



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'd like to welcome you to this MLN Connects National Provider Call on the National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement or QAPI. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, learn about the reform of requirements for long-term care facilities highlighting the behavioral health services and pharmacy services section. A Tennessee nursing home will also discuss innovative approaches that they implemented to dramatically reduce the use of antipsychotic medication. Additionally, CMS experts 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 and materials from today's call in previous registration emails. 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.

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

Presentation

Michele Laughman: Thank you, Leah, and welcome everyone. As Leah mentioned, we're going to have two presenters today. One will speak on the reform of requirements for long-term care facilities. And then we will have a nursing home administrator discussing some of the key strategies that they utilized to help with their process of reducing the use of antipsychotic drugs. Following, I'll share a little bit of information about the partnership. And, then, Debbie will close the call with an update about QAPI.

Before I introduce our first speaker, I'm going to turn it back over to Leah for a quick 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 count of the number of participants on the line with us today. Please note, there'll be a few moments of silence while we tabulate the results.

Kayla, 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 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. Again, if you are 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, Kayla.

I'll now turn the call back over to Michele.

Presentation Continued

Michele Laughman: Okay. I'd like to introduce our first speaker. We have Ms. Diane Corning. She is a health insurance specialist within the Clinical Standards Group here at CMS. Ms. Corning is also a registered nurse and an attorney. And she will be providing information about the reform of requirements for long-term care facilities, and she will highlight the behavioral health services section, as well as the pharmacy services section. Diane, I turn it over to you.

Medicare and Medicaid Programs: Reform of Requirements for LTC Facilities

Diane Corning: Okay. Thank you, Michele.

One of the comments that we received when we put out our proposed was that we did not actually define behavioral health. So, I wanted to start out – with talking about our definition of behavioral health – it should be there on your second slide. And we – for the purposes of this rule, we’re defining behavioral health as a resident’s whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

We took – we wanted to take a holistic view because long-term facilities, in addition to getting care – giving care, are also the residents’ residence. So, we felt that it had to be holistic, and we also wanted to make sure that we included prevention. So, we did add the definition of behavioral health to the final rule.

I’d also like to take a minute to emphasize that, although we made behavioral health a separate section, it should be – we want – this was a comprehensive assessment and update of the long-term care requirements. And the section for behavioral health works with all of the other sections to help – what we wanted to do was increase the quality of care for all residents.

One of our main themes throughout the long-term care requirements was person-centeredness. We want the – we want our residents to be, as we define it, the focus of control, and we want them – we want to support them in making their own choices and having as much control as possible in their daily lives and their care. So, person-centeredness was a very important theme throughout, including the behavioral health requirements.

In addition, all residents have to have a comprehensive care plan based upon their assessments. We’ve thought that – that is the sort of the crucial foundation of other requirements dealing with behavioral health. But, I would point out that these comprehensive care plans have to be prepared by an interdisciplinary team.

Now, some commenters suggested that we require a social worker or a mental health professional to be on these teams. However, not all facilities require to have a social worker and not all residents are going to really need a mental health professional. So, we did require that the interdisciplinary team have other appropriate staff or professionals in disciplines as determined by the resident’s needs or as requested by the resident. So, when someone does have behavioral health issues, we’re not requiring it, but we would certainly encourage that they have the appropriate persons on the interdisciplinary team to ensure that the comprehensive care plan is appropriate as possible.

And I’m moving on to slide 4, the facility assessment. We believe this is really a crucial part of our requirements. We need – in order for the facility to truly understand what resources it needs to care for its population, we feel that they really have to assess the

needs of that population. So, we're requiring that each long-term care facility conduct and document a facility-wide assessment to determine the resources that are necessary to care for their residents confidently both during day-to-day operations and emergencies.

Now, one of the crucial aspects of this, of course, is the resident population. So, in the title, it says it "not just about numbers." And that is one thing we wanted to emphasize. It's not just, "I have X residents to care for." It's also, we need to look into – and we do identify certain items there such as the types of diseases, the conditions, the physical and cognitive disabilities, the overall acuity, and any other pertinent facts that are present in that population. That is really – we want them to really take a look at their assessments and see the care that these – that their residents need. Now, they also have the – we also want them to have the staff competencies that are needed to care for those levels and types of care.

And here – it's not on the slide, but I did want to draw your attention to the fact we did earlier publish an emergency preparedness rule, which does contain requirements for long-term facilities. And that rule established Section 483.73. And that was published September the 16th of 2016 and can be found at 81 FR 63860. And that's – and those requirements also require a facility assessment, which can be done in conjunction with the facility assessment required here.

Moving on to slide 5. I'm going to get into the specific behavioral health requirements. Starting with 483.40, each resident must receive and each facility must provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and social well-being in accordance with the comprehensive assessment and plan of care.

And, then, down in the paragraph, I just want to emphasize certain things. Of course, it needs to be sufficient staff. That would go to the actual numbers of staff you have. And, then who provide direct services. We did have some requirement – oh, okay – we did have some discussion – we had originally proposed these requirements went to direct care or direct access staff and, apparently, some commenters were – thought that was kind of confusing. So, we've changed that to sufficient staff who provide direct services to the residents. And, then, we've added with appropriate competencies and skillsets. These would be determined by your facility assessment in which you look at your – you look at all your residents and determine what competencies and skillsets are needed to care for that population.

