



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.

During this MLN Connects Call, speakers will discuss innovative efforts from state-based Alzheimer's Association chapters related to Train the Trainer programs, as well — as well as the implementation of the Comfort Matters approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. A question-and-answer session will follow the presentation.

The CMS National Partnership to Improve Dementia Care in Nursing Homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings.

Before we begin, I have a few announcements. You should have received a link to the call materials for today's call in previous registration emails. If you've not already done so, please view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the December 9th 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](http://www.cms.gov/npc) website. An announcement will be placed in the [MLN Connects Provider eNews](http://www.cms.gov/npc) when these are available.

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

Presentation

Michelle Laughman: Hello and welcome. As Leah mentioned, today our call will focus on initiative updates and next steps, as well as presentations from the Maine and New York City chapters of the Alzheimer's Association discussing some of the successful efforts that are occurring within their states.

CMS is grateful for your time, your energy, and your dedication to the mission of this partnership. These calls are an opportunity to share new information and to highlight successful care approaches that are being implemented around the country.

We will — we all share a common vision of truly person-centered dementia care in every nursing home. Together, this vision is becoming a reality. The success of this partnership is the vision that we all have — the vision to provide care that is person-centered for individuals with dementia who reside in nursing homes across our country, as well as all nursing home residents.

Since our last call, the Focused Dementia Care Survey Pilot has concluded and each of the five states that participated in this focused review completed five surveys. This pilot answered CMS — allowed CMS to more thoroughly examine the process for prescribing antipsychotic medications, as well as looking at other dementia care practices in nursing homes. Currently we are developing an executive summary pertaining to the findings of this pilot. And once this document is approved for clearance, it will be shared.

Today we will hear from William Kirkpatrick, Program Director of the Alzheimer's Association, Maine Chapter; Jed Levine, Executive Vice President and Director of Programs and Services of the Alzheimer's Association, New York City Chapter; as well as Ann Wyatt, who is the Coordinator for the Palliative Care Project within the Alzheimer's Association, New York City Chapter.

We look forward to hearing from those of you who are sharing your knowledge with us today. These positive efforts will create success in improving dementia care for people living in our nursing homes.

Now I will turn it over to Leah for a keypad polling question.

Keypad Polling

Leah Nguyen: Thank you Michelle. 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'll be a few moments of silence while we tabulate the results.

Salema, 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.

Once 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.

Please hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please hold while we complete the polling.

Thank you for your participation. I’d now like to turn the call back over to Leah Nguyen.

Presentation continued

Leah Nguyen: Thank you Salema. I will now turn the call over to Michelle Laughman.

Michelle Laughman: OK. I would like to now introduce William Kirkpatrick. Mr. Kirkpatrick will discuss innovations through the Alzheimer’s Association that include Train the Trainer and Habilitation Therapy. Mr. Kirkpatrick?

Innovations through the Maine Alzheimer’s Association

William Kirkpatrick: Thank you very much. I appreciate the opportunity to do this brief presentation on our initiative.

I want to first acknowledge our relationship with the Massachusetts and New Hampshire Chapter and — in terms of the development of this Train the Trainer curriculum — this is a curriculum based on a model of dementia care called Habilitation Therapy, which Dr. Paul Raia, who is the Vice President of the Clinical Services for the Massachusetts and New Hampshire Chapter, developed approximately 20 years ago. He collaborated with Joanne Koenig Coste, who you might be familiar with, who is the author of “Learning to Speak Alzheimer’s.” She’s a speaker and dementia care consultant.

Train the Trainer and Habilitation Therapy

The curriculum over that period of time had been taught in nursing homes, assisted living facilities, adult day programs, home-care, and hospice settings. And all along the way there had been feedback by participants and curriculum revised throughout that period of time. So the first edition of the training was developed — or published 20 years ago, actually more than 20 years ago now, and revised, as I mentioned, based

on feedback from hundreds of alumni trainers who have sort of added greatly to the understanding about how to teach this curriculum to adult learners.

So the formal training is called, “Caring for People with Alzheimer’s Disease: A Habilitation Training Curriculum,” and it relies on the Habilitation approach, while obviously updating it in terms of how to best teach to a broad spectrum of audiences. And 2 ½ years ago, my Executive Director, Laurie Trenholm, and I traveled down to the Massachusetts Chapter to engage in training in order to become trainers of this module. And I believe seven — I believe six — five out of the six New England states have adopted this training model, this Train the Trainer model, and have been using this curriculum for that period of time.

My experience with that has been that in the past 2 – 2 ½ years, we’ve trained over 90 people throughout the state, and pretty much representing the array of train — audiences that Dr. Raia and other trainers have been involved in, which includes nursing homes, assisted — assisted living facilities, home-care agencies, more and more group homes or agencies that are providing care for the developmentally — developmentally disabled population, and folks that are aging in place developing Alzheimer’s disease. And we continue to offer that training curriculum probably five or six times a year throughout the state.

I want to just cover a couple of — sort of the highlights of the concept of Habilitation Therapy, which has as a primary goal to promote a positive emotion in a person with dementia, focusing on their strengths and minimizing limitations. And so the differentiation is that we’re really focusing on habilitation, not rehabilitation. We want to avoid focusing on abilities that the individual has lost and really focus on — focusing on helping an individual with dementia use their remaining skills and abilities.

The training is a 7-hour training that covers 13 hours of curriculum. And I just want to highlight — I’m not sure which slides are — or to the extent that the audience is seeing any of the slides, but I just want to quickly mention the specific modules that we cover in the 7-hour training: two modules on understanding Alzheimer’s and dementia, caring for the person; a module on Habilitation Therapy to really introduce the concepts; knowing and understanding the individual; communication skills, we need to know the language; does the physical environment make a difference; our approach to personal care; activity and purposeful engagement; behaviors communication, understanding and responding; and then the most recently added module, module nine, is understanding and working with families. The — many of the modules have two sections, so the total number of modules is 13.

There’s also an addendum that covers Alzheimer’s and sexual behavior. That has not been added as a formal module at this point. It may be. I’m not quite sure. But the training essentially is inviting individuals with dementia care experience who have responsibility in their agencies or facilities to provide training or in-service training to

their staff and invite them to this training. They are then certified, small c, and authorized to use this curriculum within their facility. It's not transferable in terms of being able to use the training curriculum to train any other individual outside of their — the scope of their — their job or their responsibilities within the agency. However, if the individual transfers, moves from one job to the other, they would still have that approval to — to use the curriculum to train for their staff.

