



MLN Connects®

National Provider Call Transcript



**Centers for Medicare & Medicaid Services
National Partnership To Improve Dementia Care and QAPI Call
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 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®](#).

This call will focus on infection control, highlighting antibiotic stewardship and communitywide efforts, including a presentation from a nursing home administrator. Common concerns related to the clash between individualized, person-centered care and the medical model of controlling infections will also be addressed. This is critical for residents with dementia, who often struggle to complete complex tasks and may have issues with continence. Additionally, CMS subject matter experts will share information about the upcoming Infection Control Pilot Project, as well as updates 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 email. If you have not already done so, please view or download the presentation on the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc. At the left side of the webpage, select "National Provider Calls and Events"; then select the April 28th call from the list.

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

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

Presentation

Debbie Lyons: Thanks, Leah. Hello, everyone, and welcome. My name is Debbie Lyons, and together with my colleague Cathy Lawrence, we lead the Division of Nursing Homes efforts around Nursing Home Quality Assurance and Performance Improvement as well as adverse events.

As you know, we've teamed up with the partnership on these calls in order to spotlight the importance of the systems approach when working toward quality improvement in any area vital to residents' quality of life, quality of care, and safety. The work of the partnership in improving the care for residents with dementia exemplifies QAPI best practices, including using data to set goals and track performance, performance improvement activities aimed at the underlying system, and creating an atmosphere where identifying issues and learning is a priority. Through these calls, we hope to highlight some of these best practices, as well as shine a spotlight on high-risk issues, such as adverse events.

QAPI Update

Debbie Lyons: First, a quick update on the Notice of Proposed Rulemaking, or NPRM, for the reform of nursing home requirements. As you know, the NPRM was published in July, with comments accepted through October 14th. Nearly 10,000 comments were received, indicating a lot of interest in the proposed rule. CMS is very busy reviewing and addressing the comments, and we'd like to thank you for taking the time to read the NPRM and submit any comments. CMS has up to 3 years to publish a final rule, although we do not expect to take that long. A more specific timeframe is not currently available.

Next, I'd like to share feedback from our last call in December. We want to thank each of you for taking the time to respond to our polling questions. We read each of your comments and use them to improve future calls. As you know, feedback from the frontline is an essential element of QAPI.

First, there were 1,854 people registered for our last call, which is a 5.9-percent increase over the previous call, of which nearly all were directly related to nursing and skilled nursing facilities. There was an overall 90-percent satisfaction rate for that call, which exceeded the 84.1-percent average satisfaction rate for all of 2014, and we're pretty proud of that. And we will continue to try to meet your satisfaction.

The overall themes were that participants found the presenters knew their topics well and did a good job presenting information that was relevant for both long-term care and skilled nursing facilities. Respondents said they appreciated the MLN Calls because they increased their knowledge of many important topics. There was a lot of very positive feedback for the presentations on high-risk medications, which contribute to many preventable medication-related adverse events. However, some respondents were surprised the call focused on high-risk medications and not on dementia care. And I'd like to address this since we hear quite frequently the concern that it's not all about dementia and the partnership.

As you've come to know, we've expanded the topics that are shared on these calls. In addition to the great work of the partnership to improve the lives of residents with

dementia and to reduce unnecessary antipsychotics, these calls also cover QAPI and adverse events in nursing homes.

As you may know, according to the Department of Health and Human Services Office of Inspector General report titled "[Adverse Events in Skilled Nursing Facilities: Incidents among Medicare Beneficiaries](#)," almost one in three residents experienced an adverse event in their first 35 days in a skilled nursing facility. Those events were categorized into three types: medication-, care-, and infection-related. We believe it's important that these calls share best practices when possible to help nursing homes identify and prevent adverse events, as well as highlighting QAPI best practices. Our last call featured medication-related adverse events, and today's call will touch on infection-related.

Again, we thank you for taking the time to share your feedback on this when we do the polling questions. I hope you find today's call informative and helpful, as our presenters will focus on infection-related adverse events as we take a close look at antibiotic stewardship and the great work that Holly Heights Care Center in Denver, Colorado, has done—also, CMS's Infection Control Pilot Project and an update of the work of the National Partnership.

Again, we look forward to your feedback after today's presentation. And now I'll turn it over to Leah for our keypad polling question.

Keypad Polling

Leah Nguyen: Thank you, Debbie. At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be a few moments of silence while we tabulate the results. Ronni, 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 there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

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

Presentation Continued

Leah Nguyen: Thank you, Ronni. I'll now turn the call over to Michele Laughman, Coordinator of the National Partnership To Improve Dementia Care at CMS.

Michelle Laughman: Hi, I would like to now introduce Ms. Janet Snipes, a nursing home administrator at Holly Heights Care Center in Denver, Colorado. Ms. Snipes will provide information about antibiotic stewardship involving urinary tract and respiratory infections and the unique challenges for residents with dementia.

Janet, I turn it over to you.

Antibiotic Stewardship: Performance Improvement Projects

Janet Snipes: Hi, good morning. As introduced, I'm Janet Snipes, the administrator at Holly Heights. We're a 133-bed privately owned nursing facility in Denver. I've been asked to talk about our 2015 and 2016 performance improvement projects in antibiotic stewardship.

In reviewing our infection control data for 2014, the most frequent infection we treated at Holly Heights was urinary tract infections. So, our medical directors, pharmacists, and facility staff developed a performance improvement project for the management of asymptomatic bacteriuria. We researched the literature to determine the best criteria to use to guide assessment and decisionmaking related to treating urinary infections and decided on the revised [McGeer Criteria](#).

