MLN Connects®

National Provider Call Transcript

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

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

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

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement, or QAPI. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, two nursing homes will share how they successfully implemented person-centered care approaches and overcame the barriers of costs and staff. Additionally, CMS subject matter experts will update you on the progress of the National Partnership and QAPI.

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 presentation for today's call in previous registration emails. If you have not already done so, please view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the September 3rd call from the list.

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

At this time, I would like to turn the call over to Debra Lyons, a nurse consultant within the Division of Nursing Homes at CMS.

Presentation

Debra, we are not able to hear you.

Debra Lyons: OK. It took a second to unmute my phone. Sorry.

Hello, and welcome everyone. Again, my name is Debbie Lyons. And together with my colleagues, Cathy Lawrence and Alisa Overgaard, we lead the Division of Nursing Homes efforts around quality assurance and performance improvement, as well as adverse events in nursing homes.

As you know, we've teamed up with the partnership on these significant calls in order to spotlight the importance of the systems approach when working toward quality improvement in any area vital to resident quality of life, quality of care, and safety.

We believe partnership activities exemplify QAPI best practices. And through these calls, we hope to share QAPI best practices related to the partnership, as well as other high-risk issues, such as adverse events. Now, I'm going to take just a few minutes to make a couple of announcements and share your feedback from the last call we had in June.

As most of you already know, this is a very exciting time for nursing homes. CMS has published proposed regulations, which would reform most of the nursing home requirements for participation in Medicare or Medicaid. These requirements have not been comprehensively updated since 1991, despite significant changes in the industry.

The proposed revisions reflect advances in the theory and practice of service delivery and safety, as well as implement legislation such as QAPI, which was mandated in the Affordable Care Act. We encourage you to view the proposed rule, which can be found in the *Federal Register* for July 16th, 2015. Simply type that into your Internet search engine. We also want to remind you that anyone can comment on the rule, but you need to know that the comment period closes at 5 p.m. on September 14th.

Next, I'm pleased to announce that CMS is adding an Adverse Events tab to the QAPI web page. This latest addition will be available in the next few weeks, so I encourage you to check the QAPI web page, and by clicking on the tab, you will be able to find additional information and resources on adverse events, including the CMS Adverse Drug Event Trigger Tool.

This tool is a resource that's intended to help surveyors connect the dots between frequently occurring, often preventable adverse drug events and their associated risk factors, triggers, or signs or symptoms or clinical interventions, which may mean that the adverse event has occurred, as well as probes for consideration when looking at particular high-risk medications.

We wanted to share this tool with you because we think it can also be helpful as a risk management tool for nursing home providers. The QAPI web page can be found by going to http://go.cms.gov/Nhqapi, and I will remind you that the N in NHQAPI must be capitalized.

And now, I would like to briefly share some of the feedback that we received following our last call. We thank each of you for taking the time to respond to our polling questions and to remind you that we read each of your comments, and we use them to improve future calls. As you know, using feedback from the front line is an essential element of QAPI.

First, there were 1,748 people registered for our last call, of which nearly all were directly related to nursing and skilled nursing facilities. There was an overall 88.9 percent satisfaction rate for that call, which exceeded the 84.1 percent average satisfaction rate for all of 2014, and we just thought this was great news. And we will — we promise to continue to strive to meet your satisfaction.

Overall, the themes were — respondents found the presenters were knowledgeable and gave very helpful and practical information. And this is important because one of our goals for this call is to share information that can be applied in nursing homes to really improve the care and services that meet — that our residents receive.

Also, a number of respondents said they appreciated having experienced presenters explain how they set up programs in their facilities, the difficulties they faced, and how it was working. We listened to you and are looking forward to hearing from our presenters today, who will share their innovative approaches and successes in dementia care.

Some respondents indicated that they were inspired by hearing what other facilities have accomplished to further develop dementia care in their facilities. And yet other comments noted that the presenters from our June call were from nonprofit facilities that were the recipients of donations and expressed the desire to hear about innovative funding opportunities for financially challenged for-profit facilities. And we listened to you, and so later in the program, Michele will share some information about potential funding options that may be available through your State survey agency, as well as the CMS regional office.

Additionally, you will notice that today's speakers are from two for-profit facilities that have done some really exciting work. As Leah mentioned, our call today will focus on initiative updates and person-centered care implementation success. We look forward to hearing from those of you who are sharing your knowledge with us today. These positive efforts will create success in improving dementia care for people living in our nursing homes.

And now, I'm going to turn it over to Leah for a keypad polling question. Thank you very much.

Keypad Polling

Leah Nguyen: Thank you Debra. At this time, we will pause for a few minutes to complete key 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. Kalia, we are 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 they are nine or more of you in the room, enter 9.

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

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

Presentation Continued

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

Michele Laughman: Hi. I want to introduce Dr. Anna Fisher, who is the Director of Education and Quality at Hillcrest Health Services in Nebraska. Dr. Fisher will provide information pertaining to the success that Hillcrest Health Services has achieved in implementing person-centered care approaches.

Dr. Fisher, I turn it over to you.

Person-Centered Care: Hillcrest Health Services

Dr. Anna Fisher: Thank you Michele for that wonderful introduction. And I am just pleased and so excited to share our person-centered care success story here at Hillcrest. And I am on slide 6 everyone, and I thought I'd provide just an overall state of dementia care and look at today currently.

Among Americans 71 years and older, 13.9 percent have some type of dementia. And we all know that Alzheimer's disease accounts for a majority of these cases here. And look at this staggering statistic worldwide: As of 2010, 36 million people have some type of dementia. So what is the future of dementia care here by — look at these numbers — by 2050, the costs of dementia care in the United States increase from $214 billion, and it's going to go from 2014 to $1.2 trillion. What a staggering statistic indeed.

So 14 million will likely develop Alzheimer's disease and some other form of dementia. But look at that next bullet there —if they live to 85 and older, 45 percent of these individuals can expect to be living with some type of dementia.

So, I'm on page — slide 7now. So, with all those statistics, we were saying to ourselves, "Now what? What are we going to do to be proactive in our efforts to better accommodate and provide that care for this increasing number of residents with dementia?"

So, how are we going to do this? We are going to examine best practices that can help us improve dementia care and provide that quality of life for the individuals that we serve. We need to reduce any gaps as individuals transition from the various levels of health care. We are a CCRC, so what can we do to reduce the gap as they transition from our various service lines?

