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MLN ConnectsTM

National Provider Call - Transcript

Centers for Medicare & Medicaid Services
CMS National Partnership to Improve Dementia Care in Nursing Homes
National Provider Call
Moderator: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's 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 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 CMS National Partnership to Improve Dementia Care in Nursing Homes.

MLN Connects calls are part of the Medicare Learning Network. CMS has developed a national partnership to improve the quality of care provided to individuals with dementia in nursing homes. This partnership is focused on delivering health care that is person-centered, comprehensive, and interdisciplinary. By improving dementia care through the use of individualized, person-centered care approaches, CMS hopes to continue to reduce the use of unnecessary antipsychotic medications in nursing homes and eventually other care settings as well. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. While antipsychotic medications are the initial focus of the partnership, CMS recognizes that attention to other potentially harmful medications is also an important part of this initiative.

During this call, CMS subject-matter experts will discuss the progress that has been made during the implementation of this national partnership, its successes, and next steps. Additional speakers will share some personal success stories from the field. A question-and-answer session will follow the presentation.

Before we get started, I have a couple of announcements. You should have received a link to the slide presentation and other materials for today's call in previous registration emails. If you have not already done so, please 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 webpage, select "National Provider Calls and Events," then select the date of today's call from the list.

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

At this time, I would like to turn the call over to our first presenter, Dr. Shari Ling.

Presentation

Caring for Individuals with Dementia in Nursing Homes

Shari Ling: Hi, good afternoon all. I'm Shari Ling, Deputy Chief Medical Officer here at CMS. And on behalf of CMS, we would like to thank you for your participation in today's call, as well as your partnership in this important work.

What began as an issue identified by the advocacy community and others has grown into a strong national partnership with the mission to improve the quality of care provided to individuals with dementia living in nursing homes. This partnership promotes the 3 "Rs" to providing quality dementia care—that is, *rethink*, *reconnect*, and *restore*.

We want to *rethink* our approaches – our approach to dementia care, *reconnect* with people, using person-centered care approaches, and *restore* good health and quality of life in nursing homes across the country. Together, we believe that we can deliver health care that is both comprehensive and interdisciplinary, while protecting patients from being prescribed antipsychotic medications unless there is a valid clinical indication and a systematic process to evaluate each individual. We emphasize a person-centered care approach that utilizes nonpharmacologic strategies as part of an ongoing treatment plan that may also include medications, in some cases, to meet the individual – individualized needs of each person.

We know that this is really hard work. We recognize that there are many challenges to people working at the bedside, as well as in leadership positions. We appreciate the people who are working hard to put approaches into place, such as staff and prescriber training, team communication, and resident and caregiver and family engagement. But by working together, we can accomplish our goal of reducing antipsychotic use in long-stay nursing home residents by 15 percent. We appreciate your continued commitment to this goal and to your dedication to the partnership.

So, again, thank you. And I will turn it over to Alice Bonner.

Objectives of This Call

Alice Bonner: Thank you, Dr. Ling. Good afternoon, everyone. My name is Alice Bonner, and I'm Deputy Associate Regional Administrator in the CMS Northeast Division. And welcome to our call.

Today's objectives are on slide number 4, for those of you who are following along. And very briefly, we're going to share some new outreach strategies today, describe our ongoing collaboration with the Nursing Home Quality Care Collaborative and Advancing Excellence, review some updates to surveyor guidance and the release of the third surveyor training video. We'll share some successes and recent data with you and share some stories from the field.

So, to summarize – to begin, we are really seeing a new level of enthusiasm and excitement in this national partnership campaign. And we've been learning through our calls and our outreach that wherever a facility is in terms of the national partnership, whatever level of involvement they've had so far, facilities are telling us that they're finding they can still improve. And so people are setting goals at different places along the continuum. In some cases, people are just starting out with this work. In other cases, some of you on the phone are in mid-course; you're tweaking and you're doing trainings and much more implementation. In some cases, you're much further along, and you've got sophisticated ways of looking at your quality measurement data and your own measures, and maybe you're meeting weekly. And all of this is really helping with the national initiative. So it's very exciting work.

In terms of the first three bullets, I'd just like to address those, and then I'm going to turn it over to some of our other speakers today. But the next slide, number 5, talks about our outreach strategies. And we've continued with our State coalition lead calls. We're doing this regionally now. So we get a group of States together on a regional call, and we've been doing this quarterly. We've also been doing communication with our national stakeholders on calls such as this one, and others with some of our associations and other partners. And then we've been doing more with individual outreach to providers.

And, again, it's been fascinating really for CMS. I think we're getting as much from these calls as the providers are getting from us. But the purpose is really to share information, to make sure that everyone doing this work, who's – who's – as Dr. Ling said, is working so very hard to improve dementia care that the information and resources that have become available are things that everyone knows about. It's really out there.

So we've been able to connect with individual providers. And we've been able to share, in some cases, some of the successes we've been hearing from around the country, but also talk about some of the barriers. So, just to give you one example, some folks have told us that they're challenged with having conversations with physicians or nurse practitioners and other prescribers. Sometimes they feel that there's a little bit of resistance there, or there's not, you know, an entirely team-like feeling yet. And they have asked about, you know, what they can do to address that. And because other people have found some really excellent solutions to those kinds of issues, we've been able to share that and put providers in touch with other providers. So some of the actions steps for us, for CMS, have really been provider-to-provider, peer-to-peer mentoring and information sharing on some of these things.

We had a call where Lisa O'Hara, who's a consultant pharmacist in Indiana, did a very nice presentation. And it's on our – it's on the Advancing Excellence website. It's posted there. And we had a lot of people emailing us back saying they'd like to either get in touch with her or they'd like to have access to that presentation because they thought it was so valuable. It was extremely practical and gave some really clear action steps. So, through our provider calls we're able to link folks with some of those kinds of resources.

Another barrier that we've heard about from some of you is when people are coming from the hospital or from the community and they're already on an antipsychotic, it can be challenging to understand why they were put on it, or whether they would be a good candidate for a dose reduction, et cetera. And so those also are areas where certain parts of the country, there have been cross-continuum teams that have formed, work between consultant pharmacists and hospitalists. And so we've been able to share some of those strategies as well as other medication management strategies, like having weekly rounds and so forth.

So, again, that's a brief update on some of the provider calls. We anticipate that those will continue as we go forward.

The second bullet on the objectives was about the ongoing collaboration with our colleagues in the QIO community and the Nursing Home Quality Care Collaboratives that are rolling out. And many of you are participating and very familiar with those; we hope that you are. And in some States because the State coalitions around dementia care have already been well established, those groups have decided to continue, and the nursing home collaboratives are happening as well. In other States, it has turned out that a lot of the participants are the same in both of those groups. And in some States, they've actually combined and are meeting together because a lot of the work in the collaboratives, at least a component of that work, certainly includes the focus on dementia care and reducing antipsychotics.

So different States are doing what works for them. But there's very close communication between those groups and ongoing communication with Advancing Excellence in the Advancing Excellence LANEs. So, again, what you probably find in your State is that a lot of the same folks and a lot of the same organizations are really involved in all of these different initiatives, and that there's very good crossover and cross-pollination of ideas, if you will, among these groups, the Advancing Excellence LANEs, as well.

