MLN Connects™

National Provider Call Transcript

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

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

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd 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 National Partnership updates and an overview of QAPI, as well as a presentation on adverse events in nursing homes. Additionally, Advancing Excellence will discuss their campaign for quality in America's nursing homes. 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 email. If you've not already done so, please view or download the material 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 March 10th 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. Announcement will be placed in the MLN Connects Provider eNews when these are available.

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

Presentation

Michele Laughman: Hello and welcome. As Leah mentioned, our call today will focus on initiative updates and next steps, as well as presentations about QAPI, adverse events in nursing homes, and quality through interdisciplinary design.

CMS is grateful for your time, energy, and dedication to the mission of this partnership. These calls are an opportunity to share new information about innovations in dementia care and to highlight successful care approaches that are being implemented all around the country. We all share a common vision of truly person-centered dementia care in every nursing home. Together, this vision is becoming a reality.

The success of this partnership is the vision we all have, the vision to provide care that is person-centered in a homelike environment for individuals with dementia who reside in nursing homes across our country, as well as all nursing home residents. Shortly, a final report pertaining to the findings of the Focused Dementia Care Survey Pilot will be released along with the survey and certification memo. The report describes in more detail the results of the Focused Survey Pilot that was completed in 2014, the process that was utilized, and the conclusions that were gathered based upon post-pilot data analysis. The memo will also include information about plans for piloting — or for expanding the pilot effort.

CMS plans to expand upon the work of the Focused Survey Pilot and has invited states to conduct such surveys in fiscal year 2015 on a volunteer — on a volunteer basis. The expansion projects will involve a more intensive, targeted effort to improve surveyor effectiveness in citing poor dementia care and the overutilization of antipsychotic medications and also broaden the opportunities for quality improvement among providers. Initial focus efforts will occur in Texas, with additional state involvement expected.

Today, we will hear from Debra Lyons, a registered nurse within the Division of Nursing Homes at CMS; Cathleen Lawrence, also a registered nurse within the Division of Nursing Homes; and Doug Pace, Executive Director of Advancing Excellence. 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 and quality for people living in our nursing homes.

I would now like to introduce Debra Lyons and Cathleen Lawrence. Ms. Lyons and Ms. Lawrence will provide an overview of the QAPI program, as well as information pertaining to efforts in reducing adverse events in nursing homes. I turn it to you.

Update on QAPI and Adverse Events in Nursing Homes

Debra Lyons: Thank you Michele. Hi everyone, my name is Debra Lyons. As Michele said, I work in the Division of Nursing Homes in the Survey and Certification Group here at CMS. As she mentioned, I am a registered nurse and a former long-term care surveyor for the State of Maryland. Together with my colleague Cathleen Lawrence, who is also a registered nurse, we are team QAPI — team QAPI, for the Division of Nursing Homes, and we are also the leads for adverse events in nursing homes. I'm happy to provide you with an update on QAPI and adverse events today, and I will be doing most of the speaking. My colleague is here with me, but I'll lead you through the slides.

So our goal for today's program, on slide 8, you'll see — we would like for each of you to come away from this session with a better understanding of what QAPI is, where it came from, and why all the fuss over it. I will share with you the work we've done to date for the nursing home QAPI rollout, and tell you what you can expect in the near future. And then I'll answer some frequently answered questions —asked questions —

about QAPI and how it fits with Quality Assessment and Assurance, or you know it as QAA or F520, as well as other quality initiatives. And then we'll talk about the Office of Inspector General Report on Adverse Events in Skilled Nursing Facilities that was released in February of 2014, and the work that CMS is doing to raise awareness and reduce adverse events in nursing homes.

So if you look at slide 9, I'd like to start by giving a bit of background about nursing home QAPI. As many of you may know, Quality Assurance and Performance Improvement, or QAPI, is a provision in the Affordable Care Act, which passed in 2010, requiring CMS to promulgate a new regulation on QAPI and, we think, as importantly, to develop a program of technical assistance that will help nursing homes establish best practices in quality management and help them meet regulatory requirements.

QAPI Overview

And so now we would like to give an overview of QAPI. So if you go to slide 11. So what is nursing home QAPI? Well, I'd like to tell you what it is not. It is not another program or another initiative, like so many that come along. It is the way to do all the work that must be done and done right in nursing homes today. QAPI is the coordinated application of two mutually reinforcing aspects of an effective quality management system, Quality Assurance and Performance Improvement. It is systematic, comprehensive, data-driven, and involves all nursing home stakeholders in problem solving.

So on slide 12, we wonder, well, what does that really mean? QAPI really is any quality management system that takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes. It involves everyone in a nursing home to continuously identify not only problems but also opportunities for improvement. And by everyone, we mean residents and frontline staff being active participants in quality. It also involves everyone in practical and creative problem solving that gets to the underlying system, not only the symptom. It's not a surface fix. It really gets to the root of the problem. And then once an intervention is in place, the QAPI approach is about continuously monitoring performance to ensure that improvement is sustained.

If you turn the slide 13, so what have we done — CMS done — to prepare for QAPI? Well, actually, we've done quite a bit with the help of the University of Minnesota and Stratis Health, the Minnesota Quality Improvement Organization. We developed tools, templates, guides, and worksheets that would help nursing homes of varying capability implement effective QAPI systems. These QAPI tools and resources were uploaded to a web page for nursing home providers in June of 2013. And here on slide 13, you'll see a screenshot of our QAPI self-assessment tool that can help organizations assess their QAPI readiness and develop a path for implementation.

If you turn to the next slide. As I mentioned, in June of 2013, CMS rolled out foundational tools and numerous resources on the QAPI web page that can be found on the website that you see on this slide. Here is a screenshot of that web page. There are a total of 24 tools that nursing homes may use as they delve further into QAPI by establishing systems, identifying performance measures, and monitoring them.

On slide 15 you'll see a screenshot of our guide, QAPI at a Glance. The step-by-step guide was released on the QAPI web page and outlines simple steps that can be implemented by leaders to create an environment that fosters QAPI. It really paints the picture of what QAPI looks like in an organization.

On slide 16. These tools and links to very helpful resources can be found on the Nursing Home QAPI web page located at the web address on your screen or on the slide. CMS is also very excited to announce its upcoming quality efforts through the National Nursing Home Quality Care Collaborative, where the Quality Innovation Network-Quality Improvement Organizations will be recruiting nursing homes to participate in two 18-month-long collaboratives, where the QIOs will provide training in QAPI, share best practices, and facilitate peer-to-peer quality improvement forums. This is a great opportunity, and more information will be available through your Quality Improvement Organizations, as well as on the QAPI website.

And as you see on slide — oh, slide 17 — as emphasis on resident-centered care continues to grow, we think it's important to develop materials that will engage and empower nursing home residents, their families, and advocates to be active in their nursing home quality activities. As I mentioned, QAPI is a paradigm shift for everyone, including residents who may not be accustomed to having a voice in their facility's quality work. CMS is committed to developing tools and materials that we can make available to residents, their families, and other advocates. The ultimate goal is to provide person-centered care and to focus on the person living in the nursing home.

So on slide 18, some of our efforts around surveyors. We worked with our contractors, Abt Associates, to identify ways to enhance guidance around plans of correction to include QAPI principles. Remember, QAPI is about fixing the underlying system, revised plan of correction guidance is still under review currently.

