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
June 15, 2017
1:30 pm ET

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 Call on the National Partnership to Improve Dementia Care and Quality Assurance and Performance Improvement or QAPI. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, learn about appropriate assessment and evaluation for the accurate diagnosis of schizophrenia and other mental disorders. Also, find out about the work of the Quality Innovation Network, Quality Improvement Organization and how their efforts align with the National Partnership and QAPI. Additionally, CMS experts share updates on the progress of the National Partnership and QAPI. A question-and-answer session follows the presentation.

Before we get started, I have a couple of announcements.

You received a link to the presentation for today's call in previous registration emails. You can download the presentation from the following URL—go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Finally, this call is being recorded and transcribed.

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. I'm going to get right into it. And I'd like to introduce Dr. Susan Levy, a medical director and consultant. As Leah mentioned, Dr. Levy will provide

information about the appropriate assessment and evaluation for the accurate diagnosis of schizophrenia and other mental disorders. Susan, I turn it over to you.

Accurate Diagnosis of Schizophrenia and Other Mental Disorders

Dr. Susan Levy: All right. Thank you very much, Michele. Anyway, I'm glad that you all are able to listen in today as we talk a little more about, gee, as I was thinking during this, the Partnership to Improve Dementia Care is – was launched back in, you know, 2012, and we've made a lot of progress since then but continue to have some bumps in the road and need to – for ongoing clarification of issues related to the diagnosis and management of our nursing home residents.

I do have here a disclosure slide of some of the things that I do. I currently am the immediate past president for AMDA. I am still active as a facility medical director living here now in Sussex County, Delaware and do some consulting work with Linked Senior and the Maryland/Virginia QIO, which is Health Quality Innovators. So just wanted to make sure you were aware of that.

And, thought we'd kind of just jump right into things. Let's talk a little bit about where we are and what's been going on. I mean, I think one the confusions about – that we've somehow gotten into around the diagnosis is making sure that we separate in our minds that there are the requirements and the guidance that we have about how we're supposed to take care of and provide good care for nursing home residents, and then we have measures. And they're not – they link together, but they don't totally describe exactly what, you know, some individuals have said, because, you know, in the guidance, it says you can use these drugs for certain indications if they are indeed appropriate and that's the only option for them. But that's not in the measure.

But, you know, we have to think about what – how do we set up measures? And you can start coming up with all sorts of exclusions, which you do. But, then, it becomes more difficult to actually create any kind of meaningful measure. So, I think, you know, it is important to understand that there is the guidance in terms of what your survey will be on, and there's also the measures that we're doing to look – so that you can look at your performance over time as well as compare yourself to other facilities.

So, I think we're all familiar, there's both a long-stay and a short-stay measure. We've kind of put up there on one of your slides a summary of a long-stay measure is, as it's

been defined. And, I think, where we start to get into the meat of some of this has to do with some of the exclusion criteria.

And so, you know, certainly there are exclusions for people who are not going to be counted in this measure for long-stay residents. And you also – for the short-stay residents, but, I really just put up the long-stay resident measure here. And in that case, it's residents with schizophrenia, Tourette's syndrome, and Huntington's disease. And just as a reminder to everyone, these significant mental health disorders and other conditions are relatively rare conditions that we see in the – in our population. So, I think that that's also important for the provider to appreciate, that these are relatively uncommon conditions compared to, if you will, dementia, which is so prevalent in our nursing home resident population.

So, let's talk a little bit about schizophrenia since that seems to be particularly an area of concern about, you know, how do we accurately diagnose patients with schizophrenia when they are in our nursing homes? So, again, I think some of what happened is people thought, "Well, maybe these patients are really schizophrenic, so if we change the diagnosis to schizophrenia, you know, the – we'll have a little bit of difference in how the quality measures are. They'll be excluded." And, so, how should we deal with this?

Well, you know, obviously, you know, we're not here to – we're trying to measure what's true. So we certainly do not want to be changing or making diagnoses in patients who really may not meet diagnostic criteria for those issues. And so, a little bit of, I think, what you sometimes may have heard in the field or you would hear people ask the question is, "Well, you know, is this patient schizophrenic?"

Well, certainly, to make any diagnosis, you've got to follow the appropriate care process. And that's certainly outlined in regulations. It's certainly the basic way that we all practice medicine, whether it's a physician or other clinician, is we go through a process of recognition assessment. Then we make the diagnosis. And then, monitoring, of course – actually, treatment first and then monitoring.