In terms of the third bullet, we did want to remind folks that there have been updates to the surveyor guidance, and those have been released. They were released on May 24th, so they are on the CMS website. And we also released the third surveyor training video. So we now have a series of three surveyor training videos, and they are available to providers as well. Again, those are on the Surveyor Training website. And if you have any difficulty accessing either of those resources, you know, please be sure to let us know.

So, to cover the fourth bullet, about recent data and successes that are reflected in the data, I'd like to turn it over to Dan Andersen and have him share the next few slides with all of you. So, Dan?

How to Access Your Nursing Home Data

Dan Andersen: Thank you, Alice, and hello, everyone. I'm Dan Andersen. I work here on survey and certification at CMS. Today we wanted to first show participants of the call how to access and use their data on the Nursing Home Compare website, and then

give a brief update on the antipsychotic quality measure data. I'm starting on slide 6, for those of you who are following along.

So, many of you – many of you are aware of the Nursing Home Compare website, and hopefully you access it regularly and find it useful. But for those of you that do not regularly check the website, we'd like to briefly walk you through the website and show you how to use your quality measure data and compare it to State and national averages or just other facilities in your area.

So there are basically four simple steps that you'd follow, and we'll be illustrating those on the following slides. The first step is obviously to go to the website. And the URL for that is www.medicare.gov/nursinghomecompare. It used to be nhcompare, and that will still work, it will just redirect you to the full Nursing Home Compare website.

So on the next slide, which is slide 7, you'll – you will see the landing page of the website, which provides the main function of the site, if you will, which is to allow beneficiaries and consumers to find and compare nursing homes in a geographic location.

So once you're on that website—I'm going to the next slide now, which is slide 8—once you're on that landing page, you can enter geographic information into the search bar, by city and State. You can also enter the facility name to narrow your search if you like, or you can just select the facility from the list that'll be populated by the geographic location.

Going on to the next slide, which is slide 9, you'll – you'll see – once you've selected your nursing home, you will want to navigate to the “Quality Measures” tab. The arrow on the slide is slightly misplaced. It's – you would actually be clicking on the “Quality Measures” tab that you see there at the – at the top, right above the “Nursing Home Characteristics.” It goes along with “Inspection Results” and “Staffing.” “Quality Measures” is another tab and you would select that.

On the next slide, slide 10, you'll see what you – if you had clicked on the “Quality Measures” tab, this is what you'll see. You'll see the values for each quality measure, along with the State and national averages. On the previous page, you would have also been allowed to select up to two other nursing homes to compare the values of your nursing home with others. There's also the ability – you see an arrow here pointing to the graphing function. You could select that. It's just a way to better visualize the data if you choose to do so.

I'm moving on to slide 11. Nursing Home Compare is not the only place to access your nursing home's quality measures data. You can also access these data in the Five-Star provider preview reports. Hopefully most of you are aware of this option, but if not, I would encourage you to gain access and use the data. We update the provider previews each month. Obviously, though, the quality measures are only updated quarterly—in January, April, July, and October.

On the provider previews, you have the added ability to see the three individual quarters' values and the three-quarter average that we use in the Five-Star Quality Rating System for the quality measure rating.

I've provided on slide 12 the information you need to actually gain access to your provider previews if you don't know how to do so. This information can also be gained at the QIES Technical Support website, and I'll give you the URL for that as well. You can visit www.qtso.com/providernh.htm, and that will walk you through the steps of getting your provider – access to your provider previews. It uses the same systems that States use to enter NDS information.

What the Data Show about Antipsychotic Use in Nursing Homes

Moving on to slide 13, we're switching gears a little. I wanted to give you an update on the new quality measure data we've received. So we now have the first quarter of 2013 data. These are the data that will be displayed on the Nursing Home Compare website when it's refreshed next Thursday, but you're seeing a preview on today's call. This first figure on slide 13 shows the national trend in the percentage of long-stay residents receiving antipsychotic medication, excluding those residents with schizophrenia, Tourette's, and Huntington's. The time period goes from the first quarter of 2011 through the first quarter of 2013, which is our most recent data. For reference on this – on this figure, we have – we have highlighted the baseline quarter of the National Partnership, and we have a dotted line indicating when the partnership began in earnest, around March 2012.

As you can see, the use of antipsychotic medications had – in the long-stay residents has gone from a high of 23.9 percent in Q4 2011 to 21.7 percent in Q1 2013. This 2.2-percentage point decrease represents a 9-percent reduction in the use of these drugs in long-stay residents. Put another way, this figure translates to over 30,000 fewer residents receiving these drugs, which I believe is a great accomplishment.

Slide 14 shows the long-stay antipsychotic values in each of the CMS regions across the same timeframe as the previous figure. As you can see, there's been a significant but varied reduction in the use of these drugs in each of the regions. And you can see the percentage change for each of those regions in the – in the far right column.

Figure 15 is just a graphical display of the same information. But as you can see more clearly, there's been a continued decrease in each of the regions since the beginning of calendar year 2012. Not shown here are the State averages, and those are impressive as well. Eleven States have had a reduction of 15 percent or more in the percentage of long-stay residents receiving an antipsychotic medication since the fourth quarter of 2011. Twenty-one States have had a reduction of 10 percent or more. So, overall, all of – all the numbers – all the data indicate that these – that use of these drugs is going down, and we just wanted to give you an update on those data. And I will turn it back over now. Thank you very much.

Stories from the Field

Alice Bonner: Thanks very much, Dan. And thanks to everyone on the phone. I think, as you can see, the work that you're doing is really having a significant impact. We know we have a lot more to do, but the fact that every region is seeing some improvement is really, really encouraging. So thank you.

Now, as our final objective, we have some stories from the field to talk about some of the successes and challenges that people are seeing out there. We have five speakers, and our first speaker is Joe Rodrigues who is from the California State Ombudsman Program. I think many people are aware that the Ombudsman programs around the country and the nursing home advocates around the country have been tremendous and very active partners in this initiative and none more so than the folks in California. So we're really delighted to have Joe with us today, and I'll turn it over to him.

The California Partnership to Improve Dementia Care

Joe Rodrigues: Thank you, Alice. Good morning, good afternoon, everyone. I'd like to talk you a little bit today about our experience here in California. I'm on slide 18. As was mentioned in some of the earlier discussions, the key stakeholders that participated in our partnership here in California were the usual people that we collaborate and coordinate services with: our – for-profit and not-for-profit nursing home associations; our QIO; Department of Public Health; CMS Region IX; the advocates, of course; and Long-Term Care Ombudsman programs, both locally and at the – at the State office level.

Going on to slide 19: Our work here in California started in August of last year, with CMS Region IX and the California Department of Public Health hosting a meeting in San Francisco to launch the partnership to improve dementia care and reduce unnecessary antipsychotic medication drug use in California's nursing homes. And this first kickoff meeting in August of last year really set the tone for the work that was going to take place over the next few months. It was – I think, it was a very positive meeting in that we were all looking for solutions. We all recognized this is a problem, and all realized we had to work together to effect a solution that would benefit residents.

Moving on to slide 20: The partnership decided to develop a collaborative action plan for improving dementia care and reducing the inappropriate use of antipsychotic medications. As we saw on the – some of the data that was shared earlier, here in California one in five residents in a California nursing home is on an antipsychotic medication. And we all – we all considered that to be a number that was just too high.

