MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
National Partnership to Improve Dementia Care and QAPI
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

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 and Quality Assurance and Performance Improvement, or QAPI.

MLN Connects Calls are part of the Medicare Learning Network®. During this call, CMS subject matter experts will provide program updates, a nursing home will discuss steps taken to achieve antipsychotic medication reduction in their facility, and Indiana University will present information about evidence-based dementia care training. A question-and-answer session will follow the presentation.

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 materials 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 June 16th 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 Debbie Lyons, who coleads the Division of Nursing Home Efforts around Quality Assurance and Performance Improvement.

Welcome

Debra Lyons: Thanks Leah. Hello and welcome. Again, my name is Debbie Lyons, and together with my colleague Cathy Lawrence, we lead the Division of Nursing Home efforts around Quality Assurance and Performance Improvement. As you may be aware, we have teamed up with the National Partnership on these significant calls in order to spotlight the importance of the systems approach when working toward quality improvement in any area vital to resident quality of life, quality of care, and safety.

We believe partnership activities exemplify QAPI best practices. And through future calls, we hope to share QAPI best practices related to the partnership, as well as other high risk issues, such as adverse events.

I wanted to take just a few minutes before we get started to briefly share some of the feedback we received following the last call. We thank you for taking the time to respond to our polling questions at registration, as well as the evaluation. We read each of your comments and used them to improve this call so it can be the most beneficial for you. Using feedback from the front line is an essential element of QAPI, element number 3 to be exact.

So let me share the main themes. Respondents complimented the speakers, writing that they gave well-planned presentations and were responsive during the question-and-answer session. A number of respondents said the call presented useful and relevant information. However, some had also hoped to hear more real-life examples using the improvement process. We heard you loud and clear and are looking forward to hearing from our presenters today, one of whom will share their successes in antipsychotic reduction, and the other who will talk about evidence-based dementia care training.

Many respondents found the title of the call misleading. They expected to hear more about improving dementia care, but the call focused on QAPI and Advancing Excellence. We felt it was important to give background information on QAPI to benefit those who may not be as familiar with what it — with what it is and where it came from. And in order to share some of the evidence-based systemic approaches, which we want to highlight on most, if not, all of these calls, we reached out to our partner Advancing Excellence to share the great work that they do, much of which is related to the partnership, and definitely reflects QAPI best practices.

As Leah mentioned, our call today will focus on initiative updates, antipsychotic reduction success, as well as evidence-based dementia care training. 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 Debbie. 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. 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 between — 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 continue to hold while we complete the polling. Please continue to 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

Leah Nguyen: Thank you Salema. I will now turn the call over to Michele Laughman, coordinator of the National Partnership to Improve Dementia Care in Nursing Homes at CMS.

Michelle Laughman: Hello and welcome. I'd like to introduce Angie Hunt, the Chief Operating Officer at The Cedars, a senior living community in Portland, Maine. Ms. Hunt will provide information pertaining to the success that The Cedars has achieved in reducing the use of antipsychotic medication.

Ms. Hunt, I turn it over to you.

Antipsychotic Reduction Success: The Cedars, Maine

Angela Hunt: Thank you very much. Welcome. Good day everyone. And on behalf of The Cedars, thank you for the opportunity to present.

Today, you are going to hear a story, a story of how The Cedars reduced its antipsychotic medication use in our long-term care facility, and how we were able to sustain this reduction. You are also going to hear the story from the perspective of the long-term care administrator and a chief operating officer.

I have worked at The Cedars for a total 16 years in a variety of capacities. I cannot proclaim to you that I am an expert in the field but can state that I am a concerned administrator. And like all administrators, want the best quality care and quality of life for our residents.

The agenda and objectives of my story are to highlight and identify the importance of embracing culture change, and how it supported us as we reduced the antipsychotic

medication use in our facility; to emphasize the importance of training your staff and empowering your direct care staff with the knowledge, the skills, and the tools to successfully support the reduction in antipsychotic medication use; to share with you what evidence-based programming we use to help engage our residents as we reduce antipsychotic medication use; and lastly, we couldn't have done this alone. We had help. Thus, the last objective is to recognize the need to participate with community partners to help support you along the way.

Setting the stage. Before I jump into my story, I would like to tell you a little about The Cedars so that you may be able to better relate to my story. The Cedars is a senior living community located in the heart of Portland, Maine. We are a standalone community and not part of a chain of nursing homes.

The Cedars was founded in 1929, so we are 86 years old. We're a Jewish-based organization, although we serve all — all religious denominations. We are not-for-profit and we are very mission-driven. The Cedars is comprised of three buildings that are all connected: the Atrium with 61 independent apartments, the Osher Inn with 30 assisted living apartments, and the Hoffman Center, our 102 skilled-nursing facility. All our beds are duly certified. Our skilled-nursing facility served over 820 seniors last year for skilled-nursing and rehabilitation care and has a 75 percent patient discharge rate into our community. There are two neighborhoods where our long-term care residents live.

So drilling down. Our long-term care centers consist of approximately 56 to 60 percent of our total occupancy in our skilled-nursing facility. Approximately 41 percent of our residents have a diagnosis of dementia or Alzheimer's disease. And a total of 38 percent of our residents have documented behavioral symptoms.

National, regional, and State averages of antipsychotic medication use in long-term care facilities is listed on this slide. With the national average being 22.8 percent; the regional average, 23 percent; the State of Maine average at 19.8 percent. And as you can see, The Cedars is currently at 5 percent antipsychotic medication use rate for long-term care and a 1.3 percent rate for our patients in our short-stay rehab. All our residents who are on antipsychotic medications have been reduced to the lowest dose for symptom management.

Our journey. This graph demonstrates the downward percentage trend of long-term care residents at The Cedars receiving antipsychotic medications from 2012 to 2014 by quarters. In 2012, The Cedars was approximately at 20 percent. And in 2014, we were around 6 percent utilization. The reduction in antipsychotic medication use was no easy feat, and there were a lot of trials and tribulations, and it required a lot of support to get where we are today. This is a priority for The Cedars that is always a work in progress. And I am hoping it will eventually be absorbed into our culture like the intolerance or the zero, re-strengthen our facility.

There is no one solution. I would be very misleading if I told you that there was one specific intervention or program that will act alone to support a reduction in antipsychotic medication use. The majority of people living with dementia are likely to experience the development of behavioral and psychological difficulties at some point during their illness. This is because the behaviors reflect an attempt to fulfill their needs. There is no magic bullet. There is no one component of culture change, no one program that will act alone to support the reduction of antipsychotic medication use. But there are a variety of non-pharmacological approaches that, utilized together, will make you successful.

We found that with good medical care, capital medical assessment, use of culture change and person-centered approach model of care, and engaging our residents, we were successful. This reduction was done with a great medical director at the helm and a fully engaged, multidisciplinary team, which includes the integration of family members.

While we have a great nursing department at The Cedars, please do not expect your nursing department to do it all. It truly requires all hands on deck.

