



National Partnership to Improve Dementia Care and QAPI Call

Moderated by: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. 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 & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this Medicare Learning Network call on the National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement, or QAPI.

During this call, learn how to work with physicians to ensure compliance with the new psychotropic medication prescribing requirements for long-term care facilities. Also, find out how nursing homes are putting the new QAPI requirements into practice. 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 get started, you received a link to the presentation in your confirmation email. These materials are available at the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, I'd like to turn the call over to Michele Laughman, a Health Insurance Specialist within the Division of Nursing Homes at CMS.

Presentation

Michele Laughman: Thank you, Leah. And welcome, everyone.

I would now like to introduce Dr. Arif Nazir, Associate Clinical Professor of Family and Geriatric Medicine at the University of Louisville and Chief Medical Officer at Signature HealthCARE. Dr. Nazir will discuss the role of physicians in appropriate psychotropic prescribing.

Dr. Nazir, I turn it over to you.

Working with Physicians to Ensure Compliance with the New Psychotropic Prescribing Requirements

Dr. Arif Nazir: Thank you, Michele, so much. Are you able to hear me well?

Leah Nguyen: Yes, we can.

Dr. Arif Nazir: Excellent. Thank you. I really appreciate the opportunity. Just so everybody knows, I am on slide 4 at this point. And we'll be moving on from here on your slide decks.

First of all, the disclaimer is that I am – I do not claim to be an expert in the field, as I would say that no other medical challenge has humbled me more as a clinician than addressing the needs of our patients with



dementia and having behavioral and psychological symptoms. I think it's one of the most complicated but fascinating aspects of care I provide personally. But, you know, more and more I have been able to provide such care, I have understood the value of the team and the role of the team. So physicians are no more than a team member in this very important team that has to provide this care.

So having said that, I'm just going to share with you some of my own experiences and some of the literature which I find very fascinating and helpful in addressing this and also will give you my perspective as a Chief Medical Officer how I see that I can empower our physicians and our whole organization to provide better care around this issue.

All right. Next slide, please. Sorry. Next – moving on to the next slide. So the objectives are that we are going to describe prevalence of behaviors among residents living in – with dementia in our facilities. We will list some serious side effects of pharmacological options we have currently. We will focus on the role of physician leaders and their expertise in appropriate psychotropic prescribing. And we will also talk about impact of the facility culture and staff competence for attaining the goal of safe psychotropic prescribing and safe care around BPSD.

So I always like to think about cases that have taught me personally. And I'll just try to bring a case forth. Think about quality assurance and performance improvement meeting at a facility known as Happy Fellows. It's a three-star urban facility with 125 beds. Psychotropic rates are recognized to be above the State average at this point in this building. At the QAPI meeting, which is being led by the DON, she announces that we will cut psychotropic rates by 50 percent. A committee is formed and Dr. Smith was the medical director invited. The DON and the social director – services director are other members of the – of this team now. So what do you think, if you look at the next slide, is the best initial advice? Of course, you know, answers can be gray. But what is the best initial advice, in your opinion, Dr. Smith can provide at this point to this committee?

So either it is the first option, which is the – to utilize the pharmacy consultant better so the consultant can provide a taper schedule on all residents unless contraindicated; or to do a facility assessment of – to understand what is the quality of care that is being delivered around BPSD and to really understand what the competence of the team members, including the front-line staff, is at this point; or to have a hospital psychiatrist to provide consulting services at the facility; or maybe build a multisensory room by the next quarter and set that as a goal. So let's just keep those – some of those options in mind and just look at some of the background information which may be helpful to address this case.

So as you know, there is a high prevalence of patients with Alzheimer's dementia in our country, and the majority of them, 5.3 out of the 5.5 million, are 65 and older, and many of them are going to reside in our skilled facilities. And the startling number is, you like it or not, almost 90 percent or more of them are going to be – at some point, be having issues with behavioral and psychological symptoms, or BPSD, of dementia. And so at some point, either as a caregiver or as a loved one, we will be required to address this issue.

And, you know, there's a huge slew of – if you go to slide 9, please. There's a lot of symptoms or signs that are encompassed in BPSD. So, I think we really need to make sure, when we refer to a BPSD, we are not just putting everything under the realm of agitation or aggression, which sometimes does happen where, because of a lack of competence, physicians or nurse practitioners or nurses, you know, may just address every other disorder under – symptom under aggression or agitation. So, it really serves everyone well if we can be more



descriptive of one – what the issue is. And there – these are just some of the examples that you – the patient – patients may display during their disease process.

