use it as a way of talking about many different things, including teams and communication. And it has so many different applications, which actually leads me to – we're going to talk a little bit about ideas of how to make Hand in Hand work for you.

Applications: Making Hand in Hand Work for You

And I think that – you know, one of the key things that Karen and I really hoped for with Hand in Hand is that it would be – it would be a versatile and customizable tool that even if you know – of course, you know, we hope people go through six modules, 6 hours of training, but that on an ongoing basis and at specific times that people can take bits and pieces of the training and reuse it for different purposes.

So the way the training is actually set up is that the clips are at the end of each of the modules on the PowerPoint so that you can just kind of go right to the clips and watch those with your staff. So it definitely can be customized for your own needs.

Something that we also really hoped is that all staff would participate in the training. It was obviously developed specifically for nurse aides, but is not limited, by any means, to nurse aides. And in fact, it's really – we would recommend that it would be done in interdisciplinary team meetings so that all staff have the opportunity to talk about the various scenarios that we have, and to learn together in that this a great way to model team communication and brainstorming.

I would say it's probably our dream, is that this would be a peer-led training, that CNAs would be leading other CNAs in facilitating this training. We like to think that the toolkit and the instructor guide and everything is well laid out and that it would be a wonderful thing for it to be a peer-led training.

It is something that, I think, could be used very well with family. I know one of the things that I hear a lot when I go around and talk about antipsychotics and person-centered dementia care is families' confusion about why we're reducing antipsychotics and what we're doing instead of antipsychotics. What are we replacing this with? How are you going to care for my loved one?

And I think this toolkit is a great way of introducing families to the ideas and the practices of person-centered care so that they do understand what it is that we are doing and thinking differently, and so that they can be a part of this process and this discussion.

And something, I think, is really important, which I'm going to talk a little bit more about in a bit is, you know, the real importance of supervisors and leaders knowing the content and reinforcing it.

Karen Stobbe: So when we've asked trainers and those who have been wanting to go in that position or been asked to step into that position, "What are your biggest roadblocks?" And the biggest one, always, is time and money.

And so, thinking about money, well, this is free. You should have got it in a box. If you don't have it, there's a way to download it.

And as for time, that's a nice thing, that you can, like we have been saying, do it in an hour or break it up. You know, there are so many times now that you have a quick huddle

meeting and show a 5-minute clip, and then reinforce that idea throughout the next week or 2 weeks in a dining room, in a short staff meeting, in a management meeting.

Keeping it interesting is another roadblock that we've heard before. And I – you know, we think that if it's something that you get excited about, when you look through it and there's a piece of it that really speaks to you or speaks to what your community, what your staff and your team needs, that's how you're going to keep it interesting, too.

So Sonya, if you want to check in with the – getting leaders involved?

Sonya Barsness: Yes. I'll just say quickly, because I know we're running out of time – as you can tell, Karen I can talk about this forever – so we will not do that to you this afternoon.

But just quickly, with leadership, I think, you know, a couple of things is that, leaders although they may feel like they know the content, this is a great refresher. But I think more important than that for leaders to be involved – to be present at the training and to hear what staff are saying is such an important tool.

So that when you are trying to reinforce, you know, some of these practices, these person-centered practices, that it's very important that you can understand from the staff's perspective whether or not they think this is doable, you know, what they need, and so that you as leaders then can support staff in doing this.

And just a quick example is, when we talk about knowing people with dementia and the importance in knowing people, staff might feel like they're barred to that because they might say, "Well, if I'm just sitting with a resident, you're going to think I'm not working," you know. So these conversations are a great opportunity when leaders are in the room and they can be present and showing support for Hand in Hand.

Resources

Karen Stobbe: And there's quite a bit of different tips that we have listed, different ideas. You can download this PowerPoint. If you didn't pick it, I'm sure that they will give it at the end of the talk so that you can download it. But we're going to go ahead and wrap up and let people ask questions.

We just want to say thank you to CMS for letting us work on this project. It was an interesting, great, wonderful project to work on. We were the content contributors and the script writers. And we're on hand to help the actors through every one of the video clips.