You might ask, how did we determine that we needed to reduce our use of antibiotics? The Colorado Medical Directors Association hosts a conference each year, and in 2014, they had a portion on antibiotic stewardship. We further researched and found that there are major detriments to using unnecessary antibiotics, including the side effects, drug interactions, and potential adverse events. We were already aware of high potential nursing facilities' residents having contracting *C. difficile*, as well as very familiar with the acquisition and infections from antibiotic-resistant bacteria, such as MRSA and CRE. We also were concerned about the increased risk of antibiotic-related complications, including the possibility of hospitalization and even increased mortality.

Following the quality assurance, we used the Baldrige Quality Assurance Performance Improvement Criteria in which our staff has been well trained. Our first approach was the root cause analysis. We knew there was a common practice of culturing urine. It could happen whenever families ask or if there is a change in medication or activities of daily living status. It's often one of the first things that was asked for. We found that many of our staff were not aware of the current guidelines.

We are also aware that hydration in our particular population is not always ideal, and we knew that we had a lot of education to provide. We established what we thought

were rather lofty objectives, including reducing urinalyses obtained by 25 percent, reducing the culture and sensitivity of those UAs by 25 percent, and then reducing antibiotic usage for asymptomatic bacteria by 25 percent.

Our action plan included education—as you can see, the different areas we provided education in: the McGeer Criteria; colonization; reading and actually understanding the culture and sensitivity; what asymptomatic bacteriuria is; and another education specifically designed for the certified nursing assistants and, when indicated, the patient, about what appropriate peri-care looks like; and then all the risks involved in using antibiotics inappropriately.

These are the groups we targeted the education to. It seems like a large group of people, but in our community, we often have the therapists coming and asking the nursing staff to obtain a UA. Residents, patients, and families are extremely tough as they wanted an immediate fix. And I'll show you in a minute the education that seemed to work the best with them.

Implementing the practice guidelines proved to be a struggle. I can't express how many times we repeated our training to multidisciplinary teams. We are training monthly for the first 6 months. And just when you think they got it, we had another request for a UA without appropriate assessment. We put articles in our family newsletter. We talked about it at our resident council and neighborhood meetings. Much more education was provided than I ever initially anticipated. Now, however, I have to say that our staff are our champions, and they're the first to educate families and obtain appropriate assessments.

Using a systems approach, the next slide is a flowchart that we developed to help staff understand what the protocol should be. Whenever there is a resident that UA was being discussed, we would immediately implement preventive measures which included cranberry juice at all meals, a nursing order for 240 cc fluids three times a day, cranberry tablets if indicated, and estrogen cream if indicated. Then the nursing supervisor had to personally assess the resident to see if they met the McGeer Criteria. And if they did, the symptoms were noted and the M.D. was notified to see if they wanted to order a UA and a C&S. The nursing staff were thoroughly trained and got very good at analyzing the C&S for infection. If indicated, then orders were obtained for the appropriate antibiotic. The symptoms that were found on the assessment were specifically noted on the physician's order for tracking and documentation.

So many times we found that there was not appropriate systems note – symptoms noted to order a UA, yet we were still encouraging the fluids and giving the cranberry juice, which helped to alleviate some of the initial observations. When a UA was necessary, many times when we got the C&S back, there was no reason to order antibiotics as the nursing staff are better educated at analyzing the results of the U&I – UA and our infection prevention nurse personally reviewed each C&S.

Our community has a fairly high percentage of residents with dementia. These residents presented with particular difficulties in this performance improvement project. They're often unable to convey any symptoms or pain. At times, they had exacerbated behaviors that took us a while to determine the root cause. The families would insist, "I know my mom—you have to get a UA." So our staff training included watching for changes and behaviors specifically related to agitation and anxiety, watching for a decrease in the activities of daily living, decreased mood and some lethargy, sharing information of multidrug-resistant organisms and antibiotic stewardship, and specific nonpharmacological interventions for each resident. And then, again, we always started pushing fluids and cranberry juice.

So, you might ask, what were our results? I separated this slide into two different graphs because I think it shows how long it takes to get everyone onboard and actually begin to achieve our objectives.

The slide on the left is the first half of the year. We were successful and we were very pleased. You can see that a number of the UAs we ever needed to obtain was decreased because they didn't get a UA unless the appropriate symptoms were present. The culture and sensitivities were also decreased, as were those residents who were actually treated for a real urinary tract infection.

However, the slide on the right is the last 6 months of 2015, and we were blown away by our results. There was significant reduction in all three of our objectives.

As I stated earlier, the amount of education and reeducation was substantial, but around July and August, I feel that our staff really understood and bought in to the philosophy. It helped that we didn't have any *C. diff* in our community for the year and – that was community acquired and the staff were seeing the fruits of their efforts.

On the next slide, overall for 2015, we had an 81-percent reduction in the number of UAs obtained, an 82-percent reduction in the number of C&Ss obtained, and a 67-percent reduction in use of antibiotics to treat UTIs. We far exceeded our initial goals, and we were astounded with our team's success.

This slide demonstrates the cost savings for just our 133-bed community. We saved \$2,811 by not using the lab to get a UA; we saved \$1,764 in not paying for the additional C&S; and we saved \$1,196 in an average cost of an antibiotic while at the same time doing what was right for residents, for a total of savings of \$5,771.

So, we had to evaluate what's next. We needed to continue our journey of antibiotic stewardship; we needed it to be data driven. So we just looked at our most prevalent infections in 2015. Now that UTIs were practically nonexistent, the most prevalent infection treated in our community are respiratory infections, at 53 percent of the total

number of infections. We did our research again, and our medical director selected the Loeb's criteria for respiratory infections.

