National Partnership to Improve Dementia Care in Nursing Homes & Quality Assurance and Performance Improvement (QAPI)

June 16, 2015
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Agenda

• Welcome
  Debra Lyons, CMS

• Antipsychotic Reduction Success – The Cedars, Maine
  Angie Hunt, The Cedars

• Evidence-Based Dementia Care Training
  Dr. Monica Tegeler & Dr. Kathleen Unroe, Indiana University

• Closing
  Michele Laughman, CMS

• Question & Answer Session
  Moderator
Welcome
Antipsychotic Reduction Success
The Cedars, Maine

Angela Hunt, RPT, MS
Chief Operating Officer
Agenda

• Objectives:
  – Identify the importance of culture change in reduction of antipsychotic medications
  – Utilize training curriculum to support antipsychotic reduction
  – Implement strategies for behavioral alternatives to antipsychotics using evidenced-based programming
  – Participate in community partnerships
Setting the stage.....

• The Cedars is:
  – Senior living community
  – Portland, Maine
  – Founded 1929
  – Not-for-profit
  – Mission driven
  – 61 Independent living, 30 Assisted living and
    102 Skilled-nursing facility (SNF)
  – SNF: 820 admissions/year
Drilling down.....

• Long-Term Care:
  – 56% Census LTC
  – 40.6% Dementia/Alzheimer's
  – 38% Residents with behavioral symptoms
National, Regional, State, Facility Averages

• National average 22.8%
• Regional average 23%
• State average 19.8%

The Cedars
Currently 5% LTC
All residents are on the lowest dose
for symptom management.
Our journey....

This graph demonstrates the downward percentage trend of residents receiving antipsychotic medications: 2012 at 20% to 2014 under 8% usage.
No one solution.....

There is NO one component of culture change and/or programing that will act alone to support a reduction in antipsychotic usage,

BUT

through assessment, person-centered care, resident engagement and the support of a multidisciplinary team it can be done.
The story begins....
Must haves....

• Committed Medical Director
• Engaged pharmacist
• Engaged leadership team
• Electronic documentation
It is The Cedars belief....

• Our Values:
  – Person-centered approach to care
    ◦ Choice
    ◦ Dignity
    ◦ Individuality: sense of self
Instilling Culture Change....

• Mission
• Values
• New hire orientation
• Job descriptions
• Policies and procedures
• Disciplinary process: coaching for improvement
• Neighborhood orientation process
• Neighborhood staff meeting with all team members
• Cross functional team
Other Culture Change strategies adopted

• Consistent nursing assignments
• Consistent interdisciplinary support
  – Housekeeping
  – Care coordination
  – Therapeutic recreation: life enrichment
  – Dining services staff
  – Therapy staff
• Dining services
• Emphasis with choices:
  waking/sleeping/showers, etc...
Helpful training....

• Facility-wide Habilitation Therapy curriculum
  – Adopted by the Alzheimer’s Association
  – Training centered on:
    ◦ Knowing and understanding the individual
    ◦ Communication skills
    ◦ Physical environment
    ◦ Approach to personal care
    ◦ Activity and purposeful engagement
    ◦ Behavior as communication: understanding and responding
    ◦ Understanding and working with families
Other training tools....

• Relias
  – Online educational courses
  – Library of 2,000 courses
  – Customized training plan
  – Tracking and reporting
  – http://reliaslearning.com/

• Coaching-Supervision communication style
  – All leadership positions
  – 2 day course
  – Communication brings out learning and understanding
    ◦ Skilled dialogue
    ◦ Creative interventions
    ◦ Collaborative learning

• Customer Service Training
  – Community integration, customer satisfaction, employee satisfaction
  – Community, respect, excellence, accountability, teamwork
Creative use of staff....

- Manager Therapeutic Recreation: Occupational Therapist
- 20 hours dedicated to Culture Change: person-centered model of care
- 20 hours staff Occupational Therapist
  - Tool box
  - Integrating life routines
  - Physical environment
  - Memory books
  - Decline in function
  - Behavioral concerns
  - Caregiver training
Life enrichment practices....

• Life stories
• Spontaneous activities
  – Individual and small group
• Scheduled activities
  – Large group
• Use of volunteers
Life enrichment programs....

