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.

This call will focus on effective care transitions between long-term and acute-care settings, highlighting transitions that involve residents with dementia. Additionally, CMS experts will share updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes 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 registrations email. If you have not already done so, please view or download the presentation from the following URL go.cms.gov/npc. Again that URL is go.cms.gov/npc.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. You will receive an email when these are available. At this time I would like to turn the call over to Michele Laughman, Coordinator of the National Partnership to Improve Dementia Care at CMS.

Michele Laughman: Thanks, Leah. And welcome to the call. I want to first just go over a little bit of a different format that we're going to be having for today's call. We're having a panel of four presenters, and so it's going to flow a little bit differently. We're going to go over a case study and then have some questions and then give each panel member the opportunity to give their perspective of the case study and the questions. I want to introduce our speakers.

We have Scott Bartlett, who is the Lead Long-Term Care Ombudsman at Pikes Peak Area Council of Governments within the Area Agency on Aging in Colorado.

We have Kathryn Weigel, who is the Director of Nursing at Rex Rehabilitation and Nursing Care Center of Apex in North Carolina.

We have Dr. Kevin Biese, who is the Association Professor, Universe – from the University of North Carolina within the Department of Emergency Medicine and Internal Medicine in the Division of Geriatrics.

And then we have Tammie Stanton, who is a Registered Nurse and the Vice President of Post-Acute Care at UNC Health Care System.

The following case study is presented as one example of the unique needs that individuals with dementia have in long-term and acute-care settings. All health care systems strive to provide quality care, but during transitions of care, our efforts often lack effective collaboration. Our discussion today will include a panel sharing valuable insights from diverse perspectives on how hospital systems, nursing homes, and the community can work together to resolve many care transition challenges.

We hope that this information can be utilized to evaluate the process that your nursing home or hospital may have in place. And also determine how it can be modified to improve care. After the discussion, there will be question-and-answer session. And I'm going to turn it over to Leah for a keypad polling question.

Keypad Polling

Leah Nguyen: Thank you Michele. At this time we will pause for a few minutes to complete keypad polling so that CMS has an accurate account 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're ready to start polling.

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

Leah Nguyen: Thank you, Ronni. I would now turn the over to Denise O'Donnell from CMS.

Presentation

Denise O'Donnell: Thank you, Leah. Good afternoon everyone. So let's begin with our case study.

Case Presentation—Background

At 3:30 am Mrs. Emily, an 86-years-old female, was found lying on the floor at the foot of the bed. When asked what had happened, the resident stated "nothing happened" and denied that she was in any pain or discomfort. Mrs. Emily was admitted to the nursing home 6 weeks ago with a diagnosis of dementia, hypertension, chronic urinary tract infections, and a history of multiple falls at home.

She was assisted to her feet by the staff and was able to bear weight and walk to her bed with no complaints or gait disturbance noted. Her vital signs were within normal range compared to her baseline upon admission. The resident was checked during hourly rounds with no complaints and was observed sleeping the rest of the night. At 7:30 am, the nurse's aide assigned to Mrs. Emily for the day shift assisted her to the toilet and with her AM care before taking her to the dining room for breakfast.

The aide noted that she was not her "normal self," meaning that she was usually pleasant and cooperative, engaging in conversation while care was being provided. This morning she was "different," slower to wake up, not as verbally responsive. The nurse contacted the provider and informed him about her fall earlier in the morning and her current status. An order to send Mrs. Emily to the emergency department for evaluation was obtained. The nurse called the ED to inform them that a resident was being sent for an evaluation post fall.

At 9:00 am, Mrs. Emily arrives at the ED with a transfer sheet that lists her medications and most recent vital signs, along with a phone number for her point of contact or responsible person.

Questions for the Panel—1

We have two questions for the panel. The first one is, were there steps the nursing home could have taken to potentially eliminate the need for this resident's transfer? And number two, to make this ED visit more productive and comfortable for the resident, what information should the nursing home have provided to the ED?

To start the discussion, I'm going to ask for Kathryn to begin.

Kathryn Weigel: When a changing in condition is identified, the nurse should go to a – should do a complete head-to-toe assessment of the patient and gather detailed information to give to the provider. The assessment should include all the systems—neuro, respiratory, GI, urinary. You should have the patient's chart with you when you call the provider. Know the patient's code status, have a recent set of vital signs, a blood sugar if appropriate, also notify the doctor if there are any recent medication changes.

The provider can use this detailed information to decide how to proceed. For example, blood work, KUB, X-rays, bladder scan, med changes, all with the goal to keep the patient in the facility. Any test that can be done in the facility should be done before ever sending the patient to the hospital. If the decision is made to send the patient to the hospital, be sure to send results of any testing that was done, a detailed note of the change in condition, include what's the patient's baseline, send the last H-and-P and the list of medications. And be sure to call and give a thorough report to the ED nurse.

Denise O'Donnell: Thank you, Kathryn. Scott, your comments?

Scott Bartlett: Oh yes, this is Scott, Long-Term Care Ombudsman. And I'm going to talk about how transfers to the hospital impact nursing home residents and how an ombudsman may be able to assist in certain situations. Going to the hospital can elicit feelings of anxiety and confusion for most anybody, but particularly if that person is also in pain or uncomfortable at the same time.

And individuals with dementia may have even further issues with going to the hospital. It's normally an unfamiliar environment to them, there are different phases providing care, there is a lot of activity and noises that can increase anxiety and confusion, leaving the individual overwhelmed. A resident may not even understand why they are at the hospital. If you can imagine feeling like you've been whisked away to a place you did not recognize and have strangers providing care you don't understand, you might be able to empathize with this.

I know some cases where prior history also makes this difficult for some residents. Here in Colorado, I know some folks that were Holocaust survivors and suffering from PTSD, and hospitalizations became a very difficult thing for them to deal with. And there's an absolute need for people to be send to the hospital at times. However, careful consideration should be made as to the potential for harm for certain individuals when they are sent unnecessarily.