And so it was very much of a pleasure to work on this project with CMS, under Alice Bonner and Karen Schoeneman and Chris Allen. And so we appreciate that opportunity that was given to us.

Michele Laughman: OK. Well thank you very much, Sonya and Karen. I appreciate you both being with us today and sharing that information.

Before I turn it back over to the moderator for questions, I would just like to say that we realize that it's an extremely hard job that you all do. And there are many challenges to people, you know, that help people at the bedside, as well as leadership.

But we appreciate people who are working hard to put these non-pharmacological approaches into place, such as staff and prescriber training, team communication, and resident and caregiver and family engagement. And by working together we can continue to accomplish our goal of reducing antipsychotic medication use in long-stay nursing home residents.

And we appreciate your continued commitment to this goal, and as well as your dedication, again, to the partnership.

I'm going to turn it over to Leah.

Question-and-Answer Session

Leah Nguyen: Thank you, Michele.

Our subject-matter experts will now take your questions about the National Partnership to Improve Dementia Care in Nursing Homes. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization.

In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one. If you would like to ask a follow-up question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits.

All right, Victoria, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity.

Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

Your first question is from Nancy Teresczuk.

Nancy Teresczuk: Yes. We would like to know, when is the whole project expected to be implemented in the nursing homes? Is it supposed to be implemented by the end of 2014 or – is there a certain date in mind that CMS has?

Michele Laughman: This is Michele Laughman.

I would say, you know, this is a gradual process. There's not an end-all date. It's something – the partnership is going to continue on, and we're going to reassess our goals as far as the percentage of reduction as we meet. As we meet goals, we'll then reassess and move forward with establishing and setting additional goals. But at this point, we're still working towards the 15-percent reduction across the Nation.

So I think there really isn't a designated hard stop of when we expect the implementation to be complete. We're just looking at and encouraging a continued work towards, you know, improvement of dementia care, the person-centered care approaches, as well as the reduction of the antipsychotic meds.

Alice Bonner: And this is Alice. This is Alice Bonner. And I would just add to what Michele said that keep in mind that the surveyor guidance and the trainings for surveyors, which are in the public domain, and anyone can view those – the surveyor guidance is in effect now; that went into effect. And so it may be helpful to you to understand more about what the surveyors are looking for. And that can be viewed in the S&C letter that went out from CMS that goes over the new guidance at F309 and the revisions at F329.

So, as Michele said, it's ongoing work. But if you're interested in the training that surveyors are receiving, some of the things surveyors may ask you about when they do come to the facility, either on an annual survey or on a complaint survey, those resources maybe helpful.

Leah Nguyen: Thank you.

Operator: Your next question is from Kort Nygard.

Kort Nygard: Hi. I am a clinical psychologist. Actually, I am a geriatric clinical psychologist in many ways. I've been in the field 45 years now and I've been working in nursing homes 20 years.

One of the concerns I have is that a lot of the language and materials I hear coming out of CMS focus on nurse practitioners, psychologists, physicians, pharmacists, and almost never is there mention of psychologists. And when I look at who's actually in the building in nursing homes, there isn't anybody who has a great deal of training in behavior management and strategies for assessing and altering behaviors.

So I guess one thing I would put in a plug for is the idea that there needs to be a lot more emphasis on de-emphasizing the medical model and emphasizing behavioral interventions. A couple of comments I had from the presentation, which I think is excellent, by the way: I think it's a very well-rounded and a good direction things are headed. One thing I might add is the effects of loss and grieving. And what I've found over the years is that that doesn't just apply to loss of spouse and parents and siblings and friends. It applies to loss of their role in society, loss of their possessions, loss of their

driver's license, loss of their independence and health. And I think a – kind of a grief response approach to a lot of the problems is really a very effective tool.

One thing I really appreciate that you all talked about was in trying to find – rekindle meaning and purpose. And I might refer you to a wonderful presentation that I heard at the Pioneer Network a couple of years ago from a nursing home in San Luis Obispo, California – I think it was called Mission Ridge, in which they are getting residents involved in volunteer projects in the community.