So, we don't work backwards. We don't work from this patient's on a certain medication, therefore they must have a certain diagnosis. And I think that's where maybe there's been some confusion of trying to back in from a medication that a

patient is taking or that we have prescribed and then trying to say, well, do they have a diagnosis that's not really present? So, again, if you follow the care process, you won't be mislabeling patients. And as we know, there are dangers and risks and harms in mislabeling patients with any diagnosis when that's not actually their true diagnosis.

So some of the concerns were coming out of the field and, I think, as a number of the professional organizations began to hear about these issues, it really was not – it was bothersome because we know this is not the way that you provide care for patients. It certainly isn't the way you diagnose mental health disorders. You don't go from the drug to the diagnosis. You go from the diagnosis to the management and then ongoing monitoring the patient for ongoing need.

So, I think that's a lot of what you see from the issue with the slide around the joint summary statement that then came as a result of several calls with some of the major stakeholders. I think AHCA was the initial one to jump in and coordinate the calls. But there are a number of organizations that were involved initially and over the course of several months until we actually were able to come up with a joint statement. And I have a link there, which is actually to the AMDA website, the Society for Post-Acute and Long-Term Care, which will take you to the actual details of the joint statement. I would say most, if not all, of the supporting organization that are listed on the next slide probably have also have it posted somewhere on their organization website.

But, as you can see from the list, basically, all the major stakeholders in the diagnosis, management, and treatment of patients were really involved. And I think everyone concurred that all of the clinicians really should be working towards making sure patients are appropriately diagnosed and appropriately treated. So I think that's certainly is a pretty comprehensive list.

You know, just to kind of summarize what's in the statement, again, what I already emphasized is that, particularly schizophrenia, is uncommon in older adults. It is not typically a disease that develops late in life. It can, but it's fairly rare.
So the diagnosis of new onset schizophrenia in a post-acute and long-term care setting should really be made by someone who is qualified to make that diagnosis, has had some type of mental health training, and using what are current diagnostic criteria as the basis for that decision, although recognizing, if you will, always the gold standard is

often the clinician determination or the specialist determination of what the patient's diagnosis is.

Again, the diagnosis should not be strictly just based on symptoms, but the symptoms that are present – you go through a differential diagnosis for those symptoms and then determine whether or not the patient actually meets diagnostic criteria. So, again, the symptoms themselves are many causes for the types of symptoms you may see in schizophrenia. So we need to go through an appropriate differential diagnosis for that. And we'll talk a little more about that in a minute or so.

Other comments in the joint statement were certainly that we need to be careful about not labeling patients with diagnoses just to justify the medications or other treatments. And just to pause, I mean, diagnostic error is becoming recognized as probably one of the major safety concerns that we face today. And we've seen similar examples with other diseases, someone getting mislabeled as a diabetic and then somehow ending up on sliding scale insulin and having bad adverse outcomes from hypoglycemia.

So, this is a problem not just with dementia, behavioral disorders, and mental health disorders, but it is a problem throughout that we have to be very careful that we are following the appropriate care process and diagnostic process. And we continue to look for information, re-evaluate information as it comes in to make sure that our diagnoses are always accurate because we can put patients certainly at very high risk.

You know, one of the other comments from the joint statement is that, you know, we do recognize that there are patients with dementia who have the behavioral and psychologic symptoms of dementia who may indeed benefit from the use of medications. We think that's a small group. We think that's typically patients who do have the harder psychotic-type features, although not all psychotic symptoms necessarily warrant treatment. It has to do with the severity and how they interfere with the patient's well-being.

So I think, again, we need to recognize – and that's even in the guidance, is that you have to go through the appropriate process and certainly should be showing evidence except in a severe emergency that you've had efforts to attempt non-pharmacologic interventions before using, frankly, any medication, not just antipsychotics.

So, let's talk about some of the other primary mental health and substance abuse disorders that we certainly can see and can present with overlapping symptoms. So we certainly know there's the bipolar disorders, major depression that can occur also with psychosis, the schizophrenia, schizoaffective disorders. People can have a brief psychotic disorder. And we also know that, certainly, drug abuse and intoxication withdrawal syndromes can create symptoms of thought disorder that often can lead to a – potentially a misdiagnosis. We need to be very careful that we think about all these things as we're looking at patients who are exhibiting signs and symptoms of a thought disorder.