On the next slide, you can see the Loeb's criteria and what the minimum criteria is for initiation of antibiotics in long-term care residents for respiratory infections. It gives us guidelines for symptoms to assess and when chest X-rays and lab work is reasonable.

The performance improvement project that begins in July 2016 has the objective of reducing our total antibiotic usage by 25 percent. This performance improvement project is a little more comprehensive and not just related to respiratory infections.

We will train in the guidelines for Loeb's criteria and put together a flowchart for the treatment of respiratory infections. However, we also plan on trying to reduce the use of broad spectrum antibiotics and have set the goal of achieving 90-percent compliance with ordering the right drug specific to the type of infection, the right dose, and the right length of time. The ultimate goal is to assure that any antibiotic ordered in our community is appropriate.

We're also looking at antibiotic stewardship from a prevention viewpoint and trying to assure that 90 percent of our residents are vaccinated appropriately with PNEUMOVAX® or Prevnar 13®. We also highly value the influenza vaccination process. I didn't put the influenza vaccine on this slide, because we currently have a 99-percent vaccination rate with our employees and 96-percent vaccination rate with our residents. However, we will continue to monitor these areas as well.

This measurement period will begin in July 2016 for 12 months, and the results will be compared to the same timeframe for 2015. We do, however, have to be mindful of staff resources, and we prioritize the use of our resources on an ongoing basis. If the new requirements of participation, as they mentioned earlier, are overwhelming when they are released, we may have to reduce the scope of this performance improvement project as it truly will be somewhat labor intensive and is more comprehensive than our 2015 project.

On the next slide, you can see how we hope to accomplish our objectives, by education again, knowing now that this means constant repeat education across a wide array of people, including residents and families; studying and determining prescribing practices, and education to physicians if indicated; systematically reviewing in our daily nursing report all orders for the right dose, right drug, right amount of time; and we will continue to monitor our vaccination rates monthly and continue to provide that education.

This slide shows the resources that we used for consumer education. I referred to it earlier. The CDC has a plethora of resources available that are specific to long-term care facilities. And I found them so very helpful as we move forward. We don't reinvent the

wheel when such a wealth of information is available to us. Their [core elements](#) is written in a user-friendly format and has already developed training materials. Their website is at the bottom of this slide. And if you haven't had the opportunity to review their website, I strongly suggest you do so. Our families and residents were much more receptive to information from the CDC than the information we were initially providing.

We're very pleased with the success we achieved in 2015. We thought we gave better care by improving the patient experience of care in our community, better health—we improved the health of those residents residing in our home and potentially prevented adverse events, and we reduced costs. As indicated on a previous slide, our performance improvement project resulted in significant savings. We also have an outcome of staff satisfaction as they all became the experts and champions around this issue and they feel good about the care they provide. We hope to achieve all three triple aim goals as we meet our 2016 performance improvement – performance improvement project objectives as well.

And then, the next slide is my [contact information](#) if you have any questions. So, thank you for this opportunity to present.

Infection Control Pilot Project

Michele Laughman: Thank you, Janet. Next up we will have Ms. Sheila Hanns. Ms. Hanns is a registered nurse consultant within the Division of Nursing Homes at CMS, and she will be discussing the new Infection Control Pilot Project. Sheila?

Sheila Hanns: Thank you, Michele. Good afternoon, everyone. I appreciate the opportunity to be here. Like Michele mentioned, I've been with CMS about 6 years, and, you know, I think about the audience whenever I go to share some thoughts. And I'm thinking about you guys and all of your experiences, as professional – healthcare professionals, and what you do out in the workforce. And then when we think about infection control, we also think firstly of ourselves and our loved ones.

So, I'll be sharing with you about our Infection Control Pilot Project that we have going on. I do want to mention that, although I'm speaking for this segment, I would like just to give a shout-out and a thank you to Dr. Dan Schwartz. He is technically our Chief Medical Officer here at the Survey and Certification Group. And then, of course, although while I'm presenting and working with this project, we have another – we just have a great group of folks who are contributing to this.

And also before I get more to our next slide, which will be on slide 23, you know, whenever we think about a topic and we think, well, what's the driver there? What's in it for me? Why is this important? And CMS more recently, back in December, had shared a little bit about our infection control pilot that we have going on. And again, I know that clinically you can think about infection control, but I want to share a little bit of statistical data with you. We do know that in long-term care, skilled nursing facilities,

nursing homes, that the role continues to expand as maybe residents are sicker and you think about maybe back and forth going from the nursing home to the hospital. So, we do understand that over 3 million Americans receive care in the United States nursing homes each year. And where's that number going to be going anyway, right? It's just going to be increasing.

So, data about infection control and nursing homes are limited, but it is estimated in the medical literature—I'm going to show you just a few quick things—that 1 to 3 million serious infections occur every year in these facilities. And certainly we'd like to see what we can do to prevent any avoidable infections. And then also – and some others we shared earlier, common infections do include urinary tract infections, diarrheal diseases, antibiotic resistance, staphylococcal infections, and other multidrug-resistant organisms.

And then finally, a third aspect to this is that infections are a major cause of hospitalization and death. And as many as 380,000 people die from infections in nursing homes every year. And, you know, I kind of hate to start off with a little bit of gloomy information, but, you know, that's just really a driver of the importance of what we're doing here. So, it's exciting to be a part of that.

So, you'll see on our slide 23 kind of the context behind here. We've talked about some of our drivers. So this, like with many other positive works and efforts and initiatives, involves a group of people. And so, CMS Survey and Certification Group is working with the Centers for Disease Control, the CDC, and then on – stemming on down to the Division of Healthcare Quality Promotion History and – so, you know, it was identified again that a greater work needed to be done as far as infection control. So, this wonderful group got together, utilized a source from Ebola funding that was, you know, able to be utilized for this particular area. And then, we also understand we have potential for some new regulations that might be drivers. And then also, you may have heard of the CARB initiative. So, that's a C-A-R-B, and that refers to Combating Antibiotic-Resistant Bacteria. If you want to learn more information about that, you can just Google it. But also, that's found through the White House, and then, we also have information through HHS. So, I just wanted to share that.

