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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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects®
National Provider Call. All lines will remain in a listen-only mode until the question-and-
answer session. This call is being recorded and transcribed. If anyone has any objections,
you may disconnect at this time. I will now turn the call over to Leah Nguyen.

Thank you. You may begin.

Announcements and Introduction

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

During this call, learn about a project grant award in a new QAPI Written Plan How-To
Guide to assist with performance improvement efforts. 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 follows the presentation.

Before we begin, I have a few announcements.

You should have received a link to the presentation for today's call in previous
registration emails. If you have not already done so, please view or download the
presentation from the following URL – 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 would 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, during this call, we're going to learn about a Federal Civil Money
Penalty Grant Project entitled "Creating a Culture of Person-Directed Dementia Care"

and a Quality Innovation Network will share information about the new QAPI Written Plan How-To Guide.

I would now like to introduce Mr. Chris Perna, the President and CEO of the Eden Alternative, and Ms. Laura Beck, a Learning and Development Guide at the Eden Alternative. Chris and Laura will provide information about the Federal Civil Money Penalty Grant project.

Chris and Laura, I turn it over to you.

Federal CMP Grant: "Creating a Culture of Person-Directed Dementia Care"

Chris Perna**:** Thank you very much, Michele.

Laura and I are very pleased to be able to speak with you today about the scope of this grant project as well as the outcomes that were achieved. This project process began with an open RFP issued by CMS back in 2014 to which we submitted an application. The grant award was made in May of 2015, a little more than a year later. Clearly, from the title of this project, "Creating a Culture of Person-Directed Dementia Care," it was very much inspired by the National Partnership to Improve Dementia Care in Nursing Homes.

The goals of the project**:** The project really combined discrete educational experiences that engaged different stakeholders, specifically nursing home employees in various roles as well as family members of nursing home residents. Our overarching goal for the project was to support the reduction of antipsychotics through person-directed approaches to dementia care. By person-directed care, we mean care practices that are structured around the unique needs, preferences, and desires of the individual. It also means that the person receiving care or the individuals closest to them drive all decisions around their care.

More specifically, the project was designed to help participants identify limitations of current approaches to care for those living with dementia, support the reduction of antipsychotic medication use, reframe so-called problem behaviors as unmet needs, learn how to enhance well-being for all residents, collaborate creatively with family members as partners in care, apply skills learned to everyday situations of need through creative solutions that empower individuals to live full and positive lives. And then,

finally, to act as change agents back in their organizations by sharing and demonstrating the best practices learned through the training experience.

I'd now like to introduce Laura to talk about more of the scope and the outcomes associated with the project. Laura?

Laura Beck**:** Thanks, Chris. And before I continue with the presentation, I just wanted to point out, it sounds like somebody was unmuted and it was a little difficult to hear Chris at times. So if you haven't had the chance to mute yourselves, please take this opportunity right now. It would be greatly appreciated because I'm picking up a lot of noise on my end from somebody's line. I…still audible. I just want somebody to confirm that I'm audible because it was a very loud noise on my end.

Chris Perna**:** Yes.

Leah Nguyen**:** Yes. We can hear you.

Laura Beck**:** All right. Thank you for the reassurance. That's great. All right. Sorry about the interruption.

So Chris gave you an awesome introduction to how this all began. What I'd like to do is drill down a little bit and tell you a little bit about the scope of the project. The scope of the project is captured on slide 9, if you want to know where I am in your slide deck. And the scope itself involved five states – Georgia, South Carolina, Kansas, Illinois, and Texas. Some of these states expressed an interest in participating in the project up front when we did a little bit of inquiring on our own while others were actually hand selected by CMS specifically as states exhibiting a higher percentage of antipsychotic use and had a little bit more room to grow there.

So we offered participants two ways that they can participate in the project. And if you will join me on slide 10, I can tell you exactly what those two ways are. Both tracks, as we call them, included participation in a 2-day training called Dementia Beyond Drugs. We had at the Eden Alternative co-developed this training in 2011 with author and geriatrician Dr. Al Power. Dr. Power also co-facilitated the training for the project along with Karen Stobbe and Sonya Barsness, who were contracted to support the development of CMS's Hand-in-Hand Toolkit. Now track two of the project involved

those nursing homes that registered two employees in Dementia Beyond Drugs training alone. So that's all they chose to do under the umbrella of the grant project.

For track one, a smaller number of nursing homes in each state were given the option to combine Dementia Beyond Drugs training with participation in an 8-week webinar-based training called the Care Partner Workshop, which was also developed by us at the Eden Alternative. So with this deeper dive, as we called it, with track one, the two employees that participated in Dementia Beyond Drugs training would then pair up with a family member affiliated with the nursing home they were employed in. And together, as a team of three, they would experience the Care Partner Workshop and deepen their understanding of individualized dementia care and their role as members of what we call a care partner team.

Now some of the goals associated with providing the track one option, which we're calling the deeper dive, included revealing whether or not more education actually made a difference in the engagement level of participants. We were also seeking to enrich the collaborative relationships between nursing home employees and family members and to offer family members a deeper sense of teamwork and investment in change efforts in the organization, particularly as it impacted the reduction of antipsychotic medications.

So, now what I'd like to do starting with slide 11 is actually to give you a taste of some of the content highlights that were covered through the project. And, hopefully, you will feel like you have a little bit of something to carry away with you today that might have some value in your own exploration along these lines.

So I thought I would start out by sharing a quote from Dr. Al Power. He says, "In my nursing home work, family members would often tell me that their loved ones looked better than they had in months. They would often ask what pill I had prescribed to cause such an improvement. But the truth was it wasn't a pill. It was because we had stopped the antipsychotic drug, and we had found other ways of providing support."

And what I love about this quote is it really underlines that the problem typically lies with how we view the personal expressions of people who live with dementia. The biomedical model tends to use the word "behavior" to describe personal expressions. The "behavior" is seen as just a part of the disease. It implies that, well, you know, this is

just what people who live with dementia do. They hit and they kick. Through this lens, the behavior really isn't seen as having a particular reason or purpose. And it can lead us to pathologize expressions that actually might be perfectly normal in any other circumstance, like crying when you're sad or speaking out when you're angry or frustrated or wanting to go for a walk outside to get a breath of fresh air and explore.