So the story begins. Must haves. In order to be at a 5 percent antipsychotic medication use rate, we had to have excellent leadership. I would have to give much of this credit to our medical director, who is the primary care physician to about 99 percent of our long-term care residents. He's a board certified geriatrician who holds a strong belief that antipsychotic medications have limited positive effects and can cause actual harm if not prescribed correctly. When confronted with a challenging behavior, he assists in every way to identify those unmet needs. The Cedars is blessed to have such a person-centered physician as part of our team.

Having an engaged pharmacist has been assistance to us. Our pharmacist has assisted with audits and providing recommendations to our physician on antipsychotic medication reduction. He has also assisted our facility to track progress. Antipsychotic medication usage rates are addressed in our quality QA meetings and as needed.

Another facility — another must have, is facility leadership. The nursing department cannot take this practice on its own. We need not only engaged nurse managers, charge nurses, CNAs, but life-enrichment staff, rehab staff, care coordination, dining services, and, yes, our environmental services — housekeeping and laundry.

All staff have dedicated neighborhood assignments and serve on a team. We cannot have done this without their support. All members provide their unique perspectives and have been trained on culture change and person-centered care. They are all empowered to act on resident preferences and choice.

Lastly, the use of objective documentation and data is necessary to support if interventions are successful or not. We currently utilize CareTracker, a CNA documentation software for our CNA documentation. CNAs are trained to document on mood and behavior. Sometimes it takes a lot of trial and error while assessing a behavior or an unmet need. Having electronic documentation makes it easy to identify trends and successes. The Cedars does not have a fully automated Electronic Health Record, and it has been a big drawback in looking at all the multidisciplinary documentation to get a full picture over time. Automation, with a fully integrated Electronic Health Record, is a must for us in reporting outcomes and successes.

The Cedars belief. The last item in setting the stage is The Cedars' belief in a person-centered approach to care. This approach has taken years to instill, and we still struggle with it. It has — it is important, and we have committed to giving the residents choices, preferences, dignity, and providing them with a sense of self — individuality.

When adopting new interventions and programs, it is important for us to recognize the three core values. All our programs and approach to care integrate and reflect these values.

Culture Change

Instilling culture change. Approximately 5 to 6 years ago, like many nursing skilled facilities throughout the nation, The Cedars embarked on a journey of culture change to transform from an institution model of care to a person-centered model of care. Although we still have an institutional look on two of our neighborhoods, staff has worked hard to instill this culture change.

Today, culture change is reflected in our mission statement and our organizational values. All direct-care job descriptions address a person-centered approach to care. New hire orientation to all employees focus on cultural change and person-centered care. Staff members are directed to check out resident life stories, which are available on each neighborhood. We also utilize a cross-functional team who has served as the ambassador to culture change and person-centered care. The cross-functional team is instrumental in educating staff and implementing culture change and person-centered care.

You may be asking yourself, Why is cultural change so important? It was very important to us because it helps set the stage and provided us with a foundation in which to engage our residents and develop relationships. Culture change supported the ideology of making it easier to engage residents and meaningful activities.

Other culture change strategies adopted throughout the years have been consistent nursing assignment. Consistent nursing assignments are a key component in adopting person-centered care. It strengthens relationships with our residents who are diagnosed with Alzheimer's disease or other related dementias. It makes perfect sense that

caregivers who provide care to the same resident learn what each resident wants and needs, is able to know the slight changes in health, and understand and respond to the behaviors of the residents with dementia.

We also adopted consistent interdisciplinary support on the neighborhood. This includes the following departments: housekeeping, care coordination, life enrichment, therapeutic rec., dining service — services, and therapy staff. All these key members read our resident life stories and have established relationships with our residents and their families. They are empowered, as well as nursing, to respond to the resident's needs, choices, and preferences.

We also have included resident choices and preferences with our dining services and have applied these to life patterns, like waking, sleeping, and showering time.

Training

Helpful training. Like many facilities, The Cedars struggled with residents who have exhibited challenging behaviors. We quickly realized that we needed education. People are individuals, and so are — the reasons for their behavior will vary. Understanding the residents' life history and social and physical environment in which they live affects the intervention required.

The Cedars has adopted the Alzheimer's program habilitation therapies at Alzheimer's and dementia care. This is a comprehensive behavior approach to caring for people with dementia. The program focuses on capabilities, independence, and morale to engage the residents and to produce a state of psychological well-being.

This helps to reduce and/or eliminate difficult symptoms. Training is focused on knowing and understanding the individuals' communication skills, physical environment, approach to personal care, activity and purposeful engagement, and understanding and responding to behaviors, and working with families.

This is a 12-hour curriculum and is open to all employees, even our volunteers. We provide this curriculum over a month, 3 hours per week. Our life enrichment manager teaches this course, and it is accepted as the — a best standard of care in psychological intervention by the Alzheimer's Association, Mass. and New Hampshire chapter, where it was first developed in the 1990s. It is considered best practice in day-to-day care in creating good environments for Alzheimer's disease and related dementias and within all their relationship and activities.

Other training. There have been other training tools that we have utilized to help support and educate staff. A few years ago, we elected to utilize online — an online training program for all of our mandatory in-services. In the state of Maine, CNAs are required to have 12 credit hours per year. There are other disciplines with similar requirements.

Tracking all this information was tedious and time consuming at the least, that's our contract with Relias Learning. But the big benefit to us was that Relias had a library of over 2,000 training courses and growing. Employees could access this educational library anytime, anywhere as long as they had an Internet connection. Relias has been a wonderful adjunct to our education efforts regarding Alzheimer's and dementia care.

Approximately 5 to 6 years ago, The Cedars adopted a special management program called Coaching-Supervision. This 2-day course was open to all staff who provided supervision to employees. It's conducted by two highly trained employees. Coaching-Supervision is a unique program that fosters respectful relationships throughout our organization.

Licensed nurses and other supervisors learn to support direct care staff while they are holding them accountable. This class is scheduled for three- to four- times per year, but we have struggled with consistently implementing the program due to staffing challenges with our direct care staff. It is a great program and is offered through the PHI.

Lastly, this past year we have adopted a customer service training curriculum. This program has a foundation that consists of community integration and customer — customer and employee satisfaction. Built on that foundation are five pillars:

- Community,
- Respect,
- Excellence,
- Accountability, and
- Teamwork.

Customer service is addressed upon new hire orientation, and quarterly at all employee meetings, and monthly in department meetings. The key to excellent customer services lies in building relationships with people. Customer service teaches you to understand and focus on the needs of the customer. A great bridge to person-centered care, sound familiar?

Creative use of staff. A little — a little — a little over — about a year ago, I had the opportunity to hire a new manager for our life enrichment program. After careful consideration, I hired an occupational therapist to oversee the day-to-day operations. This occupational therapist was hired to champion culture change and person-centered care. He has had 3 years of working on a specific dementia facility and is the instructor of our habilitation therapy class.