Moving on to slide 21: Between August and December of last year, which we called Phase 1 of our partnership, stakeholders convened in three in-person meetings—one in San Francisco and two here in Sacramento—and a series of conference calls, where really much of the work of the partnership was performed. The three in-person meetings were really times that the work groups reported out, but much of the work was done on these – on these conference calls that really formed the basis for this partnership action plan.

On page – or slide 22, the plan that we came out with outlined strategies that we were going to engage in to reduce the inappropriate use of antipsychotic medications. And we looked at four key issue areas: improving dementia care, consumer awareness, enforcement, and informed consent. Each of those key areas had goals and objectives to improve dementia care and to move closer to the – to the goal of ending misuse of antipsychotic medications in California nursing homes by 15 percent by the end of 2012. But our partnership wanted to go even further and say that we can reduce it by 30 percent by June 30th of this year. We, as you know, don't have those numbers yet, but we're hopeful that we're going to be close to that goal, if not surpass it.

We've been reaching out to numerous stakeholders to offer educational opportunities, not just to current residents and families but other families who may be dealing with this issue one day. Our long-term Ombudsman staff have been trained to better understand and recognize the signs of someone who may be inappropriately medicated. We've had some really excellent training provided to us by the National Ombudsman Resource Center, our QIO Health Services Advisory Group, and California Advocates for Nursing Home Reform. We've done a webinar and in-person training for our staff, who will go back to their local programs and train their own staff.

The partnership has a website which I've included a link to at the end of this presentation, where you can see the work that we've done. On our State Long-Term Care Ombudsman website we've collected some resources for residents and consumers, providers, medical directors—all the key people who need to be involved in effecting this change. And I've also included a link to the final report of our workgroup, "Working Together."

We've been able to reduce the use of antipsychotic meds by 8.5 percent since the second quarter of the year. California is – was at 19.3 percent, and I think with this new first quarter 2013 data, hopefully our numbers are going to be even lower. And, again, here are the links to the partnership website and our program's website that has the consumer and other stakeholder information.

And that's it for me. Thank you.

Alice Bonner: Fantastic. Thank you so much, Joe. And thanks to your team out there. I think listening to you – California is such a large State. There's so much going on. And the way you put together so many different organizations and pulled all of them together is really tremendous. And so thanks for being on the call today.

Joe Rodrigues: You're welcome, Alice. I just wanted to mention to sustain the work of the partnership, the partnership is under now the leadership of the – of our Culture Change Coalition. And we've applied for Federal CNP money, which we hope to receive this fall, to fund the continued work on the partnership.

Alice Bonner: OK, thank you. And our next speaker is Nancy Fendler from the Georgia Medical Care QIO, and she's going to talk with us about the work in Georgia. So, Nancy?

The Georgia Learning Collaborative

Nancy Fendler: Good afternoon, everybody. Thank you for joining us, and I'm glad that Georgia gets an opportunity to share. It looks like we have done a lot of similar things to California, just on maybe a little bit different basis. So we'll try and share those with you. Just – first of all, our learning collaborative along with the NCC has adopted their honeycomb and honeybee. So you'll see the honeycomb and honeybee throughout our presentation.

So we're on slide 32 now. And just wanted to give you our strategies of how we got our workgroup off the ground. Last June – actually last April, our health care association sent a letter to each of the nursing homes in the State noting their rate of antipsychotics. And this was an opportunity for worst to first for Georgia. We started on the high end of the spectrum and have made great gains but still have work to do. But after those letters went out, the QIO along with the LANE and other folks decided to start an advisory board. So that's our first group that we pulled together. And we had representation from the Alzheimer's Association, from CMS, from Culture Change Network of Georgia, also our nurse practitioners group, a couple of physicians, two pharmacy groups, the Department of Community Health, HFRD (which is Healthcare Facility Regulation Division), LeadingAge of Georgia, and then our medical director was also involved, and then all of our quality advisers.

So we had a great group of people that we've actually continued on after our 6-month collaborative into our learning collaborative work. So it's been a really great group of people to work with. And so, Michelle had asked us to mention a takeaway, and that – certainly one of ours is working with stakeholders, relationships that we already had in place, and adding some really great providers into that group as well has been helpful.

Then along with CMS, who made some phone calls to some of the nursing homes who had some of the highest rates in the State, we recruited homes with that highest rate. And so we started with 32 homes and worked with them throughout the 6-month time period. We had each of these homes self-report their baseline data for second quarter of 2012, which was April, May, June. And as you all may know, that was interesting work, to get baseline data, because the CASPER report did not yet include the same exclusions as we were looking to include in our project. So teaching the folks and team members at each of the nursing homes how to actually go through and find the correct numerators and denominators was a challenge. And fortunately, that challenge is no longer a barrier for us to do our work.

We did hold three face-to-face kickoff meetings in two different locations—one here in the Metro Atlanta area and then one in South Georgia to give some of those folks an opportunity to meet with us. We did have representation from all 32 of the homes, and many of our partners attended those sessions. So training was available to the QIO folks, also the advisory board people, along with teams of at least two people from each of the nursing homes who were included in these – in the collaborative.

As a part of our pre-work for the collaborative, we had each of the nursing homes call in to a webinar that we offered 2 different days at different times of day with a discovery assignment. And we actually have that form posted on our website if any of y'all would like to look at it. But this really helped us in our planning for our future work for our webinars.

Just some of the questions that were on this (it's Reviewing Patterns of Antipsychotic Use in Your Home): Do they already have a team in place? Are they documenting behaviors? Yes, we know they should be. Are they providing regular CNA education? Those are just a couple of the high points that were included.

And then, also, a breakdown of the type of residents that they had: How many – what percentage were with dementia, Alzheimer's, both diagnosis, or neither? Did they have units that were locked, or closed units? Or did they have a range of different types of residents? So that we can help them come up with plans to get their work going.

At the kickoff meeting, we had our directive for the 15-percent reduction, but we had these group – the group of the 32 homes and the advisory board come up with their own target. And, obviously, we jumped on the 15 percent. But they chose to select a stretch goal of 20 percent, and I'm pleased to tell y'all that we did meet that. We'll share that in a few minutes on the slide with some data.

So on to the next slide, number 33, "Tools & Resources," and I will share the link with you shortly on where we have this. But we already had, obviously, a QIO website. So we decided to create a webpage, similar to California, dedicated specifically to the work that we are doing. And what we would do is post all of the tools and resources and presentations from the current work and then anything that we had going on in the future as well so that folks could go ahead and have those resources prior to the next webinar or call – office-hours-type calls.

Then we provided a lot of technical assistance with phone calls and emails out to these nursing homes. As I mentioned earlier, for them to self-report data was challenging. We had them report monthly data to us. So we did reminder phone calls, reminder emails. We provided them with an Excel spreadsheet to collect the data into and had them fax that information back to us or call if that was easier. And then we collected that data on a monthly basis and sent out graphs and shared that information with them on our webinars.

As a part of our webinars, each of them had different speakers based on the topics. And as I mentioned earlier, we took that discovery assignment that we used for pre-work at our kickoff meeting and basically went through and found the low-hanging fruit and then the topics that rose to the top to determine our future webinar topics. So we had materials that came out of each of those topics. One really important piece of this was the Advancing Excellence tools that we continue to work with these folks on, and the data-tracking tool that Advancing Excellence has has been a great part of our work.