We do have our particular pilot goals, basically some of which I just shared, including to improve the assessment of infection control and the prevention regulations in nursing homes and hospitals during transitions of care. So, this is – this is encompassing both areas of where care is going to be received and provided. So along with these goals, we want to develop and test new surveyor goals so that those surveyors who go in to assess for regulatory compliance will be able to not only help to find that and determine that but also to promote transparency of the regulations. Because ultimately although – you know, CMS – we are regulatory; you know, our final goals together in the healthcare field is just for the positive, excellent care for residents, and then finally to prevent infections in nursing home residents.

So, just to mention, this survey, it's actually with the – you know, it's educational survey. So, I'll tell you a little bit more about that in a few other slides. And so basically with preventing infections in nursing home residents, I like to think of that as helping facilities to help themselves. And that's just such an important piece.

So on slide 25, we see we're talking about the actual pilot surveys. So, that's a piece – a very significant piece of this to help reach our goals. So, we're conducting – we're going out in the field and we are conducting unannounced surveys. These surveys will be educational, and they'll be based on some very specific facility selection criteria. So, we have a lot of activity going on at this time—very exciting time.

So for 2016, which we're here now present, we will be conducting a pilot of 10 surveys. And it's more of a beta testing at this point where we have a tool, since we're talking about creating some tools here, that can be used where the surveyors will go out and assess where the facilities are at as it relates to infection prevention and control.

And then, once we connect – obtain that information, then we'll be able to turn that around and proceed into our next year where we will be conducting surveys of 40 hospitals and 40 nursing homes. And that gets really exciting when you start to think about the transitions of care and developing action plans—and then also identifying and deploying technical assistance teams, and then – because that's our ultimate outcome with this initiative, that it's broad but also very specifically based. And then in 2018, we'll have the revisit surveys conducted.

So, I talked a little bit about tools – surveyor tools and processes. And so we have some new proposed regulations. And then I mentioned the CARB initiative. There is also the pilot nursing home worksheet that we have developed that we'll be using—actually just coming up here later in May and June. And then we'll also be revising a hospital infection control worksheet that had been previously created. And that'll – again, that'll be utilized more in 2017 as we look at those facility types. So that, again, will support as we want to assess for infection control and prevention during transitions of care.

So if you look on slide 27 and we think about new processes, so these survey tools that we just talked about—they'll help and support to lead to new processes. We're always looking for improvement. You know, Debra Lyons talked earlier about quality assurance and how important that is. And this just fits right in there; it's a perfect fit.

So, once we've done these surveys, we gather that data. We're going to then want to analyze that and look at the hospital and nursing home survey results, develop action plans for improvement—ways that, again, we can go back to our original initiative of preventing and controlling infection. And also, a system will be set up for providing some technical assistance for those facilities to help them be the best that they can be in this area. And then we'll be performing some revisit surveys as a piece of that.

Whenever any kind of project is done, it's always very important to see, you know, have we aligned our actions to our goals? Did we meet our desired outcomes? And so, I'm answering this question that I'm posing to you—what will be our metric? How will we know we're successful here? So, we will be using the National Health Safety Network, which you may have heard of as – referred to as the NHSN. And that also – you can learn more about that if you'd like at the CDC website. But there's some information there and, you know, we do hope that there will be – we are very excited and hopeful that there will be an improvement.

So again with our final outcomes of pilot, and I'm on our page here, 28. These tools will help with consistency, right? We want consistency across the nation. We want to know that that care that you or I go into or that our loved one goes into to receive is going to be the very best that it possibly can be. We want transparency. We want to know – we want those who are giving the care, those who are assessing for the care to know the same thing so we can reach that same goal. We will be testing our new processes, again, as an outcome, and assessing infection prevention during transitions of care, and then optimizing surveyor assessment of infection control regulations in hospitals and nursing homes.

And then, this final bullet here talks about preparing for the future. It just continues to go on—that scaffolding, the learning and building and ways that we can improve infection control in all of the facility types of long-term care and hospitals.

You know, I really had – appreciate the opportunity to speak with you today. I think you can tell I'm very passionate about the subject—it's very important. You can see my contact information, sheila.hanns@cms.hhs.gov. So, thank you for your time and the opportunity. I appreciate that.

National Partnership Update

Michele Laughman: Thank you, Sheila. I would now like to share some updates related to the National Partnership. We have completed the development of a second interim report for the partnership. And this report will include a summary of the 2015 Focused Dementia Care Survey expansion effort. The report is making its way through the CMS clearance process, and we anticipate it to be released in the coming weeks. We are continuing to conduct the Focused Dementia Care Survey, and this is a continuation of the expansion efforts that took place in fiscal year 2015.

Recent data from 2015 quarter one to 2015 quarter three for the partnership was shared in March. And we have now seen a 27-percent reduction in the rate of antipsychotic use in long-stay nursing home residents, which means that we have surpassed our second goal of achieving a 25-percent reduction by the close of 2015. And the recent report doesn't include quarter four of 2015, so we are eager to see the final numbers for the year. The National Partnership has engaged the nursing home industry

across the country around the reduction of antipsychotic medications and creating homelike environments that support person-centered care for all residents.

We thank you for your participation in today's call, and we look forward to continued collaboration and partnership. And I just want to note that our next call is scheduled on Thursday, September 15.