The implication is that the brain changes are causing the various expressions of distress. And this view doesn't recognize the individual's experience and the environmental and relational factors that often cause the stress. And by blaming the distress on brain disease, it very quickly becomes a slippery slope toward drug use that might not be actually necessary. So the idea is to never accept that any personal expression is merely a symptom of dementia until you've thoroughly identified the unmet needs that the individual is trying to communicate.

As you can see on the slide here, there are three kinds of audits listed. And these are one way that you can become a good detective. They provide a framework for sleuthing out medical, environmental, and experiential factors that might be causing the distress in the first place.

So if you'll join me on slide number 12.

Speaking of experiential audits, there are some tool sets that we like to utilize to identify unmet needs. One tool set are these seven domains of well-being that you see here on the slide: identity, connectedness, security, autonomy, meaning, growth, and joy. Now in 2006, the Eden Alternative received a grant to bring together a group of culture change thought leaders to define what they thought well-being was, like, really, how do we get our heads around this. The result was the identification of these seven domains that you see here on the slide and that I just read off to you.

And when the person living with dementia is well known for who they have been and who they are today, their needs can be more easily recognized and met. And to build a depth of relationship, there needs to be consistent connectedness for this person. Once identity and connectedness are strong for this individual, then autonomy and security can be strengthened. Imagine how difficult it can be to optimize someone's choices and help them feel safe when they don't know the people or place around them and vice a versa. So, those around them – you know, they, too, may know little about the

individual. When these first four domains are strong, it becomes very easy to bring more meaning into daily life and to offer opportunities for the person living with dementia to grow and experience joy.

So, through a series of focused questions, care partner teams are able to systematically determine how well each domain is being met for someone living with dementia. And what's so impactful about using the domains – at least this is the feedback we can get from people at times – is that we all need these things. And, so, the fact that they are personal and involve sort of a visceral connection, we're able to make the domains a tool to make life easier not only for the care partners to discern what the need is at hand but for the person who is experiencing the distress. Having the domains be so personal also helps care partners relate to and appreciate the value of making sure domain is – pardon me – the well-being is of the highest quality for each individual.

So if you'll join me on slide 13. There's another tool set that we will use from time to time to help us to identify unmet needs. And what it involves is an awareness of the three plagues of loneliness, helplessness, and boredom and their antidotes. So the work of Dr. Bill Thomas, who is a co-founder of our organization, identified the negative impact of loneliness, helpless, and boredom on the well-being of the human spirit. Now as care partners seeking to reveal someone's unmet need, we can ask ourselves, Maybe they're lonely. Could they be lonely? Are they helpless? Are they feeling helpless? Or might they be bored? The antidotes to the plagues are companionship in the form of close and continuing companionship – that would be the antidote to loneliness. The opportunity to give as well as receive is the antidote to helplessness. And spontaneity and variety are the antidote to boredom.

You'll notice how the antidotes align with the domain of well-being. Companionship aligns with the need for connectedness and being well known. Giving as well as receiving aligns with autonomy and growth. And spontaneity and variety aligns with meaning and joy. Quite honestly, you might come up with your own combinations given the opportunity to think about it from your own perspective.

So if you can join me on slide 14. To successfully apply these tool sets, you really need a framework for thinking about care that is based on reciprocity and collaboration. So the concept of care partnership as we see it at the Eden Alternative helps develop a culture of meaningful care that does not see the needs of caregivers as separate from the needs

of care receivers but, rather, it advocates for the entire care partnership. So, this means that the person living with dementia is an active partner in their own care. Other members of the care partner team include nursing home employees, family members, friends, and volunteers. And, together, they acknowledge that opportunities to give as well receive are alive in every moment and that they should be leveraged to enhance and support well-being on a daily basis.

So join me on slide 15, if you will. So, care partnership serves as a kind of supportive container then, within which teams can successfully assess unmet needs. Imagine, then, three kinds of transformation that create an even broader support system needed to help teams move beyond drugs and to truly supporting well-being for people living with dementia over time. These three kinds of transformation are personal, organizational, and physical transformation.

Now, if we can't transform how we view dementia and people living with it and transform how we interact with them based on our change perceptions, then organizational and physical transformation don't have a chance. When it comes to organizational transformation, happy, empowered employees mean happy, empowered residents. And in order to support strength-based dementia care, both employees and residents must be empowered members of the care partner team. And if you haven't made the physical environment responsive to the unique needs and well-being of people living with dementia, such as meeting their sensory needs in a particular way in terms of how the space is designed, their ability to communicate their needs might be further compromised.

So you can see how all of these different supports we've just covered work together in a mutually supportive and integrative way that sets up all members of the care partner team for success and creates an environment that supports enhanced well-being for elders through the reduced usage of antipsychotic drugs. It's really about setting the teams up and the residents who are a part of those teams up for success. They need to have the right supports in place to be able to put these particular approaches to care into action in a really highly successful and satisfying way.

All right. So if you'll join me on page – pardon me – slide 16, we're going to talk a little bit about the project evaluation and our outcomes. The project evaluation essentially focused on three things – what was the shift toward person-directed perceptions about

care, if and how participants engage with what they learned and applied or put it into action, and, lastly, we're going to take a mile-high view of how trends in antipsychotic use in the participating states changed during the grant period.

So, let's start first with how perceptions changed. And if you look here at slide 16, participants experience a 17-percent average shift toward person-directed perceptions of dementia care from pre-test to immediate post-test. So that means just within the training experience itself, people changed the way they thought about things. From pre-test to followup, which was 4 months later, improvement remained above the projected outcome. Participants experienced an 11-percent average shift toward person-directed perceptions of dementia care. And our projected shift when we applied for the grant was that we would make a 5- to 10-percent shift toward person-directed perceptions.