So on to slide 34: So our Georgia Learning Collaborative is part of the NCC. We recruited 103 homes, which is about – almost 30 percent of the homes in our State. Thirty-five of the homes – or excuse me, 20 of the 35 homes have joined that Georgia Learning Collaborative. So, I believe Alice mentioned before, there are homes who worked on this work last year and are continuing to work on it this year, and we certainly have seen that as well.

Again, we are encouraging everyone in our learning collaborative to sign up for and access the Advancing Excellence tools. And we actually have had so far 62 of our 103 recruited homes who have signed up and selected medications as one of their goals on the Advancing Excellence tool, which is really going to help us to continue to see how they have improved.

And then the tools and resources that we created. One great tool was we had a social worker who talked about getting resident profiles so that as you started a reduction, the folks who were taking care of residents who were being reduced would find out what helped a particular person go to sleep at night, or what they preferred to have happen at bath time. So those behaviors that could become a problem were hopefully offset by good communication to the staff who were taking care of those residents.

Next slide is slide 35. And as I mentioned, we did have self-reported data when we went through this project. And with the self-reported data, we came up with a 32.67-percent average reduction with the 32 homes. When the CASPER reports came out a couple of months ago – I guess, about a month and a half ago – in June, I was able to pull the actual data from the CASPER reports for these same homes. And I was pretty impressed that the number came out to 32.65-percent actual through the CASPER reports. So they did a really good job of self-reporting that data. Sixteen of the 32 homes had higher reductions than our collaborative average of 32.65. And 24 of 32 homes had a higher reduction than our State average of 16.3.

So we are really excited about what we were able to do. And as I mentioned earlier, these were some of the homes in our State who had really high rates. I hate to tell you how high they were—over 75 percent to start with. So we are really excited about the reductions they were able to make. And I would say the number one comment that we heard from them was just bring it to their attention was the best thing to do.

So next slide, slide 36 just gives you a couple of small screenshots of what we have on our website. Our Georgia Learning Collaborative, as I said, is our learning collaborative for all of the Phase 2 work. And we have a link inside of that Georgia Learning Collaborative webpage on to all of our antipsychotic projects that we had before. So we have access to recordings and PowerPoints and tools and resources from the webinars that we did each month along through last year from July through the end of the – of the year.

As I mentioned, we did continue our advisory board and have added to that group to continue with our learning collaborative. So, that's been really, really helpful.

And the – our – one takeaway that – another one I wanted to mention is our advisory board has decided to issue a statement to clarify the goals for the nursing homes across our State. I do believe there are some homes who are really getting the message that – hopefully, not from us – that the target is zero. And they're really working hard to meet that. So we want to make sure that folks understand that our goal is a *reduction*. And we know that there are some folks who do need to be on antipsychotics, but making sure that you're working with your physicians and your psychiatrists, and care planning everything correctly is what we want to make sure that they're able to do. So we're actually working on that right now. We do have a Georgia Medical Directors Association meeting coming up at the end of this month, so we want to have that statement out and available to the medical directors across the State in the next couple of weeks.

And last slide, slide 37: Just want to wrap up, and we – again, as I mentioned before, we're continuing along with that theme that the NCC has had, with the honeybees and the honeycombs, and just making sure that everyone is aware that we're all working together on this as a team.

And that's it.

A Few Takeaways

Alice Bonner: Terrific. Well, Nancy, thank you so much. And I do want to emphasize one of the last points you made that's so important, which is, again, from CMS and all of our partners in this work, this is really about individualized, person-centered approaches to dementia. It's not about getting the rate of antipsychotics or any other drugs down to zero. That would just be chasing a number, and that is not what our patients and our residents need. What they need is for us to really be individualizing so that people who, you know, should be on these medications based on a thorough evaluation and a comprehensive team approach, as you described, are going to remain on them. And people who are going to benefit from nonpharmacologic approaches and other approaches to dementia care have that as part of their care planning process. And I'm so glad you mentioned care plans, because they are just so critical to reaching our goals of improving dementia care in this national partnership. So, thank you.

I heard a couple of other really great takeaways that you mentioned. And, you know, one was that just bringing attention to the issue really helped a lot of the homes. They didn't realize their rates were so high. So that helps us understand why the data is so important. I heard you say that the data-tracking tool on Advancing Excellence was really helpful. And I heard you talking about one initiative building on another. So the fact that the – you know, the national – the nursing home quality collaboratives rolled out at the same time allowed you to build on that and on the State Coalitions for the dementia care, and vice versa, so thank you so much.

Our next speakers do not have slides. So you can just listen in. And our next presenter is Margie Donegan who's from the Glen at Willow Valley in Pennsylvania. So, Margie?

Dementia Care at the Glen at Willow Valley

Margie Donegan: Hi, good afternoon. I'm Margie Donegan, Health Care Administrator at the Glen at Willow Valley, a 205-bed skilled nursing facility, which is located in Lancaster, Pennsylvania. Our facility's effort to reduce antipsychotic medications has really been an ongoing process over the course of several years. It includes many quality assurance process improvement initiatives.

Just to give you an idea of our reduction efforts, in 2008 our percent antipsychotic medication use was at 20.6 percent. In February of this year, we now have a percentage of 13.23. Our process has been multidimensional as well as multidisciplinary, and has transcended resident-focused care culture change as well as 2½-year environmental enhancements through our renovations. I'd like to share with you what practices we have attributed to our success.

Our facility had a total commitment to the goal of reducing antipsychotic medication. The commitment must originate with administration and must encompass the entire team. We first focused our medication reduction efforts on our 49-bed skilled dementia unit, where we identified our highest usage of antipsychotic medications, and where we did see most of our behaviors. We do have a formalized dementia care program in which our operational model shows resident-focused care as the center of the program. The continuum of care criteria is used for appropriate placement, based on our residents' assessment. We assessed for cognitive function, activities of daily living, and involvement in daily group recreational activities or therapeutic engagement. We do utilize a comprehensive assessment tool called our resident profile, which is completed by a family member even prior to admission, and does provide vital information to the care team about the resident, including their preferences, any medical history, daily routines, and behaviors.

We're very fortunate to have a certified dementia specialist that's our RN Clinical Manager on our dementia unit, who possesses 20-plus years of experience working with residents with dementia. It is her passion as well as the clinical expertise in behavior management, understanding antipsychotic medications, along with knowing the importance of staff and family education, which has greatly contributed to our success. We're fortunate also to have a consistent, knowledgeable, and cohesive interdisciplinary team, all of whom play a key role on the team.

Our behavior management program is very instrumental in our efforts and success in antipsychotic medication reduction. When a behavior is identified, our IVT team will review the behavior at our next standup meeting. The teams attempt to determine the root cause analysis of the resident's behavior. Is this a new behavior, or is it related to a possible change in condition (for example, a fever)? If the behavior is new, the behavior is monitored for 5 to 7 days to identify the triggers and what interventions are most successful in defusing the behavior. The behavior management team is championed by our social service and includes rec therapy and a nursing representative.

Involvement of the frontline staff is vital to the success of the program. One example is when one of our residents was having a lot of behaviors on the 11:00 to 7:00 shift. The CNA in consultation with her indicated that the resident would wake up every night very cold. She went to the blanket warmer and got a warm blanket, and it was instrumental in defusing the behavior.