Next, although CMS was charged with developing a program of technical assistance for nursing home providers, we certainly recognize that in order for QAPI to take hold and truly be grasped by the industry, we also need to provide training for surveyors. We are currently working to develop surveyor training in the basic principles of quality. And lastly, when the QAPI regulation comes out, we will have new guidance for surveyors for how to determine compliance.

Frequently Asked Questions about QAPI

If you look on slide 19, you'll see we're going to talk about some frequently asked questions, including what is expected of nursing homes now, how does QAPI fit with QAA and align with other initiatives, and I'll also address the QAPI regulation.

So what is expected of nursing homes now?

It is important for everyone to know that the materials that CMS rolled out and any future QAPI materials that would be made available are not mandatory, nor are they required for compliance to the forthcoming QAPI regulation. They are offered to assist nursing homes make the shift toward a more data-driven, systems-oriented, and sustained program. There are many tools available in the public domain, through corporations, and from vendors. Nursing homes will not be required to use any specific methodology or material that CMS has developed.

We do think that now is the time to get started with laying the foundation of QAPI. CMS will be delighted if every nursing home in the country will review the introductory materials available to them and understand what QAPI is and begin implementing the principles that can help transform nursing homes into a better place to live and work. We're encouraging nursing homes to review the QAPI materials available on the QAPI web page.

Having said that, it's also important to understand that although there's not a requirement for QAPI, QAA is enforced. Facilities are currently expected to have a QAA committee, comprised of the director of nurses, a physician, and three other staff, meet at least quarterly, and most importantly, identify issues and develop and implement appropriate plans of action to correct identified quality deficiencies. We believe the QAPI materials that have been rolled out can help facilities with the work they are doing currently under QAA.

So how does QAPI fit with QAA?

And we've had this question from many providers. As you know, QAA are Quality Assessment and Assurance — is the existing regulation at F520. And as I just mentioned, it requires you to have — nursing homes to have a QAA committee meet at least quarterly and identify quality issues, as well as develop and implement appropriate plans of action to correct these quality issues.

We expect the QAPI regulation will merge with and supplement and enhance the QAA regulation. QAPI is about establishing the principles that support continuous data-driven, systems-oriented quality management that can be sustained during transitions. The CMS tools and training materials have been designed according to those principles and will not conflict with the existing regulations. The goal is that each facility will establish systems and best practices that will help them to identify issues and

opportunities for improvement, uncover the root causes of issues, and then develop and implement systemic improvements that can be sustained.

If you look at slide 22, how does QAPI align with other initiatives such as Advancing Excellence, the Partnership for Dementia Care, the National Nursing Home Quality Care Collaborative, and other state coalitions?

The topic-specific initiatives of Advancing Excellence, the Nursing Home Quality Care Collaborative, and the National Partnership to Improve Dementia Care in Nursing Homes provide excellent evidence-based tools and resources to help nursing homes improve systems in specific areas. They can support facilities in applying QAPI principles by implementing performance-improvement projects and using data and feedback in conducting systematic analysis and developing systemic actions related to those focus areas.

But it's important to remember that QAPI is broader and more comprehensive than topic-specific focused improvement areas. QAPI is ongoing and comprehensive. It deals with the full range of care and services offered by the facility. When fully implemented, QAPI should address all systems of care and management practices. QAPI represents the shift to a systematic, comprehensive data-driven approach to quality management and sustained improvements.

On slide 23, I'm going to talk about the QAPI regulation, and I know everyone wants to know about that. CMS does not have a timeline for release of the QAPI regulation. It will be published for comment before it is finalized, and all nursing homes stakeholders—including providers, consumers, and trade organizations—will have the opportunity to comment on it. Interested parties can track the progress of this regulation by periodically checking the unified agenda, which is a schedule of regulations that will be put out for review in comments. The unified agenda may be accessed by going to www.reginfo.gov.

On slide 24, this is kind of our logo, and we truly do believe that QAPI can transform the lives of nursing home residents through continuous attention to quality of care and quality of life.

Adverse Events in Nursing Homes

So now we're going to turn our attention to another issue affecting nursing home residents, and that is adverse events. On slide 26, you'll see that in February of 2014, the Office of Inspector General released its report, Adverse Events in Skilled Nursing Facilities: The National Incidence among Medicare Beneficiaries.

On the next slide you'll see some of the findings, which were shocking. The report stated that one in three skilled nursing facility beneficiaries were harmed by either an adverse event or a temporary harm event within their first 35 days of being admitted in a skilled

nursing facility. Nearly 60 percent of those events were found to be preventable. The leading causes of preventable harm or substandard treatment:

- Inadequate resident monitoring, and
- Failure or delay in necessary care.

Of the identified events, 79 percent caused either an extension to the stay or the resident had to be hospitalized. And the OIG report estimated the cost to Medicare for the residents who were hospitalized as an astounding $208 million for 1 month.

If you turn to slide 28, the adverse events that were noted in the OIG report fell into three categories:

- 37 percent were identified as being related to medication,
- Another 37 percent were related to care, and
- 26 percent were related to infections.

So CMS — what has CMS been doing in response to this report?

First, together with our contractor, Abt and Associates, we facilitated a meeting on September 23rd of 2014. This was a call to action to our partners, sister agencies, and nursing homes stakeholders to come together, to roll up our sleeves and create a groundswell of activity and support to really raise the industry's awareness of these shocking findings, and then to create the momentum and inspire them to work together to reduce adverse events in nursing homes. We had organizations representing nursing home providers; clinical, professional, and consumer advocacy organizations; as well as former — one former nursing home resident. They were sister agencies, as well as experts in quality and safety. We are continuing the momentum through quarterly calls with this group.

On slide 30 — in addition, CMS is responding to the OIG recommendations by collaborating with our colleagues in the Agency for Healthcare Research and Quality by working to develop the definition of adverse events, as well as developing a listing of potential events or precursor events that includes risk factors and triggers that typically lead to adverse events.

On slide 31, you'll see that we are also looking at how we can improve surveyors' abilities to identify noncompliance that leads to adverse events. There's a lot of guidance in the State Operations Manual, or the SOM, that isn't easily accessed. We are looking at ways to use the survey process and consolidate this excellent guidance in the SOM so that adverse events, or the potential for adverse events, are identified and cited appropriately.

CMS is developing a focused survey with the goal of reducing adverse events by enhancing surveyors' abilities to identify when an adverse event has occurred and the extent to which nursing homes have systems in place to prevent them. This focused survey is based on the standard survey process and sample selection and uses tools based on the OIG trigger tool, as well as guidance found in the State Operations Manual. We hope to begin testing this summer.

On slide 32, and as we continue to develop training materials for both providers and surveyors around QAPI, we will be mindful to include adverse events in those materials. For instance, as we come to agreement on definition and the listing of potential events, we will include these in guidance and any training developed for providers or for surveyors. We will emphasize systems for identifying, tracking, correcting, and evaluating adverse events.

And so, I just want to thank you for participating in today's call. If you have any questions, please — any questions about QAPI or adverse events, do feel free to email either me or my colleague Cathleen Lawrence, or send an inquiry to the QAPI email box address on the slide.

Thank you very much. I'm going to turn it over to Leah.

Keypad Polling

Leah Nguyen: Thank you Debra. 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.