Now if you can join me quickly on slide 17. Regarding engagements, the evaluation methodology for this focused mostly on track one participants, which we were calling the deep dive before. And steps taken to put the ideas into action – this is what we were looking for – how did they do this; did they do this? Eighty-eight percent of track one participants said they are definitely using what they learned from the Dementia Beyond Drugs training based on followup surveys. From the perspective of the partner workshop content, 77 percent of track one participants indicated that they were definitely using what they learned from the training based on followup surveys.

Now, participants indicated whether they were sharing what they learned by word of mouth, small group discussions, hands-on implementation, whether they were doing presentations, and in services. And in terms of both educational experiences, participants relied on a blend of each. We did notice a decent percentage indicated that word of mouth was a means of engagement, which was, honestly, a really good sign to us because these person-directed approaches tend to rely heavily on weaving concepts into daily interactions and operations. So we really wanted to see that conversations were happening and that they were impactful.

Now if you were to join me on slide 18, we'll take it to the next level in terms of how our evaluation unfolded.

The project evaluation also included taking a look at how participating states compared in regards to antipsychotic use during the actual grant period. Now I want to be clear that we're not trying to attribute any positive statewide changes in antipsychotic use to our project in particular. But we thought this would be a really interesting data point to explore. And so it was included in the project methodology.

Data represented "the percentage of long-stay residents who received an antipsychotic medication," as reported in CMS's Nursing Home Compare data set. And all CMS-certified nursing homes in the five project states were coded by the following group types: nursing homes not participating in any part of the project, nursing homes that only sent people to Dementia Beyond Drugs training, and, lastly, nursing homes that engaged their participants in both Dementia Beyond Drugs training and the Care Partner Workshop.

And what we found was that there was an overall – which is really an aggregate measure – 5.83 percent decrease in the use of antipsychotic medications in participating states during the grant period. That's looking at all of them together. But then we had a chance to look at it state by state. A state-by-state review showed that each state except South Carolina also experienced at least a 5-percent decrease in the use of antipsychotic medications. And we had projected at least a 5-percent decrease for participating states. So that was an interesting outcome.

And if you join me on slide 19, as I mentioned earlier going into the project, we wanted to explore the impact of education on making positive changes. And what we saw was that participating nursing homes experienced larger absolute and relative percent reductions in the use of antipsychotic medications than those nursing homes that didn't send anybody to be a part of the grant project. And this – you know, we – this seemed like a pretty good indication that, yes, education is indeed a vital tool for effecting change. The outcome backs up this notion and helped us see that this was an important part of creating a tipping point for participating homes regarding.

And if you'll join me on slide 20. We also received different kinds of qualitative feedback from participants about their experience of the project as a whole. Here is one example from a family member named Lynne Jordan. She was participating as part of a team from a long-term care community in Monticello, Georgia. We share this comment

mostly because we feel that the addition of family members was one of the distinguishing qualities of the project.

She says that, "Learning about person-directed dementia care, along with the care partner team approach, provided me a whole new perspective on the care my mother receives. Observing the care partners at The Retreat and joining those staff members in the Care Partner Workshop helped me understand the day-to-day as well as the long-term challenges and successes of care." I love this quote because it doesn't even matter whose training it was. The point is that engaging family members in some way—in a really active way—so that they can feel integrated is really a valuable choice to make.

Other remarks we received from family members included feeling like more of a true partner now with the rest of the employees. They felt more valued. They felt more integrated into conversations about care and problem solving. Others felt that they were better positioned to advocate for their family members after the project.

And so this is where we're going to close our presentation portion of what we have to share. We understand that you'll be able to ask us questions at the very end of the call today. So, please, I hope you've jotted some down. And if not, just hold on to them.

Keypad Polling

Leah Nguyen**:** Great. Thank you.

Laura Beck**:** Thank you.

Leah Nguyen**:** Thank you, Chris and Laura.

At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results. Ronnie, 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.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

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

Leah Nguyen**:** Thank you, Ronnie. I will now turn the call back over to Michele.

Presentation Continued

Michele Laughman**:** So, next up, we will have Ms. Jane Pederson, Chief Medical Officer at Stratis Health, and Ms. Kristi Wergin, a Program Manager at Stratis Health. Jane and Kristi will be discussing the QAPI Written Plan How-To Guide. Jane and Kristi?

Guide to Developing a Written QAPI Plan

Kristi Wergin**:** Thank you very much, Michele, for inviting us to share this guide to developing a written QAPI plan. I am Kristi Wergin, and I do lead the QIN-QIO Nursing Home Quality Improvement team in Michigan, Minnesota, and Wisconsin, and we really appreciate that you've asked us to share with the group today.

If you'll see on slide 22, hopefully, after we briefly introduce you to this guide, you will be able to identify why your nursing home should be developing a written QAPI plan, how to use the guide to develop that plan, and steps you can take to get started in either developing your plan or ensuring that the plan you have developed is in line with the reform of requirements for long-term care facilities.

On slide 24, you will see that this guide was developed by the Lake Superior Quality Innovation Network Nursing Home team. And as you can see on this slide, Lake Superior QIN serves the states of Michigan, Minnesota, and Wisconsin.

On the next slide, 25, taking the time to develop a written QAPI plan as you – I'm sure you all know, it is a requirement under the new reform of requirements for long-term

care facilities. Giving careful thought and putting these thoughts into a written plan will ensure that your home has a guide that will lead your team toward an effective, comprehensive, and data-driven QAPI culture that improves resident outcomes and quality of life.

On slide 26, it gives more details about the regulation. As of November 28, 2017, all nursing homes must have a written QAPI plan available to present to the state survey agency or Federal surveyors. CMS did estimate that it could take 56 hours for a nursing home team to complete this written plan. And after hearing from providers in Michigan, Minnesota, and Wisconsin that this was going to be a challenge, we decided to create this guide. Please keep in mind that although your written plan must be completed in November of this year, documentation that this plan has been implemented does not need to be completed until November 28, 2019.

I will now turn the presentation over to Dr. Jane Pederson, who will familiarize you with the guide. Dr. Pederson is the Chief Medical Quality Officer at Stratis Health, and she supported the development and implementation of the QAPI Program through the development of tools and resources that are being used by nursing homes all over the country. We feel fortunate to have her provide feedback as we develop this guide. Jane?