If a resident can be treated in the nursing home safely, this is preferable. I think that's generally understood by nursing homes, but I suspect sometimes that pressure of regulatory fears or maybe family may be the difference between treating the resident in the nursing home or sending them to the emergency department. As an ombudsman, our client should always be the resident and our work always geared toward their interests.

I have received complaints from family members that feel a nursing home should have sent their loved one to the hospital when it did not occur. It's difficult for some family members to understand that not every fall or injury should mean a hospitalization. Nor really do they understand the agitation and confusion that could have been avoided if the resident had stayed in the nursing home rather than being sent out.

That's why it's important to plan in advance with family and with your hospital. If an individual has frequent falls, for instance, the nursing home should discuss with the family what their limits and their process of assessment are and when a person is to be sent out. Family, in turn, can be educated and share their own expectations and perhaps particular information about the resident that maybe helpful in planning for hospitalization.

An ombudsman can be helpful in educating the family and providing consultation with nursing homes in this regard. And I think at times an ombudsman can make a difference in cases such as this.

Denise O'Donnell: Thank you very much, Scott. Kevin, your comments?

Kevin Biese: This is a great conversation, and I appreciate very much being a part of it. This is Kevin Biese. I'm an ER physician with bill appointment and Geriatrics at the University of North Carolina. And I get to spend a lot of my time working with residents from long-term care facilities, both in an organizational fashion, trying to help our institution coordinate care better with our – with the long-term care facilities who with we most frequently share patients, as well as through some innovative telemedicine interventions I'd like to touch base on.

I think the theme that we're going to hear again and again today is, if they don't have to go, please don't send them. We're honored to take care of older adults and patients with dementia in our emergency department. But no matter how good the care we deliver, and we do our best to deliver good care, there's almost guaranteed some level of iatrogenesis from the transfer.

I think that providing care in nursing homes as well, I'm aware that there's a constant sense of risk. What if we miss something? What if something is bad and we don't catch it? And I get it. Our culture – a lot of the external stressors all point in that direction. But I think that sense of risk always has to be balanced with the guaranteed some level of iatrogenesis. If the patient has baseline dementia, and they go through a transfer and they're putting into an ambulance, and they're brought to the emergency department, and they meet lots of new people, and the lights are bright and the questions are loud, and the background noise is not insignificant, delirium is certainly possible. And at the very least, an unpleasant day is unfortunately almost guaranteed.

So, some ways that that can be avoided. A really thorough understanding of patient care wishes. I think we need to go beyond code planning and really understand what kind of interventions do you want at the end of your life, and how can your family help advocate for those? We just heard that from Scott. What kind of conversations can

happen with the family and patient in advance? Patients in skilled nursing facilities are often frail, often towards at the end of their life.

Bad health events are not unanticipated. They're completely anticipated and can be planned for. I think also the role of observation. Something might be wrong, but is there an opportunity for the primary care provider to call again and check in a couple of hours? Can they be reassessed? There's not always a perfect answer to that. Sometimes the assessment in the emergency department has to happen right then.

And finally, as I alluded to, I think that there's a role for telemedicine in all of this. I provide some telemedicine to these acute-care, to skilled nursing facilities. And it's so rewarding, because we can so often keep patients in this facility. The utilization of technology is not what it can be in our health care system, and there are some great programs out there. If you do send them, because I think that's the question you're coming up to next, and I've got some comments on that, if the decision to send them happens.

Denise O'Donnell: Thank you, Kevin. Tammie, your comments please.

Tammie Stanton: Yes, I'm also very thankful to be part of this beautiful conversation. Hospitals and post-acute providers have the same goal, to avoid the transfer of the patients to the ED and the potential risk of a hospital readmission. All hospitals should be very willing to work closely with their nursing facility partners to help them manage their patients at their own facilities, either through education, shared communications, or transition them as safely as possible when necessary with the appropriate communications.

If you don't have a clear and direct communication connection with the clinical leadership in your emergency department, please reach out to them to establish that relationship. You can jointly create best practice and tools to optimize the patient outcomes. And as Kevin said, telehealth can be a great connection to create a good solution as well.

Denise O'Donnell: Thank you very much, Tammie. Now I'll turn it over to Michele.

Case Presentation—Additional Background

Michele Laughman: Okay. I will continue on with the case study. So, the resident is evaluated and waits for the x-ray and lab work results. While in the emergency department, Mrs. Emily becomes anxious and she attempts to climb out of the stretcher. She is also incontinent of urine. It is now 11:30 am, and she has been in the emergency department on a stretcher for 2½ hours. The nursing staff feels that she is becoming more disoriented as the activity level of the ED rises, and the constant noise from call bells and various pumps and monitors adds to the sense of chaos.

Questions for the Panel—2

So, we have two more questions for our panel. What skills should the emergency department staff possess to effectively support expressions or indications of distress for a resident with dementia? And what steps can be taken to ensure that the needs of residents with dementia are supported by emergency department staff? And we'll start with Kathryn.

Kathryn Weigel: The knowledge of gerontological nursing principles, which basically means the specialized care of the elderly adult. The elderly are often hard of hearing and may have poor eyesight. It's important to face the patient when speaking to them, speak slowly and clearly. They're prone to skin breakdown, they need to repositioned every 2 hours, they maybe incontinent and have to be checked for that. The patient may have dementia or may misperceive their surroundings.

Trying to keep the environment as calm as possible. Always explain procedures prior to performing them. Always encourage a family member to accompany the patient if at all possible. They may be unable to verbalize their needs. When a patient's agitated or upset or antsy, try to determine their unmet need. Are they hungry? Do they need to use the bathroom? Are they cold? Are they hot? Do they need to get up and walk? Are they in pain?