And moving on to slide 10. We've got – the next part I will discuss is – and we did make some changes here from the proposed. And while your facility assessment will determine your competencies and skillsets, we also say that these skillsets – these competencies and skillsets must include, but are not limited to, knowledge of and appropriate training and supervision for caring for residents with mental and

psychological disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder that have been identified in the facility assessment.

We added a history of trauma and the PSD language in response to both internal and external comments. We feel that this is basically the acknowledgement that our long-term care resident population does include individuals with PSD. And as we know now, PSD is not only – is certainly a problem for some veterans, but is also a problem for other individuals who have encountered trauma during their lives. So, for example, you could have domestic violence survivors who also have these issues. So, we feel that within the competencies and skillsets, those would certainly be included. We also have implementing non-pharmacological interventions. And this is tied to our pharmacy services requirement.

On to the next slide. This basically is extending some of the requirements to – that were there previously basically for residents who displays or is diagnosed with one of these behavioral health issues, that they receive appropriate treatment and services to correct – either correct the problem or at least attain the highest practical medical, mental, and psychosocial well-being. Or if a resident whose assessment did not reveal or does not have a diagnosis that doesn't – the resident does not display a pattern of decreased social intervention and/or increased withdrawal, angry or depressive behaviors, unless the resident's clinical condition demonstrates that the development of that pattern was unavoidable.

And the next slide is specifically about dementia. Many of the commenters on the proposed rule were very upset that we did not specifically mention dementia in the proposed requirements. Well, first of all, we didn't actually propose anything, so – or any specific requirements on dementia. So, we really didn't have the background. We haven't done the research yet to propose some specific requirements to dementia.

However, that is a very important issue in our long-term care facilities. So, as we reviewed it, we did believe that what we could do is specifically mention dementia within the behavioral health services. Now, I will say it wasn't mentioned initially because we thought our language was broad enough to cover it. But, so many of the commenters were very upset that it wasn't mentioned specifically that we did add in that section that residents who display or are diagnosed with dementia receive appropriate treatment to attain or maintain his or her highest practical physical, mental, and social well-being. Now, we are going to retain the comments that we received. So, if there is further rulemaking, the comments on dementia will be reviewed.

The next section had to do with rehabilitative services and medically related social services. The first requirement basically, if someone needs rehabilitative services for mental disorders or intellectual disability, the facility is going to be – and it's required in the resident's comprehensive plan of care – the facility either has to provide it or obtain it from an outside source that is a Medicare and/or Medicaid provider of those services.

The next one I would like to mention – we received quite a few comments on the social worker requirement provision. We did not – we basically just had a comment on adding gerontology as one of the other base that could substitute for being a social worker. But, we also – the majority require – or comments, rather, were very upset about people not having enough social workers in – facilities not having enough social workers in their facilities to really provide the care that residents need. Most commenters were either, well, just to require that every facility have a social worker. Some wanted us to have a ratio of a social worker to so many residents. And we really didn't think – agree with either of those. First of all, we didn't make any proposal to have social workers in facilities that had 120 or less residents. And, also, a ratio – we just didn't have the background to either propose or to finalize any sort of ratio.

So, what we did was we – the requirement for 120 or more beds – or more than 120 beds still stands. However, in behavioral health services, we added that facility must provide medically related social services to attain or maintain the highest practical physical, mental, and social well-being of each resident. So, we are requiring that they receive the social services. This should also link to our facility assessment. The need for social services should be established through the facility assessment that the facility should perform. However, we're not requiring a specific social worker requirement. So, it would be up to the facility whether they wanted to hire more social workers, have them part time or just choose to – you know, if they made an arrangement to get them. So, we do have the requirement that each resident receive the medically related social services. But we are leaving it up to the facility how to provide those.

And on the next slide, I wanted to talk about pharmacy services. This is – of course, it – pharmacy services goes to all residents. But much of this also really directly applies to our behavioral health residents.

The first thing I'd like to discuss is the monthly medication regimen review. That requirement is the same. We have added that each review must include a review of the resident's medical record. That specifically – we had proposed that that'd be included under certain circumstances. But many of the commenters said that, you know, they just thought it was implicit in doing a drug regimen review that the medical record would be reviewed. And as we looked at all the circumstances under which we really felt it absolutely had to be, it just became more and more apparent that it really – in order to really have a thorough review of the medication regimen and also hopefully pick up any irregularities sooner, that the entire medical record should be reviewed during that medication review.

In addition, the pharmacist is going to have to report irregularities not just to the attending physician and the Director of Nursing but also to the Medical Director. And we have some more requirements there about the documentation. We also added about policies. Many commenters were a little concerned that we didn't have, say, a timeframe or any – we didn't address what if the pharmacist found something that

could be detrimental to the resident and needed urgent action. So, we have added that the facility must develop and maintain policies. And those policies should contain timeframes for the different steps in the process and also steps that the pharmacist should take if they identify any irregularity which requires urgent action to prevent harm.

Also, another important section was we defined psychotropic drugs. We received a lot of comments on our proposed. And I just wanted to point out that, well, first of all, the last – the proposed – in the proposed definition, the last element was a catch-all phrase “any other drugs with similar effects.” And many people thought that just made it so broad that it would be unmanageable and it would also include drugs that really weren’t of a concern clinically. So, that has been removed.