As far as the other medical conditions that we need to be cognizant of, we already know that dementia itself can be associated with psychotic features. It's one of the symptoms that we certainly can see. And not just Alzheimer's disease but other causes of dementia often can exhibit these same types of symptoms as can patients with vascular dementia or just having had a stroke, patients with brain tumors, other infectious problems that can, you know, certainly cause – particularly brain infectious problems that may cause these types of symptoms.

And some of the other things, and again, this is all part of our differential, why we sometimes when we see these symptoms, why we're doing lab tests to look for other nutritional deficiencies like B12 deficiency. Do we look for evidence of other systemic illness, thyroid disease, other things that may create these symptoms and that certainly warrant medical treatment and not be addressed as a primary psychiatric disorder.

So – and certain medications can affect the brain and can certainly bring on many of these symptoms. And we all have had examples, I'm sure, of where we have started patients on a variety of medications that can cross the blood–brain barrier and have seen adverse side effects that looked very much like a thought disorder, like psychotic symptoms, and, of course, are often under-recognized delirium, particularly we see in patients who have acute medical illness but, for many causes, that can certainly can occur.

What I put up there next is actually a flow chart. It comes from a guideline that was developed that I think is still very solid from the American Geriatric Society—I think there are other guidelines out there that certainly support this same process—about how to approach the management of psychotic disorders and other neuropsychiatric

symptoms in patients, you know, with dementia but, really, how we look at these symptoms and how we approach reaching a diagnosis. And then, again, remembering it's after we diagnose, we intervene with treatment and then ongoing monitoring of the patient's response to that treatment.

So, you know, again we have to have a stepwise framework – a stepwise process and develop a framework about how we think about this. And, so, I certainly encourage you to refer to that full guideline also for some additional guidance.

Okay. So let's talk about back again a little bit to the primary mental health disorders, in particular psychosis and, in particular, schizophrenia. And, I think just, you know, recapping a little bit on what are some of the criteria. You know, certainly key to the diagnosis are the psychotic symptoms we often think of, the hallucinations, delusions that occur. And so that is, you know, often something that we need to be, you know, very familiar with.

But, again, you can have these psychotic symptoms with other mental health disorders such, and it may – particularly manifestations of bipolar disorder, with schizoaffective disorders and with just separate delusional disorders. But, again, these are your primary mental health disorders.

We've already talked about how we can see these symptoms as part of a medical illness and that again we always need to think even in someone who has a diagnosis for mental health disorder if their symptoms are worsening, if there's something else medically going on.

And it's also important, and we'll show in the next slide, all of this can overlap. As people age and patients with mental health disorders are – you know, do age, they may also develop dementia. And so we may have to tease out the overlap between their mental health disorder as well as dementia and potentially even superimposed delirium when they may have an acute medical illness. So it's not always cut and dry. But I think we have to go through a clear, methodical process to help tease this out and then to help us then with coming up with a diagnosis and then subsequent management.

So what do we know about mental health disorders in nursing home residents? Typically, we know that these are patients that tend to be admitted to nursing homes at a younger age. And we also know that if they're admitted, even if initially for a short

stay, they may actually end up – have a higher chance of becoming a long-stay resident. They may have an established diagnosis. They have an acute medical problem. Their mental health problems may be managed with current medications, and they may be stable. However, their symptoms can also exacerbate with the stress and acute medical illness.

So, I think one of the keys is that we really need to continue to question diagnoses and make sure that we do everything we can to certainly get as much information from the proceeding stay when we can about what the actual cause was, what the symptom was, what were the behaviors that we were seeing and certainly not inaccurately label patients just because of the medications that they take.

Okay. If we're going to have a – so we have patients that are going to come in to our facilities that have established mental health problems. We need to understand those problems. We need to do – get a good history just like we do for any other problem they have. If they're diabetic and come to us, we try to find out how long they've had it, what treatments they've been on in the past, what's worked, what hasn't worked. We should do the same thing with the patient with an established, you know, primary mental health disorder.

But what happens if the patient now begins to exhibit new symptoms in our facilities? How do we approach those patients? And, again, you know, I think what we do tend to see is that we sometimes aren't as accurate. We're sometimes are a little sloppy on our initial psychosocial assessment. Or sometimes we just frankly don't have the information.

And – but, it is important that we really do take our time to make sure that we ask those questions about prior mental health history that will help us understand – establish a better baseline for our nursing home residents. So, I think that certainly is important.

When we talk about many of these diseases, these are diseases that typically develop earlier in life. So, usually, the history will reflect that many of these symptoms developed quite earlier in the patient's life. They may have been able to remain functional for a long period of time. But often you'll get a history of either prior psychiatric hospitalizations or prior psychiatric treatments when you actually make the

effort to try to drill down and obtain the history. And that will then change your – that history information is so key in your establishing a diagnosis.