We all have to remember any change in the patient's surroundings is difficult for the demented patient, and we should try to make every effort to avoid unnecessary trips to the hospital.

Michele Laughman: Okay. And next, Scott.

Scott Bartlett: Yes, I think it's important to note that this seems to have started at about 3:30 am. At this point, it's now 11:30, and this resident's been on the stretcher for 2 ½ hours. ED staff are now noticing incontinence and disorientation. And at this point the fall is still just speculation. You know, she was found laying on the floor. Change in behavior was also noted as reason for sending her out.

But there could other reasons that are not been explored yet. The resident's routine has been disrupted. She's in an unfamiliar place with strangers and is saying, by climbing out the stretcher, that basically she's had enough. The balance between the ED staying and being a benefit to the resident leaving the nursing home for care is becoming questionable. We know that this woman has a history of falls and UTIs, and at this point, neither has been confirmed or ruled out as a possibility.

I believe that coordination of care and communication between levels of care and family is very important and could help with cases such as this. It's not always natural for those who work in health care to discuss the future and coordinate. As often it feels like we're just trying to get through one issue so that we can focus on the next. However, taking the time to form relationships and discuss challenges and issues is very important to solve a number of issues in long-term care, including this one we speak about today.

The Pikes Peak region where I work, one of the things that we're doing and I've been asked to discuss, is we have a long-standing community long-term care ethics committee that meets on a monthly basis. I co-chair the committee with the medical director, named Dr. Feinsod. This committee is attended by facilities, assisted living nursing homes, our department of health, law enforcement, home health agencies, like colleges and a number of others. Most importantly for this conversation, both of our local hospital systems also attend.

The past few years we've seen our local emergency rooms in both hospital systems be so full of resident of long-term care that they can't find a place for other patients to be in the emergency rooms. The example in this case is about a fall, but locally our problems have been more about other issues. But I think it amounts to the same. This committee is working on forming subcommittees to address how long-term care residents transition between hospitals and long-term care.

And some of the things that we're identifying is learning, you know, what each other's interests are as far as what they can do, what they can't do, what the expectations are. We've uncovered that there's been a lot of misunderstanding about what each level of care can and cannot do. For instance, one of the things that we've been discussing is residents that become agitated in the hospital and then are discharged or released back to the nursing home with things like IM antipsychotics, which are generally not acceptable in long-term care.

I know there's a better understanding because we've met with physicians from the hospitals about what – you know, at discharge what does a long-term care need from the hospitals and also vice versa. The goal of the committee is to identify problems of transition of care and also to form relationships between the two levels of care, ultimately to reduce hospital admissions. And ultimately to do the things as best as we can and are able to for long-term care residents.

And so, you know, I guess the importance that, like Kevin said, I think communication and collaboration is very important, and I agree with him, that you're going to hear a lot of that. That's kind of the general theme that at least I believe is important in this conversation.

Michele Laughman: Okay. Thank you, Scott. And then we'll turn it over to Kevin for your comments.

Kevin Biese: Thanks again. I'm going to pick back up on Scott's comments about communication before I go to the competencies the emergency department should possess, which I can comment on that, certainly, as well. The communication should be in the context of ongoing communication.

So as it was alluded to earlier, one of the most powerful relationships that can be formed is between the emergency department and the skilled nursing facilities that send patients to that nursing – emergency department. There's usually patterns.

Sixty percent of our skilled nursing facility patients come from five different facilities. We're not going to have relationship with every facility that could ever send us a patient, but it's unacceptable to not have a relationship with those five. So that when

they, come we have some sense of where they're coming from, what capacity to care for patients that facility has. That's critical. If they need IV antibiotics—probably not in this case, well maybe. But if they need that IV antibiotics, do I need to admit them or can I send them back to the facility. Who do I talk to? Is there one call – is there one number I can call in and find the nurse that knows why this patient was sent?

That background information, which is I think best coordinated over donuts and coffee in quarterly meetings, goes a long ways towards helping us all take better care our patients. When the decision to make a patient is sent, standardized approach to communication is really helpful. So the INTERACT guidelines, I'm sure many of our listeners are familiar with, by Joe Ouslander out of Florida, are really helpful because they standardized that communication. And I'm working Joe right now on figuring out how we can make that communication even more helpful to emergency department providers.

A thorough understanding of the patient's baseline. A lot of the patients that come to us with dementia are obviously cognitively impaired and are not functioning at an extremely high level. I as the provider in the ED don't know whether this is the way they always are or whether they're worse today. I don't always know whether I'm doing a mental status evaluation or just checking to make sure their bruised arm isn't broken. And you don't really want me doing a lot of additional tests that aren't needed because I may find things that aren't helpful and proceed with interventions that are harmful.

In this case, the primary care provider or the SNF provider was contacted. It is so helpful if I can know as the ER provider what the provider who knows the patient long term is concerned about. Why are they sending them? If we can know what suggested diagnostics and interventions are, certainly we may find other things, we may need to do other things, but that gives a great starting point. We just need a head CT to make sure that didn't happen and then we're happy to take care of – the patient back to the facility. That's fantastic. That makes a much shorter length to stay for that resident and gets them back to where they're more comfortable more quickly. That type of communication is – is critical.

Finally, if we're going to get innovative, I think one of the best things we could do is have a short video of all patients that are sent to the ED. That may sound crazy, but why

is it crazy in a world where my mother talks to her grandchildren or reads them stories over FaceTime from seven states away? A video that shows what this patient looks like at baseline would communicate more to the ER providers than almost anything else about how they usually are and what's different today.

Moving on to the question about what the ED should do. I think the best place to point for that is the Geriatric Emergency Department Guidelines. I'm going to say that again because I hope everybody jots that down: Geriatric Emergency Department Guidelines. If you Google that you will find them listed under ACEP—American College of Emergency Physicians, Society for Academic Emergency Medicine, American Geriatric Society, Emergency Nursing Association. They're listed in several places. It's a 40-plus-page document of what we—the people who spend a lot of our waking hours focused on how to take better care of older adults in the ED—think are best practices for older adults in the ED.