We also removed our proposal to include opioid analgesics. Many people were very concerned that this could really detrimentally interfere with pain management, especially due to the PRN limitations that I’ll discuss in just a minute. So, as of now, the – our definition is any drug that affects brain activities associated with mental processes of behavior. These drugs include, but are not limited to – and then they are same four that we had proposed – antipsychotics, antidepressants, anti-anxiety, and hypnotic. And there should be – there’ll be further guidance – sub-regulatory guidance in the IGs that will probably have more – provide you more detail on those areas.

The next slide – basically, if the resident is not on a psychotropic, we want to make sure that they do not receive one unless they are being treated for a specific condition diagnosed and documented in their clinical record. Also, if a resident is taking a psychotropic, he or she receives gradual dose reductions and behavioral interventions unless clinically contraindicated in an effort to discontinue the drug.

I would like to just mention briefly many commenters were a little concerned that we – that might be used to disrupt residents that are stable for some condition. People gave us a lot of different examples and said, “Well, if they are stable, why would you want to force behavioral interventions or gradual drug reduction?” I highlighted “unless clinically contraindicated.” Our whole goal here was to improve the quality of care, not to do anything detrimental to residents.

And, certainly, I imagine this will be also in some sub-regulatory guidance – what needs to be done. But, if any of this – if either of those are not appropriate or clinically contraindicated, we would think that, you know, certainly, the attending physician or their primary care would document the file. But, in no way if we – when we said “unless clinically contraindicated,” we didn’t want people to think that somehow we were trying to force this on anyone if it wasn’t appropriate for the residents.

Also, one of the big things that we did here was we actually put a limitation on PRN orders for psychotropics. We thought this was really important because there were so

much concern that psychotropic drugs, in particular, could be prescribed for residents for reasons other than their own personal benefit. So, as a general rule, PRN orders are limited to 14 days. And, then, we provided two exceptions. If the attending MD or the prescribing practitioner believed it was appropriate to extend beyond 14 days, they could document that rationale and indicate the duration of the order. This was intended for people who were – who were on some type of psychotropic medication long term, but they only need it intermittently and, you know, if we required it every 14 days, it really wouldn't amount to any benefit to the resident. So, we provided that exception.

However, we believe that because of the importance of antipsychotics, especially the potential detrimental side effects that they contain, we limited them to 14 days, and they cannot be removed unless the attending MD or prescribing practitioner evaluates the resident for the appropriateness of that medication. We thought that that was essential. There was a lot of concern that some residents were being put on PRN orders for antipsychotics and it was for an extended period of time and they weren't being evaluated to see if there needed to be changes. So, PRN orders are limited to 14 days. And I imagine that will also be in some of the sub-regulatory guidance – what is required for the evaluation of the resident.

And that is pretty much my presentation. The last slide contains my contact information. If you have any questions and you don't get on the line today or I can't answer it or you would just like to contact me, please feel free. That's my phone – that's my direct phone number and that's my email here at CMS. And thank you so much for your attention.

Michele Laughman: Okay. Thank you, Diane. I appreciate that.

Next up will be Mr. Douglas Ford. Mr. Ford is a nursing home administrator at the National HealthCare Corporation in Fort Sanders, Tennessee. He will be discussing innovative approaches that NHC implemented to help in the reduction of antipsychotic medications.

Doug?

A Collaborative Approach to Reducing Antipsychotics

Douglas Ford: Yes, ma'am. Thank you. I almost thought about taking some medication in preparation for this. I've been a little nervous. But we'll try to get through it.

My name is Doug Ford. I'm the Administrator of NHC Fort Sanders in Knoxville. With me today is Dr. Kim Quigley, who's the founder and CEO of Basis Health Group, and also Amy Morgan, who is the Director of Nursing at one of our sister facilities, NHC Knoxville.

Back in 2014, if you happen to be looking at the slide—it's slide number 20—we were struggling with our antipsychotic use in comparison to national averages. In the second quarter of 2014, we were averaging just over 21 percent. We began to try to focus on

antipsychotic reduction and had a little success into the third and fourth quarters, dropping it from 21 percent to 20 to 18. But, our three-quarter average was still running 20.3 percent compared to the national average of 19.3.

During this time, we were having a great deal of dialogue with our Medical Director, who is part of Summit Medical Group. And he introduced an idea in December of 2014 of bringing onto our staff a psychiatrist by the name of Dr. Kim Quigley. And I have to tell you, as a nursing home administrator, my first thought was bringing a psychiatrist onboard to decrease antipsychotics may not work. But, pleasantly, we were very happy to have Dr. Quigley join our staff. And she and our Assistant Director of Nursing at the time, Amy Morgan, began to work on the process of trying to address our antipsychotic use.

During this time, as you know, CMS was strongly encouraging skilled nursing providers to encompass and use QAPI, Quality Assurance Performance Improvement, as part of our QA process. So, we began to look at the foundation or the parameters of QAPI. As we moved through that process, again, on slide 20, you can see in the first quarter of 2015 we made tremendous strides in reducing our antipsychotics. We dropped it down to 10.5 percent on the long-stay residents and 2.1 on short stay. Then, the second quarter of 2015, we got it down to 6.8 and 1.2. So, we felt very comfortable that we were making the proper strides.