And then, obviously, what can we do to maximize resources and minimize cost? And by doing that, we can track it — our progress through our QAPI processes and our efforts.

So, as we move on to slide 8, you will see the best practice recommendation. So, research galore — much time spent on really delving in and honing in on, what are best practice recommendations? We want something innovative. We want something creative, something energizing.

And so in our research, the Montessori Method is what we came across. It's evidence-based, and it really, it's a nonpharmacological philosophy in dementia care. So I want to give you just a brief overview. You might be asking, "What is Montessori?"

The Montessori Method

It's more academic. And we mostly think of Montessori as kindergarten through sixth, to our youth. Well, let me tell you what Montessori is — I'm so excited. It's based on the philosophy of Dr. Maria Montessori, who is an Italian physician. And years ago, she really applied the philosophy that underprivileged youth could learn. They were capable of learning if you simply provided them choices and provided them alternative ways in their environment.

So then, fast forward, Dr. Cameron Camp — who is a research scientist as well as a psychologist — he took this — Dr. Montessori's philosophy and applied it to dementia care. And what this philosophy is — it is very person-centered, it is tailored to their learning, and it customizes that activity at every level, at every stage of the dementia process or the journey here.

And we do this through the cognitive stimulation, enhancing their psychosocial skills, really improve upon their neuromuscular strength. And I'm talking, their gross motor skills and their fine motor skills, and any activity, we want it to be multisensorial. They need to be stimulated in all of their senses here.

So what research has shown — evidence that these activities that were Montessori-based were of more benefit to the residents than regular activities. And the evidence really showed that it improved their ability — to really — to perform any task, deal with any challenging behaviors, and saw a reduction in psychotropic use.

So, moving on to slide 9, more on the Montessori Method then. It is really a holistic approach that really considers that entire person physically, emotionally, intellectually, and socially. And this is lifelong learning — just because an individual is cognitively impaired or has some type of dementia, they are still capable of learning if we just give them the opportunity and create the environment to accommodate them.

So, in other words, as the stage of dementia progresses, these individuals, they may no longer be able to say to you, "Anna, I want to start an activity."

We have to anticipate, we need to be proactive, because they may not be able to tell us that. So, these Montessori activities, it really gives them the sense of self-purpose. It instills that confidence in them, and these activities also give meaning.

Again, I emphasize that sense of self-purpose. They need to see a reward — it's fulfilling for these individuals. The beauty of these activities, too, is they can engage in them for short bursts of time. And as my presentation continues here, I'll actually share with you some examples that we are currently using in our own communities here.

We use real-life materials, and keep in mind, with activities, you want it to mirror what it was like when they were growing up, what it was like to live in their own home. So whatever we can do to accommodate that. These activities, they are structured, we show, we demonstrate by visual cues, and then we allow them to do that.

So, again, we're showing them visual cues. They, in turn, are able to do a return demonstration. The other big benefit to applying the Montessori Method here is, these activities, and as simple as some of them can be, we can intensify that activity. So once an individual have mastered an activity, we want to see if they can take it to the next level. And again, I'll show you some examples later on in the presentation here.

So we can go from simple to complex, and they're failure-free activities — we allow them to pick up that activity, engage in it, and put it back if they are done with it — they are failure-free. So again, what we really emphasize here is not based on, maybe, so much of the quantity of time

— it is the quality. If we can engage them in an activity for 5 minutes — wow, we have been successful. And in turn, they have been able to engage.

So as we started employing this Montessori Method, we had done some research in the area here. And everyone, I'm on slide 10. We had done some research in our local area to see if there was a Montessori school. And we are blessed in our State to have the only secondary Montessori school, which is junior high and high school.

And so I contacted the school, we partnered with them, and we developed a program where on Fridays, these students would come out to our community, our facility, and they would dedicate an entire Friday as a Montessori Day, not only for our residents, but this was actually incorporated into the Montessori students' syllabus.

This was part of their school curriculum everyone. This was not a field trip, so this was part of an educational component of their curriculum. But think of not only the win–win situation for the youth, the young students working the intergenerational activity with our residents. But now, we have a new, innovative, creative method here to provide dementia care.

So the Montessori students started on their Fridays in 2011. This school year, in fact, starting next month in October, the students will be returning to one of our new facilities here, so we are excited about that. So 2011, they started interacting with our assisted living residents, using the Montessori activities. And keep in mind, please, that throughout this whole duration, while they are here on Fridays, we started our own research study under the eyes and consultant of Dr. Cameron Camp, who really founded the Montessori Method in dementia care.

So 2011–2013, you can see there on slide 10, we started with our assisted living residents. And then we expanded, 2013–2014, assisted living, then our memory support, and then our adult day center. And then, keep in mind here, we have started out with our assisted living, but well intentions, we are going to move these activities into our post-acute skills in all of our diverse service lines. Because the beauty, again, of the Montessori Method, it is applicable to all levels of care — that's what is wonderful. It is all person-centered, and it's all about choice.

So in 2015, as I just indicated, we will be moving to our new facility and employing the Montessori Method there.

So, as we move to slide 11, some of the Montessori activities that we engaged in, and we have the structure of activities for the mild stage, moderate stage, and the end stage, or I should say severe stage, excuse me. And then some of the techniques we used, again, were to really enhance stimulation of gross motor skills. And I can't emphasize enough of the use of the fine motor skills.

And you'll see in the lower left-hand corner of that slide, the pincer grip there. If you have your individuals utilize and maximize the most of that pincer grip, it will really help your individual sustain longer their activities of daily living. They're going to be able to dress themselves, self-pericare, self-oral hygiene, self-feed, and on.

So some of the things that we use there, again, were simple scientific experiments — I want to share a really quick story. You see the little carrot tops, everyone, on the plate — it's in your

lower left-hand corner. Who would have ever thought those little carrot tops would have been so successful?

What we did was cut those carrot tops off, put it in a small plate, and this is part of their scientific activity for our residents. And the residents would become highly engaged in watching that little carrot top sprout. It gave them something to look forward to every day, something such as a simple activity as this, but yet really stimulated their mind. They wanted to see the growth.

So moving on to slide 12 — more materials that we used. So, these materials were really cost-effective, they were reasonable, and here's why. We were using sensorial materials that we were looking at and finding in our own facilities, in our own communities. Again, you want to try to find resources that are in your own location, that mirrors somewhat when they were in their own homes. So some of these materials, the students would make on their own. Some of them we actually purchased from Montessori vendors at well at minimum cost. But most of these activities were creative and made within our own facilities and by our students.