Not all of them have perfect evidence, but they make a lot of sense and they can make a big difference. And they're focused in four areas. One, structure—how do you physically setup the emergency department to limit the risk of injury? Two, education—what courses do your nurses, physicians, NAs need in order to be well-prepared? Three, processes—what kind of screening instruments, how do you organize your care in the emergency department? And four, community connection—the emergency department has to go from being the front door of the hospital to the front porch of the hospital that connects well with the community. Check out the Geriatric Emergency Department Guidelines.

Two other comments on that. One, there's now something called the Geriatric Emergency Department Collaborative, which is a limited number of hospitals—today seven; within a couple of months, nine; within 2 years, 50—that are coming together to create best practices in caring for older adults, sponsored by the John A. Hartford Foundation and then Gary and Mary West Foundation.

We're really excited to get together, share best practices, and learn and hopefully teach nationally how to take better care of older adults. And that program is happening around the country. And feel free to check it out if your emergency department is interested.

Last comment. Well-trained volunteers, the emergency department should be the community's emergency department. So much of what has to be done to take good care of patients with dementia is really about assessing their needs and being with them and being present with them. This was mentioned earlier in the conversation. Why not make it an emergency department that welcomes in the community, that trains the volunteers and helps them be part of the care-giving team that takes care of older adults when they're vulnerable and have to be in the emergency department?

Michele Laughman: Okay. Thanks, Kevin. And, Tammie.

Tammie Stanton: And I'll just add on to all the great things the rest of the team has said. Health care systems should provide a dementia-friendly ED environment, an area that accommodates for the sensory concerns of these patients. Staff should be trained on the special care needs, and the clinician should get a warm hand off from the previous lead clinician to ensure the optimum transition. Shared and consistent communication across care settings helps provide patients and family with the additional comfort and confidence.

And one of the key things we've found is, as patients do transition back and forth, and as you do get to know the providers across, speak confidently about the care – providers in each other's place. We don't want the ED representative talking poorly about the nursing home facility providers that sent them, and vice versa. So speak confidently. If you can't do so, form that relationship so that you know each other and you can say, "Yes, that facility does a great job. We know you're getting great care there," and the reverse to be the same.

Michele Laughman: Okay. Thank you. And now I'm going to turn it back over to Denise.

Case Presentation—Conclusion

Denise O'Donnell: Okay, it's now 2:00 pm. And the results from the X-rays and CAT scan of the head are negative. Mrs. Emily is diagnosed with another UTI. She is medicated for pain and given a commonly prescribed antibiotic that she just finished taking prior to her admission to the nursing home. At 4:30, Mrs. Emily arrives at the nursing home, agitated, confused, hungry, incontinent, with a small reddened area on her coccyx that is non-blanchable.

The director of nurses contacts the provider, informing him that Mrs. Emily was given a dose of the antibiotic in the hospital. The provider orders the antibiotic for 10 days, with a repeat urine culture and sensitivity. Mrs. Emily's daughter stops at the nursing home, as she does every evening. When she arrives at 5:15, she finds her mother as described above. She had not been notified that her mother had fallen or was taken to the emergency department.

Questions for the Panel—3

This scenario has been fabricated, but many of you are probably saying to yourself, "this happens all the time." So we have the last two questions for the panel -- and I understand that some of you have already – some of the panel members have already addressed some of these issues in their prior responses. But the first question is, what are the lessons learned from this case study? And number two, how can we change current practice in transitions of care, based upon the lessons learned?

Kathryn, we will start with you.

Kathryn Weigel: Ensure your center does a complete assessment of the patient if there's a change in condition. Maintain open communication between nursing, the family, and the provider. Perform all available tests in your center and avoid unnecessary hospitalizations. If you do have to send a patient to the hospital, be sure to send all pertinent information and call and give a thorough report. And lastly, try to determine the patient's unmet need when behavior changes are noted.

Denise O'Donnell: Thank you, Kathryn. Scott, your takeaway points?

Scott Bartlett: You know, like I said before, communication, collaboration, you know like was said before about, you know, doing this in advance, not while, you know, something like this is occurring, but, you know, forming relationships, opening up dialogue and communication with, you know, other levels of care.

Certainly the daughter in this scenario would have been important, she might have insight. And I like to point out, she might even be a surrogate decision maker who has fiduciary responsibility to be involved. So, you know, just careful consideration, assessment, communication, and collaboration.

Denise O'Donnell: Okay. Thank you very much. Kevin, your takeaways?

Kevin Biese: Thank you. I – I have some – there's some jeopardy here of repetition, but I think the points are so important, that may be okay. I'd – to echo back in what's been said. All efforts to not send, and I say that knowing fully that sometimes folks have to come, and absolutely it's the right thing to come sometimes. And frankly, there's a lot of external pressure, so I understand.

But some ways that patients can be managed in facilities when possible are through rigorous advanced care planning options, telemedicine, the use of observation, checking back in on the patient. All of these can expand the care capacity of nursing homes. Easy for me to say, except I do participate in some of these programs. And it is possible. And my hope is that as our health care system continues to evolve that these programs will also be more financially sustainable as we move towards a more value-based care.

As far as the communication itself is concerned, this communication between the facility and the hospital and the emergency department shouldn't be de novo each time. It should be in the context of an ongoing conversation, regular meetings, clear connection patterns, and an understanding of the capacity of each facilities. Very simple – maybe not simple, but fairly straightforward. If you work at a hospital, invite the skilled nursing facility leadership that sends patients regularly and sit down and have a quarterly meeting.