Kayla, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Again, if you were 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 hold while we complete the polling.

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

Presentation Continued

Leah Nguyen: Thank you Kayla. I will now turn the call over to Michele Laughman.

Michele Laughman: I just wanted to say thank you Debra and Cathleen for your presentation. And next up, we will have Mr. Doug Pace, and he will be discussing Advancing Excellence's campaign, Quality through Interdisciplinary Design.

Mr. Pace, I turn it over to you.

Quality through Interdisciplinary Design

Doug Pace: Thank you Michele, and thank you for the opportunity to be on today's call, and I am pleased to spend the next few minutes with you discussing Advancing Excellence. So let's go to slide 35 and begin with a little bit of an overview.

Advancing Excellence was formed in 2006 as an extension of the quality first initiatives at the American Healthcare Association and LeadingAge, and then interest from them and other organizations working in and with nursing homes to have a collaborative effort around quality initiatives. The Advancing Excellence in Nursing Homes Campaign was formed, and nursing homes were encouraged to register for the campaign as a commitment to quality in their communities.

A few years ago, AE continued to grow and became an incorporated 501(c)(3) nonprofit organization, and the organization was launched as the Advancing Excellence in Long-Term Care Collaborative. The AE Board made the thoughtful decision to broaden the organization to have the opportunity to develop initiatives across the continuum of long-term services and support. And up until last fall, the Advancing Excellence Campaign was the only initiative of the collaborative. We'll discuss some of the new areas in a few minutes. I'd like to also note that many organizations besides nursing homes, especially assisted living, find tools — find value in the tools and the resources that are on the Advancing Excellence website.

We've been very fortunate to work closely with CMS since its inception. And CMS has provided funding to Telligen, the Colorado QIO, to provide support for Advancing Excellence by hosting the website, housing the data, manning the help desk, preparing reports and analysis, and many, many other tasks. We're pleased to report that funding will continue through the 11th Scope of Work. AE also hosts, as you can see from the slide, the CMS Partnership to Improve Dementia Care on our website, and we encourage you to visit there to get great information and resources.

On slide 36, you see Advancing Excellence's Mission and Vision. I think our mission is great, it's short and simple — making nursing homes better places to live, work, and visit. I would point out that in our vision statement some of the keywords there are person-centered, quality of life. Person-centered care is really the lens through which

we do all of our work; the importance of a stable and an empowered workforce; and the dedication to improving both clinical and organizational goals.

If you move to slide 37, Advancing Excellence is the largest and most diverse coalition of stakeholders that is helping to improve care in long-term services and supports. It has 41 member organizations, which include 22 national organizations, six supporting companies, six advisory members, including CMS, the Administration for Community Living, AHRQ, ASBE, and the VA.

The campaign is voluntary. It's voluntary for anyone who wants to use the resources and tools — again, not just nursing homes. We know that many multilevel facilities and communities use the tools in different parts of the community, and they come back and benchmark those results. The great thing about Advancing Excellence, too, is that it's free. And how is it free? Well, we're funded in many different ways. One is by grants. We've had a large grant from the Commonwealth Fund Foundation that actually expires at the end of this month, but we've been fortunate to have that grant since our inception. We also get dues from our members. And again, as I said earlier, we get CMS support by them supporting Telligen.

Another new opportunity that, I think, the providers on the phone would be interested to know about is a new category of membership for providers. Certainly, the first priority for the provider community is to research the tools, select what goals you want to work on, and enter your data in a dedicated quality improvement program. But we also heard that many providers would also like to be involved in the organizational side of Advancing Excellence. And you can become a provider member if you go, again, to the Advancing Excellence website, we have an application, and we have a flyer that talks to you about all the benefits of that. But as you'll hear in a few minutes, the nine Advancing Excellence goals are evidence-based tools that help you begin a dedicated, evidence-based, measurable quality improvement program in your community.

On slide 38 is some really important data. As I mentioned earlier, the first marker for Advancing Excellence were nursing homes who have registered in the campaign. And you can see the impressive statistic that currently we have 62 percent of homes registered.

The other important information is that about a year and a half ago, we released the nine organizational and clinical goals and asked communities to select two or more goals so they could learn the Plan–Do–Study–Act, or the PDSA, process and start to benchmark their outcomes. And as you can see, 20 percent of those communities are currently in that stage.

Also notice the consumer and staff numbers. We really encourage you to get your staff to sign up and for your residents and family members as well. Advancing Excellence is a great topic for family and resident council meetings and for staff meetings and to get

excitement at every level that you are making a commitment to quality. So we really encourage you to sign up and to have your staff to sign up.

The other great benefit of Advancing Excellence is the State-level support. There are 53 State- and territory- based LANEs, those are local area networks for excellence that are ready to help you get started on your quality improvement and getting involved with AE. These are volunteer, diverse groups that meet monthly or more, and a reflection of many of the organizations that are at the national level. They're always interested in more people joining their efforts. So if you want to know how to get involved at the State level with your LANE, you can contact me, and we'll put you in — for the right person in your State.

Slide 39. These next two slides just show how we're doing by State. This slide shows how many nursing homes have registered and selected two or more goals. It's easy to see that Ohio is one of our stars. Ohio has — had a reimbursement program that gives incentives for different types of initiatives, and AE has been part of that program for the past few years. Colorado also uses the consistent assignment tool. And Tennessee is in the process of looking at the Advancing Excellence tools as they move to a different reimbursement strategy. We know that this is a trend that many States are looking at, and we ask that you contact us if you know of activity in your State.

We want to reach out to as many States as we can who are looking at developing value-based purchasing models, performance improvement programs, or other initiatives. There's no need for them to start from scratch. We can show them how other States are using the AE tools and resources. So, again, we really encourage you to contact us and put us in contact with your State leaders.

Slide 40 shows data that has been consistently entered for 6 or more months. To be listed as a participant in the campaign, you must enter data consistently for at least 6 months. And why is that? Because you need that much time to really start looking at trends.

Now AE has a new feature that sends you a reminder when it's time for you to enter your data on the goals that you've selected. And we're hearing from a lot of people that that's really helped them to remember every month that it's time to enter their data in on the goals that they've selected.

As you explore our website and start looking at the goals, you'll see that each goal has an Excel workbook that needs to complete — to be completed each month. And there's a summary report of nonresident-level data that must be submitted each month to us. It's really important to complete that function each month. And remember, it's OK to train more than one of your staff to enter the data. It's quick and easy, and we have a help desk to help you.

Clinical and Organizational Goals of Advancing Excellence

Moving to slide 41, here are the nine clinical and organizational goals that were a year and a half in development by the leading national experts in each area. I want to give you a quick highlight of each goal.

So improve staff stability. A stable workforce is fundamental to providing the highest quality of care and life in nursing homes and sustaining performance improvement. Working on this goal will provide nursing home staff with resources and tools to improve staff stability, especially by reducing staff turnover. And the result will be better care for the resident and a more satisfied workforce. We know working on this goal may also reduce costs that are associated with high turnover rates.

Consistent assignment. That means the same person takes care of the same resident every day he or she goes to work. Staffing this way lets meaningful relationships develop between staff and residents and, in turn, promotes person-centered care planning and individualization of care practices. We're hearing that both staff and residents are happier, and early literature indicates improved quality of care and life. Working on this goal will provide nursing home staff with a standard definition of consistent assignment, tips to implement consistent assignment, and a method to measure it. The result will be improved relationships between staff and residents, and increased quality of care and life.