Life Enrichment

This has been an excellent hire for The Cedars and has supported our culture change efforts in a very positive way. His position is 20 hours in Life Enrichment. And Life

Enrichment, I should have told you, was our therapeutic rec. department. We call it Life Enrichment.

His other 20 hours are working in the rehabilitation services department, where his main focus is with our long-term care residents, which he knows very well and he knows their families. He has provided a multitude of OT services for our residents diagnosed with dementia. Some of the examples that he does is develop toolboxes or activity boxes with meaningful activities that residents can engage with, integrating life routines. He develops Memory Books to enhance communication and reminiscing. He works with challenging behaviors and provides therapy for residents with a decline in function. But whatever he is doing, he is educating and supporting — supporting staff in the care of our residents with dementia.

Life-enrichment practices. I think one of the most important practices that the Life Enrichment Department has is the adoption of the life — of the resident life stories. There are so many positives to having life stories. Life stories help us provide meaningful activities, identify routines, preferences—likes and dislikes, helps us develop small groups with common interests, and, importantly, helps staff to connect and relate to the resident on a more personal level.

We have two life-enrichment assistants. Both of our life-enrichment assistants are on — each assigned to a long-term care neighborhood. Life-enrichment staff have office space on the neighborhood and are expected to spend most of their day on the neighborhood. This gives life-enrichment staff time to conduct spontaneous activities in a small group setting or one-on-one. This position also supports residents who are having a difficult day and might need more one-on-one engagement.

Lastly, the use of volunteers has been extremely helpful for us. Volunteers are matched to residents and programs for their special gift. We have approximately 70 active volunteers in our organization. We're support — those volunteers are supported by a volunteer coordinator, which is a 24-hour position. Volunteers bring in their pets — their pet dogs, and they also participate in intergenerational programs and much, much more. Volunteers work closely with our Life-Enrichment Department and nursing services. They are an integral part in promoting resident engagement.

Life enrichment programs. So let's dive into some of our programs. The first is The Cedars Salon and Day Spa. It is more than — more than just a luxury. It's a unique therapeutic experience. The salon and spa is a retreat, where residents can spend time with their families or friends. The resident is showered with undivided attention. A spa manager utilizes life stories and works with family members and the residents so that they know their hairstyling preferences.

Aromatherapy and hot towels are utilized in this service. A spa manager is not a contracted person, but an actual employee of The Cedars. She has attended all our educational offerings regarding dementia.

The Cedars Salon and Day Spa is all about the residents, and the residents can choose from facials, foot soaks, massages, paraffin dips, and a variety of care services and much, much more. It brings pampering to a whole new service for them.

Our flower program is another program, and it's the most popular program. Who doesn't like flowers? This program supports our philosophy of preferences, choice, dignity, and individuality. Residents participate in a flower arranging class facilitated by a florist. This program can be done in both a small or large group setting, and residents are very excited and proud of the end product.

Technology, the use of technology. We have tried to embrace technology. And one exceptional program that is evidence-based and has achieved national recognition is Music and Memory. This program was funded by Dan Cohen, the executive director. This is a relatively low-cost, high-impact program, and it meets the needs — it meets our core values of what we want — we are looking for in a program.

If you have not seen the recent film documentary, "Alive Inside," you can check it out on Netflix. This program utilizes iPods or iShuffles to create personalized music playlists. Personalized music will unlock deep-set memories stored in the brain. Music memories are stored in your prefrontal cortex, which is an area that can stay intact, even when people — even with people suffering from severe dementia. When a familiar tune is played, it creates a memory, and this resident becomes alive — thus the name Alive Inside. Our experience with the program has been very positive. We have — we have observed improvements in mood, decrease in anxiety, decrease in agitation, improved alertness, improved attention. Some residents, they're tapping their feet, they're smiling, they're singing, and they converse more.

The program is relatively easy to implement. And if you go to the website, www.musicandmemory.org, it will tell you how to get certified, and you'll be on your way. Dan Cohen goes out of his way to provide you with this great evidence-based program. He thinks of everything, and even provides you the policies and procedures for it.

Our second — our second technology program that we use at The Cedars is called It's Never 2 Late. This is an adaptive computer program for seniors, with the belief that it is never too late for seniors to join the digital computer world. It was founded in 1999. It's Never 2 Late is a system build on a picture-based touchscreen interface that allows the user just simply to touch the screen. The content is engaging, it's educational, it's spiritual, it's personalized. You can connect with family and friends and enjoy many

different kinds of activities. The company has focused on engagement tools for seniors that have dementia or other cognitive disorders.

This is another evidence-based program. We have taught many family members how to use this technology, and they use it with their loved ones when they come and visit them. Even our rehabilitation department can use this and can bill for therapy services. So to learn more about this technology you can go to www.in2l.com.

Future program development. There are two programs I just wanted to tell you a little about that we are definitely going to be implementing this fall. One is Opening Your Minds to Art. This is another evidence-based program. It's an intergenerational program. And it uses visual — a visual art program. They use abstract art for people with dementia. It was developed by the Scripps Gerontology Center at Miami University in Ohio. It also has all the right values for us — high resident engagement, preferences, choices, dignity, and supports individuality. We are all going to utilize — we are going to utilize college students as our volunteers. You can check this program out at www.scrippsoma.org. The program is about $500 for the certification, and it's about $2,000 to purchase all the art supplies for that program.

And lastly, the second program that we are going to be implementing is a TV memory lane. This program was developed by Alban Maino, who is a film documentary producer. He has developed a multisensory, interactive film collection, he uses — and he uses vivid video, music, photography, recorded sounds, and aromas to stimulate recollections, to enhance communication, and to orientate individuals with dementia. Preliminary research demonstrates many positive benefits from his program. You can check his program out at Memory/Lane.tv. You will be very impressed by it.

Partnerships. There are many barriers to implementing culture change, adding new programs, working on decreasing antipsychotic medication usage, but The Cedars could not do this alone. We had many partnerships within our community to help us along our journey. These partnerships have created a safe place to exchange information and feelings, provide us with diverse perspectives, and create ongoing dialogue on common goals. Some of our partnerships that — some of our partnerships that The Cedars utilized to help us reduce our antipsychotic medication usage are listed on this slide, and I would like to thank them for all their help.

So in ending, I would like to just review the eight takeaways from my story. So the first one is, there is no one-size-fits-all when it comes to supporting a reduction in antipsychotic medication usage. The second, having an engaged medical director or primary care physician in multidiscipline — and an engaged multidisciplinary team is a must.
The third is culture change and adopting a person-centered model of care created a great foundation for reducing antipsychotic medication use. Four, being true to core values for the residents by choice, dignity, and sense of self, it will serve you well. The

fifth is providing educational opportunities to staff. That is a must; there's never enough education.