It can go a long ways toward better understanding each other, as Tammie mentioned earlier. When folks are sent, check out INTERACT. It's a good standardized tool and can go a long ways. And finally check out Geriatric Emergency Department Guidelines.
I think they're the best thing out there for the ways emergency departments can be made more appropriate, less harmful, and more helpful for older adults.

Denise O'Donnell: Kevin, thank you very much. Tammie.

Tammie Stanton: Again, we keep saying collaborative and partnership. And it truly is a partnership. It's not the hospital telling or the ED telling the nursing home facility what needs to be done. We need to hear from you what we can do better as well. So feel free to open up those discussions and make sure we hear from you. We have given all our

facilities access to our electronic medical records. Please reach out to your hospitals to see if you can get that if you do not have that.

We are expanding our education plans for our patients and their families to understand the benefits of not transferring the patient to the hospital or the ED and to make sure they are triaged appropriately. And makes – as Kathryn said, expanding mobile X-rays and other services like that. And expanding or improving our education on advance care planning for our professionals and our internal staff as well as the families.

And I think this is a great time for our skilled nurse facility providers with value-based care. The new options like the 3-day waivers are making this level of care even more attractive and easier to access.

Denise O'Donnell: Thank you very much, Tammie. And now 'll turn it over to Michele.

Updates Related to the National Partnership

Michele Laughman: So that concludes the panel discussion. We'd like to thank all of our speakers today. Having a panel that includes such diverse perspective is helpful in gaining a better understanding of care transition process. We appreciate your time and participation in the call. And before we begin the Q&A portion of the call, I'd like to share some updates related to the National Partnership, and then following, Debbie Lyons will speak about QAPI.

We have recently completed the Focused Dementia Care Surveys for fiscal year 2016. The Focused surveys were conducted in Alabama, California, Colorado, Georgia, Illinois, Indiana, Massachusetts, Michigan, New Mexico, Oregon, South Dakota, Tennessee, Texas, and Washington State. This was a continuation of the expansion effort that took place in fiscal year 2015.

Recent partnership data, as of quarter one of 2016 was shared via email in August. And we have now seen a 30.3-percent reduction in the rate of antipsychotic use in long-stay nursing home residents. The national prevalence of antipsychotic medication use is currently 16.6 percent, which means that we have surpassed our 3rd goal of achieving a 30-percent reduction by the close of 2016. And we're eager to see the continued progress throughout the rest of the year.

Again, we thank you for everyone's participation. We look forward to continued collaboration in partnership. I think that's been the theme of our panel today. And I just want to shout out that our next call is going to be on Tuesday, December 6th. And now I'm going to turn it over to Debbie Lyons for the QAPI update.

QAPI Update

Debra Lyons: Thanks, Michele. And congratulation on amazing progress with the Partnership. Hello everyone, 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 Improvements, or QAPI, as well as adverse events. Today, I'm happy to announce that we have added some helpful tools, resources, and links to the QAPI webpage.

Specifically to our adverse events tab we've added the following: a link to the Society for Post-Acute and Long-Term Care Medicine's quality prescribing guidance for safe administration of anticoagulants, diabetic agents, as well as opioids. We've also added links to the CDC's infection control assessment tool for long-term care, as well as the National Healthcare Safety Network's surveillance system.

And lastly, we added a link to the Institute for Healthcare Improvement, or IHI, skilled nursing facility trigger tool for adverse events. In addition to updating the Adverse Events tab, we added a tab for nursing home consumers, where nursing home residents, their families, and other advocates for nursing home residents can find resources to help them engage in and take an active role in their nursing home quality.

We encourage you to check out these updates and other tools and resources available on our webpage by going to http://go.cms.gov/Nhqapi. And I will tell you the N has to be capitalized. That's http://go.cms.gov/Nhqapi with a capital N. Also, if you have any questions related to nursing home QAPI or adverse events, please send us an email with your inquiry to Nhqapi@cms.hhs.gov.

I want to thank everyone for participating in today's MLN call. And I'll turn it over to Leah.

Question-and-Answer Session

Leah Nguyen: Thank you, Debbie. We 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 the 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 one to get back into the queue, and we'll address additional questions as time permits. All right, Ronni, ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch tone phone. To remove yourself from the queue, press – 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're 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.

Please continue to hold for your first question. And your first question comes from the line of Wendy Meltzer.

Wendy Meltzer: I would appreciate if the panel could discuss the practicality and usefulness of including a discussion specifically about following up on specifications when – during a conversation between the nursing home and the emergency department that Dr. Weigel was recommending.

Denise O'Donnell: I'm sorry. Could you possibly repeat that? I'm not sure if everyone heard all parts of it.

Wendy Meltzer: The discussion before included a recommendation by the doctor, which seems to me to make a lot of sense, that there be an ongoing relationship between the emergency department and the nursing homes that do the most frequent referrals to the hospital. And I was wondering whether it would be help – it seems to me it would be helpful, but I don't know if it would be practical, to include in that discussion a followup of what actually happened with the residents who were sent the hospital and then returned to the nursing home?

Denise O'Donnell: Kevin, did you want to start the discussion for the panel?

Kathryn Weigel: This is Kathryn. I'm not sure I understood the question, but I thought that what the doctor was saying in my opinion, if we call a doctor and give them a report on a patient and the doctor may say, "Well, let's do some testing and continue to monitor the patient and wait on sending the patient to the hospital right away and then to, you know, call back in a couple of hours and see if there was any change in condition, are things looking better?" Rather than sending the patient right to the hospital.

Denise O'Donnell: Kevin, are you on?

Kevin Biese: Yes, did that answer your question? I want to make sure we got the question right. Or was the question more about sort of the ongoing communication between the skilled nursing facilities and the hospital?