There are some recommendations in terms of modules that are trained — modules that are used for the different makeup of staff in each of the agencies or facilities. This is a very flexible, very user friendly curriculum. The Alzheimer's Association requires all 12 hours for direct care workers, with a recommended 13th hour on the family module. And we recommend 2 hours of training for ancillary staff, and the first 2 hours work — work very well with this, that's really sort of the baseline understanding of Alzheimer's and dementia. And the ancillary staff, we think, will also benefit from learning the 2 hours on communication.

The flexibility carries on in terms of how trainers put together the modules or facilitate the training over time. Some trainers have provided training at the time of shift change for 1-hour sessions and then followed through a training for 12 weeks. And this way people capture — the trainers capture — most attendees. Other trainers have required staff to attend two 6-hour training sessions, back-to-back days, for instance. The ideal may be to offer four weekly 3-hour training sessions for direct care staff and one 2-hour training for ancillary staff. But the curriculum is flexible enough to really be utilized in any particular respective agency or facility.

I want to go back to one of the slides that I think that the audience is able to see, and that's the slide — we had Mrs. Mary Lopez at the center of Habilitation care. And I want to just focus on briefly the five domains that are illustrated there. And these are the five key areas in which we can make — we can make a change that will lead to a positive emotional sort of response in a patient or a client.

It starts with communication and then the physical environment. So we really think about and talk about the importance of — the influence of the physical environment, our approach to personal care, the importance of purposeful and meaningful engagement throughout the day, and then behavior as communication. That piece gets into a little bit of what Dr. Raia refers to as behavioral sleuthing and using in a sort of behavior log to — to identify behaviors and triggers, either internal or external triggers to behaviors that need to be responded to.

And once again, using one or more of those domains allows staff to be able to redirect and lead an individual to a more positive emotional state. So the communication obviously relates to words, body language, nonverbal communication, and really helping staff be aware of the — the sort of increasing importance of nonverbal communication; the importance of the environment in terms of making a big difference for the person

with dementia, really keeping the person with dementia in the middle and focus in terms of our approach to care; giving the person with dementia a sense of purpose and belonging; and then understanding, again, the concepts of behaviors communication.

I know that Dr. Raia wanted to be a part of this call and he was not able to, but I understand that he has been involved in a CMS-related research project looking at the use of the Habilitation criteria in nursing homes in Massachusetts and measuring the impact towards evidence-based sort of data, if you will. And my understanding preliminarily is that there are some significant outcomes to that research that demonstrate the influence or the effect — the positive effect of Habilitation Therapy.

So let me stop there and see if anybody has any specific questions. I can talk more about the setting up the training modules. We don't have time — time, obviously, to go into a lot of details about Habilitation, but I invite anybody to contact us to learn more about it. Thank you.

Michelle Laughman: Bill, we're going to take all the questions at the very end of the call.

William Kirkpatrick: OK, OK.

Michelle Laughman: Do you have more material that you want to cover or is your part of the presentation complete?

William Kirkpatrick: I think I'll stop there. And I'll, you know, take the questions at the end and ...

Michelle Laughman: OK.

William Kirkpatrick: OK, thank you.

Michelle Laughman: OK, that's great. Well thank you Bill.

Next up will be Mr. Jed Levine and Ms. Ann Wyatt, and they will be discussing innovations through the Alzheimer's Association that include Palliative Care and the Comfort Matters approach.

So I will turn it over to Jed and Ann.

Palliative Care and the Comfort Matters Approach

Jed Levine: Thank you Michelle. Thank you everybody and thank you so much for inviting us to present this very exciting project today on this teleconference. I want to give you some background first, and we're on slide number 13 here, just about kind of the relationship that the New York City Chapter has had with the nursing home world in New York.

We have for many, many years done a lot of training and workshops and have developed relationships. Some of it was state-funded, actually many years ago. But despite those best efforts and the best intentions, I think, of the people who are working in nursing homes and really wanted to improve care for people with dementia who are their residents, it was very difficult to see any long-term benefit. I think there was always a lot of excitement around the training, but clearly we needed to do more than training, which is why this project is called The Training in Implementation Program.

And so we actually had a social work student come in to do a summer project for us, and it was really to do a white paper, and to help us think about what is the appropriate role for the chapter in improving care for residents with dementia who are in nursing homes. And she actually wrote a very extensive paper and had done both external reviews, spoke to many staff here, spoke to family members as well, and came up with a series of recommendations and some insights that were actually very helpful to us, one of which was that there needed to be more coordinated effort. There needed to be a — not only in training but in other work with folks who work in nursing homes. And as a result of that white paper, we hired a consultant, my colleague Ann Wyatt, to help us think through and work with nursing homes.

And we convened, as one of the recommendations, a task force of nursing home senior management who were interested in improving care for people with dementia in those nursing homes. And out of that task force, we developed several conferences, which were held sometimes once a year, sometimes twice a year, for us to be able to deliver more information. Because one of the findings both out of the Palliative Care Project and out of our other white paper was that there was no consistent method of delivering dementia care information to people who are working in nursing homes, and they clearly wanted that.

And so, one of the other results of that — of our white paper and of the nursing home task force — was to create an easy way to deliver information to people who work in nursing homes about dementia care and we started a series called “ADvancing Care.” And all of this is available, free of charge. Anybody who wants to subscribe, go into the New York City Chapter website, which is alz.org/nyc, hit on Publications, and you’ll see it there. And these were one-page documents with — written around specific issues in dementia care. And they’ve been very successful, and we have, I think, over 500 people who are subscribing now.

And then we got some additional funding to do the same thing for family members who have relatives in residential care. And that project is called “Care ADvocate.” That newsletter is called “Care ADvocate” — very much the same kind of topic, whether it’s using finger foods or music or identifying pain or looking at environmental stimulation or regulation. We use the same topics, but they’re written from the point of view of a

family member reading it rather than a staff member reading it. So that's a resource for you that you're welcome to subscribe to.

And it is also, Ann reminds me, that we have also translated "Care ADvocate" into Spanish as well. And so — and if, hopefully, we'll get some funding one day to do that in Chinese because we have a large Chinese population here in New York City as well, so.

As a result of Ann's work as a consultant with us, she came into my office one day, said I have something I think you should hear about, and it was a project — an approach to care that was developed at the Beatitudes Campus in Phoenix, Arizona, called at that point "Comfort First." And it's, you know, it sounded like they had done a lot of work and a lot of evaluation. So this was an evidenced-based approach.

And we sent Ann out there to take a look at it and she came back and said, "This is the real deal." The unit — the dementia unit, which as many of you know who work on dementia units can feel very, very chaotic, very disruptive, a lot of noise, a lot of distress being vocalized by residents with dementia, and there's often a lot of staff turnover. They're not places where staff generally want to work, but it's — she said this was totally different.