Okay. So some of the other things – obviously, look at old records. You may not have access to everything, but it may be important to try to obtain old records, to talk to prior providers and see what other information you – may be available as you try to paint this picture for the resident who's now living with you. And I think those are all key, is to really try to obtain that prior information.

Okay. If you really are at a point where, you know, there really is no prior history of psychiatric treatment and this seems to be the – you know, the first time the patient's exhibiting symptoms and are making you think that they have one of these mental health disorders, you know, I think, well, more commonly when we're seeing these symptoms, what we're going to really end up with is a diagnosis that – actually, what we're seeing is early symptoms of dementia. Because that's certainly the much more common and prevalent disease than development of a new mental health problem such as schizophrenia. So the picture kind of gets reversed there, is that we go with what's the more prevalent disease in this setting, which certainly would be dementia.

Okay. And just remember, how do we do a thorough diagnostic evaluation? Obviously, history, history, history is really key. Then we follow up with the medical evaluation, the patient – the examination of the patient, mental status assessment of the patient, blood work and, when needed, further psychiatric evaluation from a mental health professional to help us further come up with an accurate diagnosis.

And then, again, back to the same concept. You know, treatment comes after we make the diagnosis for the most part, except in maybe severe emergencies when we have to intervene before our diagnosis is 100 percent clear. So, you know, I think it's important that we have open discussions about the various treatment options, that we make sure whatever treatments that we're proposing or evaluations that we're proposing are certainly – are always in keeping with the patient's advanced care planning and wishes.

So – and then, again, you know, we go into monitoring after we have made a decision to treat and we monitor and see what the effect of our interventions were. And again, sometimes, the clinical course will help further shed light on what the actual diagnosis has been. And, again, ongoing assessment and re-assessment. If medications are

started, do they need to be continued? And, again, the process that I think we are all increasingly familiar with in terms of reassessing needs for medication.

Okay. So, what are some of the things we can do to better approach behavioral health in nursing homes? And what you've seen is a lot of facilities that have been very successful – and it's not that we want to split up behavioral health from medical problems. It's all together. That's why we really feel that these patients often benefit from a true interdisciplinary team approach.

So, when we talk about the health realms, we really are talking about including a lot of members of the interdisciplinary team, that we really look at models of medical and behavioral co-management and that we see where there – if there are mental health providers that provide services, that they're working together with the attending staff, the MPs, the PAs in the facility, and working with the medical director in the facility to really make sure that we're working well together as a team, making sure that there's someone who manages the diagnosis list and who's actually making the diagnosis if you're – certainly if you have mental health providers and then refining that over time.

And, I think, many of us have the experience – we go in and there's multiple mental health diagnoses and we're kind of – we'd like to get the actual much more specific diagnosis for the patient. Also discussions about who's actually managing psychotropic medications, who's doing the monitoring, who's doing the oversight. And is that the primary attendings? Is it the mental health attendings? How are they working collaboratively? And, of course, the result –the important result – role of the consultant pharmacist who kind of helps particularly keep us on track with any necessary gradual dose reductions, any additional information we need about the medications or their potential adverse effects. And again, of course, as this also leads into the QA and A process and our QAPI process, is making sure that all psychotropic medication use is really included into that process in our building.

When I talk about the practitioners, I have a slide here that shows the overlap and that really there should be good coordination between the medical director, the primary attendings, and the mental health practitioners. And all of those roles should work together for better recognition assessment, diagnosis, treatment, and monitoring of the patient.

So, I think, with that, those are, you know, basically my comments. I think that the key is that we should accurately diagnose our patients, that we need to recognize that certainly dementia is much more prevalent in our nursing home population than mental health disorders. We all recognize there are facilities that maybe do have patients – more patients of mental health disorders. But we know that and they'll be identifying that in their – as we move forward and discuss the services that they provide.

Michele Laughman: Thank you very much, Dr. Levy.

Next up will be Ms. Kaylie Doyle, Program Manager at Telligen, and Ms. Kelly O'Neill, a Program Manager at Stratis Health. Kaylie and Kelly will be discussing the National Nursing Home Quality Care Collaborative. Kelly?