We would engage them, and you can see activities, gardens, and baking. Some of the highlights from this slide — Mensa games, which are really mind games. And they really target the spatial, mathematic, the language activities. And I tell you, if you engage these individuals, your residents, your patients with puzzle books, quizzes, these are all Mensa-type activities.

And again, we may refrain from engaging them because we think they may not be able to because they are cognitively impaired. Well, I'm here to tell you firsthand, they are quite capable of engaging if you give them the opportunity. So art materials that you can see here, as illustrated in these pictures here, we would set some of them on carts so they are easily visible to our residents. So it's all about choice.

They were able to walk up to the carts and pick an activity — again, they're failure-free. Allow them to engage on their own. The bells — you're going to hear me tell a story about that here in a few slides.

So, on slide 13, we structured these activity stations at our facility here at the club, which was our adult day. We would have different stations in the environment, in our community here. What we tried to do was have a variety of activities. So at any given moment in time, it is often hard and challenging to keep individuals stimulated. They quite often get bored or they get restless. They need to move on.

So, again, this is all about choice. We designated different areas of our facility to showcase and handle some of these activities.

So, in slide 14 then, moving on, what was our study's goal? Sure, we wanted to look at, maybe, the pharmacological side of that. But what we really wanted to hone in on was, how could we improve their participatory engagement and social interaction? We really wanted to see the psychosocial aspect of this. This is what's driving their quality of life.

So our study goal — we have — our evidence of progress was based on data that was captured during periodic assessments. We used what was called the engagement measure tool — this

was an evidence-based tool that we used to capture our data. We collected this data. And again, we would report up through our QAPI effort. We collected it, we analyzed it, we investigated it, and then we identified any issues, areas of opportunity to improve upon what we were already doing. And then, we're going to continue to monitor the effectiveness of such activities.

So on slide 5 — on slide 15, you will see the illustration on the right-hand side. And this was actually taken in a private room where we would showcase or we would have our data. You can see the engagement tool, the students there, spread them out on the residents here.

We collected data on 44 residents over a period of time. And look at how many activities that we offered them — 94 potential activities. I'm pleased to say right now, we have exceeded 101 activities. But again, the students were very much involved in the data analyzing with supervision from not only the Montessori instructor, myself, and the team members from our facility were actually involved. So it was very much a performance improvement project, a collaborative effort from all disciplines.

Again, and really, I must say, we have really used that PDCA cycle to really see and continue to monitor the effectiveness of our Montessori Method in our facility.

So on slide 16, some of our study's conclusions here, the residents, we have evidence that have shown constructive and positive engagement and interaction while they were involved in these Montessori activities. So again, 44 residents that we continue to monitor, we showed positive and constructive engagement.

Their positive behavior and mood also showed a significant improvement in that. And what we also found — just a wonderful result — unanticipated result — here you can see, they exhibited helping behavior. Residents were helping each other. When they saw somebody struggling with an activity, another resident went over and more or less took over in a nonverbal manner to show them how to do the activity. It was absolutely beautiful.

And then what we also showed was, you can see there that decreased PRN, as needed psychotropic use. So, again, the really, the intent of our study was to focus on the psychosocial aspect of it.

Slide 17 — conclusions of their favorite activities. Playing, but the bells by far exceeded the activities. And you can see, as illustrated there, really quick, I want to share this successful outcome. These bells really enhanced that fine motor skill. But on top of the bells, and I know you cannot see it from the illustration, but actually has the note, a picture of the note, of the sound that plays.

And these individuals who were maybe nonverbal, you should have seen them come to life — their vibrancy, that, when they could see and play those bells, they knew when something was out of sequence. They could tell. So, again, some of the favorite activities based upon the evidence and the data we collected, you can see there.

The parquetry tiles, I really wanted to emphasize, really allowed their artistic expression and ability to shine through. They could put together these tiles in a failure-free format, and they were so proud to see their results.

Slide 18 — optimal outcomes using the Montessori Method. Really, the bottom line here is, it provides them a choice of activities, regardless of where they are in the dementia stage journey here. Promotes that holistic focus, that person-centered care. And I will tell you, these activities, these resources, they are simple. We got the community involved. We had nursing students come in to watch. And the family members, they were intrigued by this new method, yet we were using simple resources, simple activities — it was just wonderful.

And so on slide 19, as I start to close, moving forward, what are we going to do? Well, we know that as the number of people with dementia — it's going to continually increase. It's critical that we are better equipped to work together in a collaborative effort to accommodate this population. We need to stay really on top of it and be creative and innovative in our approaches here.

We know already by evidence, this has really motivated team members. It's moted me — motivated me, you can all tell. But it's motivated a community, it's motivated our family members. It has united people. It stimulates the mind.

And what one thing I've really seen is how beautiful this intergenerational activity is. It came full cycle, and so further research and education is critical. Yes, we are going to continue our study in our diverse care settings, and we are going to continue educating our team members and our family and our community on how this Montessori Method will help these individuals with dementia.

The other thing I just want to say really quick here on, we've also started developing our dementia care kits for our therapists so they can take, and, those dementia care kits using the Montessori activities into our home care patients. So again, this encompasses all realms of care. And most importantly, improves the quality of life for the people that we serve.

I want to thank you for allowing me the opportunity to share my story. Michele, back to you.

Michele Laughman: Thank you Anna.

Person-Centered Care: Washington Rehabilitation and Nursing Home

Next up will be Mr. Bret Brown and Mrs. Heather Exum. Bret is the Nursing Home Administrator, and Heather is the Director of Nursing at the Washington Rehabilitation and Nursing Center in Florida. They, too, will be discussing how they successfully implemented person-centered care strategies while overcoming the barriers of cost and additional staff.

Mr. Brown and Mrs. Exum, I turn it over to you.

Bret Brown: Good afternoon. I just need everybody to imagine just real quickly that an administrator and a DOM will be sharing the same phone headset, so there may be a slight pause as we pass the phone back or fight over the phone to get a point made out, though, but I just want to put that in your mind. And I'm going to turn over to Ms. Heather Exum first.

Heather Exum: Thank you. And as I begin, my focus is mainly on how we began our journey into person-centered care. Where did we start realizing how important it was here and the direction it took us in the beginning?