Increase person-centered care planning and decisionmaking. That means that each resident of a nursing home has a choice about his or her daily routine, activities, and health care. Staff places value on listening, learning, and knowing each individual's background and personal preferences, regardless of the individual's cognitive ability or their length of stay.

Using the MDS 3.0, the Artifacts of Culture Change, and similar tools, the nursing home staff works with the resident and family to develop a care plan, so that the person's daily routine mirrors the individual's aspirations and can adapt to the changing needs as they evolve. Working on this goal will ensure that a resident's needs are met according to personal preferences.

Reducing hospitalization safely. Nursing home residents are often sent to the emergency rooms or hospitals when a chronic condition worsens or from an acute illness, such as pneumonia, develop. When nursing home staff are prepared and have the skill to treat residents with more serious illness on site, residents benefit since they avoid transfer trauma and other negative consequences of hospital admissions. Working on this goal will enable staff to safely care for residents on site using evidence-based tools and practices to reduce rates of hospitalization without compromising a resident's well-being or wishes.

Using medications appropriately. Medications help promote the resident's highest practical, medical, mental, physical, and psychosocial well-being. Inappropriate use of medications can compromise a resident's well-being and even cause death. Initially, this goal will focus on medications that are used to control behavior such as antipsychotic drugs. And working on this goal will provide the nursing home staff with alternate — alternative nonpharmacological interventions for residents who otherwise would be treated with antipsychotic medications. And we believe the result will be better health for residents.

Increasing resident mobility is a part of daily care. It's important to maintain a person's physical and psychological well-being. Immobility can result in complications in almost everybody's system, which can lead to further disability and illness. Working on the mobility goal will help nursing home staff address mobility issues, including walking, range of motion, transfer, use of restraints, prevent — and prevention of falls. And we believe that this will improve the residents' health, quality of life, and give them more freedom of movement and more activity.

Preventing and managing infections. We know that nursing home residents are vulnerable to infections, and implementing key practices such as hand hygiene and careful use of antibiotics can prevent the development and spread of more complicated antibiotic-resistant infections in the nursing home setting. Working on this goal will help nursing home staff use evidence-based practices to identify, monitor, and decrease the number of in-house acquired infections to protect residents, as well as staff, from such harm.

Pressure ulcers. A pressure ulcer, as you know, is a painful wound that can lead to a hospitalization and even death. A pressure ulcer can be caused by increased pressure on an area, poor nutrition, hydration, lying in a wet or damp bed, or having many chronic conditions. Working on this goal will help nursing home staff identify residents who are at risk of developing pressure ulcers in order to prevent their occurrence and help identify pressure ulcers in the earliest stages to heal them quickly. The result is better care for the resident. In addition, nursing homes will reduce the high cost of associated pressure ulcer care.

And finally, decreasing symptoms of pain. Pain is an unpleasant experience for anyone, but it's particularly miserable for the elderly in nursing homes. Some nursing home residents, especially those with cognitive impairments, don't even know how to express their pain. Nursing home staff are sometimes unaware of medications and other interventions that can alleviate the pain. Working on this goal will help nursing home staff identify pain symptoms and give staff the skills to effectively treat pain.

So when your community is ready to start the quality improvement journey, we have lots of resources on our website under the tab for each goal listed to help you. Remember, you've got to get all your staff involved. If this is viewed as another

management or nurse leadership initiative, you're really dead in the water before you get started. Dedicated quality improvements must — need a communitywide initiative and getting frontline staff involved as leaders is crucial.

To help you decide where to start, there are webinars archived on our website under each goal. I recommend that you bring your team together and view the webinars. Each webinar gives you an overview of the tool, what is necessary to collect, staff, resources, and more. Some of the goals are very easy. For example, the staff's stability is one quick turnover measure. Consistent assignment is an example — is much more involved, but it's an excellent tool because it really shows — or if you're having the same person assist the same resident as much as possible.

For those of you in multifacility organizations, we have a new feature. The AE Board recently voted on and approved a data sharing agreement. If an entity wants to see data from multiple facilities, then they would contact us, and we would send them the necessary forms to fill out. At the end of each month, a specific data run could be produced for a specific number of homes, preferably all using the same goals, and then you can benchmark between communities. If you want more information about the data sharing agreement, please contact me.

And lastly, this summer we will be releasing a new video series around each one of the nine goals. We filmed these last week in Washington, and these are going to be about 3- to 4-minute quick teaching videos that'll be great for huddles or for team meetings. So watch out for those coming soon.

Advancing Excellence and QAPI

On slide 42, I just want to reinforce what you heard earlier about the alignment of Advancing Excellence and QAPI, and you can see how AE mirrors the QAPI requirements. And so, we believe, if you're working on Advancing Excellence and you're selecting goals and entering your data consistently, you're well down the path of QAPI success.

Slide 43 discusses how the AE goals help with QAPI. We'll talk more a little bit later, but I want to point out the circle of success. The circle of success is a PDSA framework for systematic performance improvement, and it's the cornerstone of this phase of the AE Campaign, and it's the process that you will use for all of your goals.

Slide 44 gives you more information about the alignment between AE and QAPI. I know for many of you, talking about root cause analysis is somewhat daunting, but we hope to help ease your concerns and show you that it is feasible, and it's the right thing to do in your community. Also important to note is that we have vetted resources to help you guide interventions and how to train staff on working collaboratively and efficiently. And lastly, having fact sheets that you can share with consumers, staff, and your leadership teams really does help you make this a true communitywide effort.

Slide 45. You know, this is talked about earlier, but as a former nursing home administrator, I think the marriage of QA and PI is such a positive approach and really does put the community in the driver's seat to not react to what many times is a punitive situation, but to have the ability to showcase positive change with measurable data that will improve the quality of care and the quality of life for residents.

Slide 46. What you see here is you learn more about AE and the ease of use and the tremendous data that you'll have available for you to use in many different ways in your quality improvement program. Our tools give you resident-level data for use in your community, including trend graphs on the individual level where you can scan for patterns. As I mentioned earlier, the person-centered care tool has a wonderful report that shows you by resident, by wing, or by neighborhood, or the entire community, how residents' needs are being met versus how they requested their care to be delivered.

Slide 47 just shows that — how AE is working with and aligns with the 11th Scope of Work. I want to thank CMS again for their commitment to AE by providing funding to the Colorado QIO and for also the CMS role as an advisory participant in Advancing Excellence. Their participation truly has been invaluable.

And this slide just shows you how the AE data aligns with the 11th Scope of Work, the CMS composite score QM, and the additional task alignments in the 11th Scope of Work. This is another example of the importance of starting today on your plan for a dedicated quality improvement program or continuing your focus and making sure it's embedded in the culture of your community.

Participating in the AE Campaign

Slide 48. I just want to remind everyone, again, how important it is for you to become a participant in the AE Campaign, not just a registrant. Remember to select one organizational goal and one clinical goal. Most communities prefer to start with an organizational goal to get used to the PDSA or the Plan–Do–Study–Act process. Also, remember, it's OK to start small. If this is your first foray into measurable quality improvement, you should start with a single wing or a neighborhood, and let them get comfortable with the process and then celebrate their success. Then when you're ready to move it on to the rest of the community, you'll have that good experience under your belt. Staff who started the first initiative make great trainers for the rest of your community. So I would really encourage you to have your frontline staff take a leadership role on the team.