National Nursing Home Quality Care Collaborative

Kelly O'Neill: Thank you, Michele. And hi, everyone. This is Kelly O'Neill with the Quality Innovation Network National Coordinating Center team. Thank you for the opportunity to talk with you today about the collaboration and the collaborative work that the QIN-QIOs or the Quality Improvement Organizations are doing with nursing homes across the country. I'll cover a few slides and then turn it over to my colleague, Kaylie Doyle.

Today we will talk about QIO areas of focus with nursing homes, provide some updates on the National Nursing Home Quality Care Collaborative, share examples of how the QIO work supports and aligns with the good work of the National Partnership and QAPI initiatives, and then talk about some of the tools and resources that are publicly available through the QIO program.

So Kaylie and I are part of the Quality Innovation Network National Coordinating Center or the QIN NCC. Telligen holds the contract for the National Coordinating Center, which supports a national network of 14 QIN-QIOs as they implement the National Quality Initiatives of the QIO program. The National Coordinating Center provides analytic and technical assistance, helps spread promising practices and innovative approaches, and facilitates opportunities for a peer-to-peer learning and connection.

The next slide shows a listing and map of the 14 QIN-QIOs. And if you're not familiar with your QIN-QIO, you can Google "QIO program" and you'll find a locator and contact information. Or you can reach out to me or Kaylie and we can help you as well.

So I know that many of you are already working with your QIN-QIO as almost 80 percent of nursing homes across the country have signed on as part of the National Nursing Home Quality Care Collaborative in each state. So these collaboratives are led by the QIOs. And the broad focus of the collaboratives is to improve quality of resident-centered care and safety.

And they focus on national areas of importance such as reducing inappropriate use of antipsychotic medications, implementation of antibiotic stewardship, and implementation of QA and A and QAPI to improve systems of care. So QIOs provide quality improvement support for nursing homes at no charge to the nursing homes.

I wanted to mention that one measure used in the collaborative is the Quality Measure Composite Score, which is comprised of 13 publicly reported long-stay quality measures that represent processes and interrelated systems of care within the long-term care setting. And if you're not familiar with the Composite Score, you can contact your QIO for more information.

QIOs have been focusing on aligning their efforts with important state-level partners and stakeholders so that they coordinate and collaborate wherever possible to support nursing homes. For example, many QIOs provide leadership for various nursing home initiatives in their state, such as the National Partnership to Improve Dementia Care; the National Nursing Home Quality Improvement Campaign, formerly known as Advancing Excellence; there are state culture change coalitions, antibiotic stewardship groups, etc. So they've helped stakeholders in coming together to support nursing homes. QIOs have been working with their state survey agencies, trade and professional organizations and advocacy groups, and other partners to support QAPI implementation and other components of the 2016 Reform of Requirements for Long-Term Care Facilities reg. So many of the QIO focus areas align nicely with the regulation, for example, QAPI, infection control, and behavioral health.

Last year QIOs recruited a cohort of nursing homes in their state collaboratives to submit data into the CDC National Healthcare Safety Network, or NHSN, in order to

establish a national Clostridium difficile infection, or CDIF or CDI, baseline for nursing homes. While we know a fair amount about the burden of CDI in our country, the data source is primarily from hospitals, and it is important to us to know what the burden actually looks like in nursing homes.

So this cohort of homes is collecting data from March through December of 2017 to determine a baseline for nursing homes for the first time. QIOs will work with these homes to submit – support their submission of data into NHSN, and they'll also with all participants in the collaborative to prevent and manage C. difficile infections and to implement antibiotic stewardship.

So as I've mentioned, close to 80 percent of nursing homes across the nation are working with their QIOs in the collaborative—so, about 12,217 nursing homes. Of those, about 2,630 are one-star homes. And the cohort that I just mentioned working to submit C. difficile infection data into NHSN is about 2,341 homes.

So I will show you two data slides. The first slide shows progress on the National Quality Measure Composite Score – so the 13 measures combined from November 2015 through February of 2017. So there are four different lines on this graph. They represent the group of collaborative homes working with the QIOs. One line represents all homes in the country. Another line represents nursing homes not participating in the QIO-led collaborative. And then the last line show – the dashed line shows homes participating in the collaborative since early on – early 2015.

So you can see that all the groups have lowered or improved their composite score. Lower is better. But homes participating in the collaborative are doing better than homes that are not part of the collaborative.

And this slide shows progress – the next slide shows progress on the long-stay antipsychotic measure. So you can see that nursing homes supported by QIOs and other national and state partners and stakeholders such as those Dr. Levy mentioned have – the nursing homes have really done a great job in reducing the percent of long-stay residents receiving antipsychotic medications. So, with that, I'll turn it over to Kaylie.