Slide 10. These BPSD really have consequences, right? I mean, first of all, the moment our patients start exhibiting BPSD, you know that they are having a quality of life issue. We all may be distressed from those BPSD but, guess what, you know, the person who's more distressed from those BPSD are our patients themselves. So I think that's the most important point.

And also, the moment our patients start exhibiting BPSD, we know that their cognition starts declining at a steeper rate. And as it does happen, the more burden does it put on the caregivers. So it just becomes a whole chaotic scenario because everybody's kind of suffering at a higher rate now. And then, this also leads to nursing home placement at a high rate. And studies now show that people or patients who face BPSD actually are at a higher risk of dying. And of course, all of those factors then eventually lead to higher cost of care for the health system. So we are talking about a real issue. It's not just a cosmetic issue. It really, really is something with consequences.

So how do we address a BPSD in nursing homes? And again, this is no rocket science, right? I mean, there're only three approaches: either you use an approach without a medicine, or you use an approach with a medicine, or you use an approach which includes both, right? But how do you decide which approach? And I think it'll be pretty safe to go in that order – that you should always start with a nonpharmacological approach and then you may or may not add a pharmacologic approach to make a combo out of that. And in some situations, you may end up only being using a pharmacologic approach. But I would say, pretty much in almost all cases, there is some real value for using a nonpharmacological approach, and we'll talk a little bit about that.

But I think whatever approach you use has to be very, very much well-grounded into a person-centered or patient-centered approach. It's not about what suits you well or what suits the staff well. It's about what is going to suit your patient well. And we just cannot figure that out until we really, really understand the patient's disease, the reason behind it, and why they're manifesting the problems.

So there is just no one person on the team who can claim to be able to do that as a physician who – or a nurse practitioner who only visits the patient for a few minutes every other week just cannot make any claim on understanding the BPSD. It has to be a whole interdisciplinary approach to this. Everybody on the team, including the dietitian, the therapist, the nurses, and very, very importantly, the CNAs, and the families who spend lot of time with the patient have to bring their intel and their understanding of the issues before one can move on forward with addressing it. I think the one big thing we can do is to avoid rushing to a solution. I think a lot more time needs to be invested in understanding the problem.

Slide 12 is, like, a very, very important thing which I learned from Dr. Levenson's article which was recently published in JAMDA, which goes through a very comprehensive approach in addressing BPSD. It's that it's not – it's no different from understanding, let's say, angina. I mean, we need to get more information, right? We just cannot go and put the patient into the cath lab and do a catheterization and put a couple of stents into them and hope they will be fine.



We really need to understand what are the scope of the problem and then decide on the interventions. And then, once you decide on the intervention, that's just the beginning, right? You still have to make sure that the intervention indeed was the right intervention. And then you have to go back and monitor and adjust your intervention based on the patient's response. So really, addressing BPSD is no different than addressing a complex other – any other complex medical problem. You have to go through a process of diagnosis – history taking, diagnosis, and then management.

Slide 13. You know, I just wanted to share again from some good work done by Dr. Levenson, you know, some of the key broad – key principles that you can find useful, you know, as a physician or an interdisciplinary team in addressing BPSD. We just have to address – we all have to acknowledge that every single patient we see on a given day is very different from the last patient we saw. And, you know, I see sometimes, as a physician, I tend to start developing some biases. For example, if I saw five patients with peptic ulcer disease which led to GI bleeding for my patient, that kind of plays in my mind. And the next five patients I see with GI bleed, I'm just going to assume that they have a peptic ulcer disease.

So, it's very common for clinicians, for health care givers, for family members of patients to start developing these biases. And, you know, one of the common biases which I think you all can relate well to is that we all tend to think about UTIs the moment we start thinking about BPSD, and right away we want to do a UA and put somebody on antibiotic. I think that is not the right approach, because that kind of takes us away from an evidence-based, patient-centered approach. So, we really have to acknowledge that we have to try as much as humanly possible to not think about our previous biases and address every patient scenario as a new scenario.