Before turning it over to Leah for our question-and-answer session, I'd like to introduce Karen Tritz, the Director of the Division of Nursing Homes, who will share some information about a quality measure related to the use of antipsychotics in older adults in the inpatient hospital setting.

Karen Tritz: Great. Thank you very much, Michele. Good afternoon, everyone. I wanted to share with you some developments from the agency that are relevant for the work that all of you are doing on the National Partnership To Improve Dementia Care.

In April 15th, CMS posted to its Measures under Consideration list a measure that would review the use of antipsychotics among older adults in the hospital setting. And that is open for public comment between April 15th and May 15th, and I would encourage you, if you're interested, to take a look at that and provide public comment. They have the link to public comments on that section of the measures under consideration.

And just – I've noticed all of you in the field know that we're, from the nursing home side, very interested in this measure for two reasons. One of which, we know that many folks who come in to the nursing home on antipsychotic medications may have that medication started in the hospital setting and then transferred into the nursing home for recovery or long-term residency. And we also know that, for those residents that are in the nursing home now and may be going out to the hospital due to an acute illness or injury or fall or infection, as we heard today, may have antipsychotic medication started in the hospital setting and then come back to the nursing home setting. So, we're very interested in this kind of crosscutting measure that has implications for the work of all of us in the National Partnership To Improve Dementia Care. So, we'd encourage you to take a look at it and provide any public comment that you would like. That's it from my end.

Question-and-Answer Session

Leah Nguyen: Thank you, Karen. 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 question to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits.

All right, Ronni. We're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to ensure 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.

And your first question comes from the line of Lisa Garner.

Lisa Garner: Okay, are you ready? Okay...

Lisa Garner: ...I have a question for Janet. Hello.

Leah Nguyen: Go ahead.

Lisa Garner: Oh, okay. Here's my question. On slide 12, we see the reduction of UAs that were treated with antibiotics, and we had a question. Did you look at any evidence or diagnosis of sepsis that had occurred, especially urosepsis? Did you compare that within each quarter?

Janet Snipes: We did look at that. And we, during this timeframe, did not have any urosepsis. During the calendar year 2015, we had none.

Lisa Garner: You had none. Okay, and so we think that would just be really great to share with everyone, that they would be comfortable that we didn't actually miss giving someone an antibiotic that they really needed. We thought that would be helpful.

Janet Snipes: Thank you, I appreciate that feedback. And you're right; I agree with you.

Lisa Garner: Yes. And we had another question about the cranberry juice. We didn't see on that slide, did you do an analysis on the cost of the cranberry juice and the estrogen and the cranberry tablets?

Janet Snipes: I did not include that, no. No. Cranberry juice is something that we kind of routinely give here.

Lisa Garner: Okay. Okay.

Janet Snipes: We just specifically wrote a nursing order to make sure that it was done three times a day, so I did not do that cost analysis.

Leah Nguyen: Thank you.

Lisa Garner: Okay. Well, thank you very much.

Janet Snipes: Yes.

Operator: Your next question comes from the line of Carrie Allen.

Carrie Allen: Hi. My question actually was a little similar to the previous question, but really more specifically, I was wondering why you chose to incorporate cranberry juice and cranberry tablets, it seems like, on everyone as part of the protocol.

Janet Snipes: Some of the literature shows that cranberry helps prevent UTIs and treat those that are just starting. And so, we chose to do it. And some of the literature's a little questionable, but we had had success in it just prior to starting this particular performance improvement project. It was more anecdotal though. And so we decided to go ahead and incorporate that in there.

Carrie Allen: Okay, thank you very much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Pam Cipriano.

Pam Cipriano: Hello, thank you. My question is for Janet. I'm curious—why did you pick McGeer's Criteria for UTIs and Loeb's criteria for pneumonia?

Janet Snipes: Our medical directors took a look at both of them. We have two medical directors and they studied them. And the McGeer's Criteria seemed very easy to understand and explain to our nurses. For respiratory infections, they liked the Loeb's criteria better. They thought it was just a little more detailed and felt that it gave them what they were looking for to move forward into this year. So, it was really selected by our medical directors. They pulled several resources and just liked this one the best.

Leah Nguyen: Thank you.

Operator: If you'd like to ask a question, press star 1 on your telephone keypad. Please stand by for the next question.

Your next question comes from the line of Mildred De Castro.

Mildred De Castro: Hi, I was just going to ask, when you guys did the study on the UTI using cranberry pills, if you guys used both cranberry pills and cranberry juice at the same time, and whether you looked at what are the – there were lesser incidents on

male vs. female, and also if you've used it for patients that are taking warfarin and whether it increased the cost for your PTT for warfarin.

Janet Snipes: We didn't always use both cranberry juice and cranberry tablets. We pretty much started the cranberry juice on everyone for a period of 5 days from the initial time that UA was being discussed. The cranberry tablets were not used on everyone. That was a physician determination, as was the estrogen cream. And we did use the cranberry juice on the males and females. And even if they were on warfarin, we did use, and we did not have any adverse effects.

Leah Nguyen: Thank you.

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

Linda Behan: Hi, thank you. Janet, first off, congratulations to your center for all its success. My question is regarding the initiation of your preventative measures.

Obviously, if urinalysis was being discussed, the patient was showing some types of signs and symptoms that brought this into question. So at that point, if I'm understanding you correctly, your nursing staff puts the nursing measures in order, such as encouraging fluids and the cranberry juice.

At what point did you contact the physician and let them know about the possible signs and symptoms you were witnessing and the preventative measures? So, did you put preventative measures in place, see what happened, and then call the doc? Or did you notice the symptoms, call the doc because we have to notify about changing condition, discuss the preventative? I'm trying to look for the timeliness of calling the doctor with the prevention.