Kaylie Doyle: Thanks, Kelly. And hi, everyone. This is Kaylie Doyle from Telligen. And I'll be reviewing a few of the resources developed by the National Coordinating Center that

are available to you on the QIO program website as well as through your local Quality Improvement Organization.

So the first resource that we want to share is the National Nursing Home Quality Care Collaborative Change Package. The Change Package focuses on successful practices of high-performing nursing homes. And high-performing nursing homes were identified through review of an array of different nursing home quality data, and then site visits were conducted at 10 homes across the country to identify themes that emerged regarding how they approached quality and carried out their work. And the intent was to share and spread best practices learned from these homes with nursing homes across the country. So the practices in the Change Package reflect how the leaders and direct care staff at these sites shared and described their efforts.

So the Change Package includes a menu of strategies or change concepts and actionable items that any nursing home can choose from for the purpose of improving resident quality of life and quality of care. And the strategies that are included in the Change Package are: Lead with a sense of purpose, recruit and retain quality staff, connect with residents in a celebration of their lives, nourish teamwork and communication, be a continuous learning organization, provide exceptional compassionate clinical care that treats the whole person, and construct solid business practices that support your purpose.

So in addition to the Change Package and actionable items that are related to each of the strategies I just listed, there's also a success story template. And this is intended to encourage nursing homes to document and share success stories as they work through improvement initiatives. And it also includes several health care improvement bundles. So, as many of you are likely aware, a bundle is a proven approach that helps providers deliver the best possible care for residents and patients. It's a structured way to improve the process of care and outcomes. And it includes a set of evidence-based practices that, when you perform them collectively, they've proven to improve outcomes.

So we have a slide listing – the bundles included in the Change Package are avoidance of unnecessary antipsychotic medications in nursing home residents living with dementia, encourage nursing home residents' mobility, prevent health care acquired infections, prevent C. difficile infections in nursing home residents, and a QAPI bundle. So all of

these are included in that Change Package and, as I said, available on the QIO program website.

So another resource in addition to the Change Package that we'd like to make you aware of is a set of online training sessions. These training sessions were developed by the National Coordinating Center in collaboration with several experts and partners in the field. Slide 42 is showing the screenshot of the training sessions' introduction page as well as it includes a link to where you can access the resource on the QIO program website.

So there are six training sessions that we've developed. The topics when you go to the website will be listed on the left-hand side of the webpage. But I'll also read them. So the session topics are communication strategies to promote quality and safety using TeamSTEPPS®; exploring antibiotics and their role in fighting bacterial infections; antibiotic resistance; antibiotic stewardship; C. difficile Part One, which provides the clinical overview; and, lastly, C. difficile Part Two, which includes strategies to prevent, track, and monitor C. difficile. And so we developed the sessions with the purpose of providing information, tools, and resources to nursing home staff and stakeholders to enhance their understanding and knowledge of stewardship and C. difficile prevention.

And there's a variety of ways that the resources can be utilized. We do encourage you to engage your local Quality Improvement Organization to assist you in customizing the training sessions to meet your needs and goals.

But some of the items for our nursing home leaders to consider and decide when you review the sessions are which components of the sessions will be helpful for yourself as a nursing home leader and which to include in educating other staff, how you can use the material during education sessions or use it as a self-study, and how to customize the content.

So all the content in the sessions is optional and can be adapted. You can print each session or keep it on the webpage and project it and, also, how to best provide the training over time. So the intent when we developed these sessions was not to review all the content all at once. So you can think about what's the best timing and how – and flow of using that content for your needs.

And, so each training session has a standard outline or structure. They include the – so, I listed how each session is structured. There's a welcome; objectives; how you can use this session; an orientation, which is similar to a detailed table of contents; topic information; interactive activities and scenarios, including discussion questions; informational handouts; take-home messages; links to additional resources. And there also is an opportunity to apply for a nursing continuing education credit and/or a certificate of participation for all of the six sessions.

And that is our overview of some of the resources available to you all. Thanks for having us and listening to our presentation. I have our contact information on this slide, and we're happy to answer any questions or connect you with your local Quality Improvement Organization in your state.

National Partnership & QAPI Updates

Michele Laughman: Thank you, Kaylie and Kelly. I appreciate your time and participation in today's call.

Before we begin the Q&A portion of our call, I'd like to share some updates related to the National Partnership. And following that, Debbie Lyons will speak briefly about the implementation of Phase Two of the final rule and the rollout of the new survey process. She'll also cover the evaluation results from our last MLN National Provider Call in March and touch on QAPI.