And what makes things a little bit more complicated, particularly in geriatrics in general but also in BPSD, that most of the time the symptoms you are going to get are not going to be very simple symptoms or specific symptoms, right? I mean, we may just see a patient who's falling more or somebody who's just not, you know, answering the way he used to answer, right? I mean, they may not have a fever; they may not have a rash for us to look at. But most of these symptoms are very nonspecific. And that makes, of course, this whole aspect of treating BPSD a little bit tougher.

But, again, that does not give us the reason to act prematurely and act rash – in a rash fashion, right? I mean, that is exactly the reason why we need to proceed with caution and in an interdisciplinary fashion because there is some serious risk. If we try to use an intervention which is premature, we may lead to some extra risk. Think about diagnosing somebody with a behavior with UTI just because they had dirty urine or, you know, they had asymptomatic bacteriuria. Now you've put them on antibiotic and they end up with *C. diff* and hospitalization and they maybe die. I mean, how many cases we have in the health care system currently just because of our premature intervention. So, I think we have to keep caution when we are trying to address BPSD.

So we really need to understand exactly what changed in the patient's story that they started exhibiting the BPSD because, more often than not, the BPSD are really a call for help. They are basically a call for some need our patients have, you know, and they may be thirsty and they may be in pain and so forth. So, I think it's really important for the front-line staff to help physicians understand and the other key team members understand what changed in the patient's life that may be causing them to exhibit.



And I would say that is the most crucial step. I think if you do not feel confident with that step, you need to continue to dig deeper and you should keep your urge from treating people prematurely. It's very important to be considering broad differential diagnoses, particularly when you're seeing geriatric patients in general, but around BPSD.

Slide 14 just gives you an overview of some of the differential – common differential diagnoses I consider when I'm thinking about behaviors. I mean, there're medical causes as – which lead to delirium. There're medical conditions, our medications, right? I mean, how many medications by themselves can lead to behaviors and delirium? And it's a very common iatrogenic cause of BPSD is by – is medication side effects. Of course, our patients may have true psychiatric unless – which either were not diagnosed or were in remission for a while, and now they're seeing an exacerbation of their psychosis or other chronic mental illness. Similarly, anxiety, depression, etc. can play a role in that.

It's very important to remember that people – patients who have dementia, again, very high risk of having neurocognitive disorders. So, we just need to make – you know, there may just not be another reason. It's just that the dementia during its course is leading to the BPSD.

And then, of course, the next slide goes through this – it's the environment and personnel. So slide 15 kind of lists, you know, just simple changes in personnel around our patients in the facilities who are used to a certain caregiver or a certain schedule. Or maybe we – they have a new caregiver or an agency nurse who just does not know the patient well and now are rushing through the care may just be enough to induce a behavior – not making – and just not paying attention to the patient and not communicating to them. Even though the patient may have dementia, it helps a lot for us to explain on a given day why we're doing what we're doing. Suddenly surprising the resident is another common – where a patient may be startled and exhibit behaviors. And then, noisy environment, poor lighting, rooms that are just not very comfortable, or patients just being alone or scared are some of the other reasons – environmental reasons.

So, some of the key broad interventions that we can do which I think would apply to most of our patients when we're thinking about managing BPSD. As a physician, I always think about these five or six things right off the bat as I'm trying to diagnose the issue – that I'm also thinking some of those things. I need to know what the vitals on my patients are. Is there a sepsis that is involved at this point? Has I – have I missed any rash on their back? Is there an ulcer which has popped up? So I think – I can't even tell you how many patients with behaviors eventually were found to have an infection which was not a UTI but was a bad ulcer or an ear infection or a bad sinus infection. So, all those common things that happen to us on a given day would be happening to our residents, but they're just not able to describe them. And they rarely read the textbooks. So, you don't – let's not blame them for that. It's just that they are going to present themselves in a very nonspecific way.

Pain – there's enough data that is coming out that patients with osteoarthritis were not complaining of pain, because they just can't communicate, may be exhibiting it as behaviors. So, it's very important to consider pain management in our patients. And using simple medications like acetaminophen as a first-line agent is not a bad approach.



Very, very important, one of my top favorite things to do when I'm seeing patients – new patients in buildings is really work on their list of diagnoses they have, right? I mean, some of – sometimes our patients have 25 diagnoses lists, right? And then you look – go through the list. Some of them are contradictory even.