Some of them are doing telephone work, calling people in the morning to see if they're still able to get to the phone. Some of them are cooking meals at the local homeless shelter. Some of them are doing hospice volunteer work in the nursing home. It's just a refreshing, amazing program. And I think...

Karen Stobbe: Kort?

Kort Nygard: Yes.

Karen Stobbe: Kort, this is Karen. And I just want to say that's Matthew Lysobey who's the administrator who spoke about that. And he – they actually wanted to feel a sense of purpose again. His residents said they were tired of saying "thank you," that they wanted to say "you're welcome."

Kort Nygard: Yes.

Karen Stobbe: And that's how powerful – that they found a way so that they made home-made soaps to sell at the farmer's market so they could raise money to go prepare food and give it to the homeless.

And Kort, just so everybody knows, too, is that Kort works with Dr. Al Power, and has done presentations with Dr. Power, too.

Kort Nygard: That's true.

Alice Bonner: That's great. This is Alice.

I just want to thank you for those terrific comments, Kort. And say that we – I know Michele, in particular, and myself, and Dr. Susan Levy have been doing more and more work with the American Psychological Association, which is APA. They've been a terrific partner. We're hoping to get both the national group and individual psychologists in every State more involved in this work because we completely agree, it's a tremendous resource, tremendous skill set that psychologists bring.

The other group that we have really been working with is social workers. And in facilities that have a social worker, very often, who's involved with families with dementia and, in some cases, has special training in dementia and case management. Of course, social

workers can have a huge impact. And we've seen it in some of the studies in the behavioral rounds, behavior care planning, et cetera.

So with both psychologists and social workers, these are critical roles that can make a big difference in nursing homes.

And we would, you know, absolutely echo what you've said. We would encourage everybody on the phone to go back to your organization and think about the role of the professional social worker and any psychologists who you may have coming into your facility. And maybe we can get – Karen, it sounds like you know the administrator at San Luis Obispo. I think that is an absolutely phenomenal idea, the idea of residents volunteering in the community. Maybe we can follow up and try to put folks in touch with that program and maybe even have that administrator speak on a future call. That would be great.

Karen Stobbe: He would love it.

Leah Nguyen: Thank you.

Kort Nygard: A couple other comments I had that I wanted to borrow from other people.

One is, Phil Thomas talks about the most important thing is relationships in nursing homes. And I think that's something that we all need to keep emphasizing, is that we've got techniques for dealing with problems, but at the root of it, we need the CNAs and the nursing staff to be thinking, "I am in a relationship job and that's what I do for a living. And along the side, I also help people get dressed and help people get fed and that kind of stuff."

A comment I had about a training technique was, I think it's a great idea to do these short in-services. One thing I might add to that is have them fan out, for say, a half an hour after the brief presentation, and go try out the concepts. And then come back, reconvene, and say, "OK. What were the problems? What didn't work and what did work?" which really is a nice way of getting people from the abstract to the concrete.

Karen Stobbe: Exactly. Mm-hmm. These three are...

Alice Bonner: Tremendous ideas and ones that people on the phone listening to us today can just go back and do.

So I think that's terrific, giving people a little opportunity, a little homework, if you will, just an opportunity to go and try out some of the techniques that they've learned through these short, very short, you know, vignettes that they've watched, or short trainings, is a tremendous idea.

We want to give other folks a chance to ask some questions, too. But Kort, I think we'll want to be back in touch with you. You've got some tremendous expertise and these are just really terrific comments. So we thank you for that.

Kort Nygard: Quick question. How do I download materials if I'm not working in a nursing home?

Alice Bonner: Leah, I think that one's for you.

Leah Nguyen: Are you referring to the slide presentation for today's call?

Kort Nygard: I'm sorry?

Leah Nguyen: Are you referring to the slide presentation for today's call?

Kort Nygard: Yes, yes.

Leah Nguyen: OK. Just go to www.cms.gov/npc and then select "Upcoming Calls and Events" and select today's call from the list. And it's posted there on a webpage for this call.