Recent partnership data as of quarter four of 2016 was shared in April. And we have now seen a 33.2-percent reduction in the rate of antipsychotic use in long-stay nursing home residents. The national prevalence of antipsychotic medication use is now 16 percent.

In the coming months, we will be holding regional calls with the state dementia care coalitions across the country. These calls will occur in July and August, and they will be held on a bi-annual basis moving forward, as they had been in the past.

Following the calls, we plan to develop a resource containing best practice strategies that are shared. This will be an update to a similar resource that was shared in 2015. The resource will be sent through email correspondence as well as being added to our

resource repository on the National Nursing Home Quality Improvement Campaign website. And that website is www.nhqualitycampaign.org.

Additionally, we want to let you know that the website to access the Hand-in-Hand training series has changed. We received a good number of enquiries about its new location. And the easiest way to access Hand-in-Hand is through the CMS Surveyor Training website. Hand-in-Hand is listed as a provider training and it can be found by completing a course catalog search. So when you type in "Hand-in-Hand," it will take you to the training. It is no longer available in hard copy, but it can still be downloaded for free. We are also reviewing the materials to determine which modules will need to be updated and will begin the revision process soon.

I'm going to now turn it over to Debbie Lyons.

Debbie Lyons: Thanks, Michele. Hello, everyone. My name is Debbie Lyons. Together with my colleague Cathleen Lawrence we lead the Division of Nursing Home efforts around Nursing Home Quality Assurance and Performance Improvement and Adverse Events.

So let me start with an update on some of the changes that are coming along. We've been very busy at CMS. As you are aware, CMS issued the final rule for the Reform of the Long-Term Care requirements last November 28th, 2016. You should also be aware that CMS made the decision to use a three-phase approach to implement this rule. Phase One, which was implemented last November 28th, 2016, consisted of requirements which required little to no additional guidance. Phase Two changes are to be implemented this upcoming November 28th, 2017. And, lastly, Phase Three changes will be implemented on November 28th, 2019.

The Phase Two changes, which we'll implement this November, include additional regulations, revised and/or expanded guidance, and new F-tag numbering system. The new regulations and associated guidance is going through clearance and will be released in advance sometime this summer along with surveyor training, which will be available to the public.

Now I'll share some information about the new survey process you may have heard of. CMS will be rolling out a new survey process to coincide with the Phase Two

implementation this November. The decision to create a new process was the result of years of data gathering, study, and testing of survey processes.

It combines the best of the Quality Indicator Survey, or QIS, and the traditional paper-based survey. The new survey process will be a computer-based system. The new survey consists of two parts. The first part is sample selection, which is based on observation, interview, and record review. And the second part is further investigation of the issues identified and facility tasks.

And then this survey will be rolled out with the new F-tags and the Phase Two guidance, as I said, in November. All is scheduled to be launched on November 28th, 2017. For additional information, we have uploaded a slide deck with notes on the new long-term care survey process. You can find this by going to our website at www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html. Boy, that was a mouthful. And if you didn't catch all of that, I'll give you an email box address in just a second so you can send us a request for the link. It will also be posted in the transcript of this slide session.

We will be hosting an MLN Connects Call on Tuesday, July 25th, from 1:30 to 3:00 pm to give an overview of the Phase Two regulatory and guidance changes and the new survey process. So stay tuned for that information.

Additionally, if you have questions about the rule, its implementation, or the new survey process, please send your enquiries to nhsurveydevelopment@cms.hhs.gov. Let me just add a disclaimer, however. If your question relates to guidance which is not in effect yet and still in development, we may not be able to discuss details of that guidance until it's released in November. We recommend that you review the implementation table within the final rule and any preamble language, which provides rationale for some of the regulations changes.

Now let me briefly review the results of your evaluation of our last call, which was in March. We ended up having 1,390 registrants for the March call. The overall satisfaction rate was 86.79 percent, which was better than the overall satisfaction rate from 2016, which averaged 82.56 percent. So we were pretty pleased with that.

When you receive the evaluation, please complete it and please feel free to expand on what topics would make these calls more meaningful to you. Your evaluation of the content – first, we'd like to thank you for your comments. As I said, you know, your feedback is very helpful and assists us in determining what topics we're going to cover in upcoming calls. So please complete your evaluation when you get it.

We received many comments about practical and useful tools that can assist you both in the work of the partnership and with QAPI. There were some comments such as, "We would like a session completely devoted to QAPI," and others which said it would be – it would have been more helpful to hear more in-depth information about the dementia project.