And we began speaking to Beatitudes and we developed a program here after a lot of work and a lot of funding to get this off the ground. We created a 30-month project that is — that will bring this Beatitudes, now called "Comfort Matters" project here.

Why did we need to that? And I'm now on slide 14, which is that clearly we were — we know that people with dementia, on average, spend 40 percent of the time of the disease in — in the advanced stage.

Remember that Alzheimer's is a long-term illness. Eight to 10 years is average, but it's not unusual for somebody to live for 20 or more years, and many of those years will be spent at a time when they are quite dependent upon somebody else for all of their activities of daily living. Many of them will require nursing home care because the burden on the family becomes so extreme. And often, as you might know, the well — "well" caregiver who is elderly themselves, has neglected their own medical care, has predeceased the person with dementia.

So by age 80, 4 percent of Americans will enter a nursing home. However, for those who are 80 and have dementia, 75 percent of those 80 and above are in nursing homes, and this is a large component of the nursing home population. So there was — we needed to do more to provide better care for people with dementia in —in residential care.

Some of the things that attracted us to this Beatitudes model were their core principle, and this actually, you know, goes hand in hand with the Habilitation model, which is that behavior is communication. That as the individual with advanced dementia loses their

ability to tell you that they are tired, that they're hungry, that they're thirsty, that they need to use the bathroom, or that they are wet or uncomfortable, or that they are in pain — that their behavior will clearly communicate that if you know how to read the behavior and if you know how to read the individual with dementia. So that very much appealed to us — and the concept that comfort is the standard that we're looking for. Everybody wants to be comfortable. How do we make somebody who is in the advanced stage of dementia comfortable? And they have figured this out.

So another component that we were considering is that we talk about Alzheimer's as a terminal disease. And we certainly — we're beginning, you know, we have for many years tried to educate families about that, but there needs to be an embracing of that both on the staff level and on family caregiver level as well.

And so we started a project — now I'm on slide 15 — where we engaged three nursing homes. And again this is, you know, in New York City, nursing homes tend to be large institutions — the smallest of which in our case is 350 beds, the largest is over 700 beds. And worked with their hospice partners because we wanted the hospice providers to also be on the same page and have the same information. And there were going to be four phases of the project. This started in July of 2012 and it's ending up the end of this month, 2014. It's actually hard to believe that that 30 months have gone by so quickly, but we have learned a lot.

Let me also say that we — in the meantime, we are beginning to plan for the future and looking at — we got a strategic planning — or capacity-building grant to develop a strategic plan which we are completing now to say, "How do we continue this work with those three homes that have already made a significant investment and commitment to this approach?" And then, "How do we take this to other people who needs to know it," people who are in the community providers, home care, hospital care and others? So we are looking at that.

There were four phases to the initial project. One is training. The other is piloting the unit — piloting the approach on a unit. So each home identified a unit and they also had identified a manager, a site coordinator who was kind of to be in charge of making this happen within the — within the pilot unit and within the home. And then there was another phase of the project, which was sustaining the change on the pilot unit and then spreading it to the rest of the dementia care recipients in the nursing home. And then to come up with a final document, which is, "Palliative Care for Advanced Dementia: Guidelines for Implementation," that Ann is busily working on this month.

So I'm going to turn the program over to Ann Wyatt, who is our consultant and really been the champion and the mentor and the coach and the guide for this — for this project. So Ann?

Comfort Matters Training

Ann Wyatt: Good afternoon everyone. It's a pleasure to talk about this project, which has been really very, very exciting from start right up to, absolutely, today.

This project, of course, required extensive training. But as Jed said, one of the things that we started with was the notion that training was important, but so also with implementation. And if this was going to really go anywhere, we really had to deeply engage managers as well so that they could help to make happen the organizational adaptations that would be needed in order for the staff on the floors to be able to really deliver the kind of care that they were learning to expand to.

So we started of course with a 1-day training for the leadership of all the homes, which included the CEOs and department heads and other managers. Followed by — we brought people from — three people from each of the nursing homes plus someone from each of the three hospice programs out to Beatitudes for a couple of days so that they could see for themselves what exactly it was that we were talking about and hoping to move toward.

Beatitudes did a wonderful job of really connecting us so that, for example, we asked that each home send — excuse me, the site coordinator for the home and at least one direct — direct care staff person. And so, for example, the CNAs got the tour, got to talk to different department heads, but also got this other CNAs. One home also sent a physician — she got to talk to a physician in addition to the other staff that she was able to speak with. So that was a very useful beginning. We also brought several people from our own chapter staff out so they could become familiar with what it was we were talking about.

This visit was followed up training for the pilot unit and supervisory staff for these units, obviously. Although we were training staff on the unit — all disciplines and all levels — whoever they reported to needed to have as much understanding of this process as possible.

Finally, the sort of centerpiece of our training and implementation throughout the entire project were we asked that all three of them commit to hold weekly meetings on each of the units with as many disciplines as possible participating so that they could use these meetings as the touchstone for trying out new practices, for comparing notes, assessing how they were doing, and what not, and giving people really a chance to talk through what they were learning. Which all three facilities, not only did they commit to this, but actually as we come to the end of the 30 months, all three homes — all three pilot units — are continuing after 2 years to have these weekly meetings. And they've been one of our very definite success stories.

Then in addition to these weekly meetings, we've had Webinars, phone consultations with Beatitudes. Staff from Beatitudes has made several full-day visits to the facilities —

I think three altogether — where they've spent time on the unit really talking to staff and connecting with them.

And also, one of the additional purposes of the pilot units, which I made a commitment to go to most of the meetings — and I did indeed, particularly for that first year, go to almost all of them — was so that I could get a sense of what additional resources they might need, whether that be articles, training materials, specific consultations with Beatitudes. For example, as a couple of the homes move towards implementing the dietary practices, we made sure they had a chance to talk extensively with the dietary staff out at Beatitudes and similar kinds of things.

Evaluating the First Year

We also made the decision right up front that we would have a very extensive evaluation of that first pilot year, that this would be a really important thing to do. In a very simple way, we wanted to demonstrate as much as we could that it worked on the one hand, and on the other hand that it didn't cost more money.

So the evaluation components included a — artifacts of culture change in dementia care 1-day programmatic assessment in which Tena Alonzo from Beatitudes and Dr. Carol Long, who is their — has been working with them for some years as a researcher, came and spend time on the unit looking at things like how many people were sundowning, excuse me, and just various other features of the unit. And they did this at the beginning of the process and then they did it at the end of the pilot year, which was last December. And they spent a full day in each home.