Dr. Jane Pederson: Thanks, Kristi. On slide 27, you'll see – what I want to start with today is just first looking at the table of contents of the how-to guide. What you'll see on that slide is that the guide is outlined around the elements of QAPI but also includes some sections – and we'll walk through these as well – on the resources and some of the templates and things that you can use. So, what we'll do today is I'm just going to walk through each of these sections just to give you a flavor of what is included in the guide and maybe some helpful hints as how to use that for creating your own QAPI plan.

So let's go to the next slide, which is the purpose of your organization's QAPI plan.

We ask you to start out with this when you're creating a plan just to help – have your team kind of sit down and say, So what are we going to use this QAPI plan for in our organization? Your QAPI plan, while it is a requirement, is something that's meant to be a living and breathing document. It's meant to be something that if someone new comes into your organization, they can pull this down from the shelf and say, Oh, okay,

so this is how this organization is approaching QAPI. This is how this organization is building it into their work.

So this slide just shows one of the examples that we put in the slide. It's just we realized that, like anyone, sometimes when you're staring at a blank piece of paper, it's hard to know where to start. And so for each of these sections, we have provided an example just to give you something to build off of. The examples are – they're pretty generic and pretty basic. But, you can modify them, put in your own details, cut, paste, whatever you'd like to do, just to give you a place to start.

So you'll notice on this one that in the Purpose, it doesn't just talk about performance improvement projects, which we'll touch on a little bit later, but it really gets into things beyond clinical conditions such as all – like all those symptom – systems – sorry – that impact quality of care, satisfaction, and quality of life.

So let's go on to the next slide, slide 29, which is the Scope. So, first, when you're looking at filling out your plan and looking at your scope, it may be helpful to just start by listing what services you provide. This helps you not only individualize your plan but to really kind of put a picture in front of yourself of everything that needs to be included in that plan so you don't – basically don't forget any aspect of the unique services that your organization provides.

Then, for each of these services say, Well, what are some of those key issues we'd like to address in QAPI? At that point, it might be helpful to start thinking about, What are some of our current quality improvement efforts that we already have underway? Now, I wouldn't recommend going into great detail in describing your QAPI efforts in here or in the plan in general because those are things that can be described elsewhere. For example, when we talk about your performance improvement plans, your team should be – the team working on those plans should be documenting and tracking the work they're doing. That doesn't – all those details don't need to be part of your QAPI plan but more of a high-level description of what you're working on as far as each of these service areas.

And then, finally, it's helpful to include any other supporting evidence that you might be using or thinking of using in the scope of your plan. Now, this might be best practices

that you've been referring to, evidence from the literature, or even just learnings from your previous work.

On slide 30 there's a better picture of the example that's in – part of the Scope section of the QAPI plan. And, again, I'm not going to read through this. But you can see it's a relatively general example and, again, meant to be something that you can modify, put in your own, you know, details of how you're going to do that in your organization.

So the next slide is on guidelines for governance and leadership. As you likely know from previous presentations or descriptions of QAPI, governance and leadership involvement and support can really be the factor that either limits or creates success in integrating QAPI into your organization. So these are just some of the things that you consider, some of the questions you may want to be asking yourself as you're addressing governance and leadership in your organization. I'm going to do this a little bit out of order because, I think, a couple of them tie together.

I am going to start with responsibility and accountability. It's very important that you give accountability and responsibility of QAPI in your organization. Now, this shouldn't just be to one person. But there does have to be some place or some group or team that is responsible for QAPI. There also needs to be an understanding that that – whoever it is, team or person, needs to be really reporting to the governing body of your organization. In fact, I would say it's very important that the governing body in your organization be actively involved in QAPI. It should be something that your board or whoever, depending on your structure, is really expecting to hear about. They're expecting to have quality and QAPI a part of their discussion. I would say if you have board members even having board members involved in some of your QAPI work and some of your performance improvement projects.

The other thing that is very important for governance and leadership are the other factors listed on these slides. They need to make sure you have a framework for QAPI and that adequate resources are being given to the work. They also have to, I would say, do something that's very important. And that is create the culture of QAPI, a place where it's okay to ask questions and, in fact, asking questions is encouraged. Also, a culture that's not punitive. To really be good at doing QAPI, we need to have a culture where mistakes and human errors are seen as learning experiences or learning opportunities rather than a reason for punishment because you want people to be

bringing these opportunities so that you can learn from them and do better going forward.

The next section is on feedback, data systems, and monitoring. I'm going to take longer on this section just because there's some tables that we've included to help you work through this. We've divided this section into three sections, all of which are structured similarly. And they're listed on the slide: data sources to analyze performance, data sources to identify risk, and data sources to collect feedback and input.

So this is just an example. This is one of the sections. But this is how they are all laid out. We have a table so that you can actually look at, Okay, what data sources do we want to include for this area? I'm going to start at the bottom of this slide, where we've created just a suggested list of data resources. This isn't meant to be, Oh my goodness, we have to do everything on this list. But this is, again, just meant to be something to kind of jog your thinking to say, Oh, which are the ones that are important to us?

I would stress in this section that sometimes less is more. QAPI is not about tracking as many data sources as you possibly can. It's really about tracking the data sources that you will actually be using to guide your improvement efforts. And keep in mind, you know, the QAPI plan is a living and breathing document. So you can always go back and add or subtract. If you're listing 20-plus data sources under every one of these sections, you're really listing too many. Go back and skinny that down and really say, Which ones are we really going to use? I would say maybe 10 at the most in each of these. That's a lot to track on and to track on in a meaningful way.

So let me just go back to the table. If you look at the left-hand column, it's where you list out the data sources that you're expecting to look at. And then the columns going over from left to right are just questions that you can ask yourself. How often are we going to collect this data? What benchmarks are we going to use for this one? Who will actually analyze that data, etc. So you're really making yourselves sit and think about, Okay. If we're going to use this data source, how are we going to actually use it? Again, you don't have to put a huge amount of writing into each of these boxes but enough so that you are really telling yourself, This is how we are actually going to use this data source.