We strive to find interesting, relevant topics and presenters for each call. Our goal is to provide you with both practical and effective techniques and approaches which are generally publicly available and have data that supports their effectiveness along with an emphasis on a systems approach or, you know, how to use QAPI approaches. We will continue to search out the best practices and effective tools to assist you in your important work with the partnership. If you have any questions, please send those along with your comments.

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 nursing home QAPI or adverse events, send us an email at nhqapi@cms.hhs.gov.

Thank you, everyone, for participating in today's MLN Connects Call. I'm going to turn it over to Leah and our moderator for the question-and-answer session. Thank you.

Question and Answer Session

Leah Nguyen: Thank you, Debbie. We will now take your questions. As a reminder, this call is being recorded and transcribed. Once your line is open, state your name and organization and then ask your question. If you have more than one question, press star, one to get back into the queue, and we will address additional questions as time permits. All right, Dorothy, we are ready for our first caller.

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.

Your first question comes from the line of Pamela Heckman.

Pamela Heckman: Hi, this is Pam Heckman with the New Hampshire QIN-QIO. Is it possible for you to slowly repeat the website for the slide deck that was referred to by Deb Lyons? It would be helpful if I could get it now.

Debbie Lyons: Hi. This is Deb. Yes, I can. And if it is helpful, it's – well, I'll just go ahead and read it. It's www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html.

Leah Nguyen: This is Leah, the moderator. I was just going to say I'll go ahead and email that out to everyone. I'm going to send an email as soon as the call ends with a link to the evaluation to everyone who registered, and I'll include this URL and the other resource mailboxes that Debbie mentioned as well.

Debbie Lyons: Thank you.

Pamela Heckman: All right. Thank you.

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.

Your next question comes from Carmen Bowman.

Carmen Bowman: Hi. This question is for maybe Michele. I think you're the lead on the dementia-focused care survey. Just curious if those survey forms will be changed anytime soon to correlate with new tag numbers? And, then, also curious if the content will change or not. I want to give you all kudos. The content is excellent. The practices that you've included under your Part Four Dementia Care and Related Practices are just very individualized and culture change–centered. However, I don't see any of that same language in the new regulation or the new draft guidance. So I was also curious about that, please. Thank you.

Michele Laughman: Hi, Carmen. It's Michele. We – actually, we have updated the tools somewhat from the versions that were released. So there have been some changes. I will be making additional revisions based on the new F-tag number system. And, so, that will be coming. But, as far as the content, we look at the content every year and make some tweaks and revisions. So, that will definitely be looked at as well.

Carmen Bowman: Thank you.

Operator: There are no further questions at this time. I will turn the call back over to you, Leah.

Leah Nguyen: Thank you. Dorothy, can we prompt just one more time to see if anyone else wants to ask a question?

Operator: Absolutely. As a reminder, 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.

And you have a followup question from the line of Carmen Bowman.

Carmen Bowman: Hi again. So, Michele and anyone on the line, just any further thoughts on why the current new – pardon me – the new draft guidance is much shorter regarding the dementia care than it was prior? It seems to me that the prior guidance really covered a lot of best practices. It was nice to see. And now they're not listed in the current draft form of interpretive guidance. Any comments on that?

Michele Laughman: Since the guidance hasn't been released, we can't really comment on that at this time, Carmen.

Carmen Bowman: Okay. And then, I just had one culture change comment, if anyone is interested. I wanted to thank Dr. Levy for all her great information and just point out that as a physician, you know, physicians make rounds. She mentioned that – or you mentioned that, Dr. Levy. And I know that in this movement, everyone, we've talked a lot about purposeful rounds and doing rounds more often. I just wanted to put in a plug for non-institutional language. Rounds are exactly what physicians do predominantly in a hospital.

And, so, if you're interested in working on your culture through language, which costs no money, you might consider different language. Some homes are calling it proactive checking in with residence. Whenever we use the word "proactive," we just kind of remind ourselves and anyone hearing it that, really, the wave of health – the future of health care is to be more proactive to prevent falls and prevent incontinence and who knows what else we can prevent. So, I just would challenge everyone to think about words you use and does it reflect hospital or home. Thanks so much.

Additional Information

Leah Nguyen: Thank you.

An audio recording and transcript of today's call will be posted to the MLN Connects Call website. See slide 51 of the presentation for a link to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary.

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 conference call. Presenters, please hold.

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