On slide number 21, I just put the five components of QAPI. And what I'd like to do just real briefly is kind of walk through that process. And in the governance or the design phase, in governance and leadership, we began to look at who our primary stakeholders were. We felt like the Administrator, Director of Nursing, Assistant Director of Nursing were part of the stakeholders. But, we also had our staff psychiatrist as well as our Medical Director and our pharmacist involved in that group.

During the feedback, data system and monitoring phase, we began to take a look at different tools that we could use to identify the population that were being affected by the antipsychotics and to try to determine what tools that we might want to put in place. One of those tools was just simply CMS Five-Star Quality measure data that gave us these numbers on the previous slide.

But, we also took a look at the CASPER report. The CASPER acronym stands for Certification and Survey Provider Enhanced Report. Now, this report kind of gave us a drilldown on which specific patients were receiving antipsychotics. But even at that point, we had to gather more information.

In the performance improvement part of QAPI, we began to use a tool internally called Rapid Cycle. And we identified all the patients on the antipsychotics, specifically what sort of antipsychotics they were on, how long they'd been on it, taking a look at a little bit their family history. Had the patient never been on it? Was introduced to it, you

know, in the acute care setting? Never got discontinued in long-term care setting? So, we began to really focus on and target gradual dose reduction in part of that Rapid Cycle process.

In that process, over on slide number 22, we also utilized our Quality Assurance Committee. Monthly, we have our Medical Director and one of our attending physicians attend our QA meeting. And during that time, we were reporting back to that committee our Rapid Cycle study, our QAPI progress, reporting data from the CASPER report from CMS Five-Star report and kind of keeping tabs on how we were moving along with the process.

I feel like the meat of the QAPI process really comes in the systematic analysis and action phase. And this is where Amy Morgan, our then Assistant Director of Nursing, created a communication board with Dr. Quigley because, you know, perhaps one of them may not see the other, but when Dr. Quigley came in to round on her residents, the communication board would help these two stakeholders continue to monitor their gradual dose reduction, what were the effects, communication with the families which I think is also an important aspect of it.

They also developed an Excel spreadsheet just to keep up with the gradual dose reduction because at the beginning of this process, we had a lot of people in antipsychotics, so it was difficult data to keep up with. And, of course, during that process, we were targeting all the antipsychotics in that family but, specifically, Haldol and Seroquel seem to be two of the medications that we were most concerned with.

So, as the process continued, we had some challenges along the way. Not everything was real smooth. One of the things that we noticed while we were focused on our long-stay residents that the – we had a slight increase in short-stay antipsychotics. So, Dr. Quigley got back together with Amy and the stakeholder team. And we realized that some of our long-term care patients were coming back on antipsychotics or short-stay residents were coming in. And we were kind of focused internally on our long-stay residents. So, we began to shift some of our focus to new admissions.

Then, during that process, we also noticed an upsurge in our falls. This concerned our QA Committee. So, the QA Committee suggested that we do a sidebar Rapid Cycle study to take a look at the correlation between the residents who were going through the gradual dose reduction and our falls. We were very pleased to find out that the residents who were falling were not in the group of the residents that we are doing the gradual dose reduction on and, therefore, there was no correlation between our QAPI study and the increase in falls. And, thankfully, about a month or two later, those falls tended to decrease and we were back in line.

Then, I think another part of this process was that we lost Dr. Quigley from this medical practice. She began her own company. And Amy was promoted to the Director of

Nursing at one of our sister facilities. I think what I want to say about QAPI is that by using the QAPI process and having stakeholders that were highly motivated to address this, even though these two very valuable women to our center are now no longer here, our numbers continue to be very positive compared to national average. In the second quarter of 2016, we were at 8.3 percent on long stay and 2.1 percent in short stay. So, we're still well within those parameters for antipsychotic reduction.

And the systems that these two individuals put in place are continuing, and we've been very successful in it and our Medical Director has been very supportive. I think it's highly important to involve our medical group as well as involving the families. I heard in our previous presentation the importance of the social workers in this process. I think that plays a large factor in it. And the pharmacist was a key element in this. The pharmacist was extremely helpful in coming back over the top of this information and continuing to monitor.

So, that's the short version of our study.

National Partnership Update

Michele Laughman: Thank you, Doug.

I'd now like to share some updates related to the partnership. I'd also like to start by thanking the speakers that we had today. And everyone will get an opportunity to ask them some questions in a little bit.

We appreciate everyone's time and participation in these MLN calls. And I'm just going to share some updates and, then, I will pass it to Debbie Lyons, who will speak briefly about the final rule implementation timeline. She will also discuss some of the evaluation results from our last MLN call. And, then, she'll share some information about QAPI.

So, for fiscal year 2017, we are continuing to conduct more of the Focus Dementia Care surveys. The surveys remain as unannounced surveys of records. And we continue to focus on nursing homes that have higher rates of antipsychotic use. Recently, in October, I shared updated Partnership data. And, so, that included quarter two of 2016. We've now seen a 31.8-percent reduction in the rate of antipsychotic use in long-stay nursing home residents. The national prevalence of antipsychotic use is currently 16.3 percent. And we really want to congratulate all of our stakeholders and our collaborative partners in the success of this national effort. And we really look forward to continued partnership from everyone as we move into 2017.