So, on page 21 of the slides, I'm going to — the objectives that I'm going to be covering are:

- The approaches that we made and our efforts to make things successful.
- What is our actual facilitywide results of antipsychotic med reduction?
- Some of the barriers that we face, and I'm sure many of you out there face, and how we overcame them here.
- What's the impact of the quality of life on our residents?
- And how we continue to maintain and continue our efforts to decrease this antipsychotic use in our residents.

So when we begin talking about the approaches we utilized, it goes back to around 2012, 2013 — our company, Signature Healthcare, afforded us the effort and let us begin to be part of the Pioneer Network Initiative. We would meet at one of our sister facilities — there were three of us involved in it. And the administrator and DOM would go to the meetings. We learned so much from those. And we would brainstorm with our sister facilities to come up with ideas.

And one of the things that Brett and I picked up was the antipsychotic med reduction. We felt that that was something we strongly needed to do at our facility. So when we returned from the meetings, we presented this information to our interdisciplinary team.

At first, they were a little skeptical, but initially, you know, they questioned, "How do we do this? Why would we want to do this?" And after they heard all the information that we had gathered, they became very fired up about taking on this initiative. We knew this was going to be a huge challenge at that time in our building — 33 percent of our residents were on antipsychotic medication. I have to give kudos to my Social Services Director, Amy Rogers. She was definitely the team leader and cheerleader on this that took this initiative on and kept us on track.

So the first thing we did, of course, was to get our medical director and our house psychiatrist on board. Luckily, being in a small town, we don't have very many physicians. In that aspect, so, it was pretty easy to convince them. The need was there, our physicians are very much, you know, trust us. We have that relationship, and so they were on board with starting this project of reducing the medications.

They advocated with us on this approach. And mainly, their issue was, let's starts small, you know, start baby steps, start with a small group, not try to do everything at one time. And I think in our building, and I know for myself, it was at this point where I, myself, and others started realizing, hey, it is about that individual resident. We need to look at that individual resident and stop grouping them, you know, these are the residents on antipsychotics, these are the residents that have to be fed, you know, things like that, and start looking at each one as an

individual. With that, we started learning more about the residents, their history, what they did for a living, things they like, things they didn't like, what kind of triggers they had. And it really got the whole facility focused on that.

So our next hurdle was the education of staff and families. And education is very huge in our company. It is one of the pillars of Signature. The more education, the more knowledge you have, the stronger you are, we feel. So with this, we not only educated our staff, we educated our families and residents who were able to learn the importance of this.

It took a long time — it's still something we do every day. Education is always ongoing. We discussed with them about how we're going to look at each resident individually and that we would never do anything that would harm that resident.

We told them, gave them different ideas of some behavior modifications, and looking at a behavior, not as, this resident is just wanting to act out, but, Why are they doing this? We learned how to start looking for a root cause analysis. You keep asking, why are they doing this? Why do they want that? What do they want? Why? Why? Why? And soon, you realize that there is usually a basic need that person is wanting, and that is why they are acting out.

Also, with this, our therapy team came up with two different rooms in our buildings. One of the rooms was specifically designed with activities for our higher functioning residents to keep them engaged, and we called it our Beautiful Minds Room. They did amazing things. They would do science projects, they would build volcanoes, they would do art projects, they would do gardening.

Sometimes you would go in, and one resident would be doing one project, and another resident would be doing another, just depending on what they enjoy doing. We also had another room that was called our Sensory Sensations. And this had more activities for our cognitively impaired residents. A lot more stimulation-type activities — we would have a time of day where we would lower the lights to kind of calm the room in the evening time when a lot of residents would sundown and things like that.

The addition of these rooms as we were going through our reduction process was huge. Therapy would — before a person would be put in the appropriate room, therapy would screen them and stage them as to what levels they are at. So, definitely was a team effort there.

Again, meetings, meetings, meetings. I mean we all are in meetings all the time. But in these meetings, it was a group effort. We had frontline staff. We had nurses. We had the management team. As we would pick the certain residents that we were doing the med reductions on, we would get the feedback from the staff, 3-11 shift, 11-7 shift, they are so much a part of our QAPI meetings and our weekly at-risk meetings. They know that their voice is heard.

And then, when we have the small successes, when we are able to get that resident off that medication, and we see that resident come alive and participate where they used to not — those are the things that we celebrate. And just to see the joy on the families' or the staff members' faces is amazing.

And again, I can't begin to tell you the support that we have gotten from Signature. We started this with the Pioneer Network. And individualized care is the most important thing, seeing each resident as their own self. And that began us on our Eden journey, and we are part of the Eden Alternative.

Again, on slide 23, we were part of the Pioneer Network study. When we began, as I told you, we had 33 percent of our building who were on antipsychotic meds. So, that was 56 residents when we started. It took us about 15 months, and we were able to reduce down to 18 residents. And six of them actually had the true schizophrenic diagnosis, and the physician, you know, wanted them to stay on their meds.

And currently, we have 16 residents receiving antipsychotic medications. Of course, there's always barriers, there's always people you have to win over. There's times when something you tried didn't work — that's when we were so dependent on— our — the QAPI process, because we would come back in, we would look at what we put in place. We would talk about it. We would come up with our new ideas and try them out there.

Physician cooperation. Like I said earlier, luckily — we have some great doctors here who are all onboard with what we do with patient-centered care, reduction of meds. I know in larger facilities, there's multiple physicians. And some are old school — don't know, you know, the new way to do things as we see it. But we are very lucky in that aspect.

Family education is ongoing. We still have the family members, you know, "Mom has been on this medication forever — you can't take her off of it." So, we work with those, again, on a case-by-case scenario. There's times that we see the reduction did not work.

We don't look at that as a failure, we look at that as, hey, we tried, we understand this is what's best for the patient, and we move forward from that.

Staff education is always ongoing. In the beginning, pretty much my phone number and Amy, my social services director's, phone number was on speed dial for all the nurses. We told them, before you try medication or call to get a shot for a resident to calm them down, call us, let's talk through. Let's see what's going on.

We live close to the facility. We would come up here and see what was going on, until the staff learned, hey, we can try these things. We can do these things. We know what triggers, we know what doesn't. We know what can calm the patient, and things like that. So the philosophy in our building is, you try everything first before you go to a medication.

Again, when you have new admissions coming in or even some of our patients that go to the hospital, they may come back on an antipsychotic from the hospital. We work with our local hospitals. We have even gone next door to our local hospital if one of our residents is being combative or having issues, and gone over and given them a bath, and talked to the staff there. They are just right out our back door, so we are lucky in the fact that we can do that.