The family members are also very important as part of the process. The insight into the resident's behavior is really invaluable. So once the behavior management team, then, develops a care plan, it must be communicated to the entire team on all the shifts. For residents with more challenging behaviors, we utilize the expertise of our consulting psychologists and psychiatrists to assist with behavior management. Most of our consultants work strictly with the geriatric population.

We also have an antipsychotic drug committee, which meets on a monthly basis and is attended by our consulting pharmacist, social worker, clinical managers, and rec therapy. The committee reviews all residents on psychotropic meds, any new admissions, and regulatory dose reductions. Additionally, the committee reviews the resident's behavior management records, which document our PRN medication, interventions prior to administration of medications, medication effectiveness, and any side effects.

Educating our licensed nurses on the regulations and policy and procedures standards of care for psychotropic drugs is key. Also, all of our PRN psychotropic meds, we request the physician's order for a 10-day stop date, which then requires the team to reassess the effectiveness of the medication. Additionally, we do weekly audits to ensure that the nurses are following the procedure to make certain PRN medications are not administered unless nonpharmacological interventions have been attempted. Also on admission, a list of all our residents' medications are faxed to pharmacy.

Involvement of the medical director and attending physicians is critical. Our medical director, a geriatrician, takes an active role in physician education on the appropriate use and correct diagnosis for antipsychotic medications. Under his direction, one of our geriatric trained attending physicians has successfully utilized medications such as Neurontin, for mood and pain management, with great success. It is this physician practice that has made a significant impact on reducing our antipsychotic medication usage in our facility.

We also require mandatory dementia training for all those team members who work on the dementia unit, and this is taught by our certified dementia specialist. All departments are encouraged to attend. The program focuses on understanding the disease process, behavioral management, successful individual care techniques, therapeutic engagement training, and also the latest research on dementia and dementia care.

Our rec therapy team focuses on a person-centered therapeutic engagement program based on the resident's interest, their cognition, and ability to participate in the programming successfully. Activity programs are shorter in duration, and times are

adjusted based on the resident's rest period and trended times of increased behaviors. Team members are also trained in one-to-one individualized programming.

So in summary, it becomes evident that our best-practice standards for antipsychotic medication reduction cannot really be attributed to just a few practices, but the combination of many over time. And even though the team identified the aforementioned best practices for successfully reducing our antipsychotic medication percentages, all agreed there is still opportunity for ongoing improvement.

Just three takeaways I'd like to share:

- Stay the course of culture change and resident-focused care. Get to know your residents—who they are and what their past has been will enable the care team to better understand the resident's needs and how best to meet those needs.
- Passionate, consistent, and committed team members who are well educated in behavioral management, individual therapeutic engagement, and your facility's practice-of-care standards.
- And third, commitment and support of the leadership team, including the medical director, administrator, and director of nursing.

I'd just like to take this opportunity to thank the Pennsylvania Department of Health for their acknowledgment of our facility's efforts in the reduction of the use of antipsychotic medications, and certainly appreciate the opportunity to share our success. Thank you.

Additional Important Themes

Alice Bonner: Wonderful. Thank you, Margie. And in addition to those great takeaways that you mentioned, I just also wanted to reflect that you talked a lot in your presentation about the families and how that's such an important part of your program, and the family filling out an assessment and sharing information about that individual even before the individual gets to your facility, when that's possible. And so that's a really terrific theme for you to bring to us today.

It also sounded like another theme was very close collaboration among the psychotropic drug committee or team that you have and your geriatric psychiatry and psychology providers. I know one of the things we hear a lot on some of the calls that we have with folks around the country is, you know, that they really want to have a much closer relationship among the primary care teams and physicians, nurse practitioners, and nurses, and the consultants or specialists who come in who have such great expertise in geriatric psychiatry. But, you know, it's so essential that those – that those individuals are all working really closely together, and that there's good communication and opportunities to really talk about these residents with the residents and the family. So I'm glad you spoke about that.

One final thing to note: You did mention one of the mood stabilizers. And that's something people have brought to us as well from a lot of facilities. They've said, well, you know, what if there's just a shift in prescribing to mood stabilizers instead of antipsychotics? Which – mood stabilizers may be appropriate in particular instances and

may be effective, but they do still represent, as you said, a psychotropic drug. So you were very careful to let us know that people were only being placed on any medication after they had been tried on nonpharmacologic measures first and approaches.

So I think that's really a very important take-home here. The surveyors and the surveyor guidance does instruct surveyors to consider and to look at other kinds of psychotropic medications or psychoactive medications in addition to antipsychotics. So it can certainly be that anybody who's on any of these medications, that there's good documentation in the record, as you mentioned, of the approach using nonpharmacologic interventions first, the interdisciplinary team collaboration, which you described really well, and so forth.

So thank you so much for sharing all of that. The one final thing I'll say, it certainly sounded like you had many wonderful professionals who have particular expertise—certified specialists in dementia and so forth. And I'm wondering if some of the folks who are listening today may think to themselves, "Well, gosh, you know, we don't have all those people in our facility." And so maybe during the questions and answers, you know, there'll be some good dialogue about, you know, how you got started on this path, and how facilities that don't necessarily have all of those different types of specialists can still make improvements, you know, sort of one step at a time because you really described a wonderful comprehensive program. So thank you.

Unfortunately, Andy Rosenzweig is not going to be able to join us today. So, we're going to skip over that presentation and go to our last presenter, Laura Gitlin, who is a researcher at Johns Hopkins University. She's going to share some of the thoughts from their team. So, Dr. Gitlin?

Research on Dementia Care

Laura Gitlin: Thank you, Alice. And thank you for this opportunity. My name is Laura Gitlin, and I'm the Director of the Center for Innovative Care in Aging that focuses on developing and testing and implementing novel interventions for older adults in the home and community and in residential facilities.

I wanted to share very briefly with you a new pro – an ongoing program of clinical research that's designed to prevent and reduce behavioral symptoms, primarily of the agitation type, in people with dementia, using an individualized, person-centered, nonpharmacologic approach. The program, referred to as the Tailored Activity Program, involves identifying the preserved capabilities of the person with dementia; their previous and current interests, hobbies, and occupations; and their functional capacity, from which activities are designed that match their capacity and interest. And then caregivers, whether formal or informal, are then trained to set up and monitor and use the activities on a daily basis and learn how to communicate, provide cues when needed, or to monitor the activity.

The intervention is implemented primarily by occupational therapists, who are very much overlooked when – and are not necessarily part of behavioral management teams, but yet

they do possess a very specific skill set in training that makes them ideal for being part of the team using a nonpharmacologic approach.

So the Tailored Activity Program involves about eight sessions. They can – the length of each session depends upon the setting in which it occurs. If at home, it may be up to an hour duration. In a facility, it may be a shorter, of 20 minutes to a half an hour. And the intervention itself can be accomplished over a few weeks or up to 4 months—again, depending upon the funding mechanism to support the program or the setting in which it's involved.