Wendy Meltzer: Yes, it was the later. I'm really interested in – I mean, I think that if you're discussion the usefulness of referring to a hospital or not or sending someone to the hospital, it would seem to me to be helpful to know what the usefulness of sending them actually was in the long run, I mean, what actually happened with the resident…

Kevin Biese: Right.

Wendy Meltzer: …in the long run after they went back?

Kevin Biese: I think that's a great suggestion. I've been fortunate to be a part of several of our meetings with the skilled nursing facilities, and I think Tammie Stanton is also – who's also on the line as well – has also been a part of several of these chain meetings. We haven't done as much case-by-case review in the meetings I've been a part of. I think it can be very helpful. I think it needs to be balanced. To be frank, it's not where I would start those conversations because I, you know, I think that there's a lot of miscommunication and misunderstanding on both sides sometimes.

And sometimes the best thing to do is to sit down and just get to know each other a little bit first, understand where each other is coming from, have a sense of what the skilled nursing facilities, where they are, how many residents they have, you know, what capacity they have, so that we can speak with…

Denise O'Donnell: Did we lose you? Did you lose connection?

Leah Nguyen: Yes, we're still on.

Denise O'Donnell: Oh, okay. I'm sorry. It seems like we have lost Kevin. Is the rest of the panel there?

Tammie Stanton: I'm here. This is Tammie. I can pick up from where Kevin left that.

Leah Nguyen: Sure. Thank you.

Tammie Stanton: Yes, sure. We have started quarterly meetings here, but our next step was to set up a more monthly process with those who we refer to the most often and use some of those patient scenarios to say, "What happened? What could have done better? What information could we have shared back and forth? What tools should we develop?" I've been talking to some of our peers as well, and they, for instance, created a tool for dialysis patients. What is the type of information that this particular patient might need? And what are the lessons learned by using actual patient scenarios?

Putting it different, it seems kind of interesting to put different providers in the room together, and then the different levels—having home health, having the nursing facility providers, having private AD agencies, having D&E companies all in the same room together to talk about best lessons learned from each other. It's very engaging to do so, and doing so very often, at least once a month.

And then our plan is to put together a steering committee of advisors to help improve that, and bring in some family members as well and previous patients.

Leah Nguyen: Thank you. We'll go ahead and take our next question.

Operator: If you'd like to ask a question, press star one 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. And your next question comes from the line of Michael Ellenbogen.

Michael Ellenbogen: Hi. I really appreciate you talking about this subject, and I think there's also some other issues that maybe need to be considered. My mother is also in a nursing home, and she is living with dementia herself. And it seems to be the quick answer every single time that there is any kind of a fall incident that they have to rush them into an emergency room. Because they're trying to cover themselves. I've had to fight with them multiple times not to do that.

On her last occasion, she ended up at the nursing – I'm sorry, at the emergency room, and I immediately got there and I asked her if she was okay and she felt she was. I spoke with the doctors and told them it was an error for them to even bring her there. He agreed, but they didn't want to release her. They insisted that if I did take her, there would be consequences that she would not be able to go back to the nursing home, she would not be able to be admitted unless they had a clean – clear bill of health from the hospital.

And we spent an agonizing 8 hours there until we were able to finally get to the conclusion that there was nothing wrong. And to top it off, I am also living with Alzheimer's. So it was really very hard for me to deal in that environment. I could only imagine how hard it must have been for my mother who is much further off dealing with this disease.

Denise O'Donnell: So, Richard, so your question is exactly – has to do with what? When residents are sent to the emergency room and then are kept even though they might have advanced planning? Is that what your question was about?

Michael Ellenbogen: I think you're referring it to me. My name is Michael, but…

Denise O'Donnell: Oh, I'm sorry. I apologize. I'm sorry.

Michael Ellenbogen: No problem. No, the question is why is there laws preventing the hospital from allowing them to leave and to go back to the nursing home and that they can't be accepted back without, I guess, the proper approvals. That's a problem there, because I would have yanked her right back and taken her there, but she was not allowed to leave and she would not be admitted back into the nursing home without the proper paperwork.

Denise O'Donnell: I see what you're talking about. Obviously we can't address the legal aspects, you know, but if you would submit that as a comment we would be happy to get back to you about it. But I wondered if any of the panel could discuss the implications there for advanced care planning because I think many of our panel members spoke to that, that instead of having the emergency room staff having to kind of guess what needs to be done and what happens, you know, what is the value of having the advanced care planning documentation with you so you know what's going on?

Would anybody in the panel like to speak with that – to that?

Scott Bartlett: This is Scott, long-term care ombudsman. I don't know how to answer that specifically, in that instance. But I would encourage, you know, to get the ombudsman, the local ombudsman involved to help with that. To identify, open up a line dialogue, and help resolve that issue.

Denise O'Donnell: We have – I think we have Kevin back now. Kevin, are you on?

Kevin Biese: Yes. I apologize. My land line must have some issues. I am back on. So, you know again, I, too, can't really respond adequately to the individual circumstance, although I can sort of – I can certainly empathize and, from my own parents' journey, and I feel sorrow for that. Because it's not the way it should work. And that experience that you and your mother had is not what any of us would want.

I think that there's a lot of different levels, but the greater clarity that can be provided first to the nursing home facility, to the skilled nursing facility, and then to the emergency department providers about the patient care wishes. There is a sense in the emergency department that, of course, in order to send a patient back to the facility, the facility has to accept them. I'm not aware of legal implications other than if the facility is not able to accept the patient, then we can't send them back. And that may be what you were confronting, but I'm not certain.

But again, anything that can be done to sort of have a shared understanding of what your mother's wishes are, what her care goals are, and then a real conversation about

how to best accomplish those can circumvent, or at least end more quickly, a lot of – potentially iatrogenic testing and just the experience that you had.

Leah Nguyen: Thank you. We're ready to take our next question.

Operator: Your next question comes from the line of Karen Schoeneman.