So, it's a really important role a physician can play or a medical expert can play is help the building with cleaning up these diagnoses when they're seeing patients. All those organic brain syndromes and encephalopathies and delirium that happened 2 years ago and organic brain syndrome, you know, all these terms that you don't even use anymore. Somebody who had a GI bleed 3 years ago – that diagnosis is on the chart too. Somebody who had a pneumonia 6 months ago, and that's still on the chart. All those things create noise, and a patient who's going through BPSD can really benefit from getting rid of – cancelling some of that extra noise because that kind of confuses everybody who is involved in that team.

So, it's a great service we as physicians can do is to make sure that – figure out what is true and what's not true and also try to figure out what kind of dementia our patient has. I mean, has there been investigation in the past? Because if somebody has a dementia of Lewy body disease, their management may be very different as opposed to somebody who has a frontal lobe dementia. So, I think that is an important job for us to do is really to get to the truth of the matter in regards to what information is available in the chart.

And again, second important topic for me and my favorite topic as a geriatrician – always, always look at the medication list. There – honestly, other than a few pills which our patients need forever and ever and ever, there are not 15, 20 pills which our patients will need forever. And let me give you some examples around, of course, the proton – the famous proton pump inhibitors. Do our patients need proton pump inhibitors forever? Do our patients need antidepressants forever, right? Some of them may do, actually. But, you know, many of them may not have needed antidepressants. And all these medications when combined together may be causing a lot of interactions which may then be leading to more BPSD or premature BPSD behaviors for our patients. So think about that.

Very, very, very important for us to take our time and spend energy in doing very meaningful advanced care planning. This leads into that story about the patient which I was talking about earlier on. We have to really understand why our patients are where we are – where they are and what do they expect from us. And it may not just be the patient who would explain that to us. It will be the family members who're really engaged. Maybe our front-line staff would be able to add that understanding for us.

And the good thing is that, starting 2016, we do have – as physicians and nurse practitioners and PAs, we are able to bill for some of this time too. So, I think the system has empowered us clinicians to spend more time to really understand what patients know about their problems and their diseases and, God forbid, if there were some urgency – some emergency, how would they want us to help them. I think having that discussion when there's no crisis and when there's no chaos can go a long way in helping us when there's indeed chaos.

So, I would really highly challenge everybody who's on the call is think about does your facility or does your health care system enable you to do proactive advanced care planning process. And if the answer is no, I would highly recommend that this is one of the most proven, evidence-based strategies which can improve to – the quality of care you provide to your patients and the families. You should definitely invest in that.



Slide 17. There are many individualized approaches that work in some scenarios. These are not the broad strategies that are going to work for everyone. So – but the slide 17 goes through – lists some of these strategies that work for individual patients. So, it might be worth your time to explore if music therapy or light therapy or aromatherapy may work for one or some of your patients.

Again, I would not recommend that you throw this as a chicken – a kitchen sink to everybody, because I think that will be wasting some key resources. But really, some of these strategies have been shown to prove for certain patients and may be worthwhile trying for some of your patients who you're not been able to help so far, and they may be helped through these. Again, I am – I – it's not in the scope of this presentation for me to go into detail of this. But I just want to put it out there.

It's very important, in slide 18, is that we actively monitor BPSD. I would recommend against going through what the DON in this case suggested. Or it's like "Oh, we're going to take every single patient and cut their pills by half." I think that is not the right approach to take in my mind. I think the de-prescribing should be a by-product of your care. It should not be end-all purpose, right? So – and if you take that approach, you absolutely will get to de-prescribing. But I think that we have to do our homework first and we have to just make sure that de-prescribing is part of our intervention and not the intervention.

We do have to continue to look at our plans and modify our plans for care based on more information we are getting from the families. So we have to continue to modify our care plan based on more information we are getting. And if – of course, if we do add some medication to address the BPSD, our monitoring has to get more intense because now we have to look for side effects, right? We just cannot continue medications if they are not either having any effect or if they are having side effects. Either way, you need to monitor and know that. And even if they are helping, you need to know they're helping so that you can continue them and document that clearly.

Role of consultants, like psychiatric consultant, is very important. But they need to be part – integrated as a part of the team. You just cannot assign the whole BPSD management to a psychiatrist and move on. I think there just has to be one more team member who will help you with that. But we just cannot rely on one consultant to address. Otherwise, you could lead to some premature interventions, as we discussed before.