Kort Nygard: Thank you.

Leah Nguyen: You're welcome.

Operator: Your next question is from Pam Meador.

Pam Meador: Hi, everyone, this is Pam Meador. I'm the RN project coordinator from WBMI in West Virginia, West Virginia's QIO.

And I just quickly wanted to say that we partnered with the West Virginia Geriatric Education Center and the State ombudsman and did a couple of "train the trainers" across our State for the Hand in Hand program, just to introduce the long-term care facilities to the toolkit.

And it was received fantastically. They all enjoyed the program, they learned from it. And better – even better than that, they brought CNAs to the "train the trainer," they brought activities personnel, social workers, as well as clinical leadership to be trainers of the Hand in Hand toolkit. And it was a great opportunity for us to introduce them to it. And word of mouth, everybody is wanting to – us to have another one, which we're planning to do.

But my question was, several facilities, as you know, they can't find it or they misplaced it or it was – came to somebody that left and absconded with it. And we direct them to the website. And I noted at the website it said that there was going to be, like, one mass reshipping of those who've requested it. Is there any idea when that's going to happen?

Leah Nguyen: Michele, do you want to take that one?

Michele Laughman: Yes. I'm not quite sure about that. We do not have any additional free copies at this point. So information that we're providing is strictly on how to get that information by purchasing it. So I'm not sure.

Pam Meador: OK.

Michele Laughman: All of the free copies that we have, have long ago been sent out. And we are definitely out of all of those.

Pam Meador: OK. And I think they'd be interested in purchasing them, as well, because – and even at the QIO, if we could get some of those. But we'll get back on there and look.

Thank you guys so much. It was an excellent toolkit. Thank you.

Michele Laughman: Certainly.

Karen Stobbe: I'd just like to say – I'd like to say, yay! That's great. Great to hear from West Virginia. That's wonderful.

Michele Laughman: And also, in addition to purchasing it, you can download it, as well. So that's another option.

And if you have questions related to, you know, obtaining copies of that and purchasing or downloading it, all of those types of questions can go to Chris Allen. And I believe, Leah, you're going to provide that information at the end?

Leah Nguyen: Yes. We emailed it out earlier this afternoon, too. And I'll provide it again at the end.

Michele Laughman: OK. Thank you.

Leah Nguyen: Thank you. Victoria, it looks like we have time for one final question.

Operator: Your final question is from Suzanne Tidwell.

Suzanne Tidwell: Good afternoon. Great presentation, guys. I was not aware of these materials available. I will definitely be implementing them.

I have done some dementia training in my building. One of the things that I heard you talking about was watching the behaviors. One of the things that I teach my staff is to watch their own behaviors and how the residents react to it.

One of the most common things is coming with change of shift. People start talking about going home, getting their car keys, getting their purses, having to pick the kids up, having to make dinner, and this triggers all kinds of behaviors in our patients. They think they've got to go home, too: "Oh yes. I've got to make dinner."

Karen Stobbe: Of course.

Suzanne Tidwell: So one of the things that I – that I really challenge my staff is when they see a patient starting to act out, to question themselves, see what their behavior may have triggered it.

Karen Stobbe: Right. And we – that is – that is definitely in the training, to where we really promote them taking that step back and looking at what did they just say, what did they just do? And that's why we really wanted to turn it to that actions and reactions, thinking about what was their action, and that that person is just *reacting* to you.

So I agree completely. And yes.

Suzanne Tidwell: Great. Thank you very much.

Karen Stobbe: Thank you.

Additional Information

Leah Nguyen: Unfortunately, that is all the time we have for questions today. If you have questions for CMS about Hand in Hand, you can email them to chris.allen@cms.hhs.gov. And again that's Chris, C-H-R-I-S, dot Allen, A-L-L-E-N, at CMS dot HHS dot gov. Her contact information was provided in an email about the presentation that you received from us earlier this afternoon.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 43 of the presentation, you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Leah Nguyen. I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on the National Partnership to Improve Dementia Care in Nursing Homes.

Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-

This document has been edited for spelling and punctuation errors.