Six, add evidence-based programs that support your values and engage your residents. Seven, remember, all hands on deck. Use the expertise of your staff, nursing cannot do this alone. And then the eighth, form partnerships outside of your community to assist you. You will be surprised how many people are very open and forward with their — with their — their experiences. Remember, it took The Cedars actually years to get where we are today, and we are very thankful for all those who have helped us. So thank you very much, and thank you for having me

Evidence-Based Dementia Care Training

Michele Laughman: Thank you Angie. I appreciate that wonderful presentation. Next up will be Dr. Monica Tegeler and Dr. Kathleen Unroe, both within the Department of Internal Medicine and Geriatrics at Indiana University. They will be discussing an evidence-based dementia care training program. Dr. Tegeler and Dr. Unroe, I'm turning it over to you.

OPTIMISTIC Dementia Training Program

Dr. Kathleen Unroe: Thank you. This is Kathleen Unroe, and I'll be starting us off to provide some context of the overall project in which this dementia care training was developed.

So our agenda this afternoon is, we'd like to describe our 6-week-long OPTIMISTIC dementia training program, describe the four behavior categories that we used in designing this training, discuss some of the results of our before and after surveys from this training, as well as our process for skills validation, and then discuss some barriers to implementation and reasons for success.

So again, just to provide the overall context, this dementia training was developed as part of a multicomponent CMS demonstration project, under the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. This is a joint initiative that is funded and administered by the Center for Medicare & Medicaid Innovation and the Medicare-Medicaid Coordination Office.

The population that we're focusing on with this initiative are long-stay nursing facility residents, and who are mostly a dual —dually eligible population. This project started in the fall of 2012. It's a 4-year-long project, so we have just over a year left. And there are seven sites across the country doing this — doing this initiative. So we at Indiana University are one of these seven. We are all referred to as ECCPs, enhanced care & coordination providers.

The primary goal of the initiative is the reduction of avoidable hospital admissions. We also are trying to improve resident health outcomes, improve transition processes between hospitals and our nursing facilities, and reduce overall healthcare spending.

We call our project OPTIMISTIC. It's an acronym, Optimizing Patient Transfers in quality, and Improving Symptoms: Transforming Institutional Care. We were awarded $13.4 million over this 4-year project. We are working with 19 facilities in central Indiana. At any given time, we have about 2,000 long-stay residents enrolled in these 19 facilities in the project. And again, this is our primary goal, reduction of the avoidable hospitalizations.

A very basic overview of this large project, we have core components:

- Improving medical care,
- Enhancing transitional care, and
- Improving access to palliative care, including advanced care planning.

We have registered nurses embedded in each of these facilities to lead delivery of the OPTIMISTIC intervention, and they are supported in managing residents and quality improvement by nurse practitioners. We have half a dozen nurse practitioners who cover a group of facilities. These providers are, in turn, supported by the geriatricians on the team.

And I will turn it over to Monica Tegeler now to detail our experience with dementia care training as part of OPTIMISTIC.

Dr. Monica Tegeler: One of the things we noticed in the first 2 years of the project was that dementia with behavior disturbance was one of the top five reasons that the long-stay residents were being readmitted to the hospital. And with discussions with the facility staff, they constantly reported that they had challenge in managing the behaviors of the patients with dementia. And in the State of Indiana, the dementia training requirements are for 6 hours of initial dementia training and then 3 hours of yearly training. Unfortunately, they don't specify the type of training. So there's a great diversity in terms of what is actually done in each facility in regards to dementia training.

Description of the training. We had 6 weeks where the — people came together for a half a day, once a week. It was definitely an interprofessional training. There were 24 nurses and nurse practitioners who were employed by the OPTIMISTIC project, and then we invited 17 dementia care champions from each of the participating nursing homes in the project. And the dementia care champions came from a variety of backgrounds that included chaplains, nurses, social workers, and activity directors.

Before the training started, we actually did a pre-test survey to look at whether the participants felt confident in managing certain behaviors or not, and then after the training, we did a post-test survey to compare the two results. In each session, we would do brief video vignettes. Most of these were from CMS's Hand in Hand series. We would then have small group discussion of the various vignettes, and we would do role play scenarios for each category of behavior.

Behavior categories. We utilize the behavior categories that were developed by Jiska Cohen-Mansfield and published in the 1995 journal International Psychogeriatrics. She divided behaviors into physical and verbal, and then she divided them into aggressive and nonaggressive behaviors. We thought this was the most way to categorize behaviors in order to determine the most likely etiology.

So physical behaviors are divided into physically aggressive and physically nonaggressive behaviors. Examples of physically aggressive behaviors include kicking, biting, hitting, spitting, and damaging property. Physically nonaggressive behaviors include wandering and repetitive actions.

For the verbal behavior categories, there is verbally aggressive and verbally nonaggressive. Verbally aggressive behaviors include cursing and verbal threats. Verbal nonaggressive behaviors would include repetitive statements and repetitive noises.

So we had six different weeks for the training sessions. The first one was devoted to the positive approach that Teepa Snow developed. She has several DVD videos that are available for training, and this is from the "It's All in your Approach" DVD.

A quick summary of that, if you've not heard of her approach, is that you would wave to get the person's attention when you are about 6 feet away between public and private space. You would call the person by name, extend your hand, shake the person's hand, and then move your hand to a position that she calls the soul shake, at the same time, getting to the person's level and to their side in order to best have a conversation with the person and also to — any direct care needs.

The second session was devoted to verbal nonaggressive behaviors. The third session, to physically nonaggressive behaviors. The fourth session, to verbal aggressive behaviors, the fifth session, to physically aggressive behaviors. The last session, number six, was dedicated to teaching strategies in order to disseminate the skills to other nursing staff in each facility. We knew that it was not practical to take all of the CNAs and nurses out of the facility in order to do a training. So we decided to have one person, the dementia point person, be responsible for teaching others in their facility. So there were various strategies given, including teachable moments in how to prepare a microlesson. Assessment. Participants were filmed during an interaction with a standardized patient from the university demonstrating a behavioral symptom. So these were trained, standardized patients. The participant was then given structured feedback in different

areas. An assessment of the resident — they would consider environmental, physical, emotional, and medical causes for the behavior. They would be able to do root cause analysis and determine the most likely cause for the behavior, and whether the intervention was appropriate. It needed to be specific for that particular scenario and not just the behavior in general.

Other pieces of the structured feedback included communication skills, which included verbal and visual cues, professionalism, whether the participant was respectful to the patient, whether they were using the name of the resident, and whether the care plan was adequate: Did it include a positive approach? Did it include caregivers?

Pre- and Post- Test Results

So results from our studies. There were 42 participants who completed the pre-test self-efficacy survey that rated his or her comfort in the following types of behaviors — physically aggressive, physically nonaggressive, verbally aggressive, and verbally nonaggressive. Thirty-five participants completed the post-test survey, 37 participants interacted with standardized patients, and 16 completed the pre-, post- test, and skills validation.