The next slide, slide 34, is an example with just some of these elements completed. And we do have these elements – these completed forms within the how-to guide. But, again, it shows you – sometimes it's just as simple as putting, We're going to collect this weekly, or We're going to look at this monthly, and just identifying who should be expecting to hear this data, who should be expecting that we'll get this information and how are we going to use it.

So the next section that we look at is performance improvement projects. And my guess is that every facility has worked on a number of performance improvement projects over time. But there are some unique aspects of PIPs in QAPI.

The first is prioritization and selection. And if you've had a chance to go out and look at the CMS tools, there is a tool on the CMS website that guides your team through prioritization. And the advantage of using this objective tool is it really helps you focus on projects that are most relevant to your residents in your facility rather on the projects that you'd maybe like to do or seem easiest to do or maybe that everybody else is working on so you feel that you should work on them, too.

Another aspect that you may not be as familiar with is the use of charters. And charter is something that is developed by the team that's leading QAPI in your organization and then given to the team that will actually be carrying out the project. The charter should clearly describe the project as well as provide any background the team may need. It can provide anticipating measures to determine if the project was successful or has an impact. Keep in mind that the charter is meant to tell the team what they're being asked to address and not how it should be done. That's really the role of the team as they determine the best approach or interventions to solve the problem.

The PIP section asks – also asks you to state how you're going to document the work as you go along. I think it's always easy for us to finish a project and then move on to the next thing. And then we don't have that history documented anywhere to look back on what we've done. So it really asks you to clearly state, Okay, how are we going to document the important work that we're doing in QAPI so that we don't have to go back and reinvent the wheel each time and we can actually keep learning along the way?

The last section or the last element of QAPI that's listed on slide 36 is systematic analysis and systemic action. We always say that all the elements of QAPI are equally important

to success. But for me, in many ways, this element represents the heart of your QAPI work. To really effectively use QAPI to improve your organization, you need to be good at systems thinking, understanding how all your various processes work together and that a change in one may change in another.

And so in this section, it's really asking you to say, How are we going to embed this kind of systems thinking into our QAPI work? It also asks you to articulate how you're going to sustain the work going forward. I think another thing that we often forget in quality improvement is that we put so much effort into the performance improvement plan, you know, selecting interventions, measuring, and then we think, We got it. We had success. Now we can move on. But sustaining those improvements can be just as much work as getting them in place in the first place. So it's very important to articulate, How are we going to put that sustaining piece into our processes? How are we going to do that on an ongoing basis? And, so, that's what the example is – the examples that are here are helping you get some ideas of how to articulate that and how to approach that in your QAPI plan.

Finally, there's a couple of slides that are just examples of some of the resources that are included in the QAPI plan. And when you look at this online, they all have the URLs that you can click on. So I would encourage you to take advantage of these resources as you're creating your QAPI plan and as you're working on QAPI in your organization.

There's also an appendix that has all the templates and blank tables that you can use. Feel free to pick the ones that you want to start with or that seem most relevant to your organization. Feel free to modify them to best fit your – the needs of your organization. Again, they're meant to be a guide so that you're not staring at a blank piece of paper wondering, How am I going to create this QAPI plan, but instead to give you some structure to start from. So here's just an example of, like, the table that I showed you earlier that is in the appendix that you can fill in.

And then, finally, on slide 40 is the URL to get to the guide. So you can click on that and get in there and play around with it. And if you have any questions, please feel free to contact Kristi. She can also direct you to me if you have direct questions for me as well. Okay?

National Partnership Update

Michele Laughman**:** Thank you, Jane and Kristi, appreciate that. And thank you to all of our speakers today. We appreciate your time and participation and preparing for the call.

Before we begin the Q&A portion of our call, I'd like to share some updates related to the National Partnership and the following deadlines briefly.

The Focus Dementia Care Surveys have continued for fiscal year 2017. The focus surveys remain unannounced surveys of record focusing on nursing homes that continues to have high rates of antipsychotic medication use. Recent partnership data as of quarter 3 of 2016 was shared in January. And we have now seen a 32.4-percent reduction in the rate of antipsychotic use in long-stay nursing home residents, which means the national prevalence of antipsychotic use is currently 16.1 percent.

Future partnership goals are currently under development, and we've had internal discussions. But additional information will be forthcoming. The goals of the partnership will continue to be collaborative, achievable, and remain consistent with the current mission. And I'd also like to just remind you to please continue to visit the National Nursing Home Quality Improvement Campaign, which is NNHQIC – their website to find the National Partnership Resource Repository. The Comprehensive Resource Repository is located at www.nhqualitycampaign.org and contains helpful tools for persons living with dementia, family members or care providers, as well as professionals.

I will now turn it over to Debbie.

Debbie Lyons**:** Thanks, Michele.

Hi there, 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.

As you are aware, last November CMS issued the final rule for the reform of the long-term care requirements. You should also be aware that CMS is using a three-phase approach to implement this rule. Currently, the interpretive guidelines for the phase two changes are set to become effective next November 28th. We intend to release an advance copy of the guidance and training on these changes this summer. If you have

any 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, which was in December.

We ended up having 1,332 registrants for the December call. And you may recall that in my discussion, I said registration had been coming down and that we would continue to study to see if this was a trend. Well, it does seem to be a trend. In September, we had 1,485 calls – registrants. And for the call before that, we had 1,854. And to go along with this trend, we've identified that overall satisfaction has been declining. Overall satisfaction with the December call was at 78.89 percent, down from 85.51 percent for the call on September, and for the call before that, 90 percent.

To address these trends, we'd really like to hear from you. When you receive the evaluation to – you know, at the completion of this call, please fill it – you know, complete it and feel free to expand on whatever topics you think would make these calls more meaningful for you because, after all, this call is – you know, it's for you and we want to, you know, deliver the content that you want to hear.

Moving on to your evaluation of the content of the last call, first, we'd like to thank you for your comments. Your evaluations included comments such as, "There were many unanswered questions," "Many questions were deferred to the mailbox with no answer at the given moment," "It was not helpful to be referred to an email address to answer questions about regs that went into effect in November."