And there's three phases to the program. The first phase is a comprehensive assessment, as I alluded to, in which the occupational therapist takes a very careful history and interviews the family as well as the person with dementia to identify interests and things that – previous occupations that may help form the type of activity that is introduced, as well as a whole set of performance-based assessments that enable the OT to identify the best functional capacity of that person and the very specific types of cuing that person may need in order to engage in the intervention. So this is a very psychosocial and strength-based model. The assessment also includes an understanding and an observation of the physical environment and also the capacity of caregivers, what they will need to know and learn in order to be successful about using the activities.

In the second phase, three activities are introduced one at a time. And, again, formal or informal caregivers are taught very specifically how to set up the activity, how to cue, and so forth. A written-type document called an activity prescription is provided; in a facility it becomes part of the medical chart, if you will, so that others can see exactly what the activity is, how to set it up and use it. And the activity prescription also includes what the person's capacities are: what are their strengths, how long can they attend to an activity, do they have fine or gross motor capacity, and so forth.

And then the third phase of the intervention involves the occupational therapist working with the family member and/or, again, formal providers to take the lessons learned from introducing that activity and showing how those specific strategies, such as communication or simplification of the environment, can be used as part of everyday practices to support the person in the environment in which they're at. So the program targets people with dementia at the mild to moderate to moderate-severe stage of the disease, and with any etiology, who are experiencing any kind of neuropsychiatric behavior, but as I said, primarily of the agitation type.

Now this program was initially tested as a Phase 2 pilot study funded by the National Institute of Mental Health, with 60 persons with dementia and their family members at home. And from that, it was found – from that trial – Phase 2 trial, it was found that we were able to reduce the agitation and the frequency of other behaviors, and we were able to enhance engagement and quality of life of the person with dementia, and the effect sizes were very, very large. We also found that we were able to free up the time that families reported themselves having to spend in daily supervision or doing things for the person by about 5 hours. And that – this work was published in the *American Journal of*

Geriatric Psychiatry in 2010. And because this was at the time and continues to be at the time one of the few studies to show reductions in agitation, there's been a tremendous amount of interest, and a variety of settings have taken this program and tailored it to their setting.

So this program is now being tested in the VA, and it's funded by the VA in Gainesville. It's being tested in Australia, with a generalized dementia population, through their national government. And also an Alzheimer's Association grant is funding this program to test it specifically with people with frontotemporal dementia. We are now testing this approach in a much larger Phase 3 efficacy trial for at-home caregivers and people with dementia through the National Institute on Aging. And the Administration on Aging has funded Kentucky to implement this in adult day centers there. And Scotland is rolling out this program throughout their country.

And the one program that – it is a work in progress – that's the most relevant to all of you who work in facilities is a program now funded by the Alzheimer's Association to evaluate the feasibility of implementing this in a chronic care hospital. And in chronic care hospitals, which are often part of hospitals now or also part of subacute facilities in nursing homes, there is a tremendous overuse of chemical restraints. The chronic care hospital that we're working with at Hopkins is an average of 21-day stay – hospital stay for people who have general psychiatric issues, the vast majority of whom are coming in with dementia. They're coming from home, nursing homes, assisted living, or the hospital because of behavioral complaints of the setting from which they're coming.

And we just wrapped up this pilot feasibility trial, and we have been able to show that even in a very fast-paced, 21-day-stay environment, that the OT is able to quickly, on the first and second day of admission, interview the family and take careful assessments of the person with dementia, identify three types of activities (primarily of the leisure type), and develop activity prescriptions, and then train the rec therapists and the certified nursing assistants to introduce these activities on a daily basis. And we are still evaluating, so I don't have data yet to see its effect on the reduction of chemical restraints. The anecdotal comments suggest that this is a very promising approach. And, again, as I said, what makes this very important is that we're able to show that an individualized, person-centered, and I must say, labor-intensive approach is possible even in a very fast-paced environment such as a chronic care hospital.

Now, one of the – or several of the take-home points I would say thus far is that we really must establish new clinical pathways in these chronic care hospital settings. And the team that we have amassed to do this includes occupational therapists, nurses, rec therapists, medicine, and psychiatry. And now we're working together to take the lessons learned from this feasibility study to develop a clinical pathway so that the first choice is to – that – in which a person is demonstrating some behavioral disturbances that typically will result in a call for some kind of intramuscular shot or other kind of chemical restraint, is to use the activity.

And the lesson, I guess, I would just want to share with you at this point is that we have learned that this requires entirely new way of thinking and new competencies. And some of those competencies include how to be a member of an inter-professional team and how to engage in team work, what the roles of an occupational therapist, rec therapist, a CNA, a nurse, physician, and psychiatrist, and psychologist, I should say, and possibly social work has vis-à-vis the use of these activities and other nonpharmacologic approaches—competencies in knowing how to, as I said before, act as a member of a team, showing respect and knowledge as to what they bring to the group. Also, a key competency is learning how to problem-solve, although all health professionals will say that, of course, clinical work is all about problem-solving. There is a very specific way of problem-solving in order to derive the best nonpharmacologic approach.

Competencies also include knowledge about behaviors and how to read facial messaging about, possibly, signs of underlying pain or infection, and how to read preclinical signs before behaviors such as agitation escalate to the point that staff are relying on chemical solutions versus nonpharmacologic.

So, again, I'd like to thank you for being able to share this work in progress. And this is where we are at at this point. And I look forward to the opportunity of coming back to share also the data that we have from some of these feasibility and cross-national studies. Thank you.

Alice Bonner: Fantastic. Thank you so much. So today we've heard from State coalitions, QIOs, advocates and ombudsmen, providers, and now researchers. So it's been a phenomenal group of speakers. Thanks so much to all of you. I know most of you are still on the line, perhaps not all of you, but we'd like to move now into our Q&A portion of the call. And just encourage people to think about, you know, what outreach strategies you may have used successfully and really implemented that have led to changes in your nursing home. And encourage people to talk about very practical solutions that they may have put into place, if they'd like to mention that as well as ask questions.

So I'm going to turn it back over to Leah, who's going to be our moderator for this part of the call.

Keypad Polling

Leah Nguyen: Thank you, Alice. At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results. Victoria, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using only one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and

eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

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

Please hold while we complete the polling.

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

Feedback About Medicare Administrative Contractors

Leah Nguyen: Thank you, Victoria. Before we start the question-and-answer session, we would like to make a special announcement. CMS will soon provide a new opportunity for Medicare-enrolled providers and suppliers to give us your feedback about your experience with your Medicare Administrative Contractor, or MAC, the contractor that processes your Medicare claims. This new assessment tool is called the Medicare Administrative Contractor Satisfaction Indicator, or MSI. Your feedback will help CMS monitor MAC performance trends, improve oversight, and increase efficiency of the Medicare program.

Each year, CMS will randomly select its MSI administration sample from a list of providers who register to become a participant. If you would like to register to become an MSI participant, more information is posted on the July 10th call webpage. Thank you.

Our subject-matter experts will now take your questions about the CMS 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 question to just one. If you would like to ask a follow-up question or ask more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits.

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

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Please hold while we complete the Q&A roster.

Question-and-Answer Session

Operator: Your first question comes from the line of Susan Crane.

Alice Bonner: Hi, Susan.