Participant comments were very helpful. They said, “Best, most informative and up-to-date dementia I’ve ever attended.” “I really enjoyed role plays because it allowed me to practice skills in a safe environment.” And, “The filming was an incredible tool to learn our style.” So we really had very positive feedback.

Before the training survey, most participants felt comfortable managing the positive approach and managing verbally aggressive and nonaggressive behaviors. But they were less comfortable managing physically aggressive behaviors and performing root cause analysis to determine the cause of the behavior.

After the training, we did another survey, and most of the participants felt comfortable managing physically nonaggressive, verbally aggressive, and verbally nonaggressive behaviors. But a few still did not feel comfortable managing physically aggressive behaviors.

When we reviewed the results of the skills validation, we saw that all met or exceeded expectations for professionalism and communication. A few of the participants did not meet expectations for assessment of the resident. Most of this was related to not recognizing the severity of the dementia. They were not able to correlate a nonverbal patient had severe dementia. Nearly all met expectations for problem-solving and intervention.

In the followup survey we included 11 of 19 buildings, the ones who attended at least three of the six trainings. It was performed by three members of our dementia

workgroup and we assessed the staff buyin, nurse CNA perspective, activity programming, barriers that each facility had experienced, and successes.

The facilities offered several different barriers to change. In four buildings, they reported that they didn't experience any barriers to change and they were able to implement the programs successfully. Two facilities reported that they had difficulties with consistent staffing and turnover in the building. Two facilities reported that there was resistance from the staff and just a lack of understanding of the program. One reported that the focus in the facility was more on rehab. and finances and not on dementia. Another reported corporate policies as a barrier to implementation, and another building reported that corporate training was not flexible in order to incorporate this training.

There were other barriers that were observed as well. Nearly all the facilities that had a dementia unit had a long hallway that was not circular for residents to wander. And only three buildings had separate rooms for activities, the rest were dual-purpose rooms, usually the dining room, so that was not available when the dining room was being cleaned or prepared for meals. Most of them do not staff activity person over the weekend, and some don't even have a dedicated activity person; they utilize one person for the entire building.

Buy-in from the staff. In all of the buildings, the administrator was very supportive of the dementia training project. And in regards to the director of nursing, seven buildings, they felt that the director of nursing was supportive, three thought they were not supportive, and one, was not recorded. For the unit managers, again nine facilities felt that their unit manager was supportive and two were missing. For social work, eight were supportive and three were missing. And for the activity director, all 10 — 10of the 11 buildings were very supportive. So in general, the dementia point person felt that the staff in the building, including the administrator, unit manager, director of nursing, social worker, and activity director, were very supportive of this idea of our training.

We also looked at the nurse and the CNA perspective, whether they felt that the behaviors that the residents were exhibiting were preventable, they were triggered by either environmental or other sorts of things, or whether the behaviors are really attention-seeking behavior. And what we found was that, it was 50 percent with the CNAs, half of them believing that behaviors were do — that were preventable, and other half believing that behaviors were related to attention-seeking behavior.

And some of the buildings reported that it really depended on what shift. There was a difference between day shift and evening shift and night shift. For the nurses, most of them felt that the behaviors were preventable. Some of them, that the behaviors were attention-seeking. And again, there was a large variability by shift. They also reported that it really depended on the level of experience. The more experience the CNA and

nurse had, the more likely they were to view behaviors as related to preventable triggers rather than attention-seeking behavior.

We also looked at activity programming. There were different characteristics that we looked for in order to determine how robust the activity programming was. So we looked at a mix of physically active and less active activities. And seven of them had a good mix, three of them did not respond. For meaningful work, example would be folding laundry or wiping off tables. Six facilities had that; three did not.

In terms of layering, meaning more than one activity, only half of the buildings were able to do that. In terms of appealing to both men and women residents, only two had really robust train — appropriate programming for the men. Most of the stuff was focused to the women, and in terms of whether they — staff felt the dementia was appropriate and not childlike, most of them said that they felt that it was.

And the other question was whether the activity program was carried out, or whether it was mostly just listed on a schedule, and most of them felt that it, indeed, was carried out.

There was a good mix of physically active and less active activities. But there's definitely some room for improvement with layering and appealing to male residents.

We also asked the buildings to identify their reasons for successful implementation of the program. One building cited a survey tagged for lack of appropriate activity programming as impetus to improve their training. Another facility felt that the person that had been — dementia-prevention had been trained, had several years of experience at the facility, and was trusted by management to implement this new program. Several facilities pointed out that the training provided them more confidence in how to address these patients and their behaviors, and it also increased the awareness of approach and opportunities to mentor staff, especially the CNAs.

The next step as part of the OPTIMISTIC project is that we are dividing the training into 10- to 15- minute minisessions that don't require extra time at work or extra pay by the facility in order to implement the program. The instructions are all included in these little minisessions, and the props that are required are very minimal. We're piloting this at two facilities. And next year, part of this dementia training will be presented at three regional meetings in Indiana that are part of the collaborative sponsored by the Indiana State Department of Health. This will be in 2016.

And that's the end of our presentation. Thank you for the opportunity to present our OPTIMISTIC project.

National Partnership Updates

Michelle Laughman: Thank you Monica and Kathleen. I would now like to share some updates related to the National Partnership.

Recently, our efforts have been devoted to the expansion of the Focus Dementia Care Survey Pilot. Upon completion of the initial pilot, CMS revised survey materials and tools based upon surveyor feedback and data analysis. CMS is now expanding upon the work of the focus survey pilot and has invited states to conduct these surveys in fiscal year 2015 on a voluntary basis.

The expansion project involves a more intensive, targeted effort to improve surveyor effectiveness in citing poor dementia care and the over utilization of antipsychotic medication, and broadens the opportunities for quality improvement among providers. Initial focus efforts will occur in Texas and Mississippi, with additional state involvement expected. Any state that may be interested in participating should send a notification via email to the DNH behavioral health email inbox.

Previously we had mentioned a Federal C&P grant opportunity that had been announced. The Email Alternative, Inc., was seen to be the most eligible applicant and has been awarded a grant for their project entitled, "Creating a Culture of Person-Directed Dementia Care." Their project consists of a multistate interdisciplinary initiative, combining in person and online group education, self-directed learning and application, implementation resources, and the opportunity to engage with other nursing homes in the pursuit of best practices.

"Creating a Culture of Person-Directed Dementia Care" has a project goal to support the continued reduction of antipsychotic medication through person-directed care practices that redefine perceptions of and approaches to dementia care. In collaboration with LeadingAge state affiliates and healthcare associations, The Email Alternative plans to engage direct care staff from nursing home across five state:

- Georgia,
- South Carolina,
- Kansas,
- Illinois, and
- Texas.

We are grateful for the efforts of so many people and organizations. Based upon recent data that was shared, we have now seen a 20.1 percent reduction in the national rate of antipsychotic use in long-staying nursing homes. The national partnership has engaged the nursing home industry across the country around reducing the use of antipsychotic medication with momentum, and success in this area that is expected to continue.