So those are some barriers that we have to deal with. And of course, training new staff and continued education, you have a staff member that comes from another building, you have to teach them what we do here, and no, we don't call the doctor to get a medication first. We do

this, and this, and this before we go to that route. So education is always ongoing. And we are always learning new things from new studies of different activities and things that we can do.

And as far as the quality of life in our building — I'm on slide 25. Again, it all goes back to individualized care and improving, you know, the relationships. One thing we've learned through Eden — it's all about the relationships. You build that relationship with your resident, with your families — we have the consistent assignments, you know. We do the huddle with our CNAs and nurses, so everyone knows what's going on. Residents, you know, that once were on antipsychotics, that pretty much were closed within themselves, we would see them come alive and participate.

One of my favorite stories is of a little gentleman who basically was not a behavior problem. He would sit in his chair, quiet as he could be. And we began reducing his medications, and it went slowly from him saying hello to people, acknowledging, "Hey, good morning," to he started remembering staff members' names — some were their real names, some were names he gave us, but he still remembered that name. From there, it went to singing — he loved Old Motown. We would have karaoke, and you could hear him up and down the hallway singing.

His daughter was just amazed at where he had come from. And she was fearful of taking that medication away because Dad had always been on it. But just to see, even in my mind now, I can see him with that microphone, smiling ear-to-ear singing. So, it's the stories like that that keep you going and letting you know that is what's most important.

Of course, our staff is more engaged, those relationships are there. They'll be the first to come to me and say, "Hey, I think, you know, Mr. So-and-So is doing great with this med reduction." Or, "Hey, I know this is going on, you know, he is not responding well." You know, things like that. So very much open door policy to come talk — we listen to everyone.

We have great resident family and staff satisfaction when we do our surveys. As far as State and Federal surveys that come in, we have great outcomes from those. And this, in turn, allowed us to initiate Holistic Caregiver, which Bret will go over in just a couple of minutes.

And how we maintained this? It's our culture. It's what we do. It's taken us several years to get to this point, but, you know, staff know and are continuously trained on behavior management and dementia care and individualized care.

In Signature, we have buildings that are serenity buildings, and they specialize in this dementia care. They have been wonderful to us, teaching us, guiding us things. I can't go on enough about how important it is to network with other facilities and learn from other facilities.

We are the ones that are doing it every day, we're the ones out here, and who better to ask than those that go through it and understand it. And again, as Bret always says, and one thing we always admire is, if it's the right thing to do, then it will work out. And we always remember that what we're doing is the right thing for our residents, and we never give up on making things better for them.

So, at this point, I'm going to turn it over to Mr. Bret Brown, and he is going to go over Holistic Caregiver, which is what we are initiating and doing here at our facility. Bret?

Holistic Caregiver

Bret Brown: Hi, good afternoon. I want to again thank the Pioneer Network and, you know, Eden Alternative for the resources that we have used from them, guidance, modifications of a lot of the things that they have in place with those networks. And I just want to say, thank you very much. Great resource — I have — to have them.

I'm on page — slide 27. Understanding — what I want to attempt to cover today is understanding the role of the holistic caregiver, you know, why implement the holistic caregiver?

I encourage you to go ask a housekeeper when a resident needs, maybe, to go use the restroom or needs nursing care — how many steps that housekeeper has to go through before we can actually serve that need for the resident. And so, we found out that when a resident needed to go to the restroom, it took a housekeeper, you know, a good 3 to 5 minutes to, maybe, find an aide, a nurse to get them to serve the resident. So, that was one of those aha moments to — we need to have a point of care that is almost immediate to serve our residents.

We are going to discuss how the Holistic Caregiver Model works and the extensive training that we did here at Washington Rehab to get our staff to the point of understanding and having a good flowing process. We had our barriers. We had our obstacles that we had to go through as we made this transition, things that we may have completely forgot about like, forgot about that, and have to go back two or three steps and re-implement other steps moving forward. And then the rewards that we are seeing as a result of this model.

On slide 28 — Holistic Caregiver — what is it? It encompasses the role of a CNA along with the restorative aspect. It also is the housekeeper and activity assistant all into one person. Again, the reason why we decided to do this is from what we have learned when we joined the Eden Network, what we learned in the Pioneer Network, with the reduction of antipsychotics — we realized having a more individualized plan or approach for our elders related to good outcomes. We came up with a program: Signature Healthcare did help us create a program called Simply Me, as each resident is introduced, to our facility and even our residents that we currently have, we need to know more about our elders. So we have a form or we have a sheet that is filled out on each of our elders. It talks about what their occupation was, it talks about, you know, what are their favorite colors, what are their favorite holidays, what are their favorite TV shows?

So, when we have a new elder come to our building, it's nice to have, if they love the History Channel, go ahead and let them know, hey, the History Channel's on Channel 36, so they can have that and make that smooth transition to us. You know, what are their favorite foods, their favorite snacks, their spouses' names, their nicknames?

Being able to know that person-centered care helped also with their care. These signs are put up or framed in each of our resident rooms. So when we have staff, which I'm very proud, we have the consistent assignment. But when we bring in new staff, this gives them a way of being able to learn their elders, on their modules, or their neighborhoods even better.

And again, this also reinforces through the Simply Me, it just reinforces the stronger relationships that we have with our elders. True quality of life — we celebrate individual birthdays on our neighborhoods, and I will explain more about neighborhoods in just a minute.

The holistic caregivers are able to share a lot of their talents with the resident. How often would a— we asked one of our housekeepers, you know, What is one of your favorite hobbies? Well, I like to crochet. Wouldn't it be neat for you to get a group of residents on your neighborhood and teach them crocheting?

You could just see eyes light up as we went through our learning process about all the advantages that could happen with our quality of life events. We started doing personalized outings, headed to Walmart. Each neighborhood going to Walmart, getting specific things that they need. Going out to movies, football games; we even have an initiative to where we have our elders go on vacations, flying on planes, going to Boston, to the beach, to Disney World — that's the true quality of life that we are offering our residents here at Washington Rehab and Nursing Centers.

I am moving to page 30, the holistic caregiver working in their neighborhoods. Again, the Eden Alternative allowed us to create smallness with having neighborhoods throughout the facility. We are a rather large facility -— we are a 180-bed certified building.