Slide 19. We talked – we know that antipsychotic options exist and psychotropic options exist. But unfortunately, there're no U.S. FDA-approved options at this point for BPSD. We do know that there's credible literature that mortality risk increases both with conventional and atypical antipsychotic agents, including pneumonia, stroke, and death. So, you know, we really, really want to choose our patients who need to be on these medications. And when we do use these medications, then these have to be discussed really well with the patient and the family members and there has to be goal-setting done: when we're going to stop these medications, and how we're going to monitor them, and so forth.

Slide 20, you know, again, just shows that there is benefit from these medications. There's, you know, a systematic review that shows that. But they always come at – with a price. So, you just need to know what the price is. And that discussion has to happen before we institute these medications. So, everybody needs to be on the same page when we – if we do plan to use psychotropic agents.



Slide 21. I always like to share that with my learners that, you know, managing behaviors is not any different than managing a pressure ulcer, right? Unless you address the whole health care issue for that resident, that ulcer is not getting better. Similarly, for the behavior, you just cannot address the behavior by itself. You have to address the whole patient. You need to be very clear in your definition and documentation what you're trying to address. You need to make sure that the family and the patient know exactly what you're doing and why you're doing it. You will not – medication will not help unless the etiology – for example, in the ulcer case, the pressure has to be relieved, right? If you don't address that pressure issue, then the patient is not going to get better.

Multipronged interventions are needed. And once you are done with that, once that resident is better, just expect that there's going to be a recurrence. So, prevention is really, really important, right? You just can't stop the care. You have to continue because once you have behavior, you know that the risk for recurrent behavior is going to be high. And once the medications have done the job, you do not continue the medications on ulcers that have healed, right? You stop the medication. So, I mean, you should always be considering the same thing. If you do use psychotropics, then you should always think about when you can stop them.

So let's go back to our case on slide 22. So what would be the best approach? And in this case, I would use the option 2 because I think we really, really need to understand for this case what happens in this building. What is the staff competence? What kind of care are we providing? Before we jump on an answer, a quick fix to the problem of the building, we really need to understand what our – as a team, our capabilities are to provide BPSD management.

And on slide 23, there are some recommended plans for improving behavior at your facility. And it again just kind of repeats what we already talked about: that a person-centered approach is a culture of your facility. It requires staff competence. It requires focus on other issues like polypharmacy, use of INTERACT® for better communication. So, you just can't improve psychotropic care by itself with all the rest of the issues not being managed also. So, it really is part of the whole culture.

You need a team. It's a team approach. Physicians by themselves is not – by themselves cannot really address this issue. Documenting, assessing, and monitoring is key. Detailed history to plan nonpharmacological measures is very important. And then when you use psychotropics, we have to make sure that everybody's educated about their use—we monitor them well. And once the benefit and the goal is achieved, then we should talk about monitoring and cutting them off. And then, psychiatrists can be a part of the team. But we need to make sure that we address all the issues before we consult a consultant on our team.

Next slide. I'm – again, I'm not going to be – claim to be an expert in the changes. Recently, this came through CMS regarding psychotropic use. Some of the key things which I know is that the definition for psychotropic has been expanded to a drug that affects brain activities and antipsychotics, antidepressants, antianxiety, hypnotics are included in there. We do have a new limit on using PRN psychotropic for 14 days. And any extension has to be based on prescriber rationale only after evaluation of the resident by the prescriber. So, I think we just have to remember these new requirements.

Slides 25 and 26 I'm just going to go through quickly. It's about some of the changes in the F tags around the psychotropic use. And then, gradual dose reduction, again, we have to make sure that we do certain attempts



to gradually cut down the doses of these medications. Again, I would not just make this the intervention. It needs to be done in the scope of the whole holistic patient-centered approach by the team rather than just by an isolated attempt to cut pills.

And this – slide 27 just shows you that AMDA, American Medical Directors Association or Society of Post-Acute Long-Term Care Medicine, does have a great guideline which you can use for the whole team to help you with that.

And just the last minute or so, I'm going to share with you that, as a chief medical officer, I'm happy to be a part of an organization which does believe in the holistic approach of addressing the BPSD issue. And on slide 28, you can see that we are using a framework of staff training, quality-of-life initiatives, medical director role, and then specialty teams to address this issue of person-centered BPSD.