We thank you for your participation in today's call and we look forward to continued collaboration and partnership. 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, but before we begin, I would like to remind everyone, 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 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 line will remain open during the time that you are 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.

The first question comes from the line of Melody Malone.

Melody Malone: Good afternoon. Thanks for taking my call. I had a question about — Where are the new survey materials located?

Michelle Laughman: Hi, this is Michelle Laughman. The survey tools and resources, they are not being provided publicly. So we are only sharing them with the state agencies that are involved in the focus survey process.

Melody Malone: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Mary Gracey-White.

Mary, your line is open.

Mary Gracey-White: Thank you. I appreciate it. I enjoyed the presentation. I just have a question regarding the OPTIMISTIC dementia training. In the slide, you did give us an example of the positive approach, but for the other areas that were covered during the training, like the verbal nonaggression, physical nonaggression, etc. Are there any

further slides or information where I could see examples of the training in those particular areas, especially in the area of physical aggression?

Dr. Monica Tegeler: So this is Dr. Tegeler. We are planning to publish the information and the protocols. They're one-page interventions that are based on, you know, environmental, physical, emotional needs. But we did not include that in the presentation today.

Dr. Kathleen Unroe: We're, I mean, we're still refining it through this process with these microlessons, but we're working quickly to package it together so that we can get it out there. Thank you for your interest.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Richard Mollot.

Richard Mollot: Hi, thanks for taking my call. I was wondering if you could speak a bit about any enforcement trends you're seeing regarding F329, F309, F222 in particular, but on the dementia care, of course, in general, outside of the pilot that is.

Karen Tritz: Hi Richard. Thanks for the question. This is Karen Tritz from the Division of Nursing Homes. And we haven't done a recent analysis of enforcement specific to 329. We are continuing to look at enforcement trends across the board related to the nursing home surveys. And for those of you on the call and Richard, stay tuned on our website. We're intending to be posting enforcement data there shortly with a description of the different categories of enforcement. As many of you know, there's different types of enforcement actions, so more to come. But please stay tuned to the website for additional information on trends.

Richard Mollot: Thank you. Thanks.

Operator: There is a followup question from Melody Malone. Melody, your line is open. That question has been withdrawn.

If you would like to ask a question at this time, simply press star, then the number 1. Again, to ask a question, please press star 1 at this time. If you would like to withdraw your question, press the pound key.

There is a followup question from Melody Malone.

Melody Malone: Yes. For the OPTIMISTIC team, I wondered if any of your time would be provided virtually for the rest of the country could benefit from your work?

Dr. Monica Tegeler: We're actively working on that. Again, I'm excited that people are interested in this, but, you know, this demonstration project has really been an opportunity to develop a number of different tools and protocols. And right now we're working on how to package those so that we could share them. But you are right, I think things that are web-based would be much easier to, you know, disseminate. So, thank you.

Melody Malone: Thank you.

Operator: There is a question — a question from the line of Celeste Brooke.

Celeste Brooke: Hello, I really enjoyed your presentation. My question is, for the culture change, and in getting every discipline involved with the person-centered care, did you start from the bottom up? Or did you take the leadership and make sure that they were into the culture change?

Angela Hunt: Hi, this is Angie Hunt, thanks for the question. I definitely — well, I'm the chief operating officer. We definitely talk about, at a leadership level, in senior management, the programs that we're implementing in our community. So it was definitely accepted from the top and it went down. And we also used the cross-functional team. We had employees from every department learn about culture change, go to other facilities, see the culture change, do DVDs on culture change. And basically — I had a receptionist go up and teach the nursing staff what culture change really is. So basically, it's a whole big effort. But definitely, you want to have your senior management bought into it. Thank you.

Operator: Your next question comes from the line of Dr. Yao. Dr. Yao, your line is open. If you're on a speakerphone, please pick up your handset.

And that question has been withdrawn. The next question comes from the line of Lori Putz.

Lori Putz: Yes, we enjoyed your presentation. I was wondering on the OPTIMISTIC program again, if they would be willing to share their pre- and post- test survey for evaluating participants' self-efficacy in managing the behaviors.

Dr. Kathleen Unroe: Sure, we can share that.

Lori Putz: That would be awesome. Thank you.

Operator: Your next question comes from the line of Wendy Meltzer.

Wendy Meltzer: Yes. I wondered, for the people from Indiana, whether you have even preliminary results from your work, and if you do, whether you've correlated success rates to specific factors at specific facilities?

Dr. Kathleen Unroe: Are you talking about the overall demonstration project on reducing avoidable hospitalization or the dementia training in particular?

Wendy Meltzer: Yes.

Dr. Kathleen Unroe: Yes, so not yet. There is an external evaluator, evaluating all seven of the sites. And, you know, some results have been shared with us, but we're not permitted to share them. So it's all — all ongoing. Sorry, I can't share that.

Dr. Monica Tegeler: But we certainly have — but what we have had is excellent success in terms of maintaining relationships with our partner facilities. One of our greatest successes has been the retention of our clinical staff. We've had very low turnover of our RNs in particular, who are part of this initiative and have invested a lot in their training. And so, Ms. Hunt's presentation about how valued, you know, training is to staff plus our training of our own OPTIMISTIC staff and then taking it back to the facilities, that's been very highly valued. But, thank you.

Wendy Meltzer: OK, thank you.

Operator: Your next question comes from the line of Sherry Sapp.

Sherry Sapp: Yes, thank you for the training today. I had one question about the different behavior — the behavior training and approach. I didn't see anywhere where anybody had like a mean level of cognitive function. Our population has a very low cognitive function on the BIMS scale, typically 7 and below. So just — do you think that that makes a difference in approach training?

Dr. Monica Tegeler: We actually don't worry too much about the level of cognitive impairment in terms of using the protocol. It looks more at what are the environmental factors, what are the physical factors within, and what are the other, you know, residents, how they're interacting in the milieu. And so, we can certainly sympathize that patients that have a very low BIMS score have more difficulty communicating. But again, it's not necessary to know what their actual BIMS score is in order to be able to use the protocols.

Sherry Sapp: OK, thank you.

Operator: Your next question comes from the line of Wendy Fearnside.

Wendy Fearnside: Thank you. I have a question about the OPTIMISTIC training, where you videotaped staff interacting with residents. And just wanted to know what — how the residents were selected and what you mean by a standardized patient?

Dr. Monica Tegeler: Actually, we did not film at the actual nursing facility. There were no actual residents involved. A standardized patient is an actor who is paid to portray a certain patient scenario. So we created the patient scenarios and had them inter — act those out.

This is a very common tool used in medical students' education and also resident education. So these were standardized patients that were from Indiana University. So there was no possibility of patient privacy violation.

Dr. Kathleen Unroe: But it provided the opportunity for the staff member to be able to watch what they do and how they approach people, which is very enlightening for the participants in the training.

Wendy Fearnside: OK, thank you.

Operator: Your next question comes from the line of Walter Geary.