So this is the most important slide in the presentation that I'm giving today. This is the backbone of the nine goals. We have a tremendous amount of resources on each stage of the cycle to help you achieve success. So if you look at — on each goal on our website, it shows you how to identify your baseline, how to examine your process, how to create improvement, how to get involvement of leadership and stakeholders, how to monitor the progress, how to sustain the gain, and most importantly, how to celebrate

success. A lot of times people forget that last piece, and it's really important that when you've met your goal or you're working hard towards meeting your goal, that you reward and you thank the team that's working on this.

We're always looking for great success stories. So in your community, if you have an example of working on the tools, on how that has impacted your community and the residents and the quality of services that you're delivering, we would love to hear from you. We would love to feature those in our newsletter, so let us know if you have any stories that you'd like to share with us.

Slide 50. We already talked about the information on these next two slides, but I just want to reinforce the importance of root cause analysis or probing questions. I would suggest that this is one of the first topics to get your staff comfortable as they start on this quality improvement program.

And then, if you're looking at slide 51, your team's got to understand that this is a systematic approach to problem-solving, and they've got to ask those why questions that go just beyond systems — symptoms. This is where you, as leadership, must lead by example and show determined focus around this process and those five why asked questions, and going beyond the symptoms to find that root cause is really important and one of the most crucial features of the circle of success in the PDSA process.

Slide 52. So now, as I am about to head this off to — hand this off to Michele in a couple of minutes, I just want to remind everyone to get involved, to register, to participate, and enter your data monthly. And the website is shown on this slide, and it shows you where you can get all this information.

New Advancing Excellence Initiatives

On slide 53, I mentioned to you earlier that up until last year, the campaign was the only initiative of the Advancing Excellence in Long-Term Care collaborative. I want to briefly mention two new initiatives that we've launched. The collaborative has partnered with Hallmark Business Communications around an employee recognition program called "You Make a Difference." And we know that the background of any successful organization is a strong and stable workforce. We also know that most communities don't think about new and different ways to recognize staff and the difference a small contribution can make in someone's work. "You Make a Difference" is a program that makes it easy for you to reward and recognize your employees anywhere, anytime. And the website is listed there, where you can find out more information about that.

I'm also pleased to announce that Advancing Excellence is going on the road this year with Dr. Bill Thomas in the Age of Disruption 2015 Tour in 30 cities. Advancing Excellence is a national tour sponsor and will be hosting a 2-hour workshop in each city around disrupt infections, creating a community of prevention. Contact me to learn

more about these exciting initiatives or if you look in the February issue of our newsletter on the AE website , the 30-city tour has been announced there.

Slide 54, just additional information. I want to thank you again, and let's all make nursing homes better places to live, work, and visit. Michele, I'll hand it back to you.

Next Steps for the National Partnership

Michele Laughman: Thank you Doug. I would now like to share some information about next steps for the National Partnership. We are grateful for the efforts of so many people and organizations. Based upon recent data that was shared, we have now seen a 19.4 percent reduction in the rate of antipsychotic use in long-stay nursing home residents. The National Partnership has engaged the nursing home industry across the country around reducing the use of antipsychotic medications with momentum and success in this area that is expected to continue.

As most of you know, on February 20th, a press release was issued pertaining to the Five-Star Quality Rating System for Nursing Homes. Nursing Home Star Ratings will now include the use of antipsychotic medications when calculations are made. CMS is focusing on change areas that have been identified by consumers and other stakeholders. As CMS standards for performance on quality measures are increasing, many nursing homes will see a decline in their Quality Measure Star Rating. The changes in ratings reflect that CMS raised the bar for poor performance that should be recognized as high quality, and anticipates nursing homes will make quality improvements to achieve these higher standards.

CMS will continue to monitor the reduction of antipsychotics, as well as the possible consequences. For example, CMS will review prescriptions for anxiolytics and sedatives and hypnotics to make sure nursing homes do not just replace antipsychotics with other drugs. In addition, CMS will review the cases of residents whose antipsychotics are withdrawn to make sure they don't suffer an unnecessary decline in functional or cognitive status as a nursing home tries to reduce its usage.

There has also been an expansion in the efforts of many State Dementia Care coalitions beyond nursing homes to include cross-continuum teams that have hospitals, assisted living, home health, and nursing homes all working together across settings within communities. This is in recognition of the fact that many problems with antipsychotic prescribing occur during or related to care transition.

We thank you for your participation in today's call and look forward to continued collaboration and partnership.

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

Question-and-Answer Session

Leah Nguyen: Thank you Michele. Our subject matter experts will now take your questions about the National Partnership to Improve Dementia Care in Nursing Homes and QAPI.

Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one. If you'd like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits.

All right Kayla, 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, press the pound sign. 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 questions, so anything you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

Your first question comes from Michael Ellenbogen.

Michael Ellenbogen: How are you doing? My name is Michael Ellenbogen, and I'm actually a dementia advocate. I hear some great programs being created and some great measures that are being created. The concern I have is, how many people living with dementia are involved in these processes that you folks are creating to try to determine what's best for people with dementia?

Leah Nguyen: Could you hold on for a moment?

Michele Laughman: Hi Michael, this is Michele Laughman. I just wanted to touch on — within the partnership and really the grassroots efforts of the partnership, we began by either developing or empowering groups in every State that encircles this mission. And so now every State across the country has a Dementia Care Coalition with, you know, the mission and insight of trying to improve dementia care for nursing home residents within their State. Those groups differ per State and, you know, some are more widely attended, others are not, but every State has a group that's embarking on this mission. So that's just one area that we're trying to get down into the trenches and really get into the nursing home distinctly and individually.

I don't know if, Karen, you'd like to add to that?

Karen Tritz: Hi, this is Karen Tritz from the Division of Nursing Homes at CMS. Thank you very much for your question Michael. I think the involvement of individuals who experience this on a day-to- day basis is critical. As Michele indicated, the State coalition is one avenue that – for folks that are interested in participating in the work of the State in organizing around dementia care and improving dementia care, that would be certainly one avenue to have participation heard. At the national level, we talk frequently with individuals who represent residents and residents themselves in a number of our activities and welcome that feedback.

So if there are, you know, additional questions, please feel free to send — or suggestions you have about increasing that, please feel free to send a suggestion to the mailbox as well, and I think we have the mailbox in the slides, Michele, that's right?

Michele Laughman: Yes, that's correct. It's located on the last slide.

Debra Lyons: This is Debbie Lyons, and I just want to chime in and add that, although, you know, with QAPI, we have thought to engage actual nursing home residents in the development of our consumer materials, to engage and empower nursing home residents and/or their family members or advocates to be involved in nursing home quality activities. So we've participated in numerous calls with actual nursing home residents, former nursing home residents, and certainly with their advocates to help us to steer the development of these materials. So we agree, you know, it's critical that we have the perspective of actual residents when we are developing these materials and programs.

Doug Pace: Michael, as an advocate, are there suggestions that you might make for — to folks on the phone?