Slide 29 just shows some of the expectations we have from our medical directors in our organization. We talk openly about this issue. We provide education through articles and webinars. We are promoting a lot for 2018, specifically for medical directors to be present at the resident side to do the education for the interdisciplinary team around many different issues, but also psychotropic use and addressing behaviors. We now are putting a lot of focus on polypharmacy and advanced care planning.

And we are also promoting for our medical directors to be part of the Society of Post-Acute Long-Term Care Medicine for professional development. And the key thing which we are going to work on in 2018 is to make sure that our medical directors have the data so that they can see where they stand region- or company-wide and Nation- or statewide in regards to their prescribing of psychotropic medications so they can compare their performance in that.

And the last piece is Signature HealthCARE in slide 30 and subsequent slides. I just shared with you some of the holistic approaches which we are using as an organization to improve customer service.

So on slide 31 is the – our compassion, attentiveness, respect, and empathy approach, which is a training for staff to become the most empathetic staff towards the patient. Similarly, our – Signature has, you know, 46 facilities which are registered through The Eden Registry, which is, of course, a culture change movement. And we are increasing facilities which are certified at levels – higher levels in this program.

Slide 33 just kind of shares that all of our residents are encouraged to have resident vacations. And many of our residents have gone to Disney World and have gone to New York recently. So just promoting focus on high quality of life, not just, you know, using an approach whenever there's a crisis but, basically, as a culture, you have to promote initiatives which are conducive to high quality of life.

We have Senior Olympics every year where our residents participate, again, a very, very person-centered approach to make sure that our residents are receiving holistic, person-centered care proactively.

On slide 36, we do have specialty teams where we have highly trained behavioral specialists who can provide consultative care for patients who have behaviors. And also, we have a call center now where our staff can call and get help on issues around BPSD where they feel that they're just not able to handle the situation themselves.



So the last slide, slide 37, is just a summary. And I'll just reemphasize some of those things – important things. It's that we all acknowledge that BPSD are tough for our residents and our patients. But they're also tough on the staff and the caregivers. We all have to come together as a team. Particularly the physicians and medical directors have a big role to play to make sure that we address these issues holistically and not just by addressing using premature intervention.

We have to focus on our facility culture proactively, and we have to focus on competence for our staff that lays the foundation of excellent BPSD care in our facility. We cannot just understate the value of detailed history and assessments before we jump on to management. And then if we do use antipsychotics, which sometimes are needed, we need to make sure that they are used in the framework of very, very close monitoring.

So that is my presentation. I hope some of you found it useful. And I think there is going to be some Q&A session in the end. So, I look forward to any comments or any questions. Thank you, Michele.

Putting the New QAPI Requirements into Practice

Michele Laughman: Thank you, Dr. Nazir.

Next up will be Ms. Deb Lyons, a health insurance specialist and co-lead for the QAPI program here at CMS; Ms. Debra Fournier, Chief Operations Officer of the Maine Veterans' Homes; and Ms. Sarah Schumann, operator at Brookside Inn Skilled Nursing Facility in Colorado. These three speakers will share information on the new QAPI requirements, specifically putting these new requirements into practice. Go ahead, Deb.

Debra Lyons: Okay. Thanks, Michele. Hi, everyone. Thank you for joining today's call. My name is Debra Lyons. And please pardon my froggy voice. I wanted to share with you some of the key changes to the Quality Assurance and Performance Improvement, or QAPI, requirements, which went into effect this past November 28th. Please turn to slide 40 in your slide deck.

As most of you know, former F tag 520, which was related to Quality Assessment and Assurance, or QAA, had the QAPI requirements incorporated into it and was divided into four F tags.

F tag 865 addresses the requirement for facilities to have a QAPI plan. Guidance at F865 explains that a QAPI plan describes the process for conducting QAA activities, which primarily are identifying and correcting quality deficiencies.

F tag 866 addresses QAPI QAA data collection and monitoring, which has a Phase 3 implementation date, which means that this F tag, in its entirety, becomes effective on November 28th of 2019.

F tag 867 addresses QAPI and QAA improvement activities, which means that facilities must identify and correct their own quality deficiencies or issues.