Susan Crane: Hi. I'm with the Florida Culture Change Coalition. And one of the things I was curious about was the home in Pennsylvania, whether or not they have implemented the basic culture change operational things like consistent assignment, huddles, and those kinds of things. And I guess I'd just like to put a plug in for Pioneer Network, which is not listed on the list of resources, which has a tremendous amount of resources and is going to be coming out soon with a toolkit for implementing person-centered care. And there's a part of that that's related to reducing antipsychotic medication. Thank you.

Alice Bonner: Thank you very much, and I'll turn it over to Margie Donegan to talk about the Pennsylvania facility. But we do – I believe there are some links on the Advancing Excellence website to the Pioneer Network, but we'll be sure to take a look at that. Thank you for mentioning it. Margie?

Margie Donegan: Yes. We have started to implement, and over the course of several years, at times into – we will incorporate the various components of the culture change, yes. With our renovation project, that was sort of a focus of ours in mind when we looked at our renovation project—how we can make a much more home-like setting in our institution. So, yes, we have – and continue to incorporate culture change into our process.

Susan Crane: Thank you.

Operator: Your next question comes from the line of Brenda Sparks-Sanchez.

Brenda Sparks-Sanchez: Yes, hi. Across the nation and the different States where there have already been a lot of reductions accomplished, I'm interested to see if other people have seen in residents that were for a very long time, even possibly years, decades, on strong antipsychotic medication, when these were discontinued, did they – did other people see physiological withdrawal, like a syndrome? Because I think we have seen that here in at least one or more of our residents.

Alice Bonner: That's an interesting point. And we've – we've had that question come to us. This is Alice Bonner. I'm just going to respond, and then I'm going to see if any of the other subject experts want to chime in as well. We've seen really both. Some scenarios where at the beginning of a taper, if it's – if the taper is done too quickly and in some residents, there have been some changes where the behaviors have recurred or there have been other signs and symptoms that have occurred. But we've also heard stories where people have been on some of these medications for many years, and they've really blossomed and flourished when the medications were tapered or discontinued.

So I think if we look at the literature and the evidence, as some folks were saying earlier, it's not that these drugs are going to go down to zero use. There are some people who have been on them for a long time and have a clear clinical indication to be on them. And that's why the recommendation is that, you know, the consultant pharmacist be involved, primary care be involved, sometimes geriatric psychiatry be involved, both in making the decision about who should be – you know, who would be appropriate for a trial of a taper and also how that taper is done.

In the case that you mentioned, when somebody's been on it for a very long time, it may be that the period of time over which the taper has to occur is much more prolonged, for example, than someone who's been on it for less time. But I know that we have some other folks – does anyone else want to respond to that question as well?

OK. Well, thank you for the question, and I think we're going to continue to collect stories. One thing I would say is, we are collecting stories from around the country, both, you know, stories where gradual dose reduction has gone well and where there have been some challenges. So we'll continue to do that. But thank you. And I'd also invite people to email us and write in if you have, as our questioner mentioned, if you've seen similar issues or positive stories about gradual dose reduction.

Operator: Your next question comes from the line of Jennifer Ulmer.

Mona Hunter: Hi. This is Mona Hunter from DuPage Convalescent, with Jennifer. And I had a question just about the Nursing Home Compare website. When we went on it, we are not able to get the comparison of our facility with the State and national averages. It's not coming up. Only our facility's numbers are coming up.

Dan Andersen: Well, that sounds like they've – a glitch may be on the website. What you can do – there is a provider – an email address for providers. And that is BetterCare@cms.hhs.gov. If you can send a screenshot of that problem, we can certainly try to address it.

Mona Hunter: OK, we will do so. Thank you.

Operator: Your next question comes from the line of Beth McMaster.

Beth McMaster: Hi, this is Beth McMaster from United Church of Christ Homes in Camp Hill, Pennsylvania. I just wanted to do just a couple of comments about Margie's presentation and the certification for dementia practitioners. I have used this in the past. It is a very simple and inexpensive program for staff to go through. And their website actually has free staff training in services and toolkits available that you can sign up to receive. So I would suggest that that is an outstanding place to start or place to move forward to as we move forward providing care for those folks with dementia.

Alice Bonner: And – thank you very much for that comment, Beth. And do you have that website that you could share with the folks listening?

Beth McMaster: I do: www.n, c as in Charles, c as in Charles, d as in David, p as in Paul.org.

Alice Bonner: Thank you.

Operator: Your next question comes from the line of Marian Hollingsworth.

Marian Hollingsworth: Hello, this is Marian Hollingsworth, and I have a question that was touched upon very early on in the discussion. Has to do with informed consent and the antipsychotic drugs and hospitals. The question is, does informed – does the initial consent for treatment in hospitals cover antipsychotic drugs? I've talked to the Health Department here in California, and they say once you sign the initial blanket consent, that that gives them the right to do anything they want to you as far as drugs are concerned. And that could – that initial consent for treatment then covers – it follows over to the nursing homes, but that – but basically by doing that, there is no informed consent given on any level for the antipsychotic drugs. So how does Medicare deal with that situation? Do I make myself clear?

Alice Bonner: Yes. Yes. So this is – this is Alice Bonner from CMS. And I'll – again, I'll respond and then invite others to comment as well. There are our regulations, which are the nursing home regulations, the Federal regs. There are also State licensure regulations, and many States have separate State licensure regulations regarding informed consent in nursing homes. And then there are facility-specific policies, where facilities may actually write their own policy to require informed consent, either written or verbal, in different ways. The Federal requirement is that, you know – regulation is that the resident has the right to be informed of his or her plan of care, and that includes medications.

So it's not a Federal requirement for informed consent per se. However, in our new guidance and in our trainings for surveyors, we do talk about the resident or the appropriate legal representative, you know, must be involved and be made aware of the use of any psychoactive medication and the risks and benefits of that medication, the reason the medication is being prescribed, the target behaviors, the dose—all of that information. So, our regulations are, you know, more general and it's not specifically – we don't specifically call it informed consent. But, again, quite a few States have informed consent laws on the books, and it would not necessarily be the case that what was done in the hospital would translate automatically to the nursing home. There could be a different set of providers in the nursing home, a different primary care team. And so those discussions really need to happen in the setting of care where the person is receiving their care.

If there's documentation in the hospital, and there's documentation about the discussion that happened and about the informed consent that was given, and perhaps there's an informed consent form that was completed in the hospital—all of that is very important information and should be brought over to the nursing home and reviewed by the primary

care team. But I would say that, again, it's – it's State-by-State but, you know, I would continue to work with the folks at the California Department of Health on any further information that may come about, because sometimes those State regulations do change. But is that – does that answer your question?

Marian Hollingsworth: All right. So it's just State by State. And if your State is not as active in that, then it's more difficult to get into. Basically, advocate for yourself.

Alice Bonner: Well, I would say that there is enough in the Federal Code of Regulations for nursing homes that makes it clear that if your – if a resident in a nursing home is receiving any type of psychoactive medication, that there needs to be documentation in the record that there was a discussion with that resident, if they're able to participate, or that resident's legal representative, about the indications, side effects, the risks and benefits, et cetera. And surveyors will be looking for that.

Marian Hollingsworth: OK. Thank you...

Alice Bonner: All right.

Marian Hollingsworth: ...so much.

Alice Bonner: You're welcome.

Operator: Your next question comes from the line of Debbie Dyjak.