Michael Ellenbogen: Well, the one thing, I guess, I have learned over the years — and I've now been speaking to many people in the hospital network to try to educate the medical staff — there's many times that caregivers can speak on our behalf, but they have it so wrong. They do not understand it. And I'm not trying to blame the people or anybody outside, because unless you're in my shoes, and I happen to be living with Alzheimer's disease, there's no way you can know what the problems and issues are.

So I think it's extremely important to bring people in. And I understand some of the people who are in the nursing homes, some may not be able to do that because they're already in the low, you know, in higher stages, but I think it's also important to bring maybe people who were in a young onset stages involved in that process because they could probably shed some light on things that most people do not understand. And I can tell you, I've been doing this now for over a couple of years, and everywhere I go people are learning new things that they were shocked and never knew of. So I cannot emphasize enough, people with the disease must be a part of the process.

Doug Pace: Great, thank you.

Leah Nguyen: Thank you.

Operator: To ask a question, please press star followed by the number 1 of your touchtone phone.

Your next question comes from Markus Avery.

Markus Avery: Hello?

Leah Nguyen: Hello.

Markus Avery: My name is Markus Avery and I'm a family member. My mother is a vascular dementia patient in one of the States with low AE participation. What do I do or who do I contact at a government level if I have some concerns about antipsychotic use with my mother during her transition of care? She transitioned from assisted living to a skilled nursing facility.

Leah Nguyen: Can you hold on for a moment?

Markus Avery: Hello, I'm sorry?

Leah Nguyen: Hold on just one moment.

Markus Avery: Oh, of course.

Karen Tritz: So thank you very much for your question. We – so from the – let me — it sounds like there's sort of two questions within your remarks. One of which is, how do we — I get my State to participate more in Advancing Excellence or the other work related to the National Partnership and the State coalitions that Michele was talking about? And then the other — if I have it right, the other comment that you had was related to specific concerns that you had about your — the care that your mother was receiving in terms of her transition from assisted living. Do I have that right?

Markus Avery: That is correct.

Karen Tritz: OK. So on the — I'll take the last part of that first, and what we tell folks that have concerns about the care that they're receiving is to first do what they can to work with their nursing home and identify those concerns. If that is not an option or you've tried that, the next two avenues would be, one, the State survey agency. There's a complaint line for every – in every State survey agency where those things can be made. And also the long-term care ombudsman in that State may be a good resource as well for concerns that you have.

So for specific concerns related to care, those would be the avenues that we'd suggest. On the first two questions about the — increasing your State's participation in AE or the dementia care, I guess, I'll ask Doug to talk about the Advancing Excellence, how to encourage participation in that. And Michele, then, if you want to talk about the State coalition piece of it.

Doug Pace: Sure, sure, hi Marcus. You know, I would suggest if you could contact me, and what we can do is put you in contact with your State LANE, that's a good place to get started. And those are really the sort of boots on the ground folks in your State that's working with all of the diverse stakeholders around making sure that we get as many communities as possible to know about the campaign, to have them register, select their goals, and get started. So I would be glad to put you in connection with the State LANE.

Markus Avery: OK, I'm happy to do that Doug.

Michele Laughman: And this is Michele. Also, as far as — it would probably be good for you to get in touch with the State Dementia Care Coalition. So if you would like to send me an email, I can discuss that with you. We can go over, you know, what State it is and I can put you in touch with the leads and the community people that are involved in that State.

Markus Avery: Thank you Michele, I will do that as well.

Thomas Hamilton: Mr. Avery, this is Thomas Hamilton, I'm the Director of the Survey and Certification Group. And so this gives us a good opportunity really to think about how to provide that good advice.

You know, nursing homes have resident councils. You know, the techniques to use nondrug, nonpharmacological approaches to caring for people with dementia may be a great topic for resident councils. Some nursing homes have resident and family councils that actively involve family members of residents, and they might be enlisted. That might be a way of, also, you know, addressing Michael Bennet's — the first caller's, you know, response about actively involving residents and family members in a constructive way together with the nursing home.

You know, I think one of the things that's been truly inspiring about this national effort is the learning from one nursing home to another and how they've learned better ways of getting to know people, better ways of recognizing that the causes of someone's acting out behavior, for example, may be due to medical conditions or interactions of drugs or environmental features. And I think on the Advancing Excellence website, there's a lot of the slideshows.

From these calls, we've had regularly where we've had presenters — and there's good information there that can help put you in touch with folks in various nursing homes that have been doing so much of the good learning with regard to nondrug approaches to caring for people with dementia. And I think that's, you know, much more effective than certainly we, at the Federal level, preaching a particular course of action. It's really the learning from peer-to-peer, from one nursing home to another, that's been able to show that not only have they reduced their use of medications, but more importantly, they've improved their dementia care overall. And, of course, for people who are in the short-term, the first 100 days of placement, then it does save the nursing home money if they can do that and plow those savings into better staff training. You know, those are all, you know, excellent techniques.

And I guess as a last resort, you can always appeal to our basic requirements. In the Medicare requirements, there's a set of protections that are designed to make sure that good care is provided. Obviously, all nursing home residents must be free from the use of medications as restraints, but more importantly, every resident should have the benefit of a full assessment, a comprehensive care plan, a monthly review of medications, and if they're on antipsychotics, for example, attempts at dose reduction. They may come from the hospital on antipsychotic medications, but then it's incumbent upon the nursing home to review those medications and to attempt dose reductions to see if nonpharmacological approaches to care can be provided in a better way than can the medications. So, I hope that's somewhat helpful.

Markus Avery: That was very helpful. Could you remind me of your name again, sir, please?

Thomas Hamilton: This is Thomas Hamilton.

Markus Avery: Thank you Mr. Hamilton.

Leah Nguyen: Thank you.

Operator: Again, to ask a question, please press star 1.

Your next question comes from Mary Compton.

Mary Compton: Hi, my name is Mary Compton. Can you tell me how I locate the Dementia Care Coalition in my State?

Michele Laughman: You can contact the Division of Nursing Homes Behavioral Health email inbox or you can call, you know, contact me directly, and I can put you in touch with your State coalition lead.

Mary Compton: Is it located in the State agency or is it a separate organization?

Michele Laughman: It varies. Every State is different. But I will say that about 27 States are led or co-led by their State QIO. There are very few States that are actually led by a State agency, but it does vary.

Mary Compton: OK. How do I contact you?

Michele Laughman: You can — on the last slide it has the DNH behavioral health email inbox.

Mary Compton: OK.

Michele Laughman: Email me. I man that, and so it'll come right to me.

Mary Compton: OK, thank you.

Michele Laughman: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from Cindy Lindbloom.

Cindy Lindbloom: Hello? Hi. I hear an awful lot of talk about lowering antipsychotic drugs in the nursing care facilities. I am wondering — or thought there's a lot of talk about doll therapy, not a lot of it in the States. And what I am finding in the United States is, like, play doll, not lifelike dolls. I'm wondering if there's thoughts of looking or doing anything into that. Being on a study done from England, they have been shown to reduce — cut the number of patient using psychotic drugs from 92 percent down to 28 percent. What are your thoughts on that?

Karen Tritz: So this is Karen. Let me — sorry, it took me a little while to understand the question. If I understand, the comment specifically was that you had done — you're aware of work that's been done in England with doll therapy and what is our position on that?

Cindy Lindbloom: Yes, correct.