We definitely understand that many stakeholders are eager to learn about the implementation of the guidance for the regulations. Please note, when CMS is developing guidance which are not in effect yet, we cannot discuss details of that guidance during the development phase. We recommend that you review the implementation table within the final rule as well as the preamble language, which provides the rationale for some of the regulation changes. As always, we will make every attempt to answer questions during the call. But if a question cannot be answered during the call, we ask you to please send your question and we will provide a response via email. And as I mentioned earlier, we will be sending out an advance copy of the interpretive guidelines for the upcoming implementation phase.

As for QAPI, I would remind you to check out the QAPI tools and resources available by going to http://go.cms.gov/nhqapi. Also, if you have any questions related to NH QAPI or adverse events, please send us an email at nhqapi@cms.hhs.gov.

Thank you, everyone, for participating in today's MLN Connects Call.

And I'm going to turn it over to Leah, our moderator, for the question-and-answer session.

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 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, Ronnie, we are 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, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster.

And your first question comes from the line of Ellen Wright.

Ellen Wright: Yes. Hi. This is Ellen Wright from WESTMED Medical Group. I actually had a specific question, and I'm not sure if this is an appropriate arena for it. But I was hoping to get a little more information about the specifics of how the staff addressed some of the challenges of caring for the dementia patients, particularly, as an example – and I'll give one example – resistance to taking medications and how that was, you know,

approached – more the behavioral issues—agitation, paranoia, and refusal of taking medications. Thank you.

Laura Beck**:** Well, I suppose I should answer that. This is Laura Beck from the Eden Alternative. These are exactly the kinds of things that were addressed – the kinds of skills that would be required to deal with this sort of situation – addressed in the Dementia Beyond Drugs training. A series of techniques were provided. It's quite a long list. So I don't know that I would have time to share that right now. But, if you wanted to connect with me privately via email, I might be able to give you a little bit more detail than what I can provide you here.

But, essentially, I touched on the framework that would make it possible to, again, get to the bottom of what's going on. I mean, for one thing – let's just tease this apart a little bit. And this is in no way to pick on you and the framing of your question.

We actually start by helping people reframe how they look at "refusal." Adults technically decline. These individuals live with dementia. They are adults, and they have the right to decline their medication. Now, does that mean that efforts aren't made to get more information to get to the bottom of maybe why the decline is occurring? No. The same tools would be put into action as they would in any case when you're trying to get to the bottom of distress, concern.

So, some exploration would be done to get to the bottom of the unmet need—maybe some examination of the domains of well-being, maybe looking at what's going on in the environment when the medication is offered, maybe making sure there isn't a medical reason that the distress is taking place and that person is declining. Again, the same tools get used every time to get to the bottom of what's happening instead of just assuming that, a) somebody's being difficult, they're behaving poorly. That's incredibly dehumanizing. It's not acknowledging of what might be coming up for that individual and what might be – need to be isolated in order to figure out what to do next. There may be a very good reason why that medication is being declined.

So, yes, the employees in the nursing homes that went to the training did indeed receive information directly from Dr. Al Power, actually, that gave them the know-how and empowered them to become really good sleuths to find out why that might be taking place. I don't know if this is exactly what you wanted to hear. But, I'm assuming,

Michele, if somebody wanted to ask more questions of us, would they know how to reach us through you?

Michele Laughman: And they have – Laura, they have your email address as well on the slide.

Laura Beck: Okay. Perfect.

Leah Nguyen: Great. Thank you.

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

Please continue to hold for your next question.

Your next question comes from the line of Virginia Bache.

Virginia Bache: Yes. I have a question about the program or the project that you had. And I want to know if there was an increase in the number of staff members that were involved other than the regular staff that you have in order to make this work and function well.

Laura Beck: I want to make sure I understand the question. Would you – would – let me see if I can repeat it back to you. How about this? Let me tell you a little bit about how people participated and we'll see if that helps clarify things.

Every organization that chose to participate – if they just send staff to Dementia Beyond Drugs training, they sent two people at least. In some cases, there were three or four. If they were involved in track one, at least two people that participated in Dementia Beyond Drugs training were paired with a family member.

So, does that clarify your question in terms of an increase in staff? Help me understand better what you're asking.

Virginia Bache: So – Okay. I did – I thought that you trained all the staff in each home. But, apparently, you just trained people to go back to train other people. Is that correct?

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Laura Beck**:** What we did is we trained people and gave them the skills to go back and weave into their daily operations. So I want to be clear that they did not get a train-the-trainer experience. They were trained in skills, and they were able then to take those skills back and embed them into daily operations. And the reason why we didn't just send one person to those trainings addresses exactly, I think, what you're getting at. Is that we wanted people to feel like they weren't in it alone, that there were other members of the team there with them, and that they were prepared to help them take that information back.

Virginia Bache**:** Okay. And, so I understand…

Chris Perna**:** And – yes. And this is Chris Perna. I would just add that, typically, the people who attended the training were directors of nursing, administrators, and, in many cases, we actually had CNAs attend as well.

Virginia Bache**:** Okay. That was my next thing, was the actual hands-on staff there?

Chris Perna**:** In some cases.

Laura Beck**:** In terms of the people who participated, yes. Absolutely. We gave a list of different members of the team that would be good choices to send. And we were hoping that it would be a little bit mixed up. You know, you wouldn't want it to be just leadership that went. In some cases, a member of the leadership team like a DON and, you know, maybe somebody else from the clinical team joined that person. So, yes, it was definitely intended to meet the needs of hands-on staff, and different members of the clinical team were engaged and participating.

Virginia Bache**:** Thank you.

Leah Nguyen**:** Thank you.

Operator: Your next question comes from the line of Mary McGill.

Mary McGill**:** Hi. Thank you for taking my question. I'm interested to know two things. What skills did you train the people with – specific, you know, skills? And, also, what kind of preliminary test did you use to see if there was a shift in how the caregivers

viewed people living with dementia? Because you mentioned on one of the slides that you did a– oh, I'm looking to get it...