They also — we administered something called the qPAD, the Questionnaire for Palliative Care for Advanced Dementia, to a number of staff in each of the homes. And this was intended to get a sense of the knowledge and attitudes that staff had. And this, again, was also administered to people on all three shifts and managers as well both before and after the pilot phase.

We also looked at MDS information, and as it happens — and I'll discuss this at the end more — four of the questions that were most particularly helpful in addition to weight loss and pain management questions were for specific questions on the MDS that are not QMs, and that is rejection of care, verbal aggressiveness to others, physical aggressiveness to others, and other behaviors. We've measured these things over six quarters actually — actually seven quarters, so well before and definitely after the pilot phase. We also did a cost study and we did a pharmacy study, which included looking at both cost and usage patterns.

At this point, we're still in the process of writing up our — and pulling together all the pieces of what you can imagine was a pretty complicated assessment process, but we can say that for those interventions that were tried, they do not cost more money and the trends in terms of resident outcomes have been all trending in the right direction.

And anecdotally, I can certainly say that — and each of the facilities would agree — that we've had some really very exciting and promising results.

So the weekly meetings. The intent was really, and this is — we're moving along to slide 18 — was to give the staff an opportunity to develop familiarity, awareness, and confidence, to foster the interdisciplinary communication, which we've heard anecdotally and observed. People have reported to us it's been one of the most successful components of the project. The opportunity to sit and talk together just almost never happen on the unit bases.

It also — it's given nursing assistants a particular voice and really encouraged to ask questions and make suggestions. And then finally, to identify any constraints to implementation. If they're trying something and they discover that there's an obstacle, what is the obstacle and then what do we need to do with management to help alleviate that obstacle?

Care Practices

The care practices involve helping people to rest when they need to rest because people with advanced dementia do need more rest because, of course, dementia is exhausting. And one of the things that was very obvious pretty quickly was that when people had the chance to rest during the day that they were less irritable and less easily upset at the end of the day. In fact, Beatitudes has eliminated sundowning. And we saw that it's had a very positive effect in all three places.

And just to give you one very shining example. We had a resident at one of our facilities, and I can talk about this because the family wants us to talk about it. This gentleman had come to the nursing home after having been in a psychiatric unit and asked to leave other nursing homes because of his agitation and resistance to care. And this nursing home — our nursing home — worked with the family and discovered that he'd been a doorman, and it has been a long, lifetime habit to stay up until about 4 in the morning, to have a snack before he went to bed, and then sleep until about noon.

Once the facility adjusted the routine so that it was OK for him to be up — and they weren't trying to get him to bed, and they weren't trying to get him up early, all — almost virtually all of those behaviors disappeared. It was really quite dramatic, and as his wife says, "I have my husband back. I have my life back." She's incredibly relieved after some very miserable years having him in homes and in the psych unit, where his needs were not well understood.

Trying to calm down the environment, turning off televisions in the dayroom to a certain extent or totally in the case of a couple of places, making shift time change much less noisy — those things had a very positive impact.

One of the most important interventions involves pain, and that is to use a pain — I'm sorry, a behavior-based pain assessment and also to pretty much eliminate PRN orders, since obviously that really isn't going to work with people with advanced dementia.

And one of the most important learnings here is to really help the facility see the connection between the overuse of antipsychotics and the under use of medication — pain medications. Because, in fact, very often since the person is — with advanced dementia is unable to express themselves clearly, they can't tell us they have pain and so they express it in the only way they know how. Antipsychotics not only don't treat pain, but they suppress the person's ability to communicate even through behaviors very clearly.

So just by focusing on the appropriate and adequate identification and treatment of pain, enormous strides can be made in terms of not needing antipsychotics. And this is a huge area and one that has not by any means been explored adequately.

Food and nourishment. Food is made around — available around the clock. It's not just available, but it is offered on a routine basis as long as people are awake and are on the unit and not in bed — in bed asleep. Also, there is a new emphasis on soft and sweet foods and finding out what kinds of foods people really respond to. More finger foods, soft and sweet, peanut butter sandwiches have been a huge success in all three settings.

We're looking for more balance in terms of stimulation, both calming and stimulating activities and meaningful engagement. The activities programs are really in the process of being reworked with the notion that every single interaction between a resident and a staff person or anybody else has the potential to be meaningful — and that that's really what we need to be focusing on. And that all staff, whether it's nursing activities, social work, housekeeper, nursing RNs, managers who come up, need to be tuned into the notion that —that — those — even a 5-minute interaction or conversation can have the potential for meaning and that we — our job is to find out what is meaningful for each person. Sometimes it can be as simple as just knowing the names of their children and repeating them or asking about them. It can be any number of things. But the point is to really know the person as well as possible and to respond accordingly.

And finally, with regard to whether somebody is hot or cold, whether they need toileting, whether they need more walking, there has been a habit in New York apparently, this is — we've been told it's a little bit a New York thing to keep people in the dayrooms and to observe them so they don't fall. But in fact what's happening is that by pressing them to sit all day, we are —make it more likely to fall. So we've been working hard on that and giving people more opportunity to move around the unit for sure.

One of the facilities has developed what they call a What Comforts Me care plan, in which they really dig into what does this person like, whether it's listening to Frank

Sinatra or walking down the hall holding hands or pictures of cats or pictures of dogs or Gospel music, or — all three of them are involved with the Music and Memory iPod Project. But really paying attention to — for this person what's meaningful, and making sure that that appears on the care plan, not just what problems does this person present.

Finally, Comfort Matters refers to both specific care practices and to the process by which these practices are implemented. It is absolutely essential to listen to residents, to families, to staff at all levels and all disciplines, and for them to work together to come up with a good care plan and interventions.

Why do we need to look at palliative care through the dementia lens? Because behavior really is communication — it is not the dementia that causes the behavior, it is the dementia which prevents the person from expressing the cause of their distress. Antipsychotics may remove the person's only means of communication and will not be responsive to the underlying problem in most cases.

Finally, care settings and providers tend to want the person to conform to the needs of the setting, which means not only that person's needs may not be met adequately or in a timely manner, but that the setting itself may be causing the person distress. And the example I gave you of the man who needed to stay up until 4 is a perfect example.

Sustaining and Spreading the Comfort Matters Approach

Where we are now is that we are finishing the pilot — we finished the pilot year last December. We're working over the last year on sustaining these practices and spreading them throughout the facility because even though these are dementia units, obviously, at least half of the people in each of the settings who live there have dementia, and we want anybody who has dementia to have the opportunity to be cared for with effective practices. The work is continuing and the final document will be ready, hopefully, by the end of December ...

Ann Wyatt: ... or soon thereafter.