We're currently discussing our vision for future Partnership goals. Of course, many more discussions will be necessary as we move forward and those visions become more concrete. Goal development is a critical piece of every endeavor, and the future

direction that is taken with the National Partnership will be collaborative, achievable, and remain consistent with the current mission.

So, now, I will turn it over to Debbie Lyons.

QAPI Update

Debra Lyons: Thanks, Michele.

Hi, everyone. My name is Debbie Lyons. And together with my colleague Cathy Lawrence, we lead the Division of Nursing Home Efforts around nursing home quality assurance and performance improvement and adverse events. I hope everyone is enjoying the holidays.

As Diane mentioned earlier, the final rule for the reform of long-term care requirements reforms and overhauls the requirements for participation in Medicare and Medicaid for nursing homes. Recognizing that facilities will need time to implement some of the new requirements, CMS will implement the rule in three phases with the first phase effective this past November 28, 2016, the second phase effective November of 2017, and the third phase effective in November of 2019.

On October 27th of this year, CMS did an MLN Connects Call giving an overview of the final rule. If you missed that call, please go to the MLN Connects webpage and find the presentation for October 27, 2016. It's entitled "Long-Term Care Facilities Reform of Requirements Call." There, you will find the slides and audio or written transcript of the presentation.

In addition, CMS has issued survey and certification memos on the final rule. Memo S&C: 17-03-NH contains links to training for surveyors and providers alike on the Phase 1 implementation, which is effective this past November. Memo S&C: 17-07-NH released an advanced copy of the State Operations Manual, or lovingly referred to as the SOM, Appendix PP, which incorporates the revised regulations into the current guidance, which has not yet been changed. Look for these memos and more to come as this rule is rolled out. If you have questions about the rule and its implementation, please send your inquiries to nhsurveydevelopment@cms.hhs.gov.

Now, let me briefly review the results from your evaluation of our last call. Of course, this is good QAPI approach. The last call, which was held in September, had an overall satisfaction with the call at 85.51 percent, which is higher than the average satisfaction from the previous year. And we're very happy about that.

However, registration was significantly lower. Average registration for these calls for the year was 1,875 with registration for September's call was being 1,485. We will continue to study your evaluations to determine if that was an outlier or if this is a trend.

Many of you suggested as a result of the last call that there is not enough QAPI on these calls. What I'll say is we try to balance the topics so that we focus on the work of the Partnership while emphasizing QAPI approaches to the work that you're doing. And today's call was perfect example. Thank you, Doug. You heard how a nursing home used the QAPI approaches to reduce inappropriate antipsychotic use from their facility. We are in the planning phase for upcoming calls. So, I would encourage you to please suggest whatever topics will be the most helpful to you.

I also would like to remind you to check out the QAPI tools and resources available to nursing home providers by going to the [QAPI](http://go.cms.gov/nhqapi) webpage at <http://go.cms.gov/nhqapi>. And, also, if you have any questions related to nursing home QAPI or adverse events, please send us an email at nhqapi@cms.hhs.gov.

And I want to thank everyone for participating in today's MLN Call.

And I'm going to turn it back over to Leah, our moderator, for questions and answers.

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 your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one. If you would like to ask a followup question or have more than one question, you may press star, one to get back into the queue, and we will address additional questions as time permits.

All right, Kayla. We are ready to take our first question.

Operator: To ask a question, please press star followed by the number one on your touch-tone 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 into the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Jocelyn Montgomery.

Jocelyn Montgomery: Hi. Thank you very much for the wonderful example of antipsychotic reduction. I enjoyed that very much. I have a question in the requirements. There's dementia management mentioned in the training requirements and that it should be for all direct care staff. And my read on that is that is a Phase 1 requirement. Direct care staff isn't defined – it isn't in the definitions. I found it in the

comments. And my read on that was that it certainly would be the nursing staff, probably the activities staff, probably the social work staff. Can you just give us a little bit more of what you would expect to see and how much – how many hours or time you would want to see for those non-CNA staff?

Leah Nguyen: Hold on one moment.

Jocelyn Montgomery: Hello?

Operator: One moment, Jocelyn. They are answering your question.

Jocelyn Montgomery: Oh, okay. Thanks.

Debra Lyons: Hi. Sorry about that. We just had to put our heads together a little bit. So, this is Debbie Lyons. And you are correct. That is a Phase 1 implementation. So, basically, the current guidance still exists and still applies to that requirement. So, I would suggest that any training that you're doing now for your direct care staff for your front-line CNAs and so on is still the required training.

Jocelyn Montgomery: So, I misread it then, that it goes beyond the CNA requirement, which has already been in place to – I misread it then, because it – it appeared that it was anyone who comes in contact – direct contact in the course of the day for an individual who has dementia.

Debra Lyons: Give me one second. We have the rule right here. We're going to look at that. I'm sorry. Why don't you submit that question to the Nursing Home Survey Development email box, and we will give you a specific answer? I don't want to hold up any more time on the call.

Jocelyn Montgomery: Okay.

Leah Nguyen: And that's listed on the last slide of the presentation.

Jocelyn Montgomery: Thank you.

Operator: Your next question will come from the line of Jerome Sauter.

Jerome Sauter: Can you hear me?

Operator: Jerome, your line is open.