Janet Snipes: What we did is, as soon as the UA was being discussed, and as I said, sometimes it was just a therapist or a family member that would come to the nurse and say, "Could you get a UA on this resident?" And so, the nurse would automatically start preventive measures—just send out a notice and notify the nursing supervisor to go and assess the resident. The nursing supervisor would go then and assess the resident at that time and look for signs and symptoms. If the signs and symptoms were present according to the McGeer Criteria, then the doctor would be notified.

If the signs and symptoms were not present according to the McGeer Criteria, then we went ahead and just implemented the preventive measures and kept a close eye on the resident to make sure that we didn't have further symptoms. Oftentimes we found that there were truly no symptoms to get a UA. There was truly nothing going on. Maybe the family member felt they were more lethargic, or maybe they had not participated in therapy to the degree they had the day before. But oftentimes it was unrelated to something clinical. They did a full clinical assessment any time there was a request for a

UA. But then they just automatically started those preventive measures at the same time. So the doctor was notified if signs and symptoms were present, and then they made the determination about obtaining a UA.

Linda Behan: Okay. And if I understood you correctly from an earlier question, the cranberry juice you did for 5 days.

Janet Snipes: Correct.

Linda Behan: Okay, wonderful. Thank you so very much.

Leah Nguyen: Thank you.

Janet Snipes: Sure, thank you.

Operator: Your next question comes from the line of Susan Tesnia.

Susan Tesnia: Hi, thanks for the opportunity to ask a question. My question is actually for CMS, related to the draft guidance that was put out last October. I was wondering when that was going to be finalized and if these sort of pilot efforts that are going on using NHSN and the CDC's Antibiotic Stewardship Program are going to have a positive influence in the final rule, whether or not that'll get a little bit more specific and have all the facilities use those types of programs.

Karen Tritz: Hi there. So, this is Karen from the Division of Nursing Homes. Can you clarify the guidance that you're talking about from October?

Susan Tesnia: The draft sort of mega-rule that came out in October and there were some – there was language, oh, several hundred pages in...

Karen Tritz: Okay, yes.

Susan Tesnia: ...that talked about infection surveillance and control and also antibiotic stewardship. But the language was very general and just throughout, that long-term care facilities should have infection surveillance and control and should have antibiotic stewardship but didn't specify, you know, what those programs should look like or any reference to the CDC's programs.

Karen Tritz: Right. No, thank you. I think it was the timing that threw me. The – it originally came out in July and then closed in October so – but, yes. So we're very...

Susan Tesnia: I'm sorry.

Karen Tritz: No worries, it's fine. We're very familiar with the NPRM, and there – you're right, there was some additional language added related to infection control. I think – so where we're at with it is, obviously the rule is not final yet. We are – we have been looking at the guidance in – for those sections and have been working with our colleagues in the CDC around guidance to those so that we're looking at current standards of practice.

And I also think that we – the Infection Control Pilot Project that Sheila Hanns discussed, while they are educational surveys, I think we are looking to learn more about the quality-of-care issues and how facilities structure their infection control programs to continue to inform our guidance. So, we are expecting there will be more specifics. As usual when a reg comes out, we take a look closely related to what interpretive guidance is needed for our surveyors to interpret compliance with that. And our – really, our goal is to have it be clear for our surveyors and for providers in terms of what compliance looks like with the various sections.

Susan Tesnia: Terrific, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Sheila McGarvey.

Sheila McGarvey: My question is for Sheila Hanns related to the infection control pilot survey. My question is, it says here that it's educational survey, if you could elaborate a little bit more about that. And will you be citing on those surveys if it's noted to be educational?

Sheila Hanns: Absolutely, that's a great question. So, these are educational surveys in that – and kind of to build a little bit off what Karen was sharing there, so, we're gathering information. But we're also looking ahead to possible, you know, regulations when I mentioned about new regulations. So, these are – these particular surveys, in general, will not be citable. Now, if the survey team does find an egregious concern that might be indicative of immediate jeopardy, then that would be forwarded per our process to the regional office, and there would be some followup for that. But otherwise, in general, there would not be. It's more of a focus on education.

Sheila McGarvey: And just final with that, have you identified the nursing homes that you will be surveying?

Sheila Hanns: Well, that's a great question. We are in the process of doing so. But also those same surveys will be unannounced.

Sheila McGarvey: Okay, thank you.

Operator: Your next question comes from the line of Kathleen.

Kathleen: Hi, yes. I have a question. So in regards to the cranberry juice (inaudible) and UTI, have you ever considered (inaudible) moving around because of prolonged sitting. Does it help with that situation as well?

Janet Snipes: I'm sorry, you were cutting out. Could you repeat the question?

Kathleen: Yes. My question is in regards to the UTI. Now, you say that the cranberry juice is one of your things that you're using to help prevent that or to eliminate it. How about getting them to move around, because that prolonged sitting doesn't quite help that situation, either? Has that ever been looked at or addressed?

Janet Snipes: I'm sorry, I still didn't understand the last part of your question, I'm so sorry. I heard about the cranberry juice with UTIs. And the last part, have we looked at what?

Leah Nguyen: If you're on speaker, you may want to pick up your handset.

Kathleen: Is that better?

Janet Snipes: Much better.

Kathleen: All right. It must be the sound in my office. Yes, I understand about the whole thing about the cranberry juice. But have you looked into like the circulatory situation or having them to be moving around because that prolonged sitting kind of does put a – play into that as well?

Janet Snipes: You are correct...

Kathleen: Because I...

Janet Snipes: ...it does.