Debbie Dyjak: Yes, this is Debbie Dyjak. I'm the RN Education Coordinator at Archie Hendricks Sr. Skilled Nursing Facility. We're out on the Tohono O'odham Reservation in Southeastern Arizona. And thank you, first of all, for the presentations. They were quite excellent. And I am currently leading a team of staff here to look at addressing behavioral expressions that our residents have that would calm the residents, and do that in a nonpharmacological way. And we're looking at – we're building an algorithm that's based on behaviors and interventions that are very specific to our facility, and building that into the charting system, the electronic charting system, that our CNAs use.

So it's been quite an adventure in the last 12 months. And I wanted to comment on two things that were said. I think really the importance of raising awareness and the importance of pursuing this as a team, and that something is being done. Because I had quite a few comments from CNAs as we started this process that it was very encouraging to them to know that someone was really trying to make a difference in this area. And so I think that's very important. And we are doing some huddles on the unit—with the – which include our social service department and nursing staff; it includes the CNAs. When there is a behavioral expression, especially, you know, if it just – what they're trying isn't working, we huddle, and we are working on revising a form. So your information was very helpful for me in terms of some of the things I'm doing right now.

My question – two questions – one was the – if you could comment a little bit more on the support. Because one thing we're finding is, with the CNAs especially, they just really need a lot of support. The education is important too, but there really just needs to be a lot of support for the work that they're doing. And also, if anyone has any thoughts on the use of Snoezelen Rooms, because we have that also.

Alice Bonner: Wonderful. So I was wondering if either Laura or Margie wanted to answer that, particularly about the Snoezelen Room, and perhaps tell the – tell the audience what that would include or entail.

Margie Donegan: This is Margie Donegan. We currently do not utilize a Snoezelen Room, so I really cannot comment on that. I would just like to comment as far as the CNAs and the support that they get. We find that the more we can involve them, as far as getting their feedback, they're the ones that know the residents better than anyone. They spend so much more time with them. So the support that we see that benefits us and benefits them and the resident most of all, is that we talk to them, we get their feedback. And that's really invaluable.

Kenneth Brubaker: Alice, this is Dr. Brubaker. I'm with Margie right now. I would just say that as a geriatrician who runs a dementia unit, when I go into my dementia unit to do my rounds, one of the first things I do is spend the time with the CNAs going over the residents. Because I feel that they probably know more about the residents than the LPNs or the RNs in all – many cases. So, to me, I think we oftentimes minimize the valuable information we can get from CNAs. And so one way we can do it is elevate their status in terms of appreciation of what they do and also the helpfulness they can give me as a clinician to provide appropriate care.

Laura Gitlin: Hi, this is Laura. And I would just like to add that, in terms of training CNAs in using tailored activities, we spend a lot of time demonstrating the activities so the CNA observes the OT, and then also the rec therapist engaged in the specific activity. Then they practice using that activity under the supervision of the OT. And then when they feel confident, then they are given the charge to use the activity on a regular basis. And we find that there must be a supervisory structure in place to reinforce their continued use of the activity and to provide validation and praise for the work that they're doing. And with that, then we find that there is, you know, pretty good success in carryover in using the activities.

I really don't have direct experience with the Snoezelen except to say that the evidence is still a little bit mixed, with some studies – small studies showing a benefit for some persons and not for others. So, just wanted to let you know that piece.

Alice Bonner: Thank you. Thank you very much. Those are great responses, all of them. And so the Snoezelen is a multisensory environment that's – originally, there were some studies, I believe, from Europe. And so we've not heard a lot about different facilities using that, but it's certainly something – you know, people can go online and take a look at that approach.

I really appreciate Dr. Brubaker's comments and how important it is, again, that CNAs are acknowledged for, you know, how challenging it is and sometimes scary when people have some of these behaviors. And the support that they need—you know, I hear you asking about the support, and it's really in the management structure in a facility that the CNAs are – receive the support. I know that some of the tools and resources on the Advancing Excellence website include a tool to look at stress among staff, and what kinds of things about caring for someone with dementia that has – who has behaviors, you know, causes stress in staff and why. And some of that was from Dr. Gitlin's work (inaudible) at Johns Hopkins.

So, Leah, I'm looking at the time, and so I'm going to turn it back over to you if there's any final question. Or if we're out of time, then we'll go on to just the wrap-up here.

Leah Nguyen: Oh, it looks like – I think we have time for one final question.

Operator: Your next question comes from the line of Linda Buscemi.

Linda Buscemi: Hi, this is Linda Buscemi, a behavioral consultant in Arizona. And I actually had a question for Laura. I actually created a four-page environmental assessment, is what I called it, with different domains, to be a bit more curious and use these kind of behavioral interventions as – instead of the pharmacological intervention. My question to you is, is there any way that we can have access to any of the questionnaires, assessments, or interventions that you're utilizing?

Laura Gitlin: I'd be happy to share some of the questionnaires. We have a pretty elaborate treatment manual for the Tailored Activity Program for the way it's conducted in the home. And maybe this is something that you and I could communicate. At this point, it's still under – being tested. So I would share it on a limited basis until the trial is officially over.

For the Tailored Activity Program being tested in the chronic care hospital, again, the manual is under construction, based on our completion of the – of the implementation of the feasibility study. And, you know, when that is done, we'd be happy to share that.

For the home, we did develop some time ago an inventory of home environments called the Home Environmental Assessment Protocol, and it's specific to identifying hazards as well as adaptations made in the home that are specific to support people with dementia. And that's been published, and I can easily send that as well if that would be of interest. And I – you know, we really do need much more assessment development in this area. So I would welcome to – really welcome you and your work, and would love to see how you've managed this kind of assessment approach.

Alice Bonner: Fantastic, thank you.

Linda Buscemi: All right, thank you so much.

Leah Nguyen: Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 46.

I would now like to turn the call back over to Alice for some closing remarks.

Conclusion

Alice Bonner: Terrific, thank you. This has been absolutely wonderful and just, as usual, enriching to all of us here at CMS. And thank you to all of the presenters today. Thank you to Leah and her team. And thanks to all of you who are so busy out there, for taking the time to listen. And we hope that this has given you some ideas and that there are some takeaways that you'll be able to put into action with your teams.

There are a few remaining slides in the slide deck for this call. And there's a slide that says, "What if we don't have a lot of geriatric training or experience?" It's slide 41. It lists some websites, and I would just point out that one of our callers also mentioned the Pioneer Network, which you can look up online for additional resources as well.

And slide 42 provides the website – our email box. And you can email us questions or followup from this call or any other questions you might have.

Slide 43 is the Advancing Excellence website and it shows you the homepage. And slide 44 shows you, lower down on the homepage, that we still have that big blue button with the CMS partnership, and when you click on that, you just get a phenomenal set of tools and resources. And so please take a look at that. We are constantly updating it. It's a very dynamic website. Miranda Meadow and Michelle Laughman and others do a terrific job with that.

And then finally, just, again, my information, Michelle's information, and how to reach us.

So, again, many, many thanks. And for final closing comments, Leah, back to you.

Additional Information

Leah Nguyen: Thank you, Alice. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release the announcement in the MLN Connects Provider eNews when these are available.

On slide 47 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 that you will take a few moments to evaluate your MLN Connects Call experience.

This document has been edited for spelling and punctuation errors.

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

Operator: That concludes today's conference.

-END-