Jed Levine: Yes.

Ann Wyatt: Our most effective and exciting accomplishment, as I said, have been, certainly the meetings, also the — using MDS in ways that I think that the MDS was originally intended to be used and identifying those questions. Anytime in a care plan meeting rejection of care or physical or verbal aggressiveness is checked, the teams know that they need to dig more deeply to get to the reason for why that's happening.

We're looking to work with LeadingAge in New York on developing a dementia pain screen. We will be continuing to look at how we might do that. We have done some nice preliminary work with families and need to go more fully down this road, but a

wonderful resource for all of you that you can find both on our website but also on the Central Illinois ...

Jed Levine: Ann ...

Ann Wyatt: website ...

Jed Levine: Greater Illinois.

Anny Wyatt: ... Website – Greater Illinois website is something called Encouraging Comfort Care. We've got their permission also to translate it into Spanish, and I cannot recommend it highly enough. It's really valuable for families. It gives them really good information on what to expect with the — in the advanced stages of the disease.

And finally, because of all the emphasis, not only in New York but across the country on short-term, postacute services, there has — we believe there has been a tendency to sort of forget about dementia in many situations. And we believe one of the things we've accomplished is a renewed focus in all three facilities, which is beginning to spread to other facilities on dementia and, you know, these improved care practices.

The challenges are that nursing homes in general, and our three facilities are no exception, have tended to be very compartmentalized, which has made true interdisciplinary collaboration — it's been challenging. That to some extent they've — the staff has had to unlearn things that they've learned many years ago. For example, most staff believe that you need to keep people awake all day so they'll sleep at night. And while that's true in earlier stages, it's not so true for the late stages. And that we often arrive — if we don't let people rest during the day or don't let them stay soundly asleep when they fall soundly asleep — that we actually make them more likely to fall, not less. These are large places and that's challenging because there are many more layers of management.

Facilities — even these facilities struggle with how to use data to really monitor how they're doing. The MDS is a vast tool but again, it isn't — hasn't really been fully translated for facilities and how to use some of this information in terms of monitoring how they're doing above and beyond the QMs.

And finally, end-of-life care at hospice, we feel, has really not gotten the full attention that it needs in any of the three facilities. And that's something which we'll be looking to work more on as we go forward. There'll be more focus on end-of-life care, continued focus on sustainability and spread, more work with families, the development of these guidelines, which we will share with other homes in the city and with anybody who asks. And that's where we are.

Jed Levine: Let me just say a last word on the fact that there were many funders who generously provided the support to allow us to do this. The association or our own chapter, our board, our junior committee, 1199SEIU, which is our local union certainly has partnered with this — with us on this project, Fan Fox and Leslie R. Samuels Foundation, and the United Hospital Fund especially, and other foundations and funders have been really critical to the success of this program.

Next Steps and Future Goals for the Partnership

Michelle Laughman: OK, well thank you Jed and Ann. We appreciate that information. I'm going to now just share some brief information about some of the next steps and future goals for the partnership. We are a really grateful for the efforts of so many people and organizations. And based upon recent data that was sent out, we have seen an 18.8-percent reduction in the national rate of antipsychotic use in long-stay nursing home residents, with the state of Maine having achieved the largest decrease of 33.3 percent.

So as most of you know, the National Partnership collaboratively held a press call on September 19th to formally announce the new goals of the initiative. Several stakeholders participated in the press call, including the American Health Care Association, LeadingAge, American Health Quality Association, American Medical Directors Association, and Advancing Excellence. By the end of 2015, we plan to continue to reduce the national prevalence of antipsychotic medication use and we would like to see a 25-percent decrease, and a 30-percent decrease by the end of 2016. The baseline for these national goals is consistent with the baseline of the initial partnership goal.

The national partnership is committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care, and promote goal-directed, person-centered care for every nursing home resident. We thank you for your participation in today's call and we look forward to continued collaboration and partnership.

And I will now turn it over to Leah and Salema for the question-and-answer session.

Question-and-Answer Session

Leah Nguyen: Thank you Michelle. 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'd like to ask a followup 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, Salema, 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 lines will remain open during the time you're asking your question so anything that you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster. Please continue to hold while we compile the Q&A roster. Please continue to hold.

The first question comes from Debbie Dyjak. Debbie, your line is open.

Debbie Dyjak: Do you hear me?

Leah Nguyen: Yes, we can.

Operator: Debbie, your line is open. Debbie, your line is open.

The next question comes from the line of Michael Ellenbogen.

Michael Ellenbogen: Hi, mine is more of a comment. My name is Michael Ellenbogen and I am actually living with Alzheimer's. And I would like to see the term sundowning kind of removed from the vocabulary because I believe that paints the wrong picture about people with dementia.

For example, what it really means to me, who's living with it, it's hard to explain, but it's like when you — if you folks do a project and you're intense for about an hour, and you have to really focus — it almost kind of gives you a headache. Well, for somebody who's living with dementia, we have to put so much focus and energy throughout the entire day that it literally drains us, and we become so worn out by the end of the day. And that's what you probably refer to as sundowning, but I don't believe that should be a term that we should be using.

Michelle Laughman: OK, thank you, Michael. I don't know — I don't know if Ann or...

Ann Wyatt: I...

Michelle Laughman: I don't know if you have a comment.

Ann Wyatt: Sure, this is Ann, and I understand exactly what you mean. I think that to some extent, the term sundowning has kind of gotten in the way of understanding exactly the process that you're describing. I mean, when I ever talk about sundowning

when I'm talking about this project, I remind people how they feel at the end of their workday, that it's really a very similar process. It's just, as you say, it's a more intense experience if you have dementia because you have to work that much harder to, you know, get — get through certain processes.

So I can't say whether or not, you know, the term would be kept, but I do feel — agree with you — that to some extent it — because it's a term, it tends to kind of objectify things more than should happen. Really, the process that you're describing that you've felt, is very similar to what the rest of us feel when we've had a very pressing day. It's just that it's intensified and happens more rapidly and — and plays out a little differently.

Leah Nguyen: Thank you.

Operator: Your next question comes from Kathi Young. Kathi, your line is open.

Kathi Young: My question has to do with the meetings that take place weekly on the units. I'm assuming that that interdisciplinary meeting is taking place on the day shift. And my question is, how do you involve people on the evening and the night shift so that you've got a continuity of approach in the flow of communication?

Ann Wyatt: That's a really important question. Our facilities handle them differently and, excuse me, if they were in the room right now, they would say that they didn't do this as well as they would like to have. But nonetheless, they did work with it.