Laura Beck: A pre/post? A pre-/post-test?

Mary McGill: Pre- and post-test. Yes.

Laura Beck: Absolutely. Okay. So, let me tell you how that works. So there was a pre-/post-test for the Dementia Beyond Drugs training. So, obviously, when you have the pre-/post-test, the questions are the same on both, except that maybe on the post-test, there might be some place for them to make some qualitative comments. So – yes. So they came in, they sat down, they did a pre-test before they heard a single word of the content. And then they post-tested at the end of the training on the second day, because Dementia Beyond Drugs is a 2-day training.

So we showed you some data that there was a shift just from the beginning of the training to the end in terms of how they thought about people living with dementia, how they thought about dementia itself, how they thought about the kind of care they should be providing someone living with dementia, how they thought about the nature of the relationships that should be established with people living with dementia, how you felt about certain kinds of interactions. So, those are the kinds of things that we got to see a shift in, which was significant in terms of whether or not their perceptions were moving toward more of a person-directed approach. Same with the Care Partner Workshop. We did a pre- and post-test and, then, there was a followup test as well. Does that help with the testing question?

Mary McGill: Yes, that does. Thank you. And what about the...

Laura Beck: ...the skills. Yes. So, you know what I'm wondering? I can totally answer this question. But I happen to know that Dr. Power is on this call. And if it's all right with Michele, I think that he would be even stronger in answering the question than I. Are you comfortable with Dr. Power?

Michele Laughman: Laura, that's not a possibility, unfortunately.

Laura Beck: Yes, I didn't think so. I didn't think he could.

Michele Laughman**:** Yes. Sorry. I know he's on the call.

Laura Beck**:** All right. I just wanted to make it easier.

The kinds of skills include a number of different things. It includes how to perform the different kinds of audits that I told you about. For example, the – you know, when it's appropriate and how a medical audit should be looked into, how to perform an experiential audit, how to perform an environmental audit, which is very much like, Okay, something's happening, there is some kind of distress taking place. What is happening in that space? Who's in the space? What are the sounds? What are the smells? What are the visuals? What are the things happening in that space?

And looking for the common denominators to get to the root of the distress, there are many powerful stories, actually, of finding out – would have a strong reaction at a certain time of day...

Mary McGill**:** Yes.

Laura Beck: ... maybe on multiple days.

Mary McGill**:** Yes.

Laura Beck**:** So learning how to do audits effectively was part of the skill base. Communication skills, really drilling down into looking at what is communication when somebody lives with dementia, how do we redefine the way we communicate with that individual, how do we position our body, how do we use non-verbal communications skills as well as verbal communication skills.

Mary McGill**:** Yes.

Laura Beck**:** So these are just some of the things that make it possible to get to the bottom of what is that unmet need that might be arousing concern or making it hard to know how to respond to somebody who's in distress.

Mary McGill**:** Yes.

Leah Nguyen**:** Thank you.

Mary McGill**:** Thank you very much.

Chris Perna**:** Laura, I just – this is Chris. I would just add to that that for those of you who are familiar with the Hand-in-Hand curriculum that was distributed by CMS a while ago, we were asked by CMS to very directly connect our material to material that is in the Hand-in-Hand training so that people would have that crosswalk and understand how these different, you know, learning experiences can be leveraged against one another. So, we very directly referenced elements of Hand-in-Hand as we delivered our material so that people had additional resources to go back and reference in terms of, you know, how to apply them in a practical way in their day-to-day situations.

Leah Nguyen**:** Thank you.

Operator: Your next question comes from the line of Eilon Caspi. Eilon, your line is open. That question's been withdrawn.

Your next question comes from the line of Heather Saposnick.

Heather Saposnick**:** Hi. I have a question. How did – when – I'm curious with the decrease in the uses of antipsychotic, and it was 5.83 percent. How was that gleamed just from the usage of this program? Was there other things that were taken into account like the usage of the doctor, the usage of the pharmacist, and the overall CMS regulations that the decrease of antipsychotics needed to be put in place? So, I'm just curious, you know, how did you gleam that – the decrease of antipsychotic medication?

Laura Beck**:** Totally reasonable question. And I do want to be really, really clear here, again, that we are in no way implying that this data is a direct result of our program taking place in those states. It – what we did – we engaged Dr. Amy Elliott in taking a look at the Nursing Home Compare data. And, you know, the timing of when that data is released is a little bit tricky in terms of aligning it with the exact moment that you start your project versus the exact moment that you end it. So we certainly did the best we could with that given what was available at the time. And, so, what Dr. Elliott did was she went in and just explored the data in the states that were participating versus the states that were not during the grant period itself.

So, let me rephrase that. I apologize. That's incorrect. So, for example, in the five states—let's just say we're talking about Georgia, for one, which was one of the states. What she did was look at the nursing homes that participated versus the ones that did not. And that is how the data was assessed essentially. So, the aggregate across the states that did participate was a 5.83-percent decrease in the use of antipsychotic medications. Does that mean that happened because they were in our project? We'll never know. But we were curious to see what was happening in the bigger picture while we were doing our thing. Does that make sense?

Heather Saposnick: Yes. I did have a question to piggyback. Am I allowed to ask another question or no?

Leah Nguyen: Sure.

Heather Saposnick: Yes. I just have another question with that. And thank you for explaining that. It makes sense. In terms of the training that you provided, what is the ongoing training after, you know, Eden Alternative left these facilities? What is the ongoing training that these facilities will be getting?

Laura Beck: The ongoing training is what they were given in terms of materials. They were given the crosswalk with the Hand-in-Hand tool kit, for one thing.

Heather Saposnick: Yes.

Laura Beck: They were given some information about how to take these tools back and implement. There were materials akin to an action plan so that they were offered very specific steps that they could take, and that they were encouraged to take to put things into action. They also walked away with a participant workbook that was chockfull of takeaway exercises. In fact, the Dementia Beyond Drugs training, for example, is split up into separate sections, and every section would have takeaway exercises. These are the things that you should be specifically taking back to initiate these ideas and these skills in your organization.