Jerome Sauter: Hi. Can you hear me? Hi. Good afternoon. You answered my question already. I asked – I was going to ask the websites where I can get the availability. But, one thing you could do – where can I get the transcript of this call? What website?

Leah Nguyen: Hi. This is Leah Nguyen. It'll be posted to our MLN Connects Call website. You can go to go.cms.gov/npc. It is the same location where you found the presentation. And it will be available in about 2 weeks.

Jerome Sauter: Okay. Thank you.

Leah Nguyen: You're welcome.

Operator: Your next question will come from the line of Barbara Anthony.

Barbara Anthony: Yes. The information we've heard today has been very helpful. In Louisiana, we've been looking in nursing homes with a high use of antipsychotics and we wanted to know if CMS has considered allowing the diagnosis of bipolar to be an exclusion like schizophrenia when collecting data from the CASPER report. And we know the use of antipsychotics does affect the Five-Star rating in nursing homes.

Michele Laughman: Hi, Barbara. This is Michele.

Barbara Anthony: Hi.

Michele Laughman: We haven't changed the exclusions at this time. You know, we've gotten lots of information about bipolar. We've also gotten feedback about residents with – you know, that are going through hospice care. And, so at this time the exclusions will remain as they are for that quality measure.

Leah Nguyen: Thank you.

Barbara Anthony: Thank you.

Operator: Your next question will come from the line of Gregory Kotlarz.

Gregory Kotlarz: Yes. Hi. Gregory Kotlarz from Seniors Wellness Group of Michigan. I'm looking at slide 11, the second section or point of that slide. In reading it, it sounds like the nursing facility is responsible for preventing the occurrence of any sort of clinically significant psychiatric issue or condition or otherwise mental illness.

How are we to understand that point? What exactly does it mean?

Diane Corning: Hi. This is Diane Corning. Where we say—I think this is what you're talking about—residents whose assessments did not reveal or have a diagnosis of any of the above, does not display a pattern of decreased social interaction or increased, withdrawal, angry or depressive behaviors, unless the resident's clinical condition demonstrates that the development of that pattern was unavoidable. That's what you're talking about, right?

Gregory Kotlarz: Correct. Yes. Yes.

Diane Corning: Yes. We fully realize – I mean, there are times – it's, you know, their condition may deteriorate and it's through no fault of the nursing home. They're providing appropriate care. But, for that, it's not holding you responsible for it. But, I do feel that it would mean that you'd be providing the appropriate care and documenting the resident's condition to show that you have provided appropriate care and that their condition deteriorated anyway. It's not – it wasn't intended to say if someone's conditions worsened, you're automatically responsible.

Gregory Kotlarz: So, what is the objective definition or criteria of unavoidable?

Diane Corning: I really can't answer that. That would probably be something that's in sub-regulatory guidance. I would look to that to find more detail about that.

Leah Nguyen: Thank you.

Gregory Kotlarz: Yes. I – yes. Just a further comment. I think that's very important for the care facility. And it's, you know, if it has a specialized mental health group – and that's what I'm a representative of, a specialized mental health group in long-term care facilities as an Executive Director and practicing clinician. You know, it just seems to me that it's very important to really have, you know, clarity on that issue because it can be very subjective. I've read guidances for the state surveyors.

And, so, what you're saying, then, is this perhaps is largely left to subjective opinion based on whatever method of evaluation the surveyors are, you know, are implementing through the course of their surveys.

Diane Corning: Well, I definitely can understand your concern. The first thing I'd say is our – these are the requirements. They are – in many ways, they are not that specific because we leave that to sub-regulatory guidance. And I think that you should consult that as soon as that's available. And that should provide the detail you're looking for.

Leah Nguyen: Thank you.

Gregory Kotlarz: Okay.

Operator: Your next question will come from the line of Angela Fingard.

Angela, your line is open.

Angela Fingard: Good afternoon.

Operator: That question has – and that question has been withdrawn. Your next question will come from the line of Elvira Aver.

Elvira Aver: Just a second. So, we have – well, thank you very much. It was very informative. Our question – what is your suggestion on approval of the residents of the current plan and the resident’s participation in the current care plans and their goals? How – what is the suggestion? What are residents supposed to do? Do you want them to co-sign the care plan? Or how – what would be the evidence of residents participating in their care plan and the goals?

Michele Laughman: Who are you directing your question to?

Elvira Aver: To all of you. I’m sorry.

Leah Nguyen: Hold on a moment.

Elvira Aver: Hello?

Leah Nguyen: Hold on one moment.

Elvira Aver: Okay.

Diane Corning: So, you’re right. There are several places in the new final rule where it talks about the responsibility for the facility to inform the resident of their care plan to give them, you know, information about their care plan. We would suggest that you refer to the revised guidance as it comes out. You will be told ahead of time through various, you know, formats that we are releasing our guidance for, you know – and you can review that. Or, another thing that you can do is submit your question to the NH Survey Development email box.

Elvira Aver: We did that exactly. And we have another question, too.

Diane Corning: So, did you get a response yet?

Elvira Aver: No, we have not.

Diane Corning: Okay. Yes, well, you know, I think those email box questions are being distributed. You should be getting an answer back very shortly.