Walter Geary: Thank you. My question is for Ms. Hunt. I looked at your facility website online, and it's very impressive. And I was wondering what your patient mix — the number of Medicare, Medicaid, private pay, insurance patients are, and your financial mix in terms of reimbursement vs. donations. I saw that this is a 501(c)(3) corporation, and there's a lot of very generous donors for the facility. Thank you.

Angela Hunt: This is Angela Hunt. Thank you for that question. Our payer mix – we have about 40 percent Medicare payer mix with about 40 percent MaineCare, which is our Medicaid. And we have 20 percent private pay mix currently. And we do — we do have donations, but I don't have the exact number for you, I'm sorry to say. But we probably, on our annual drive, probably gross about $300,000.

So, we also have an auxiliary function that does help sometimes support some of the programs at The Cedars. And one of those programs was the share we received, the $15,000 donation from them to do music — music and art program for our residents. So hence, that's how we did Music and Memory. And we also did the OMA, the Opening your Minds to Art Program. So it got funded by that. So thank you very much.

Walter Geary: Great, thank you.

Operator: Your next question comes from the line of Patricia Murphy.

Patricia Murphy: Ah, yes, excellent presentation today, thank you. My question is for Ms. Hunt at The Cedars. It's somewhat of a technical question regarding your program, It's Never Too Late. You stated that it can be used by the rehab. therapy department and billed. I was just wondering if you could elaborate on that. Are you billing it to Medicare & Medicaid? And is it PTOT? And my last question is, do you — would you know if it's entered on the MDS list of minutes? Thank you.

Angela Hunt: Yes, this is Angie. Thank you very much for that question. I happened to be a physical therapist by trade, so that's an easy question for me. The Never Too Late has components in it that has a lot of cognitive programs in it. And sometimes the speech-language pathologist might use word- finding games in it, sequencing things. There also in Never Too Late has a whole therapy section. So like an occupational therapist could sit with a patient and actually go through this video, and it's a video of a home eval. And the person's walking up the stairs and they see like a — kind of like a can there or something or there's some unsafe situations. And that person has to identify those unsafe situations and talk why they're unsafe, and you facilitate it.

So there's many different little aspects of It's Never Too Late that you can weave into your therapy sessions. And we do — we do — we do bill that. And we do count those minutes of one-to-one treatment time with the patient on the MDS. I hope that helps you. Thank you.

Patricia Murphy: Thank you, it does.

Operator: There is a question from Jennifer Marks.

Jennifer Marks: Yes, my question is for Angela as well. I was wondering if you knew if the occupational therapist was cognitively staging the residents, and if so, if it was via the Claudia Allen ACL or the GDS, and then when developing those kits, were they patient-specific kits, or were they based on a staged group where several people could use those kits based on their staging. Thank you.

Angela Hunt: This is Angela Hunt, thank you for the question, OK I can't really answer the technical part about the staging, I'm sorry to tell you. But I can comment on the toolkits. They're actually …

Jennifer Marks: OK.

Angela Hunt: Basically, those kits are developed with the life stories, and working with the residents and working with their families. So there would be a kit that, let's say, if a person that you're treating that has a diagnosis of dementia, let's say they were, you know, an architect, and they built or they did things with their hands, or — so basically what they would do is, they would develop like a Tupperware box, and they would put for that specific resident things that have meaning to that person. Or somebody liked

boats, there would be pictures of boats or there would be activities that were meaningful or things that were meaningful in that person's life. So basically, on off hours, you know, the nursing staff could access that to engage the — to try to engage that resident if they were interested in doing something or wanted to engage them in some different way.

So, hopefully, that helped.

Jennifer Martin: Thank you very much.

Angela Hunt: You're welcome.

Operator: As a reminder, if you would like to ask a question at this time, simply press star, then the number 1. Again, to ask a question, please press star, then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

There is a question from Melody Malone.

Melody Malone: Yes, I wondered, since QAPI was part of the title today, if there was any discussion about where this — what the status of the regulation actually is? I noticed it's not on the Federal agenda anymore.

Debra Lyons: This is Debbie Lyons, thank you for the question. We aren't really able to give a timeline for promulgation of the regulation. What I would encourage you to do is to continue to check the reginfo.gov. It's a unified agenda, and just keep tracking it and, of course, as you may be aware, when it is put out for public comment, you will all have an opportunity to access the proposed regulation and comment on it. So we would encourage you to do that and follow it on www.reginfo.gov.

Melody Malone: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Dayne DuVall.

Dayne DuVall: Hi, it's Dayne DuVall with National Certification Board for Alzheimer Care, and the question is for the OPTIMISTIC team. On your dementia champions, I didn't hear you mention that you had CNAs in the mix. Did you include those people in that training?

Dr. Monica Tegeler: Actually, yes, we did include CNAs. We allowed the buildings to self-designate who they thought would be the dementia champion. We didn't restrict it to social workers or any other particular categories. In fact, one of the buildings that was

most successful in implementing the dementia training program utilized a CNA as their dementia point person, and she had been at the facility for a number of years and was very well respected by the management.

Dayne DuVall: Thank you very much.

Operator: The next question comes from the line of Rhonda Selvin.

Rhonda Selvin: Yes, hi, this is for Ms. Hunt. It was a great presentation. I wonder if you could tell me, did you find that both and men and women are equally engaged in some of your projects, such as your art therapy, music therapy, spa intervention, those type of things?

Angela Hunt: This is Angie Hunt, thank you for the question. Yes, I think so. Just remember, like Music and Memory, you know, we went to families and really tried to find a real personalized playlist, like when you got married — who was the — what was your song that you had your first dance with your wife with, who was the artist? So basically, if you put — so that's why those life stories are so important. I think they should be their practices and life-enrichment activities, because the more personalized you can make something to a person, the more opportunity to make that connection with them. And, you know, we've, like the Music and Memory, we've gotten good…

Even our flower program, which we need to formalize more, that even men participate in it because – and you do your own thing with it — there's no right or wrong way to do it. And it's – you're picking the flowers that you feel are more attractive to you or the colors, or you're making it your individualized thing. And I feel that those programs have been very successful, and they engage them in doing something, which I think is another great thing. Thank you.

Rhonda Selvin: That's lovely, thank you.

Operator: And there is a question from Emmett Asibido.

Emmett Asibido: Yes, good afternoon my name is Emmett, I'm a physician. And thank you for the excellent presentation. I would like to know if there is any training program in Puerto Rico.

Operator: Emmett, your line is open.

Emmett Asibido: Good afternoon, my name is Dr. Asibido. I am from Puerto Rico. Thank you for the excellent presentation. I would like to know if there is any training program in Puerto Rico.

Karen Tritz: This is Karen Tritz from Survey and Certification Group. There are — there is the QIO National Nursing Home Quality of Care Collaborative that also had similar types of linking and sharing training programs. So that may be — may be a good story for you. Actually, what I'd like you to do is, if you want to send in your question into the DNH Behavioral Health mailbox, we can get a more specific contact for you.