In one facility, for the weekly meeting, they held it towards the end of the day shift and they arranged for someone from the evening shift to come once a week a half hour early, for which they paid them, so that that person could sit on — in on the meeting and then share back the information they had. And we did say that anytime any new intervention was introduced — for example, in this particular facility, they started with a food cart and with making, you know, interesting food available and offered around — that they do make an effort to have specific conversations on all three shifts. This is, of course, as you well know, always a challenge. But we, you know, we reiterated it over and over again, and sometimes they did it and sometimes they didn't. But we have continued to press that because it's absolutely essential.

Whenever we did what we called spotlighting, which is focus on an individual resident to try to understand what was causing their distress and what possible interventions would be, we always discussed — all three shifts often requested information from the night shift as to what they were observing, and then tried to make sure that information got back to them.

And finally, you know, the care plan, all of these things, whether it's the fact that somebody only want, excuse me, whether somebody only wants to wear the color pink or they love peanut butter sandwiches, or whatever, they need to go to bed at 4, those

things belong in the care plan, and they often have not been put there. But the care plan is intended as the point of reference for everybody, all the disciplines, and all the shifts.

Kathi Young: Thank you.

Operator: Your next question comes from the line of Ravindra Amin. Ravindra, your line is open.

Ravindra Amin: Thank you. I'm a geriatric psychiatrist at Coler Rehabilitation and Nursing facility in New York City. First, I applaud National Partnership's work so far and the tremendous gain achieved.

Here's my question. I wonder if — and thank you Ann Wyatt and Jed Levine, wonderful to hear your presentations. My question is, do you know of any publications or any facilities experiencing and specifically using two-intervention — pain assessment and management, and the outcomes realized. And number two is, especially in New York City area, outcomes from Music and Memory? We are using these interventions and I'm really curious to hear about what is the experience from the peer facilities.

And using the antipsychotic medication use guideline for when to start, when to continue, and when to discontinue, we've actually realized a gain of something like close to 300-percent reduction from a 38 percent of residents being on antipsychotic now down to consistently staying below 11, 12, 13 percent cross-sectionally at any time. But I'm still thinking we have room to further use less medications and improve the outcomes from pain assessment in Music and Memories.

So those two specific areas, I was curious if you can share what you hear from around the community.

Jed Levine: Let me start and, you know, thank you, doctor, and I'm delighted you're on the call, and you certainly should be congratulated on the successful reduction of antipsychotic medications at Coler. And we actually know that there are folks from Coler who are interested in learning more about the palliative care approach, and they're going to be working with one of our ...

Ann Wyatt : Isabela.

Jed Levine: Isabela, I believe, yes — no, Cobble Hill, I think. So ...

Ravindra Amin: Yes.

Jed Levine: ... the Music and Memory project, and thank you for mentioning that as well, certainly Cobble Hill Nursing Home, which is one of our three homes, now — all three homes are working and using Music and Memory very successful — very successfully.

For those of you who don't know what that is, it's a project that was developed by Dan Cohen, who's a social worker out on Long Island and had the idea of using personalized, individualized playlist using iPods for people with dementia as a way of providing pleasure and a way of providing stimulation.

And it's been, in my viewpoint, you know, very successful. And that — and Dan has done some studies as well that show that there's been, you know, very positive outcomes and also in terms of lowering resistance to care and changing medications, and, you know, families and staff are also very, very satisfied with the program. So people can go to musicandmemory.org to find more about that. It's a very exciting project. The Wisconsin Department of Health has adopted it and is spreading it through, I think, more than 150 nursing homes now.

Ann Wyatt: Over more than 200.

Jed Levine: Two hundred, yes. And other states are also adopting it as a nonpharmacological intervention for people with dementia. And it really is — is, you know, it has significant outcomes.

William Kirkpatrick: His documentary, "Alive Inside," was featured in the Camden International Film Festival ...

Jed Levine: Yes.

William Kirkpatrick: ... coming up here in Maine.

Jed Levine: Yes, and actually, Ann is in there. But it's a great — it's a wonderful documentary.

William Kirkpatrick: It is, yes.

Jed Levine: And it really illustrates how transformative and how important this — not just music, but music that speaks to the individual — that is their music, music that they know and love. And it just — it's really well worth seeing.

William Kirkpatrick: It's very powerful.

Ann Wyatt: I think that the — to answer your question about the impact, you know, as I say, we are sort of — we are pulling all our pieces together. We have trends in the right direction. This is, you know, it's all taken longer than we thought. So our measure — our specific measurements stopped a year ago, but they've continued in all three sites to continue to work and make improvements.

But as I have said to them all from the beginning, keep in mind that in a sense your protection and your assessment is resident by resident. So in the end you'll introduce something, but you don't willy-nilly start giving everybody peanut butter sandwiches. What you do is find out the kinds of things that work and then take, you know, resident by resident, you work to find out what's going to be most effective with them. Most residents respond well to the iPod project, not all residents. So it's, you know, there's no question that these are effective interventions. But, again, you do it on an individual basis.

Overall, both the State of Wisconsin and the State of California feel that Music and Memory has made a significant contribution to the reduction of antipsychotics. But as you know, there's been a, you know, a clear effort on the part of many people over the last few years to work from a number of different strategies on how to do this.

My own belief related to reducing the use of antipsychotics and bringing more comfort to residents is to really look at what is the reason for the distress and not start with assessing what antipsychotic you're going to use. Try to get to the reason for the distress. And sometimes it could be something like not making somebody to go to bed before they want to. And sometimes it can be, you know, distracting them during the day from pain, but maybe they only need a pain medication at night. Or sometimes they need pain medication.

There's been an overuse of PRN medications, which, of course don't —are really not effective if you have pain all the time, and people can't express, they cannot describe their pain, but they certainly can communicate it. And sometimes trial dosages of pain medications are appropriate. But I would try all those things before I would rely on antipsychotics, which is not to say they never have use, but they should be the last resort.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Mary Romelfanger.

Mary Romelfanger: Good afternoon, my name is Mary Romelfanger and I'm the associate director of the brand new University of Louisville Institute for Sustainable Health and Optimal Aging. One of our major focal points besides the actual physical and health-related changes in terms of geriatric is care delivered by medical directors in associated nursing homes.

What we are very interested in in terms of this program is how to — do you — is there a roadmap for implementing it within given states by developing partnerships with both the Alzheimer's Associations and organizations such as LeadingAge and AMDA within certain states? Have those kinds of relationships been attempted yet in any states outside of New England?

William Kirkpatrick: You're referring to the Habilitation Therapy or the program from New York, or ...

Mary Romelfanger: Actually, both.