Our neighborhood, our building, excuse me, is broken up into five neighborhoods from this type model. Again, we want to put more hands, more consistent hands, on our residents every day. Our ratio as we have moved, as we have implemented the holistic caregiver, our ratio of the holistic caregiver to elder on the 7-3 shift is five to six elders per holistic caregiver. On the 3-11, it's seven to eight; and on the 11-7, it's nine to 10.

It's having hands, closeness, on our elders at all times. There are a lot of uniquenesses that we have in each neighborhood. Each neighborhood will provide its own activities. Each neighborhood has its own staffing schedule. Each neighborhood meets with their elders on a regular basis to find out what they would like to do, especially during seasonal-type events.

And so, again, it brings closeness and togetherness with our staff to our elders. The ownership of the neighborhood — we have a very competitive group. Our ownership of, you know, who can have the better clinical outcomes each month; who can have the most, I guess you could say, exciting activity for the building. Each neighborhood invites other neighborhoods to participate in different events.

There is a lot of pride that we have in each one, so the quality of life in each neighborhood is based on the resident choice, and also, the different ideas of other neighborhoods that they get. And it's a continuing snowball effect of the different things that we can provide for our residents.

On page 31, on slide 31, training and education — this was the bear of the project. From our reduction holistic caregiver and from our moving through the Eden Milestone One into Eden Milestone Two, it was very easy to have this management motivation, the buy-in, always doing the right thing for our elders. What we had to do for our staff more is to have a learning congress and show, really, the true effects of what it could have.

A lot of our management staff went through the Eden trainings, but a lot of our line staff did not have that opportunity, so we had to sell it to them, show it to them, for them to understand why we were doing the holistic caregiver model.

During our learning congress, we met offsite for 3 days. A person had to go through a 7-hour training of one of the 3 days. And so, we had over 200 staff that participated in this offsite training. We brought them in. We showed all the great things that we have been doing with antipsychotic reduction. We showed them all the great clinical outcomes, the star rating.

And then we had — and the financial success. And then we had to bring it to more of a realistic view. We created our own video, we walked through our halls and showed some of the things in our building that we weren't proud of and what we needed to work on. And we had to have that connection with the elders that we took care of. We had to look at certain areas that we didn't want to see but we had to address so they will know what we were doing was for the right reasons.

So after we ended with that learning congress, we — there was a fire that was lit. There were tears that were shed about knowing that we could do better than what we could — than what we were currently doing. We had a lot of different great learning sessions from, you know, the video, to showing the real actual chain of command.

With the holistic caregiver model, if you look at the current organizational chart of a nursing home, the administrator sits up top, the DOM, the managers, and then you finally get to the CNAs and you don't even see the resident part of that organizational chart. What we did with Holistic Caregiver is, we flipped it. The elder is first, the CNA — the holistic caregiver is second, the nurse is third. The people who have actual hands on the resident are the most important people, and the people who need to be making more of the decisions for our elders. And so, they were very, very excited on that, but because the administrator is way outside. I'm not the one who should be making those critical decisions when I'm not the closest to my elder.

And then we did some great team-working classes along with explaining the Eden and Pioneer alternative with everybody. It was from this buy-in that we were able to proceed. And I can't talk enough about the culture in our building. We did not always have the best culture in the world, but through the past 5 years, our culture has grown, our turnover is very low. So when people come, as I meet every orientee, I hire you for life unless I'm going to promote you up — it's going to be one or the other, you are never leaving me. And so that's the mentality we go into when we talk to staff.

The educating of our current staff on the holistic caregiver, about all the roles that they'll be playing. And, I will get in that in just a little bit further. We also had to educate a lot of our noncertified staff. We had to educate our housekeepers — importance of the elder — the elder approach, the individualized approach; our dietary staff who are confined to one area most of their workday. And so, yes, and that everyone gets certified as a holistic caregiver. Again, education consistently ongoing.

Slide number 32. We are proud to say, one of the hardest things that we had to do, and the decision that we were given is, let me start over — when we were asked to pilot the Holistic Caregiver, they laid it out to us; they — Signature Healthcare came and met with us, they had

the confidence that we could roll this out and make it successful for our residents. There was not a map for us to go by. There was not a check-off list that says, “OK, we got that accomplished.” We had to come up with this on our own. One of the things that we decided to do was ,in each of our neighborhoods, was to create this own nurse staffing schedule.

So as staff were — already had consistent assignments, they have their own pool of people in their neighborhood they can call in in case there was a call-in. If there was another holistic caregiver that was sick, then they already had a list of two or three people that they could call to come in, so we can keep that consistent assignment for that.

So that was setting up five different nursing schedules for each of our neighborhoods. So that was one of the barriers we — it’s one of the obstacles we decided to take on. It took a little bit more time, but we think it serves well in its purpose.

One of the other things —we— I found here in one of my missions since I have been here at Washington Rehab is, you know, de-institutionalizing the staff, the family, the residents, and the community. We’ve done a very good job with that, with the family, and with our staff and residents, but I found that our community has a different look on us.

Whenever I would tell people, yes, we went to Panama City and went out to Red Robin and had lunch, and then went to the movies,” the comment I would get was, “You let them out?” It hit hard that people still view residents in nursing homes as not an individual that they — you know — are they able to still experience things like that?

And so, that’s been my personal mission here at Washington is for the community to understand, we are here, we are still active. We — our elders have still so much more to offer. And currently, right now, we — our elders run the concession stand at the city parks. We run the concession for the baseball, the T-ball, the soccer games, the basketball games. Our elders go, and they work the concession stand, they’re giving back to the community. It gives them that sense of purpose.

We have waiting lists of that rotation of people to come in, like when we go to the movies. They want to — I have a list of at least 15 to 20 people, and we have to break up groups to go to the movies. It’s what they love to do. So just trying to get that mentality of the institutionalism, you know, from our community has been very hard.

Some of these “oops, didn’t think about that” is when we pooled and started training all of our noncertified staff like our housekeepers to be holistic caregivers and we started going through all these trainings, and we got them trained, we got everybody out there and we start thinking, well, who’s cleaning the offices, who’s cleaning the common areas, you know, who’s been assigned that? So, we had to kind of go back and rethink that as we do monthly weights or weekly weights. You know, that particular process which Heather, I’m going to hand the phone to Heather real quick so she could —

Heather Exum: With the weights, we always had a separate restorative CNAs. Well, through the holistic caregiver, all of our CNAs in the building are trained in restorative care. So it went from just a certain few to doing weights to making sure every single holistic caregiver knows how to use the weight machine, knows how to properly do it. And each neighborhood on its own has

come up with their specific people who consistently do the weights, so we still have that consistency with that.