- The Cedars Salon and Day Spa
  - Innovation of the Year Award: LeadingAge Maine & New Hampshire 2013
  - Unique therapeutic experience
  - A variety of services
  - Trained staff
  - Utilization of life stories
  - A whole new level of pampering

- Flower program
  - Most popular program
  - Overseen by a florist
  - Supported by activities fund
  - Small and large group settings
Use of technology....

• Music and Memory Program
  – Certified care facility
  – Personalized music program using iShuffles
  – Evidenced based program
  – Relatively low cost: $1,000
  – http://musicandmemory.org/

• It’s Never 2 Late
  – Makes technology and the internet accessible to all
  – Adaptive hardware, software and content
  – Can be used by Rehabilitation Therapy Department
  – My page, social, cognitive, spiritual, physical
  – http://www.in2l.com/
Future program development....

• Opening Minds to Art
  – Evidenced-based intergenerational program
  – Visual art program: abstract art
  – Developed by Scripps Gerontology Center at Miami University, Ohio
  – Benefits: expression, engagement, socialization

• TV Memory Lane
  – Multi-sensory & interactive film collection
  – Video, music, photography, recorded sounds and aromas
  – Stimulate recollection
Partnerships....

• Maine Partnership to Improve Dementia Care
• Alzheimer’s Association, Maine Chapter
• Maine Culture Change Coalition/LANE
• Healthcentric Advisors
• Senior Living Collaborative Coalition: Maine Health Association
• LeadingAge
Evidence Based Dementia Care Training

Monica Tegeler, MD & Kathleen Unroe, MD
Department of Internal Medicine & Geriatrics, Indiana University
Agenda

• Describe 6-week OPTIMISTIC dementia training
• Describe 4 behavior categories
• Discuss results of before and after surveys, as well as skills validation
• Discuss barriers to implementation and reasons for success
Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

- Joint initiative of the Center for Medicare and Medicaid Innovation & the Medicare-Medicaid Coordination Office
- Target population: long-stay nursing facility
- Medicare/Medicaid enrollees
- Awardees announced September 2012
- 4-year project
- 7 enhanced care & coordination providers
Initiative objectives

• Reduce the frequency of avoidable hospital admissions and readmissions
• Improve resident health outcomes
• Improve the process of transitioning between inpatient hospitals and nursing facilities
• Reduce overall health care spending without restricting access to care or choice of providers
OPTIMISTIC

- Optimizing Patient Transfers, Impacting Medical quality, and Improving Symptoms: Transforming Institutional Care
- $13.4 million over 4 years – 2012-2016
- 19 partner facilities, about 2000 long-stay residents
- Goal: Reduction in avoidable hospitalizations of long stay (>100 days), dually eligible nursing home residents
OPTIMISTIC components

• Core components:
  – improving medical care
  – enhancing transitional care
  – access to palliative care

• Registered nurses (RN) embedded in each facility to lead delivery of the intervention, supported in managing residents by nurse practitioners (NP) who cover a group of facilities
• Dementia with behavior disturbance is one of top 5 reasons long-stay residents are readmitted to the hospital
• Facility staff reported challenges in managing behaviors
• Dementia training requirements for nursing home staff specify length but not type of training
Description of training

• Inter-professional dementia training – half day sessions weekly for 6-weeks
• Participants:
  – 24 RNs and NPs of OPTIMISTIC project
  – 17 dementia care champions from participating nursing homes in the project
  – Included clergy, nurses, social workers, and activity directors
• Pre & post test survey design to evaluate participants' self-efficacy at managing dementia-related, challenging behaviors
• Brief video vignettes
• Small group discussion
• Role play scenarios for each category of behavior
Behavior categories

• Developed by Jiska Cohen-Mansfield, MD and published in 1995 in International Psychogeriatrics journal
• Divided into physical and verbal behaviors
• Then divided into aggressive and non-aggressive behaviors
• Useful way to categorize behaviors to determine likely etiology
Physical behavior categories

- **Physically aggressive**
  - Kicking, biting, hitting, spitting, damaging property

- **Physically non-aggressive**
  - Wandering, repetitive actions
Verbal behavior categories

- Verbally aggressive
  - Cursing, verbal threats
- Verbally non-aggressive
  - Repetitive statements, repetitive noises
Training sessions

• #1 – Positive approach by Teepa Snow
  – Waving to get the person’s attention, calling person by name, extending hand, shaking person’s hand, moving to soul-shake, getting to person’s level and side