Kathleen: ...know some – I know someone that's in their care right now, and she's been there for 3 months, had two urinary tract infections. And they're on medication. They never gave her cranberry juice by the way. And then the second thing is, I'm thinking that she doesn't get any activity. She doesn't move; she's always constantly sitting. So my concern is, like okay, has that been addressed too to keep them from not sitting for so prolonged period of time?

Janet Snipes: I completely agree with you. It does have an impact, but it was not part of this particular antibiotic stewardship study. But I think that's a great point.

Kathleen: Yes. Because I just feel like the circulatory (inaudible) everything swelling is more – just as important, not more – but just an important (inaudible) put into place for your next study, I guess.

Janet Snipes: That's a great point, thank you.

Leah Nguyen: Thank you.

Kathleen: You're welcome, thank you.

Operator: Your next question comes from the line of Chris Wolf.

Chris Wolf: Yes, my question had to do with the cranberry juice study. And I think it's already been answered, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kelly Roberts.

Kelly Roberts: Hi. I just wanted to make a comment to Janet. You need to take credit for the savings. You didn't even count your nursing time in collecting those UAs and the time it takes to administer antibiotics, IV included. I bet you had a bunch of savings there.

Janet Snipes: I am sure you are right. You are right. I probably should have done a lot more study on that. I just took the actual lab costs. But I'm sure you are correct there— medication administration time and all of that.

Kelly Roberts: Yes, well, good job.

Janet Snipes: And I just took the average. Thank you very much.

Kelly Roberts: Yes. Thank you.

Leah Nguyen: Thank you.

Operator: If you would like to ask a question, press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key. Please hold for your next question.

Please continue to hold for your next question.

Your next question comes from the line of Toby Coleman.

Toby Coleman: Thank you. Has CMS established or is it establishing a new goal for the reduction of antipsychotic medications? And a related question, what does the word “closing” mean on slide 30 which says, National Partnership Update and Closing? Thank you.

Karen Tritz: Hi, Toby, this is Karen. Thanks for the question. So, we have not established a new goal yet. As many of you may know, we announced earlier – or I believe in 2015, that our goals for 2015 was a reduction of 25 percent for 2015 and 30 percent for 2016. So, we have not revisited those goals yet. And we will continue to look at the trends and are very pleased with the progress to date and the fact that we were able to exceed the goals for 2015.

And the note on the last slide is merely a closing of the call. So we don’t want anyone to think that the National Partnership is ending or that we’re not going to be continuing the CMS’s work on this. We continue to look for opportunities to improve care processes and look at the role of antipsychotic medications and the improved dementia care overall.

Leah Nguyen: Thank you.

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

Debbie Goetz: My question is, those 10 pilot nursing home surveys—are they national? Ten nationally or ten per state?

Sheila Hanns: Oh, thank you, Debbie, that’s a great question. Those will be 10 nationally.

Debbie Goetz: Thank you.

Sheila Hanns: You’re welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Sheila Conlan.

Sheila Conlan: Yes, I know – I wanted to see if there was any studies on using the cranberry tablets vs. the cranberry juice? And if the tablets are used, how long would they be used for? What would be recommended, if anyone knows anything about the studies on that?

Janet Snipes: There were studies on that and there were specific doses for cranberry tablets to be used. We involved our registered dietitian on that, and she was the one that researched and found the dosage that we needed to use. And I believe – it’s not on that slide but I believe – actually, I can’t even tell you what it was. But she supplied the

dosage for us. And there were studies that showed that it was beneficial. However, the order did vary by patient. As you see on that slide, that one is a physician's...

Sheila Conlan: Yes.

Janet Snipes: ...order. Some physicians ordered it just for 10 days; some ordered it for 30 days. And we have residents that had an ongoing history of UTIs that are still on it to this day.

Sheila Conlan: Okay, thank you.

Janet Snipes: Yes.

Operator: Your next question comes from the line of Joan Baird.

Joan Baird: Hi, thank you very much. I very much enjoyed this presentation. I have a question for Janet. You should be very impressed with this study you did. We're working on antibiotic stewardship here at the American Society of Consultant Pharmacists and I'm going to share this information. It's wonderful.

But one question, since we kind of come at things from the perspective of the consultant pharmacist—I noticed that you said you had a brainstorming session; you involved your medical directors, your pharmacists, and your staff, which seems highly appropriate to me. How long did it take to formulate the performance improvement project? And how did – how were you able to involve your consultant pharmacist in your, you know, in your reduction efforts? Like I said, it's a very impressive study, but I am curious to know, you know, how you were able to formulate this and loop in your other clinical staff. Thank you.

Janet Snipes: Sure. And actually, it's – our consultant pharmacist is very involved with our facility. And at our quality assurance performance improvement meeting, the two medical directors and the pharmacist kind of guide this. So in April of 2014, we attended that COD of medical directors. And they had a little bit on antibiotic stewardship. So it actually took us from April to December in monthly meetings to arrive at exactly what we were going to do.

There was some back and forth, like, with the cranberry tablets and, you know, what we were going to do and, you know, that type of thing, which criteria we were going to use. But it was really a very robust discussion. And he participates with us, too, in reducing medication—all medication, not just antipsychotics. And so we got into the—okay, should we even talk about cranberry tablets and estrogen cream, that type of thing. That was kind of his role in it all. So it took us a good amount of time, you know, from April – the end of April until we decided to do it the first of January. But the multidisciplinary discussion with the medical directors, the pharmacists, and we had

nursing staff, social services staff in the room. It really was very beneficial to give it a try and see how it worked out.

And again this year, as we moved into the respiratory infections and kind of looking at the other, I brought all the guidelines from the CDC, and that's kind of what drove us with that. We were, you know, extremely pleased with the success, but the team felt that we needed to move beyond just respiratory and try to look at it more comprehensively.