Emmett Asibido: OK, that's the link that you already said that DNH_behavioralhealth@cms, that's the one you said?

Karen Tritz: Yes.

Leah Nguyen: And that's on slide 56 of your presentation.

Emmett Asibido: Yes, yes, OK. Thank you very much. Have a nice day.

Karen Tritz: Thank you.

Leah Nguyen: Thank you.

Operator: There is a question from Patricia Murphy.

Patricia Murphy: Ah, yes, this is a followup for Ms. Hunt at The Cedars. I am just following up on that question about entering the MDS and speech therapists and occupational therapists. Is that just for It's Never Too Late that you bill? In other words, is it for programs that only have in their curriculum, so to speak, that speech and other therapies are utilized, or do you bill for the other programs like the Music Memory and the day spa, etc.

Angela Hunt: This is Angie Hunt. No, we don't — we do not — we do not charge for like Music and Memory and that. Usually, Music and Memory is run by the Life Enrichment or the therapeutic rec. department. It's a program that we provide the residents free of charge. The spa and the salon, that is not done by therapists. That's done by a beautician or a cosmetologist who runs that. If somebody wants specific massage therapy services, they pay for that, those services. But they're at a very reduced cost. We're a not-for-profit facility, so our spa offerings, we try to keep them very, very reasonable so that people even on MaineCare can afford to do something in the spa.

The Never Too Late is a piece of technology, and if a therapist — if a rehab. person uses it like an OT or PT, and it's doing something like cognitive retraining with a person. Then they — they — they bill under that HCPCS code for cognitive retraining. So that's how that works with that. But we — on the other things, like the art program — or the flower program, that's all to engage the residents. That's all programming that we provide, and there is no cost to those programs. Hopefully that will help you.

Patricia Murphy: Thank you for the clarification.

Angela Hunt: You're welcome.

Operator: Your next question comes from Brenda Whicker.

Brenda Whicker: Hi, this question is for Ms. Hunt with Cedars. Can you describe your art program with more detail? Thank you

Angela Hunt: Hi, this is Angie. The Art program is a program that we're going to be doing this fall, and we just sent our life-enrichment manager to get certified in that program. But that program, I did get a little — I was at a seminar, and that's how I got interested in this program. It was presented by the people from University of Miami in Ohio, and you can go onto their website and get all this information.

But this — the art program is —usually it consists of 12 residents. They all have volunteers, and the program is run by the life-enrichment staff in coordination with an artist — an artist. And it's an abstract art program, and all the materials are real artist materials. And it's very well-done, and the people that are volunteers that support that are, I think they're trained on how to communicate appropriately, how to — it's very — there is a definite way how they introduce each part of the art piece so that people totally can engage in totally that — doing that art piece. And the final project — you know, the product is — is really beautiful. It's a great program. And if you want more information, I would go look on the website and even call them. But thank you for the — thank you the question.

Operator: If you would like to ask a question, please press star then the number 1. Again, if you would like to ask a question, please press star 1 at this time.

There is a question from the line Melody Malone.

Melody Malone: Yes, I wondered, is there any specific reason why we're not getting to see these survey documents yet for the antipsychotic survey?

Karen Tritz: Hi, thanks for your question Melody. So the survey documents come straight out of the F329 and F309 revisions related to dementia care. And so, we would — the surveyors will be looking at compliance with existing requirements, and the guidance — interpretative guidance that are based up off of the regulation at this point. So there is nothing that – so what would be advice that we — we've gotten this question before, the advice that we've been giving to facilities is to look closely at F309 and F329 as it relates to dementia care and the role of antipsychotic medication.

And all of the things frankly, all the practices that we've been talking about today related to person-centered planning, having individualized care planning that is done by

an interdisciplinary team. That there is — that unnecessary medications are not used, that the consultant pharmacist, the medical director are reviewing that, and that, you know, there is the expectation that dementia with behaviors is not an appropriate diagnosis for antipsychotic medications without additional efforts that we describe in the interpretive guidance related to the use of nonpharmacological approaches that we've been talking about today — gradual dose reductions, and really, you know, documenting the decisionmaking around the role of medications related to dementia care. And so all of those things are in the current guidance, and it's part of what the survey process will be focusing on.

Melody Malone: OK, so basically, also using — utilizing that check list for dementia care or care and services for the residents with dementia?

Karen Tritz: Yes, the checklist is certainly part of what the surveyors will be looking at as well. It's within the guidance now and is relating to all the things we've been talking about today.

Melody Malone: OK, thank you so much.

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

Operator: Your final question comes from the line of Rhonda Selvin.

Rhonda Selvin: Yes, hi, thanks. This is for Angie Hunt again. I'd like to know, if you look back over your pers – switch to person-centered care in your facilities, whether you had to increase your staff or whether you had to change the type of components of your staff at all?

Angela Hunt: Thank you very much. I will tell you that it's always a work in progress to be person-centered care. And we didn't increase our staff. But we really — I have a strong feeling that, basically, nursing is with the patient 24/7, but any issues or concerns are all — all — all the staff's concerns, you know. So basically, we try to have people, you know, answer call bells, you know, when even our housekeeper goes in to clean a room, she might sit with a resident and look at pictures and say something to the resident. We even have like a restorative program, where people sit at lunchtime that needs, like, just queueing so that they eat a hearty meal. And we have all different staff members sit at this table and just work with the residents.

So I would say that it's trying to develop people not to just have tunnel vision on their job, because I think we — I saw our problems were being very like "nursing does this, therapy does this." But we do everything together, and we need to overlap in areas to help each other out. And it still is a struggle. I mean, you still have to keep addressing that and whatnot, but it's really the right thing to do. And it makes life a lot easier to get everybody involved, and we try to have a team on the unit. So it's not just consistent

assignment for the nurses, it's consistent assignment for departments. And they get to know those residents really well, and then they can troubleshoot some of the areas that they are capable of doing that. So I'm hoping that helps you, thanks.

Rhonda Selvin: Yes, it's great, thanks.

Leah Nguyen: Thank you, and I'm going to turn it over to Karen Tritz for a closing comment.

Closing Comment

Karen Tritz: Hi, there, so I just wanted to say thank you everyone for joining the presentations today. I hope you found it helpful.

I did want to mention that many of the efforts that we've talked about today, Music and Memory, It's Never Too Late, and other projects have been funded in some cases through the Civil Money Penalty funds that are collected through enforcement actions. As you probably know, a portion of those funds, much of those funds actually, go back to the states for use in projects that directly benefit nursing home residents.

And so, there are opportunities there for these projects to be funded through that venue and have been funded in the past. So I would encourage you to reach out to your state, if that's an avenue that you'd like to pursue. And again, thanks very much for joining the call today.

Additional Information

Leah Nguyen: Thank you Karen. 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 55 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. We have two more calls coming up this week on the hospice item set and ICD-10. 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 and QAPI. Have a great day everyone.

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