Karen Schoeneman: Hi there. These are some – couple of questions about QAPI. Debbie, can you answer the following? The QAPI at a Glance tool, released in 2012, is it still up-to date or are you planning any revisions to it? And this other question is—I thank you for mentioning more resources on the website—are there any more resources than these you mentioned that will be coming out this year? Thank you.

Debra Lyons: Thanks, Karen. This is Debbie. Yes. So to answer the second question first, we do anticipate additional links and resources being added to the website. To get at the QAPI at a Glance question, as you are well aware of QAPI at a Glance was developed during our work with contractors to – as we were learning about QAPI and well before the regulation was offered as a notice for public – proposed rulemaking.

And we still believe that the QAPI at a Glance, while it was never intended to be regulatory in nature and was intended to be a guide, we do believe that it still will fit within the, you know, the proposed rule when, you know, hopefully when it comes out soon, but – and there may need to be some changes. But we think that – that, you know, that it basically provides the foundation and the beginning, you know, laying the groundwork for establishing a QAPI program.

We don't think that it, you know, if facilities follow those steps for getting started, I don't think that there would be any contradiction with the proposed rule. You know, so there shouldn't be any problem with that. There may be an opportunity for, at some point in the future, to maybe revise it, but we don't have plans for that at this time.

Karen Schoeneman: Okay. Thanks.

Leah Nguyen: Thank you. Ready for out next question.

Operator: Your next question comes from the line of Peter Aran.

Peter Aran: Hi, good afternoon. Really good session. My question – I'll state the question first and then some background on the question. The question is, have you all baked into your performance improvement plans responsibilities that you asked the primary care physician, the quarterback of the patient in your establishment, to take when he or she admits the patient to your nursing home?

So, the example would be when – Kevin, you were talking about what happened in the emergency room, how helpful it would be for you to call the patient's doctor. I'm part of an initiative that some of you—I bet most of you have not heard of, but some of you have—called the Comprehensive Primary Care Initiative, which is a CMS CMMI program in southern parts of the country.

But as of January 1, we'll be on 14 states. And the thesis behind the Comprehensive Primary Care Initiative is that we reestablish what the role of the primary care doctor is. She or he is the quarterback or the point guard in taking care of the patient.

And in that model, Kevin, we would call you and tell you, "My patient, Emily, who's been a patient of mine for 20 years, she's coming in, and these are the things she has. I don't think she should stay in the nursing home. Please get back to me after you assess her." And that would help Michael because I'm still, as the primary care doc, even if it's 2:00 in the morning, me or one of my partners would be the point guard. So, Michael, you don't have to navigate the morass or the barriers of the legal aspects. I would help make sure that your mom gets back into the emergency room.

So the question is, when you're baking in your quality improvement plans, have you included the primary care physician as an integral part of that, and making sure they feel responsible for their patient, independent of where their patient is, be it at home, in the emergency room, in their office, or in the ED? Thank you.

Denise O'Donnell: Kevin, would you like to address that?

Kevin Biese: Yes. So I gather that the direct question has more to do with folks that are running skilled nursing facilities, but I will chime in with my enthusiasm. I was a

residency director for many years and would still, today, spend most of my time teaching medical providers about caring of older adults in the ED.

And the silly line that I use is that taking care of a patient or a resident at a skilled nursing facility is like picking up a Tolstoy novel on Chapter 27. The best thing to you can do is talk to the author of the first 26 chapters. Otherwise you have no idea what's going on. And having no idea what's going on in the emergency department translates to excessive testing, interventions, and really inadequate ability to interpret the meaning of those tests, and probably unwarranted interventions.

And so, you know, I think that direct communication is so critical. And I think it's a way in which our EHRs currently fail us. There is no good reason why at the top of every patient that is owned by a primary care provide – at the top of their chart it doesn't say, "Hey, at least between these hours and these hours, if not all hours, call this number when they come in and let's talk about this patient." And you can probably circumvent a lot of unnecessary workup.

One last comment on that. When talking to ED providers, the emergency departments are appropriately very concerned about length of stay. There's always more people needing our care than are able to get it. And so if we can take even better care of patients by keeping them there for a shorter period of time, as is often able to happen by this kind of conversation like, "Don't order all that stuff. I just need to know this." Then the emergency department providers are going to be excited about that program, too. So, absolutely. Warm handoff, direct communication, makes care better for patients.

Denise O'Donnell: Kath – thank you. Kathryn, I wondered if you as a director of nurses or if any of the other panel members wanted to weigh into that question?

Kathryn Weigel: I mean, I agree with Dr. Biese. I would love to be able to have the physician – be able to contact the physician at the ER and be able to give a report. Often times, it's – we aren't able to do that. But if there's some way that we can start working towards that, or even if the doctor notifies the nurse to talk to the physician at the hospital and give direction as to exactly what he wants done while the patient's at the ER. This isn't a practice that we do now.

Leah Nguyen: Thank you. Next question.

Operator: Your next question comes from the line of Laurie Matiukas.

Laurie Matiukas: Hi, good afternoon. Thanks for the discussion today. This is actually more of a comment than a question, but it goes back to the assessment of a resident who's had an adverse event to the nursing home and whether or not they need to be transferred to the hospital. And I think it goes back to having really the appropriate staff on hand in the nursing home to do that assessment, which then I think then leads us to look again at the need for assuring that there is an RN on staff 24 hours a day in a long-term care facility, which we don't see happening. And it's not a requirement right now. So just really wanted to make that comment. Thank you.

Michele Laughman: Thank you.

Operator: Your next question comes from the line of Korey Hassard.

Korey Hassard: Hi. This is a great conference, so thank you very much. And my question is, how has the implementation of the Medicare annual wellness visit helped with the communication between a care team provider, specialist, primary care? Has there been any data validating the success of decreased emergency room visits and inpatient admissions?

Denise O'Donnell: Anyone in the panel?