So did that answer your question?

Joan Baird: Yes, that's great. Maybe we'll be able to talk again about your project, because this is a big area. As was mentioned on another question or another answer, we've got the so-called mega-rule coming out, and we want to be, obviously, involved with the antibiotic stewardship in general. And having programs like yours to look at I think will help all facilities. So, thank you again.

Janet Snipes: Thank you.

Operator: Your next question comes from the line of Pamela Vap.

Pamela Vap: Hi, thank you. And again, this has been just excellent—excellent information. I have two pretty simple questions.

Number one, probably for Sheila, you were talking about the infection control worksheet that you would be doing with the pilot surveys. Is there any chance we can get copies of that?

Sheila Hanns: Hi, Pamela. To answer your question of, if currently copies of the infection control worksheet could be distributed, the answer is no. I do respect the desire to get that information, and that's part of our, you know, ultimately transparency in looking at infections. But at this juncture, in the pilot testing and program, it would not behoove us to share it at this time.

Leah Nguyen: Thank you.

Pamela Vap: Okay. Next question was, do you know what is the national infection rate? What is the – what is – when you figure infection rate, what is the average? What, you know – where you want to be below? At one time, I thought it was something like 2.6 to 6.9 or something like that.

Michele Laughman: Hi there, thank you for that question. Our panel has discussed; we do not have a specific number to share with you at this time. But I would like to point the listeners back to a couple of – to a website that might help provide some

information in that. It goes back to the National Health Safety Network again, which – where there is a lot of data present. In fact, I was on the website and I can share that with you – website address with you at this time. But there’s – it’s just really interesting to look at some information and even some maps in breaking down infections by location, etc. So, the website’s actually very short, and I have it handy here just in case. So, that is <http://www.cdc.gov/nhsn/>. So really if you’d like, you could just go to the [cdc.gov](http://www.cdc.gov) website is what I would recommend, and then look for the National Health Safety Network.

Pamela Vap: Okay, super. Thank you very much.

Leah Nguyen: You’re welcome. Thank you.

Operator: Your next question comes from the line of Michael Ellenbogen.

Michael Ellenbogen: I just have a comment. I’ve been on some, I guess, conference calls now for many months. And I have to say I am extremely impressed by all the work that you folks have done with the antipsychotic drugs to bring down to the levels that you have and to constantly be bringing on new innovations here to help people with dementia. For me, this means a lot. I am living with Alzheimer’s. So thank you to all involved.

Karen Tritz: Thank you very much for your comment. I very much appreciate that. I would first like to say that CMS has been organizing this under the very capable leadership of Michele Laughman for the last 4 years, and we could not have done this without her and her leadership on this topic. But I also want to acknowledge the many, many nursing homes who have done the hard part and the day-to-day work of really working with residents, families, staff, medical directors, and others to really establish a culture where antipsychotic role is minimized in care and is only used when absolutely necessary.

So, I want to just acknowledge the great work out there that’s been happening. And we measure it. We try to have calls like these to highlight practices and to talk with our surveyors about it. And Michele has been doing a fantastic job over the last 4 years moving this along. But also the, you know, thousands and thousands of nursing homes out there who have really taken this on as their own performance improvement. So thanks very much for that.

Leah Nguyen: Thank you.

Operator: And your next question comes from the line of Molly Sinert.

Molly Sinert: Hi, yes. My question – actually, I had two questions for Janet. First question, did you find that patients with Foley catheters were any more or less

likely to meet criteria for UTI treatment? And secondly, I wanted to know if you had any hospice patients involved in this population. And if so, were they more or less likely to receive an antibiotic regardless of meeting criteria or not?

Janet Snipes: In regards to your first question, the McGeer Criteria has separate symptoms that are associated with catheters. And so they were included. And we did have some catheter – that where we – that we had requests for UAs that met criteria that we would do a UA on, and some were treated and some were not. We would go ahead and implement the preventive measures, and we were able to alleviate the initial signs or observations that led to that.

So, catheters were very much involved. And they did – I would say, more often than not, they did not meet the symptoms required of the McGeer Criteria to go ahead and order a UA, just because they are different from noncatheters.

And in – well, repeat your second question.

Molly Sinert: Sure, thank you. Did you have any hospice patients among the population? And if you did, was there any difference in the likelihood that they would receive an antibiotic regardless if they met criteria or not?

Janet Snipes: We did have hospice people. We have approximately nine hospice residents in our community. And we treated them the same. If they triggered for the McGeer Criteria, then we would call and ask a physician, too. And as you know, you know, some hospice residents choose to treat infections, some don't. So we follow their individual guidelines. But we went ahead and followed our complete plan. Some are started on antibiotics if they met the criteria, but they weren't treated any differently than any others.

Molly Sinert: Okay. I actually work in the hospice arena, and we just find so often that it's the families and doctors are saying, you know, we're going to get it for palliation, regardless, and they're not even going to grab a UA. So, you know, we're trying to kind of work with that, and also the nursing homes that they're residing in – is sort of difficult.

Janet Snipes: I understand. And like I said, the education, I was really surprised that it took so long and so many...

Molly Sinert: Right.

Janet Snipes: ...different educations. And I didn't put hospice in there, but hospices were a part of it as were the family members of those hospice residents.

Molly Sinert: That's great, thank you.

Leah Nguyen: Thank you.

Operator: And there are no more questions at this time.

Additional Information

Leah Nguyen: Thank you, Ronni. 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 33 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Please join us again for a future [MLN Connects Call](#). We have two calls coming up in May: on Mid- Year Quality Resource and Use Reports and How To Register for the 2016 PQRS Group Practice Reporting Option.

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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