Some other issues were documentation with quality of life. You know, usually you have two or three CNAs that work in the Activities Department that do all the activities, so the schedule at the time was scheduled around the times that they could do. We had some issues with timing now that the holistic caregivers on each unit were doing their own activities, so those were things we had to work through.

Making sure all of the holistic caregivers go to the care plan meetings, so making sure that time's allowed so that they can get to the care plan meetings with the resident and the families. So, you know, there's things we — and there's things every day that will come up — what about this, doctor's appointments? What about this? And this? And we just kind of work through them as they come up.

Bret Brown: And so we had those moments of having to rely on our holistic caregiver, our nursing staff, our managers to come up with ideas to work through these issues.

A lot of the rewards, you know, is the strong relationships we have, not only with the elders on the neighborhoods, but also with the families. When they see their loved one has so many hands on them that are concerning with them, that know them, know their habits, they trust us. We have earned their trust. They have each of — every family member has my own personal number and Heather's. We do not receive calls from them. They trust us and — that we are going to take care of their loved one.

When we went Holistic Caregiver, and giving the power to the people who have their hands on the residents, from them attending the QA meetings, the QAPI meetings, the monthly big calendar for the whole community, our whole building. And them having the input on how things are ran on their neighborhoods, it has given them just a sense of empowerment of knowing what they do actually does mean something and has an effect every day.

And it's when you have all these pieces that come together, you have that true teamwork. And it is — it's beautiful to see. We are a big family here. We all will have our disagreements, and we will all have, you know, the different things we have to work through. But through true teamwork and knowing that we have our elders' best interest in mind, then everything goes the way it should.

Our quality of life has exploded due to everybody wanting to do something for their neighborhoods in their neighborhoods and trying to outdo everybody else. So through showing how we can do even a better-centered care for our elders, it has led to terrific outcomes.

And that is it. Thank you very much.

National Partnership Update

Michele Laughman: Thank you, Bret and Heather. I appreciate that.

I would now like to share some brief updates related to the National Partnership. We are continuing our work on the Focused Dementia Care Survey expansion efforts. Surveys are being conducted in California, Illinois, Mississippi, Missouri, Nebraska, and Texas. Both California and Illinois also participated in the 2014 pilot project.

All of the surveys are expected to conclude by the end of September. And similarly — pardon me, similarly to the pilot, feedback will be obtained from all of the surveyors that participated through the completion of a surveyor questionnaire. Our team will then review the questionnaires, analyze data from the 2567s, and then we will develop a summary report. And we anticipate that the report will be released sometime in early 2016.

We also wanted to share some exciting news about the Advancing Excellent website, which continues to house a repository of tools and resources on behalf of the National Partnership. We are working closely with Advancing Excellence to update the appearance and organization of the resource repository. And we have received valuable feedback, and we're trying to incorporate some of the suggestions to create a more streamlined user-friendly page. We hope that these updates will also allow for ease of navigation. So please check the website often as these changes will be coming very soon.

As Debbie mentioned at the beginning of the call, several States have successfully utilized State civil money penalty funds to implement the types of activities and programs that were shared by our speakers today. These funds have helped nursing homes implement person-centered care approaches through staff education, leadership support, and also interdisciplinary involvement. States work with their State survey agency to apply for the State CMP funds, and the CMS regional offices issue the awards.

Additionally, on our last call I provided an update on the Federal CMP grant that was recently awarded in collaboration with LeadingAge State affiliates and health care associations. The Eden Alternative plans to engage direct care staff from nursing homes across five States — Georgia, South Carolina, Kansas, Illinois, and Texas — and their project, entitled "Creating a Culture of Person-Directed Dementia Care." This project consists of an interdisciplinary initiative, combining both in-person and online group education, self-directed learning and application, implementation resources, and also the opportunity to engage with other nursing homes in the pursuit of best practices.

We are grateful for the efforts of so many people and organizations. And based upon recent data that we shared, we have now seen a 21.7 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.

We thank you for your participation in today's call and we look forward to continued collaboration and partnership. I will now turn it over to Leah and Kalia for the question-and-answer session.

Question-and-Answer Session

Leah Nguyen: Thank you Michele. Our subject matter experts will now take your questions. But, before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue. We will address additional questions as time permits.

All right, Kalia, ready to take our first question.

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

Leah Nguyen: Speakers, can we ask that you all mute your lines, please?

Operator: Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

And you have a question from the line of Kimberly Gimmarro.

Kimberly Gimmarro: Thank you. Kimberly Gimmarro from Botsford Rehab and Continuing Care Center in Michigan. I'm interested from the speakers that just spoke, they mentioned their facility had five different neighborhoods. And I'm curious, when they launched their person-centered care effort, in particular, the holistic worker, how many of those neighborhoods were part of the initial launch?

Heather Exum: Yes, Ma'am.

Kimberly Gimmarro: I will take my response offline.

Heather Exum: OK.

Operator: Your next question comes from the line of Dane Meyer.

Dane Meyer: Good afternoon, folks. Thank you for taking the time for this. I am a project research nurse with a CMS-funded project in Indianapolis, Indiana. My question would be probably mostly toward Mr. Brown, because you mentioned it was a 3- to 5- year turnover program in order to change the culture in the facility. What was the biggest obstacle you had in turning the culture over to this patient-centered care?

Michele Laughman: Heather and Bret, I think maybe that question was directed to you.

Bret Brown: Yes, one of the biggest things that — I would say the biggest obstacle is, your staff has to truly see that you care about what is happening in the facility. I didn't come from a long-term — I didn't come from a long-term care experience — I was the teacher and coach.

And what I did was, I just coached up the staff. I showed them what was right and always do the right thing. And I showed them that I was strictly involved with care. Yes, I visit my residents every day. Once the staff got to know me and know what I expected, and my expectations were strong — it was resident care and teamwork — and it was from these ideas of moving forward, seeing me on the hallway, seeing our management staff, knowing that they have to —the things that they do. Like, one of the rules in our building is every person answers a call light. And the call light stays on until the service is provided.