In the case of the Care Partner Workshop, because that ends up being – it's actually an online offering, and it was split up into eight sessions. So that means that between sessions, teams had an opportunity to actually take specific suggestions in terms of what they should be applying that week back and put it into action and try it on. Then they

would come back at the end of that week and talk about what their experience was of trying it on. And then, they learned new skills, and then they do it all over again. So they were actually, like, implementing in the moment because it was drawn out over 8 weeks.

I mean, the other thing is that, you know, the organizations that participated got a copy of the book *Dementia Beyond Drugs* so that they could go back to it and reference it and use some of the information that was there. The training itself was based on the book in part. So, that also served as additional support.

Does that help?

Heather Saposnick**:** Yes. No, that helps. And the people who were a part of this, the professionals from these facilities that came – did they also have access to speak with trainers through the Eden Alternative besides the workbooks and the, you know… outside of it, were they able to consult with a professional on the telephone?

Laura Beck**:** We did….

Leah Nguyen**:** Thank you. I think we need to move on to the next question. But, maybe you could email our speaker from Eden if you have additional questions.

Heather Saposnick**:** Sure. Thank you.

Leah Nguyen**:** All right. Thank you.

Operator: Your next question comes from the line of Judith Ellis.

Judith Ellis**:** Hi. This is Judith Ellis from Avalere Health. My question is, again, for the Eden Alternative team. Thanks for the presentation. And this question is sort of in line with the spirit of the previous questions asked. I'm curious what was your sense of the organizational culture from the institutions of these participants? Because I'm sure many of – as I am sure you know and, you know, the call attendees are aware, things like high turnover in this industry as well as limited staff time and then, again, the organizational culture and whether there is that willingness to essentially promote champions or champion leaders to – whether through word of mouth or through formal mechanisms, promote quality improvement is really dependent on those – on multiple

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factors and kind of the support of the leadership. So, I'd be curious if there is an – if you have a sense of that based on your experience with this program and if there's an opportunity to collect data around that in the future.

Laura Beck: Okay. That was a lot. I just want to make – I was trying to follow every piece of what you're asking, and I just want to get to the kernel of it.

Judith Ellis: Sure.

Laura Beck: Let me reflect that back to you. I think what you're asking me is, Do I have a sense of what the organizational culture was in the homes that participated? Was that the first part of the question?

Judith Ellis: I guess, yes, in the spirit of ensuring that, you know, whatever training was gained by these individuals that, really, when they go back to their organizations, how do you know that they will be promoted to share those learnings in their environment?

Laura Beck: Well, this is the challenge. The challenge is, indeed, you know, can we send a spy in and make sure that they're actually doing what they're supposed to be doing? We can only hope that they are. We set them up with what they need to be successful. We give them a couple of different ways to engage during the grant project so that they can feel supported. And we hope that they indeed take that back.

Now, I can tell you, having been at some of the events – I actually taught one of them. I'm one of the co-facilitators of the Care Partner Workshop. With the Dementia Beyond Drugs trainings, which were on site and in person, I had the opportunity to be present and see kind of the spirit that these organizations brought in. I can tell you that the organizations there were hungry. They really wanted stuff. They really wanted to be able to go back and put these things into action. They were excited about having the opportunity. In terms of, will that happen and how will they do it? Will they stay committed to it? That remains to be seen.

One of the things that we teach, obviously, through the project because it is about being focused on culture change ideals, and implementing person-directed care is a big part of both trainings, is you've got to change your culture. This is not going to work if you just go in and you think about it like a program. What we teach is that you must eliminate programmatic thinking as a way to proceed whenever you're trying to make a change.

Instead, it's a process. It's a way of life. It isn't about adding to what you do, but it's about changing what you're doing already and trying something new. So, giving them the seeds of – you need to have conversations.

You need to have learning circles, as we call them, to explore and engage with people to see their willingness to be a part of the solution. They need to understand they have to be part of the solution, that there isn't going to be somebody leading the program for them. This is the kiss of death.

So, yes, that is embedded in the training that we did, that this is a process that is team-oriented. And the whole care partnership piece that I shared with you is absolutely at the core of that. Without that sense of care partnership and it being about teamwork—and that means every member of the team, regardless of their role: family member, employee, or otherwise—if they don't have the education, if they don't have the opportunity to work together collaboratively, you're not going to be successful in trying to effect change.

The other thing I just want to throw out there – and I'm so delighted to see the women who are on here talking about QAPI – is that you'll have organizations think about culture change as a project I'm doing over here, and then I'm doing this QAPI project over here. This is the huge mistake that we make, and this is exactly, in part, what this project tried to teach people.

Look for opportunities to collapse and integrate what you're doing to support your success. Culture change is a QAPI opportunity—bottom line. And these were conversations that did come up in the course of our training. And I hope I didn't go off-course. Is that what you're looking for?

Judith Ellis: Yes. Thank you.

Leah Nguyen: Thank you.

Laura Beck: Okay.

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

Rosene, your line is open.

Rosene Dunkle**:** Hi. How do you obtain the training Dementia Beyond Drugs?

Laura Beck**:** Okay. Michele, am I allowed to answer this?

Michele Laughman**:** You could refer to a website, or...

Laura Beck**:** Okay.

Michele Laughman: ... if they need to reach out to Al Power or...

Chris Perna**:** Yes.

Laura Beck**:** Thank you. I just want to make sure we're doing this by the book. You can reach out to our website, which is www.edenalt.org.

Rosene Dunkle**:** Okay.

Laura Beck**:** There – you know, if you don't see exactly what you're looking for there, there will be ways to connect with people who can help you out.

Rosene Dunkle**:** Okay. Thank you.

Chris Perna**:** You can – yes. You can just email Laura or myself, and we'll be happy to provide any information you're looking for.

Rosene Dunkle**:** Okay.

Leah Nguyen**:** Thank you.

Operator: Your next question comes from the line of Eilon Caspi. Eilon, your line is open.

And there are no more questions at this time.

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 include an announcement in the MLN Connects when these are available.

On slide 46 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. Presenters, please hold.

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