Elvira Avert: Okay. Then, another question. On the medication regimen, you said that we have to have – a pharmacist has to have a copy that has to go to attending physicians, DON, and a Medical Director. So my question is, what is role of the Medical Director on that if all of those are going to be 100 percent reviewed by attending

physicians? So, Medical Director has to look for what? And what is the proof that the Medical Director has looked into drug regimen review?

Diane Corning: Hi. Yes. We have added – we did finalize that the report of irregularities that the pharmacist comes up has to go to the attending, the DON, and now also the Medical Director. The purpose of that is to make sure the Medical Director is informed of the irregularities that are being detected. What his or her role is is up to the facility. We did not specify that. But we did feel it was important that they be included on the list that does get that information.

Leah Nguyen: Thank you.

Elvira Avert: All right. Okay. That is it. Thank you very much.

Operator: Your next question will come from the line of Angela Fingard.

Angela Fingard: Thank you very much for taking my call again. Hopefully, you can hear me this time. I am calling from TimeSlips. And we received a grant from CMS to help with reducing antipsychotic usage in nursing homes throughout the State of Wisconsin. And we're reducing it through non-pharmacological programming, a lot of creative engagement work through storytelling and other arts-based interventions. And I'm just wondering what you have – what kind of non-pharmacological programming that you have used during your – I'm sorry, I'm directing this question to Doug. What types of programming you may have used or thinking of using and, also, what research you may have looked out that may start to look at what – how that programming is impacting the reduction of medication. I know it's very early and that research isn't – is still forthcoming. But I was wondering if there's anything that you may be seeing that I – that we haven't been able to look up.

Douglas Ford: Well, I can't speak specifically to any other programming outside of our QAPI study in terms of other modalities or methodologies used in trying to reduce antipsychotics, although I've read some other types of therapies that may help. We just haven't really done that much here.

Kimberly Quigley: This is Dr. Quigley. I'm the psychiatrist that worked on it. You know, we had to get really good at communicating with all the disciplines at the nursing home and really using our activities staff very robustly. We have a great activities staff, a great dietary staff. We used to put different favorite kinds of music in people's rooms, doing, you know, all the non-pharmacological things that you talk about, even down to our head of dietary knowing everybody's favorite food and what would make them the happiest, really learning their schedule, getting to know their families very well, and using the information that we get from their families to do the best to calm them with things that have calmed them throughout their lives rather than using medications.

It was a very labor-intensive process. But, it did give us a lot of interesting experience in that most people came off the medications – most people we thought would be able to come off the medications came off the medications very, very well. It was with a few exceptions that we had to put people back on. Of course, we did a lot of homework on the front end of which people should be removed from the antipsychotics and which clinically may not benefit them at the time. The good news is we were starting from a pretty high number so that when we decreased, all the ones that came off pretty easily – we still had some patients that required it. But we were down below 10 percent and we felt like that was a better picture of clinical severity than we had had previously by using those non-pharmacological measures.

So, I would say that we used our activities staff, our existing activity staff. We didn't add activities staff. But we listened to our activities staff, and we listened to every level of care down to our dietary staff and really tried to communicate with each other where, on my communication board, any person at any level could add something to my communication board to help me in this process. So, it really was a facility-wide effort to do this.

Douglas Ford: And I think a key to what Dr. Quigley said too is involvement of the families. Whether Amy was taking to the families about the medication and the side effects or Dr. Quigley, I think an important aspect there is to involve the families because, as Dr. Quigley said, the families are the ones that can tell you what soothes the patient or what calms the patient down. And, so, I feel like the family involvement is extremely important.

Leah Nguyen: Thank you.

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

Your next question will come from the line of Wendy Fearnside.

Wendy Fearnside: Hi. Thank you. This is a question for Diane Corning. How would you determine whether the requirements that staff have appropriate competencies or that residents receive appropriate treatment for mental and behavioral disorders – how would you determine whether these requirements are being met? And are there any more specific guidances that are coming for States?

Diane Corning: Hi. This is Diane. Well, there will be more sub-regulatory guidance to provide more detail on those requirements. As far as requirements go, it all goes back to the facility assessment, which is based on the resident assessments, the care planning, and the facilities reviewing other information like the resources they have and that. As

far as specifics, like I said, I would look to the sub-regulatory guidance. But, it's very dependent upon what the facility determines from its facility assessment.

Wendy Fearnside: Okay. Thank you.

Operator: Your next question will come from the line of Jerome Sauter.

Jerome Sauter: I do have another question. As a consultant pharmacist, physicians many times will ask me what is the correct way to – well, I shouldn't say the correct way – what is the correct clinical rationale for not having a gradual dose reduction in a resident that they feel should not have one? How would they – how would – how should it be stated on the monthly recommendation from pharmacy? Basically, my question is what are the clinical rationales that would not require a gradual dose reduction of an antipsychotic medication?

Diane Corning: Well, I think, when it comes to that, that really is up to the physician. We wouldn't tell them what rationale that – it would depend on the patient, depend on the drug. It would depend on the physician. That really wouldn't be for us – up to us to say.

Jerome Sauter: Okay. So, when I'm asked the question, I can tell them that, you are the physician and your clinical rationale has to be rational. Correct?

Diane Corning: Well requirements say unless clinically contraindicated. So, I imagine there'll be more detailed sub-regulatory guidance. But, clearly, if there is a – if it's clinically contraindicated, they should be able to state why it is – it's clinically contraindicated.