It's those leading things that we went ahead and took on initially to show the staff that, you know, we're there, A, to help, B, to be sure they have everything they need to make — to take care of our residents, and to, C, know that there are really no excuses of why we can't provide exceptional care.

We lost people on the way. People have their own agenda. And if you ever say, and as I tell staff, if you ever put "I" first, then the elder is not first in what we should be doing.

So once that expectation was presented, then the building fell more in line with what we were trying to accomplish. It's not about us, it's about them. I guess that's what — the formula that worked with us.

Dane Meyer: OK. Thank you.

Michele Laughman: Hey, I just wanted to say — this is Michele Laughman, for the first person that asked a question, if you could put your question in writing, and then we can send you a response. And you can use the email address that's located on slide 37.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Lisa Cabana.

Lisa Cabana: I'm sorry, I didn't have a question, that was an accident.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Patricia Pattison. Patricia, your line is open.

Karen Kuhali: Hi colleagues. Hello, my name is Karen Kuhali, I'm the assistant director of nurses. I'm just curious — I know you have a five different neighborhood system which, in fact, I don't believe we do at currently. We don't have that setup. What is your physical plant layout to accommodate that neighborhood-type of environment?

Bret Brown: Can you hear me?

Leah Nguyen: Yes, I can.

Bret Brown: OK, just making sure. Our physical layout is — we were concerned about, you know, where the division marks up between these neighborhoods. Again, we took ideas that the Eden Alternative have that comes with how to, you know, how many elders do you want on your neighborhood.

We, in order to fit our building better, we have more elders than what they actually would prefer us to have, but it works for our building. We have two — our building is designed where it's really two squares that interconnect at one point. So we were able to have one complete hallway — we were able to have, excuse me, four of our neighborhoods that are on its own hallway, I guess you could say, that are perfectly L-shaped. So it was very convenient for us to have these neighborhoods.

We do have one neighborhood that you have to go, I guess you could say, around the corner a little bit. But it was just trying to keep those numbers as low as possible to have that individualized care. So the design of our building truly helped out how we organized our neighborhoods.

Leah Nguyen: Thank you.

Karen Kuhali: Hello? So what I'm wondering is — so is that just basically one unit, and you have like a corr — two long corridors, kind of, and one L meets the other L, is that, with a central location in the middle? Is it visual this way?

Bret Brown: Yes, ma'am. I mean, it's like what we used to call Old Hall Three. It has two neighborhoods that meet at the L at the nurses' station. It's that way also on Hall One. Our Hall Two, it has — it's our longest hall. And that hall is divided about three-quarters of the way down, is into that second part of that neighborhood on Hall Two. So it's very convenient and doesn't get — you know, very fortunate for the layout of the staff, I mean, of the building.

Leah Nguyen: Thank you.

Operator: As a reminder, to ask a question, press star followed by the number 1 on your touchtone phone. Your next question comes from the line of Stephen Crystal.

Stephen Crystal: Hi Michele. That was a wonderful presentation. Thank you. I was just wondering, with regard to the, sort of, broader questions about where the National Initiative is going.

Do you have analyses of the MDS data underway to, sort of, get a finer grain picture, or how the use is evolving in terms of the finer details — duration, dosage, dosage reduction, all those things, how it varies by type of facility staffing. And also, is there — what are the current plans that go beyond, sort of, the current QM? What are the — are there plans to review the QM itself and NQF, or is that, sort of, plan to be stable for a while?

Karen Tritz: Hi, this is Karen Tritz from the Division of Nursing Homes. A lot of different questions in there, so I'll try and give you a sense of where we are with that. We have done some initial review of other areas of the MDS, and how it relates to the reduction in antipsychotic effort for

individuals with dementia. And we've published some of that on our website, on the National Partnership website, through an interim report.

And so some of the things we looked at there were related to survey results, but we also — from the MDS side, looked at changes to — any changes in diagnosis and changes in medication. So we are somewhat limited at this point by the MDS question — structure of the question. So we haven't done any formal analysis as you suggest of specific dosages, which we know there may be, you know, more changes in specific dosages than either, sort of, on or off a given medication. And let me just say that we haven't captured those, because the MDS isn't — question isn't structured that way.

But we have — we did some of that last year and released it on our website. I think we probably — it would be worth redoing that analysis and updating that analysis, and we can take a look at that. And I think, you know, we haven't — what we haven't done as much of, and I would be interested in — in any of the speakers who may have looked at their own data on this is, we have not really looked at how it may correlate to other areas of the MDS, such as activities of daily living or falls, etc. So I would be interested in any other speakers' comments on that — that's essentially where we are with the analysis.

Stephen Crystal: That's very helpful. Thank you. And we should probably talk separately about what we may be able to do or not do in the context of our project. We still, you know, we have yet to get the National 2014, but we will talk separately.

Karen Tritz: And please feel free to send your comments and suggestions and information into the mailbox that's on the last page of your slides.

Leah Nguyen: Correct, slide 37. Are there any comments from the other speakers? OK, I think we are ready to take our next question.

Operator: Your next question comes from the line of Joy Edal. Joy, your line is open.

And that question has been withdrawn. Your next question comes from the line of Erika Coull-Parenty.

Erika Coull-Parenty: Hi, I am calling from Brentwood North Nursing Home and Rehab in Deerfield, Illinois. I am calling — I'm asking, in regards to the Montessori Method, I had been certified quite a few years back. And I'm just wondering if I have to get recertified in order to be able to teach the staff and provide this type of care to the residents on my skilled unit. And in regards to the staff, do they have to have yearly teaching or monthly teaching similar to the dementia modules that have skilled dementia units in facilities?

Dr. Anna Fisher: Great question. Thank you for that. In fact, we have Dr. Camp — he is coming to our actual organization next week to train more of the team members in the leadership team. And I don't want to speak specific to the timeframe or parameters for certification, but I believe there is, and I want to say it's every several years. But again, please, don't quote me on that.

If we would like to take this offline, if you furnish your information, I can actually follow up and ask Dr. Camp and get back to you.

Erika Coull-Parenty: That would be great.

Dr. Anna Fisher: Wonderful, thank you.

Erika Coull-Parenty: Thank you.

Leah Nguyen: Kalia, we have time for one final question.

Operator: There are no further questions in queue.

Additional Information

Leah Nguyen: Thank you. 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 36 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you would take a 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 and Nursing Homes and QAPI. Have a great day everyone.

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

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Official Information Health Care
Professionals Can Trust


MLN Connects