William Kirkpatrick: My knowledge is that the — as I mentioned, five out of the six New England chapters have adopted the training module and I believe two or three others. Dr. Raia has had conversations, and I'm — I am happy to research that, but I don't have an answer to your question right in terms of other partnerships. There may be that he has established or has worked on. I'm not aware of it, but I'm happy to follow through and be in touch with you if you could forward your contact information through Michelle, perhaps.

Mary Romelfanger: I will do that, thank you.

William Kirkpatrick: Thank you.

Ann Wyatt: For the New York Chapter, we are in the process of developing what we're calling Guidelines to Implementation, which will be done before very long. And we are going to be sharing that far and wide. It'll certainly be available, downloadable on our site.

And what we're trying to do in those guidelines is really identify steps in the process for implementation. We have presented at LeadingAge, we are talking to the New York LeadingAge folks and also to the New York City Continuing Care Leadership Coalition. We're sharing our experience wherever we go. But in addition to that, Beatitudes, if you go on to their website, which is beatitudescampus.org, I believe...

Jed Levine: I believe.

Ann Wyatt: ... or beatitudes.org, either one, they're located in Phoenix, Arizona. They are developing an accreditation process for homes that are interested in really pursuing specifically the steps in the process, the process that they've identified. And Tena Alonzo, who is the Director and Vice President for that program would be, I'm sure, happy to talk to anyone.

But they really are, you know, anxious to share their experiences. They've been wonderful with us, and so we're happy to share whatever we have. Our issues of ADvancing Care and the Care ADvocate newsletters, we tend to pick topics that also reinforce these specific care practices, and we're happy to share whatever we have. If you go on the website and just press Palliative Care, it's all there.

Mary Romelfanger: Thank you very much.

Operator: Your next question comes from the line of Derrick Arjune.

Derrick Arjune: Good afternoon and congratulations. This was an excellent program.

My questions concerns care settings and the presenter said that the setting may very well cause the patient distress. Given the fact that there's a limited amount of settings in any nursing home compared to the many needs of the patients, how best do you reconcile that imbalance to make sure that a patient or patients are properly treated and those experiencing stress because of the limited settings that they're placed in very often?

Ann Wyatt: That's an excellent question and one of the things that we — the example I gave of the man who liked to stay up until 4 in the morning ...

Jed Levine: Right.

Ann Wyatt: ... one of the things that we sometimes get stuck on. And when I say the facility may be causing it, obviously, they're not intending to cause it. But, you know, a lot of — a lot of sort of policies and procedures and ways of operation happened, you know, in response to the need or the wish for efficiency. But the reality is that if you are working with somebody who can't, you know, who themselves because of their cognitive changes can no longer do the adaptation themselves, you will have a lot. Your own time and energy, if you are trying to get them to adapt in a way that they are no longer able to do, is better used by helping to identify and respond to what's comfortable for them. So maybe the same amount of energy, but it's — one is a lot less fraught and a full of friction than the other.

Obviously, it's not always that simple, but the reality is that as the — all those rejection of care physical and verbal aggressiveness and what not will attest to, that takes a lot of time and energy. If the solution is really helping to find somebody's sleep pattern and letting them sleep or finding food that they like as opposed to giving them supplements that they don't really take in, for example, you begin to benefit from the extra effort at the beginning to really assess what's going on for the person. It's not always that smooth, but on the other hand your chances of arriving at a place that works for them and works for the staff is much greater.

And I want to add one other piece, which is that for years nursing assistants have been slapped, scratched, spit upon because they were trying to get somebody to do something they didn't want to do. If we take a fresh look at that, which is what we've been working on here, you can see that a lot of that gets terrifically reduced because they don't have to try to get somebody to do something they don't want to do anymore.

Jed Levine: And the staffing pattern at Beatitudes is no different than the standard staffing pattern here in New York City. So it doesn't require more resources. And another, you know, way of looking at this is that this is a proactive response rather than reactive to the behaviors, the negative consequences. So if you can identify what's going to make somebody comfortable, you make them comfortable. You're not going to have to deal with all the negative behaviors and the consequences. It actually is — it's smarter, it's more efficient, and it's more pleasant for everybody.

Ann Wyatt: One of the things that happened once Beatitudes really changed the environment and calmed it down and let people rest, took the TV out of the dayroom, is they eliminated sundowning. But also, they — the visitation by family members went up because it was a lot more comfortable to visit. And they have people with very advanced dementia who have been asked to leave or not accepted by other homes.

William Kirkpatrick: Yes, this is Bill Kirkpatrick. I would agree with that and that — in terms of the setting — the question about settings. I think one of the pitfalls that we want to try to avoid is thinking in terms of limitations of using any model of dementia care and feeling that their — that the setting gets in the way of using good dementia care practices, whereas — and I can speak specifically to the Habilitation model, that we want to use those techniques and methods that would — that are appropriate and would fit in in any environment or with any setting, any, you know, any staffing ratio or even, you know, in a home-care setting, if you will, by tapping into the best practices within the — the five domains. So I would support that.

I also want to respond to — we got an email and a request from Joann Murtaugh to get the link to modules that I mentioned. And I'm happy to send that to you directly. I don't have that posted anywhere directly, but I'm happy to send that to you, Joann, if that would help.

Michelle Laughman: Thanks Bill. I appreciate that.

Operator: Your next question comes from the line of Marie Desmarattes.

Marie Desmarattes: Good afternoon, this is Marie Desmarattes. I'm the administrator at Park Pointe Village in Rock Hill, South Carolina. First, let me say that this presentation was very informative. I really appreciate the effort placed into looking for ways to improve dementia care.

And my question, I think, it's partly answered. I wanted to ask where do we go from now? Is the intent just to help the long-term care facilities in New York City area or are we going to extend this to all the different other states out there?

Jed Levine: Yes, you know, the goal is to kind of pilot it here in New York. And it certainly has been piloted in, you know, it's been done in Arizona and in Chicago and other areas

as well. And so, you know, eventually, yes, we'd like to see this replicated, and for every, you know, dementia resident to be able to benefit from the Comfort Matters approach. So it's not limited to New York, but we're kind of hopefully working out the kinks and learning. You know, we know the approach works.

Marie Desmarattes: Um-hum.

Jed Levine: What we're doing is learning what kind of organizational adaptations, what has to happen from the top senior management to every worker to make this a standard of care and a standard practice in a — in a working facility. So those are the guidelines, and as Ann said, that will be available and we'll have it on our website, and we'll be able to distribute that as widely as we possibly can.

Ann Wyatt: And I — I recommend that you go to the Beatitudes website ...

Jed Levine: Beatitudes Campus.

Ann Wyatt: ... Beatitudes website as well.

Jed Levine: Yes.