Kathryn Weigel: I can't – we can't...

Michele Laughman: Yes, we can't… Yes.

Kathryn Weigel: … speak to that. The central office, we wouldn't have that information as far as data. But I don't know if there's any anecdotal information that maybe some of the speakers could provide?

Kevin Biese: I'm sad to say that I'm not familiar with the program, so I don't have the experience to share.

Denise O'Donnell: If you want to put that down as one of the comments and then we can research it here further and get back to you with some more information. If you would like to do that.

Leah Nguyen: Yes, we can do that. If you want to email it to us, we have a resource box listed on slide 20. You can send us that...

Korey Hassard: Okay.

Leah Nguyen: ... question. We'll look into it.

Korey Hassard: Okay. And then I had one additional question. My other question was how has the lack of unity with the electronic health record, with the EMR, either hurt or helped the communication between physicians and care team staff?

Kevin Biese: This is Kevin. I can comment on that, you know. I'd go with hurt. The information should follow the resident or patient or person, not the facility. And I realize that's not a very novel observation, but it is absolutely a challenge that our EHRs tend to be facility-specific rather than following the individual.

Now, as Tammie mentioned earlier, UNC, because of our collaborative outlook—and that just happens to one system, many systems do this—but because of our collaborative efforts, we work with the facilities that we collaborate with and give them access to our EHR.

But it is critical, I mean, how can we take good care of patients with complicated medical histories and an inability to give a great history if they're dealing with dementia without access to their records? And how can the skilled nursing facility really pick up on the care that we've delivered and ensure that it incorporates well into their longer-term management without access to our records? So that needs to be improved.

Denise O'Donnell: Tammie, did you want to expand on that a little bit?

Tammie Stanton: Just that we have given access to our information to the nursing homes, and then we found as we were doing a bit of an exercise ourselves that we were

sending the information to the hospitals when we were sending the patients but that hospitals or the EDs weren't receiving it.

It's great to send it, but if you don't make sure that there is a receiver there to see it, it doesn't do any good. So we're working on improving our process right now and trying to get that warm phone call. And we had talked to – I talked to a peer organization who, just this week, that were doing the very thing that we're talking about with physician, the physician in the ED is calling the physician at the facility and talking physician to physician, and they're measuring that success right now.

Leah Nguyen: Thank you. Could we take...

Tammie Stanton: Thank you.

Leah Nguyen: ... our next question?

Operator: Yes. Your next question comes from the line of Leslie Mahoney.

Leslie Mahoney: Hello. I just wanted to comment. The information given on the ED guidelines and also your committees that work collaboratively with long-term care, I think, are excellent ideas. But I had to make a comment on the order for the antibiotics. Here in California, there has been an ASL to all long-term care facilities that by January 2017 they must be in compliance with the CDC seven-step guidelines for antibiotic stewardship.

So I think it would behoove everyone who is in that loop between ED and long-term care to be onboard with antibiotics stewardship and be – or be talking about ordering those types of drugs and then sending someone back to the long-term care facility. I don't know if the physician on the panel would like to comment on that. Thank you.

Kevin Biese: So, this is Kevin, the physician on the panel. I think that antibiotic stewardship is critical, and I think that antibiotics, the – utilizing antibiotics has to be coordinated. Again, I think that the critical step for that is incorporating the cure the ED delivers into the long-term care plan of the individual that we're caring for.

So, for example, in this case, is it a UTI? Is it an asymptomatic bacteria? Were there bacteria there last week? Does that have anything to do with what's going on with the patient? And are we using an antibiotic the patient already has resistance to because they've received that antibiotic before?

It's – although it's important that the ED providers think of these things, what's even better is if they can communicate with the primary care provider, so that someone who knows the patient long term can weigh in on those issues. I think coordinated care is one of the most important steps towards antibiotic stewardship.

Leah Nguyen: Thank you. Could we take our next question?

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

Leah Nguyen: Okay. Thank you. I'll turn it back over to Denise.

Denise O'Donnell: I just had a question. It could be for the panel or anybody else out in the audience who might have – I was wondering about people's experience with the universal transfer form or the use of telemedicine technology in terms of bridging some of these gaps that we're talking about in terms of communication.

Kathryn Weigel: Kevin, I think you have brought up telemedicine?

Kevin Biese: Right. I'm happy to chime in or listen to others responses first.

Denise O'Donnell: Anybody has used – is anybody using the universal transfer form and how is that working? I know that there's a couple of states that have gone to that. Okay, I'm sorry. I was just informed people in the audience cannot just respond. Sorry about that but, if anybody –go ahead Kevin if you want to chime in.

Kevin Biese: So, I don't have experience with the universal transfer form. I do have extensive experience with telemedicine, and I can just say that there are some good patient- and family-centered innovative companies, programs out there that allow facilities to have expanded scope of caring for patients.

So if you can have – if you can provide the doctors or providers with the ability to see the patient—In the situation I work with, we're able to get EKGs, labs, do a bedside ultrasound, and send the patient for outpatient imaging without sending them to the facility. And most importantly, we're able to check on that patient again in another hour or two. Because sometimes you don't know. Maybe they're just not having a great morning but they're okay. Maybe they're just beginning to get really sick. But if I can check on them again in 2 hours and see them—literally see them again—it can go a long ways toward taking good care of patients. In the work that I do, we're able to keep patients, residents at a facility over 70 percent of the time, including for complaints like shortness of breath, abnormal vital signs, abnormal lab tests.

I think that utilizing technology as a piece of a strategy is really an important step forward. It is not the answer. Technology doesn't answer these problems, but there are some good interventions that can help provide better care for patients.

Denise O'Donnell: Thank you, Kevin. No more questions? Okay.

Additional Information

Leah Nguyen: Okay, great. 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 19 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.

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.

This document has been edited for spelling and punctuation errors.

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