Karen Tritz: OK. So I guess I would go back to something that Thomas Hamilton described in his last comment, which is that the goal of improving dementia care, reducing unnecessary antipsychotics, really goes back to also something that Doug Pace talked about in his presentation, which is person-centered care, getting to know what's important to the individual, what's meaningful for the individual in terms of identifying what may be underlying causes of behaviors that may be seen.

And so, I don't know from our standpoint that we would advocate a specific therapy, but really looking at the constellation of approaches — of nonpharmacological approaches that are meaningful to the individual resident. So not something that we would be sort of for or against, but really getting back to what the principles of the National Partnership are, which is to sort of rethink our approach to how we work with the individuals who have dementia and trying to understand and address those underlying issues or concerns that would be meaningful to them based on their experiences.

Cindy Lindbloom: Well, we've been making them lifelike — I'm talking lifelike dolls for 3 years now, with 100 percent positive feedback. I have directors of nursing in facilities that are trying to give talks on what it's doing for their homes, what they're seeing. And I have a facility that said it's the first go-to in anything over aroma therapy or over music therapies, she said, because it's the most instant and the quickest. And once again, I'm talking about lifelike dolls, not play dolls. So that's what I'm seeing. If anybody is interested with the information that I'm collecting, I'd be interested in hearing back from them.

Karen Tritz: Great. Thank you very much — thank you very much for your comments.

Cindy Lindbloom: Yes, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Cindy Evick.

Cindy Evick: Hello, this is Cindy Evick, and I was wanting to know about the staffing initiatives. I know here where we're at, we have a lot issues with families and residents and the staff themselves feeling that there are never enough staff members. And we actually do staff — we're a 91-bed facility and, which means that, you know, we would have 19 CNAs and nurses once we take away the five nurse supervisors that would have to cover a 24-hour period to provide care, and we staff with 38.

We're consistently above the minimal requirements. Of course, I don't think you could ever staff a building with the minimal requirement. But what are some ideas with how to get the staff to comprehend that, you know, that the money is what it is and, you know, Medicaid – Medicare aren't going to pay us any more, and, you know, we have maxed out our resources for staffing. I mean, we're a nonprofit and that's where we put our money. So that's one of our biggest things to deal with here.

Karen Tritz: Hi, this is Karen, I'm wondering if Alice or Doug or others on the line may want to comment on the — for those in —or other nursing homes who've instituted some of the nonpharmacological approaches and quality approaches and the staffing effect or impact related to providing quality care.

Doug Pace: This is Doug, I'd be glad to offer some initial comment.

Karen Tritz: Sure, go ahead.

Doug Pace: Yes, Cindy, that's a great question. You know, and I think what we're hearing from a lot of the communities that we work with, naturally staffing is an important issue. I think the even bigger issue is a stable staff and not having that revolving doors of people coming in and out, so I think it's about — and it sounds like you're doing this. It's a community that recognizes, and embraces the staff and teaches and trains them. We are hearing a lot of positive stories about consistent assignment because we think it has benefits on the resident side and on the staff side, and it's about that knowing and be able to alert changes that might go unnoticed if you didn't have that consistent assignment.

I think, as Karen and others have talked about today, you know, person-centered care really does make a difference. And I think if staff is really working in a person-centered care environment, that a lot of times they are able to be more effective and able to provide a better level of care than those that might be your — working in more of a staff-directed model.

And then we do know from a lot of the studies that are out there, that, you know, just having activities that are new and innovative, and certainly those can — and many times help in the reduction of antipsychotics. And it doesn't need to be medications. And really working with your staff to understand the importance of engaged care really makes a difference. And then I guess my last comment would be just that recognition piece. It's really important to recognize your staff for the good work that they are doing.

Alice Bonner: So this is — this is Alice Bonner, and I would just like to add to that in terms of — I think part of your question was about, you know, do you need to increase numbers of staff in order to do some of this nonpharmacologic work? And in the QAPI demonstration, in the 17-home demonstration, one of the homes in California specifically looked at that issue in working with people with dementia and trying to reduce antipsychotic use. And the director of nursing and the administrator started out really thinking that they were going to need to increase, you know, their staffing — their nurse staffing. And by the end of the project, we're able to clearly say that that's not what they ended up doing. They made some very slight adjustments in their activity staff, largely moving them from days to evening, and things like.

But, you know, a lot of what they did was they provided the training and the tools and the resources for the staff and the support for the staff to do the nonpharmacologic approaches. And over time, as they became skilled at them, it turned out they didn't really need more staff. They needed more support; they needed to learn how to do it. And once they did, they were able to find in at least that home that it was the case that they didn't need more staff.

So I think we've heard similar stories around, you know, the country, in different States. And so there are people who have done this without increasing their numbers.

Leah Nguyen: Thank you.

Operator: Your next question comes from Anne Cabral.

Anne Cabral: Hi, I just had a quick question. We have a lot of admissions that are coming to us from the hospital setting, and that is actually where they're being put on the antipsychotic. And so, you know, we realize when they come here to live with us in a long-term care center that our job is to look and see what medications we could possibly reduce, knowing the type of environment, which is not usually very conducive for someone with dementia, in a hospital.

And I'm wondering what kind of education is being done there to help us with, you know, always having to kind of undo what was started. And that transition is tough enough, never mind, you know, having medication be added to that — on top of that. I'm wondering what's being done on the government end to look at the hospitals as well.

Michelle Laughman: Alice, would you like to touch on that?

Alice Bonner: Sure. There's actually been quite a bit of interest in the hospital engagement network and some of the cross-continuum teams that are springing up in many States with the Accountable Care Organization activity. And so in States that have a lot a going on around Accountable Care Organizations, there's kind of a natural, you know, networking of hospitals, outpatient, you know, physician practices, nursing homes, home health, hospice — really the whole continuum.

And when you get all of those people talking together, there is a very — there can be that very positive learning network that just kind of emerges — I guess it's like a natural learning network. And so I think some of what happens in long-term care, because there's been tremendous leadership in long-term care, I think hospitals and emergency department and outpatient settings are learning from some of the things that have happened over the last several years in the CMS initiative, and also, again, some of those same hospitalists are going to skilled nursing facilities now, so they're seeing the same patients/residents in multiple settings and, hopefully, they're starting to apply some of the principles.

So I would say what we hear most often is that in communities where the long-term care facilities are finding the hospitals are sending people who are newly started already on antipsychotics, people are saying, wait a second, let's sit down together and have a conversation about this. And it's easier in some communities than others, but it really does requires somebody picking up the phone and calling the head of the P&T

committee or the head of the quality committee at the hospital and saying, you know, this is an issue for us, we're receiving a lot of patients on these medications, we're trying to move to nonpharmacologic interventions, and having the conversation. And that may, in turn, lead to greater use of nonpharmacologic therapy in the hospital.

Of course there's a lot of delirium in the hospital, and so that, you know, each resident needs to be — each patient needs to be evaluated independently for that. But I think that's some of the successes that have been noted around the country. There's still a lot of work to do in many communities. And, again, I would refer you back to the State coalition in your State or the State LANE, both of which may have that nice combination of people from the hospital setting who are also practicing in long-term home health, etc.