Marie Desmarattes: Yes, I just put it in beatitudecampus.org, is that the address to go to?

Jed Levine: That's correct.

Marie Desmarattes: OK, well I thank you very much.

Operator: Your next question comes from the line of Lilly Allen.

Lilly Allen: OK, hi everyone. I'm calling from Leader in Louisiana. Great, great presentation. Good input and we're making some strides, but we still have a long way to go.

I was just intrigued briefly with Michael's point about sundowning and wonder if there's a better term to use.

Ann Wyatt: Well, this is Ann, and what I want to say about that is that Beatitudes eliminated it, which I thought was the — I mean they eliminated the experience of it. So that's what we'd be looking for. You know, I — there may be a better term for it, but we like to sort of step back and really not use the term but just find out when people are in distress and see what we can do prevent or distract them from that distress. And that — it's really about person by person, you know, what are they experiencing and if it's distress, what can we do about it?

Lilly Allen: Great, because I totally agree. Thank you.

Operator: As a reminder, to ask an audio question please press star then the number 1. Again, if you would like to ask a question, please press star 1.

The next question comes from Sandra Fitzler.

Sandra Fitzler: Hello, this is Sandra Fitzler and I'm the QIO in Massachusetts. I worked with Dr. Raia a year ago in the innovation study pertaining to Habilitation Therapy and I am responding to the question in regards to working with partnerships within the state. We did in Massachusetts. Not only was this a partnership between the QIO and the Alzheimer's Association, but also we included the long-term care organizations in that partnership.

On completion of the project, and that was just at the end of July, we did produce a competency-based approach toolkit for providing care to people with dementia. So it's based on the domains, Habilitation Therapy and that's something that we will be making available to everyone on our website.

Masspro was the QIO who was involved in this, and because of the recent changes in the QIO approach and then now it's multistate. We are associated with Healthcentric Advisors and Rhode Island, but we hope to have that information up soon.

William Kirkpatrick: Thank you very much.

Operator: Your next question comes from the line of Sandra Ryan.

Sandra Ryan: Hi, this is Sandra Ryan. I'm a speech-language pathologist in Northern Arizona and I've spent most of my career working in dementia care. And am very excited and pleased to hear the Habilitation treatment model and the Comfort Matters model, because that's exactly what I've been doing and teaching caregivers for years in my own individual training.

My question is, I would love to have a link, if possible, to all of the presenters' email addresses for further conversations. I will certainly contact the folks at Beatitudes since I'm also in Arizona. But is there a way or a link that we can get email addresses for the presenters today? Thank you.

Leah Nguyen: Hi, this is — this is Leah Nguyen, the moderator. In the email that we send out just before the call, that had a link to the presentation, ...

Sandra Ryan: Um-hum.

Leah Nguyen: I had an email address listed in there for CMS that you can use and we can forward your information out to the presenters. And that email address is dnh_behavioralhealth@cms.hhs.gov, but I also had it listed in that email, if that's easier.

Sandra Ryan: OK, great. Thank you very much.

Leah Nguyen: You're welcome.

Operator: Your next question comes from the line of Susan Crane. Susan, your line is open.

Susan Crane: Thank you. I'm the chair of the Florida Pioneer Network, the Culture-Change Change Coalition down here in Florida, and wonderful presentation. Thank you everyone.

And I'd just like the two speakers to comment on the use of person-centered care practices, including consistent assignment and also about any preliminary data you may have from the artifacts outcome section on staff turnover and anything on staff satisfaction, did you measure that? Thank you.

Ann Wyatt: This is Ann and one issue that we have in New York is, as you know, we are in New York City, turnover is not that great so I put that out there. But I know that Beatitudes, who's, you know, speaking from the sort of the long-haul, when they started they had a very high turnover. And for the last several years, they have almost no turnover and people get on a waiting list to work on the unit. That's the quality of difference in terms of the staff's experience.

Consistent assignment, of course, is extremely important. You cannot, you know, we've use — and one of our facilities just recently tried out, you know, the ADvancing Care tool that in which you pursue to figure out for a given resident how many different people take care of them over the space of a month or a week. And even homes that often think they're doing consistent assignment, they have enough floaters in there it can easily get up there to 20 to 25 different people. And that tells you right off the bat that no matter, you know, how perfect care plan you have, and that's not usually where we start, if you have 20 or 25 different people taking care of a person with dementia who cannot tell you what they need, you're going to run into problems. So that the goal is obviously is to reduce that significantly.

Consistent — consistent assignment is extremely important. And as I said, the Beatitudes' experience, having them having done this so thoroughly over such a long period of time, is that it completely turned around staff's experience on the unit.

Jed Levine: Let me say one other word about the person-centered care approach, and I think one of the things that we discovered is that people had been exposed to person-

centered care and kind of knew the concept and thought that they were doing it, but when we were really assessing and looking at what was happening, they were kind of talking the talk but not really walking the walk, not really doing the approach and the practice in a way that really, truly was person-centered.

So I think, you know, it's a great model. I think it's a great foundation. It works very much hand in hand with the approach that we are promoting. But it's important to — and that's why I think the weekly meeting and also having somebody who is a coach to facilitate and to be responsible for making it happen kind of keeps them — keeps it honest and allows, you know, them to really look at what the practices are that they're doing. And you will see the results in terms of decreased resistance to care and improved quality of life on the — on the floor.

Leah Nguyen: Thank you. Salema, we have time for one final question.

Operator: Your final question comes from the line of Kate Lafollette.

Kate Lafollette: Hi, this is Kate L Lafollette. I'm with the Iowa QIO, and I just wondered if you've met up with any resistance or barriers with your state survey agency?

Ann Wyatt: So all of our three homes have been surveyed at least — I think twice, actually, since we started.

Jed Levine: Um hum.

Ann Wyatt: And, you know, nothing has arisen. We've dared, you know, what we've been doing with the state and we're going to continue to do that. So, you know, there's nothing — in fact, everything that we're advocating, promoting, working with them on, is all about, you know, overall it's about person-centered care, it's about knowing the person and personalized care plans.

So every bit of it is consistent, the important thing is that we really — as I said, in the end it all comes back to resident by resident, how well do we know them, how well have we connected the care plan with what works for this person.

Jed Levine: Right, and how well is it documented. It needs to be written in the care plan and that, you know, that covers a lot.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to dnh_behavioralhealth@cms.hhs.gov.

This document has been edited for spelling and punctuation errors.

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 side 30 of the presentation, you will 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. Please join us again for a future MLN Connects Call. Our next call is December 16th on Certifying Patients for the Medicare Home Health Benefit.

Again, my name is Leah Nguyen. I would 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.

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