• #2 – Verbal non-aggressive

• #3 – Physically non-aggressive

• #4 – Verbal aggressive

• #5 – Physically aggressive
• #6 – Teaching strategies to disseminate the skills to other nursing staff in each facility
  – Teachable moments
  – Preparing a micro lesson
Assessment

• Participants filmed during interaction with a standardized patient demonstrating a behavioral symptom
• Structured feedback given:
  ◦ Assessment of resident (considers environmental, physical, emotional, and medical causes for behavior)
  ◦ Problem solving skills (root cause analysis)
  ◦ Intervention appropriateness (specific for the scenario)
Assessment (continued)

- Structured feedback (continued)
  - Communication skills (verbal and visual cues)
  - Professionalism (respectful, uses name of resident)
  - Care plan adequacy (positive approach, includes caregivers)
Results

• 42 participants completed the pre-test self-efficacy survey rating his/her comfort level in managing the following types of behaviors: physically aggressive, physically nonaggressive, verbally aggressive, and verbally nonaggressive
• 35 participants completed the post-test survey
• 37 participants interacted with standardized patients
• 16 completed pre & post test and skills validation
Before training survey

• Most participants comfortable with positive approach and managing verbally aggressive and non-aggressive behaviors
• Less comfort managing physically aggressive behaviors and performing root cause analysis
After training survey

• Nearly all participants felt comfortable managing physically non-aggressive, verbally aggressive, and verbally non-aggressive behaviors

• A few remained uncomfortable managing physically aggressive behaviors
Skills validation

• All met or exceeded expectations for professionalism and communication
• A few did not meet expectations for assessment of resident (mostly related to not recognizing severity of dementia)
• Nearly all met expectations for problem solving and intervention
Follow-up survey

• Included 11 of 19 buildings – those who attended most of trainings
• Assessed staff buy-in, nurse/certified nursing assistant (CNA) perspective, activity programming, barriers, successes
• Performed by 3 members of dementia workgroup at 11 facilities
Barriers to change

• 4 did not experience barriers to change
• 2 reported consistent staffing and turnover
• 2 reported staff resistance and lack of understanding
• 1 reported focus on rehabilitation and finances
• 1 reported corporate policies
• 1 reported corporate training, not flexible
Other barriers

• Nearly all facilities with dementia unit was a long-hallway not circular for residents to wander
• Only 3 had separate rooms for activities; Rest were dual purpose – usually dining room
• Most do not staff activity person over the weekend and some units don’t have a dedicated activity person
## Buy-in from staff

<table>
<thead>
<tr>
<th></th>
<th>Supportive</th>
<th>Not Supportive</th>
<th>Missing/Reservations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>7</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Unit Manager</td>
<td>9</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Social Work</td>
<td>8</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Activity Director</td>
<td>10</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Overall - staff supportive of dementia training
## Nurse & CNA perspective

<table>
<thead>
<tr>
<th></th>
<th>Behaviors are preventable (triggers)</th>
<th>Behaviors are attention-seeking behavior</th>
<th>Mixed results – variable by shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNA</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Nurse</td>
<td>6</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Significant variability in attitudes depending on shift interviewed; Also, variance based on CNA/nurse level of experience, meaning experienced staff were less likely to view behaviors as attention-seeking.
### Activity programming

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mix of physically active &amp; less active activities</td>
<td>7</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Meaningful Work (folding laundry, wiping off tables)</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Layering (more than 1 activity at a given time)</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Appeal to men &amp; women</td>
<td>2</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Dementia appropriate (not childlike)</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Programming actually carried out</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Good mix of physically active and less active activities, but room for improvement with layering and appealing to male residents.
Reasons for success

• Survey tag for lack of appropriate activity programming
• Person trained with several years experience at facility & trusted by management
• Training provided confidence
• Training increased awareness of approach and opportunities to mentor staff, especially CNAs
• Dividing training into 10-15 minute mini-sessions that don’t require extra time at work or extra pay by the facility
• Instructions included and props minimal
• Piloting at 2 facilities
• Will present at 3 regional meetings in Indiana as part of collaborative sponsored by the Indiana State Department of Health in 2016
Closing
Question & Answer Session
Evaluate Your Experience

• Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today’s call.

• To complete the evaluation, visit http://npc.blhtech.com and select the title for today’s call.
Thank You

• For more information about the MLN Connects® National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html.


• For more information about the National Partnership to Improve Dementia Care in Nursing Homes, please visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes.html or send inquiries to dnh_behavioralhealth@cms.hhs.gov.

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