Thomas Hamilton: Again, this is Thomas Hamilton, and you know, that's a great question and some good advice from Alice. I would just put a request out to any of the nursing home folks on the phone, as you encounter situations like this, if you could send us an email to the email address that Michelle described, DNHbehavioralhealth, just describing the kinds of situations that you're encountering so that we can better understand the issues that you're dealing with, what's coming from hospitals because we are interested in trying to get more information out to the hospitals. A highlight of this issue — there's actually a couple of areas with hospitals that we really want to focus on the interactions between nursing homes and hospitals. Well, multiple areas. One, of course, is readmissions, is back and forth, but another is infections, particularly as we get more drug-resistant infection in the communities when you get the kind of back and forth between nursing homes and hospitals. That becomes an issue that hospitals and nursing homes have in common and — in, similarly, with the use of antipsychotic.

So the more we can understand the kind of situations that you're actually seeing so that we can do more in the way of case studies, the better we'll be to understand and then be able to get more effective communication out to the hospitals.

Leah Nguyen: Thank you.

Anne Cabral: OK, great, thank you.

Operator: Your next question comes from Stephanie Dewees.

Stephanie Dewees: Yes. This is Stephanie Dewees with Green Hills Community. I would like to know what the government is doing to drive improvement in the availability of psychiatric services and the funding for those services. I'm sure that you could understand that, having the experts available would certainly improve quality, ensuring that residents are diagnosed appropriately, as well as trainings for primary care physicians as well.

Karen Tritz: So this is Karen. Can you ask your question again? You indicated sort of the psychiatric — what the government was doing related to psychiatric services. Are you talking about more generally? Are you talking about individuals who are in the nursing home with, also, with psychiatric conditions? Can you share a little bit more about what your question is?

Stephanie Dewees: Sure. So try to see how — because the Government is trying to drive the antipsychotic number down, and so part of that is also the availability of psychiatric support for that. And so, most stakeholders would tell you that there is a huge gap, there's been funding that's been consistently decreased for psychiatric services. So being able to have a psychiatrist available is a big challenge. Hospitals will also share that as a big challenge for them as well. So as you want to ensure that residents are diagnosed appropriately — that you are providing them the medications that they should have based on that diagnosis. Obviously, that physician expert component needs to be there.

Karen Tritz: So I think we're going to try and hit this, I think, from a couple of different steps and areas, and I appreciate your followup comments. Very helpful. You know, from a National Partnership standpoint, we're certainly looking at the reduction in antipsychotic disease — reduction in unnecessary antipsychotics and recognize that those — there are those situations where the antipsychotic medication is clinically indicated. So I would just, you know, clarify that upfront. I think Michele can talk a little bit about the partnership with the American Psychiatric Association.

Michele Laughman: We've been working with them pretty closely, and we've been trying to brainstorm ways to have more involvement from the psychiatric community, as well as trying to get members from every State on the State coalition to be participating on a consistent basis. I know, you know, that's kind of a broad answer, not really hitting exactly what you're referring to as far as the financial piece and the reimbursement piece. But as far as the partnership, we are trying to look at it on a national perspective and also delve down into the State coalitions.

Karen Tritz: Alice or Doug, is there any additional comments you'd make about the role of the psychiatrist in the partnership and efforts to reduce antipsychotics?

Alice Bonner: Well, this is Alice. And I actually just wanted to say something about the role of psychologists because, you know, there's a group of geriatric psychologists through the American Psychological Association. They have a separate interest group actually of people who are just working on long-term care, and they're very committed to this. They're very interested in it. And they've been working with Thomas and Michele and Karen and the team there at CMS. And I think it's just — there's a great opportunity to also think not just about psychiatry, but about the potential role of psychology in developing behavioral health plans that are, again, you know, more focused on nonpharmacologics as well. So Doug?

Doug Pace: No, nothing else from me.

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

Operator: Your final question comes from George Anne Hume.

George Anne Hume: Hello?

Leah Nguyen: Hello, go ahead.

George Anne Hume: I'm a licensed clinical social worker who goes into nursing homes as a Medicare B provider. And recently there was a problem that – the public health department tagged the nursing home for the condition the patients was in, but then is unable — I said, "Well, why not just ask them how to deal with it?" And they said the public health department does not give you any help in how to deal with it or where to go. And I asked some other nursing homes with four- or five- star, and they said the same thing, the public health department only tags problems.

The problem with a person with dementia that I don't – I don't deal with people who don't have a certain level of cognition. This particular person smeared his feces over himself and over his hair. And then was big enough and in control enough, he hurt the people who were trying to clean him up. And the nursing home got tagged for this — for the condition of the patient, but there was never any help in what to do. And I'm thinking, could there be something like when I have a problem on other subjects, I just Google it, and it seems there is a body of knowledge out there.

So is there somewhere that there's a body of knowledge that you could go with a specific problem that you don't have to recreate the wheel, that somebody has dealt with this? I mean, where do you go for help when it's very specific like that? That's my question.

Karen Tritz: So it definitely is a specific case, and you raised, I think, two different issues, which — one of which is, you know, what is the role of the survey agency. I'm assuming that is the Department of Public Health that you're talking about. And then sort of second, where do you go for additional resources?

On the role of the State survey agency side, they, as you probably know, come in for a week, a set compliance with the minimum standards, the requirements for participation. They're not in a consultative role while they're there for that week, nor should they be. The folks that are on the ground in the nursing home have — will have a sense of what may be the underlying causes. They know the residents best. They certainly know them better than the State survey agency and may have a better sense of what the solutions are for a given a resident. And so that's a little bit — there's a clear

distinction in terms of the role of the State survey agency and other, more consultative resources.

Getting to your second question of where do you go for this type of help. I think a couple of resources I mentioned. You know, Advancing Excellence has on its website a number of specific tools related to the goals. And Doug, there may be ones that you're aware of related to this specific issue that you could highlight. The QIOs also to the 11th scope of work have the nursing home quality of care collaborative. And, I think, the intent of that is to create a collaboration where nursing homes can be partnered up with one another to share ideas, best practices, brainstorm solutions, and then certainly, you know, other resources really that you may be able to find on the web that would talk about different strategies.

I guess I'll stop and see if Doug or Alice or Deb, if you want to talk at all about the Advancing Excellence or quality of care collaborative as potentially resources for folks.

Alice Bonner: Yes, I would say certainly the goal with the Advancing Excellence tools and resources has been to provide enough resources that specific cases, like what you described, you know, that you can, hopefully, find what you need there. However, it's often the case that you need to speak to someone about a very specialized issue. And so the purpose of the State coalitions is that, you know, by contacting someone in the State coalition, you can say, "Could you put me in touch with either a geriatric psychiatrist or a geriatric psychologist or a geriatrician," you know, depending on what the problem is, "who has, you know, could talk to me about this issue, or a director of nursing or administrator who's had a resident like this, and how they went about finding the resources that they need."

I was struck by — when I was in Minnesota, there was a particular geriatric psychologist there who has spent a lot of his career in nursing homes and was, you know — just had a skill set that was really very deep and, you know, was beyond what a lot of typical psychologists might be able to offer. He was particularly specialized in this. So I think there are people out there. I think it's a great question. It's a particular — you know, issue that does happen with dementia. And hopefully, your State coalition can get you in contact with AMDA or the other people locally who can be of help and provide resources.

George Anne Hume: Thank you.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that's all the time we have for questions today. If we did not get to your question, you can email it to one of the addresses from the last slide in the presentation.

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

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.

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

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