Jerome Sauter: Okay. Just one last question and I'll let it go. Would a possibility of increasing a psychiatric instability be a clinical – would that be enough rationale not to create the gradual dose reductions?

Diane Corning: That might be a question that you'd want to send in to the box that Debbie had mentioned. Maybe Leah has that more information. But, I would send that question in.

Leah Nguyen: Yes, slide 28. Thank you.

Jerome Sauter: Slide 28? Okay. Thank you.

Operator: Your next question will come from the line of Barb Ostrowski.

Barb Ostrowski: Hi. Thanks for taking my call. I'm a consultant pharmacist in Michigan. And I just want to say I appreciate the time you guys have. But, you have to understand that in the real world where we practice, we are currently held to these standards and

we are being judged and evaluated based on these standards, which have been deemed to be put into effect now. So, we don't really have the time to wait for sub-regulatory guidance, nor do we have time to send a question to the box and wait for it to be disseminated and, perhaps, answered by somebody. We've already heard people who have done that and haven't gotten back clarification.

So, if you can understand our frustration with these new guidelines and the fact that you don't seem to have the specifics we need to be able to follow the new rules. I'd like you to address that and maybe see how we can troubleshoot this better so that the clinicians who are caring for these, you know, indeed vulnerable patients can do their job best and still meet the guidelines. Thank you.

Leah Nguyen: Just one moment.

Diane Corning: Oh hi. This is Diane Corning. Could you possibly send your question and any information you have to the box for us? I don't know if we really have enough to give you a good answer right now for that.

Leah Nguyen: And we're recording the call, so we can't take your personal information over the phone. So, I mean, if you could please just send us your name and your phone number to our resource box, that would be great. It's on slide 28. Thank you.

Operator: Your next question will come from the line of Rosene Dunkle.

Rosene Dunkle: Hi. Would you please define sub-regulatory guidance and share where, when, and how we can get that?

Debra Lyons: Hi. This is Debbie Lyons. Sub-regulatory guidance is the interpretive guidance that we released for surveyors to help them understand the regulation. The – any new guidance associated with the final rule will be released sometime before Phase 2 implementation, which is November of 2017. Again, you know – and that guidance is currently, you know, being drafted. Any regulation in the final rule which has a Phase 1 implementation is presumed that that is – while it may be new language, it's pretty straightforward and those are the – you know, that's how we decided and chose which regulations would be Phase 1 or which would be Phase 2 or which would be Phase 3. So, presuming that the language is pretty straightforward, we added that to the existing guidance. And, you know, where – we will be releasing the sub-regulatory guidance in November of 2017.

Rosene Dunkle: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Daisy Murphy.

Daisy Murphy: Yes. Thank you. Can you hear me?

Leah Nguyen: Yes, we can.

Daisy Murphy: Okay. My question is, is there any tools available or any guidance as to how to help us to begin to develop our facility assessments?

Debra Lyons: We will tell you that the regulations around facility assessment are very specific about the kinds of things that have to be considered when conducting your assessment. We – I know you've heard this before. We will be releasing additional guidance in November. But, because we feel that the requirements are pretty straightforward, you know, you should be able to determine the things that need to be a part of that assessment. And, of course, the facility assessment is itself going to be in Phase 2, which goes into effect in November of 2017.

Daisy Murphy: Okay. Thank you very much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Ann Wyatt.

Ann Wyatt: Yes. I have a question about the QAPI project, which was – sounds quite wonderful. And the question I had was I wondered what role sort of a tighter identification and management of pain in people with dementia might have played in helping to reduce the use of the antipsychotics?

Douglas Ford: Okay. I'd ask Dr. Quigley to answer that one.

(Crosstalk.)

Kimberly Quigley: Sure. Ms. Wyatt, thanks for the question. It was very important clinically for – when I say this whole project for us and being able to do this was about staff and whole facility communication, pain was something that I was always very interested in. I had regular reports from the wound care nurse, regular reports from the nurses about pain management, about how many pain medications they had gotten overnight per se before a particular PRN were given or we just worked very closely with the acute care hospital staff as they transitioned over to the post-acute care hospital staff and with the pharmacists while they were here to see what kind of pain medication they were getting.

And I was also pretty good about traveling down to physical therapy. We had a good relationship with physical therapy to judge how much pain people were in in both the

short-stay and the long-stay residents. So, it was a very important part of being able to help people get off these medications. That's a great question.

Ann Wyatt: Thanks.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Susan Macaulay.

Susan Macaulay: Yes. Hello. I don't have a question. But I would like to share some resources. I'm Canadian, and I'm very happy to be listening to your call. The Canadian Foundation for Healthcare Improvement last year did a collaborative project with 50-some nursing homes across Canada and had some excellent results in reducing antipsychotic use. So, I would highly recommend that project to you.

And, also, in terms of hands-on tools, the Alberta Health Services, under the title of "Appropriate Use of Antipsychotics Toolkit for Care Teams," has a really excellent set of resources which is comprehensive and includes lots of links. So, again, I would recommend that to you ...

Leah Nguyen: Thank you.

Susan Macaulay: ... and your colleagues.

Leah Nguyen: All right. Thanks for that.

Operator: And there are no further questions in queue. I will now turn the conference back over to Leah Nguyen.

Additional Information

Leah Nguyen: Thank you. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 27 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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