And lastly, F tag 868 addresses the QAA Committee. New requirements which went into effect on this past November 28th are that the committee must be composed of the director of nurses, the medical director or designee, and at least three other staff, one of whom must be the administrator, owner, board member, or



other person in a leadership role. As you see in the slide, the requirements for the infection preventionist has a Phase 3 implementation date and would not go into effect until November 28th of 2019.

And now, I'm going to turn it over to Debra Fournier from Maine Veterans' Homes, who will share how her facility began implementation of the requirements for QAPI. Take it away, Deb.

Debra Fournier: Thank you, Deb. And let me just extend my thanks to the folks at CMS for inviting me to participate on the call today. I was asked to do so from the perspective of an organization that has more than one nursing facility, so from that central perspective as well as a multilevel component. And so I'd like to start my presentation today on slide 41 just putting some context and the background of who we are.

So Maine Veterans' Homes is an independent nonprofit organization caring for Maine veterans and their families. We have five skilled nursing care centers that range from 40 to 120 beds each. We have six core values. But really, in our culture, excellence, team, and lead-the-way drive the direction of our programming.

One of our strategic priorities is hardwiring excellence. And we've chosen to use the American Health Care Association's Quality Award Program to assist us in doing this. It's a three-step process that uses the Malcolm Baldrige quality standards as they incorporated into their program. And so we've used that along with the Performance Excellence Framework to guide us in our Quality Assurance and Performance Improvement plan and program development.

On slide 42, I thought it was important to really take a step back and talk about, well, where did we start? And for us, structure was very important. And, you know, we had in place, 7 years ago when I came on board to the organization, the usual QAA committees that are required of the nursing homes. And they were in place and we were doing fairly well.

We decided, at that time, to apply for the Bronze Level Quality Award through American Health Care Association. And during this first step in that journey, we took a look at our organizational profile. So you might be thinking, "Well, what's that all about?" So during this phase, we looked at: What services did we offer in our facilities? Who were our key stakeholders and customers? What were their needs and how did we find out about those needs? What did we have for personnel and what were their capabilities and their education or capacity? We looked at our resources: What kinds of equipment did we have? What were our competitive advantages and disadvantages? And we looked along those lines with: Did we have a Quality Assurance and Performance Improvement model? And then lastly, what were those key measures that we relied upon to help us gauge how we were doing with either meeting or exceeding the needs of our customers? So that was really where we began.

Next steps, we formed a corporate steering committee that we fondly refer to as our QAPI Workgroup. We have senior leaders from each of our six homes (because we also have a freestanding assisted living facility) and our central office department heads and staff on this committee. We started by putting a charter in place for the workgroup. And we were charged with developing and implementing the corporate-wide QAPI plan. We also were asked to put together and develop and implement a results dashboard. We – our end goal really was to develop this data-driven decisionmaking culture where we could be transparent in our opportunities for identifying and improving and with what – with – really, without blame.



And then lastly on this slide, it was important to us to create those structures that included the governing body oversight of our Quality Assurance and Performance Improvement program and what those reporting structures would look like.

So on slide 43, I'm – I wanted to just talk a little bit about the tools that we used to help us develop our Quality Assurance and Performance Improvement plan and program. And really, we started with using the tools from CMS that they had published and were using during the pilot project around QAPI. We used the QAPI Self-Assessment Tool, and we still use that today. Every year, we evaluate how we're doing in that, what's our progress like, and where are our gaps. And we used the QAPI at a Glance Toolkit to help us really develop and frame out our quality assurance plan.

The model on the right of the slide 43 is our quality model that we developed during that process. And you can see on the slide it demonstrates that, really, who do we care for and who are our key customers—our veterans and our families—and the five areas that our Quality Assurance and Performance Improvement plan needs to take into consideration. So clinical outcomes, compliance, safety, the customer experience, and the value we offer are all components of our QAPI plan. In addition to that, we used the Performance Excellence Framework, as I mentioned earlier, and then developed our own prioritization and key measure matrix tool so that we could make more-informed intentional decisions around quality improvement.

On slide 44, there are some additional tools listed that we used. I'd like to highlight a few things that I think were very important to us putting into practice. And one is the standardized QAPI education. You know, with five, six organizations that we were rolling this out in, we felt it was really critical that key elements of our plan and program were presented to all workforce members and that it was standardized in our approach.

We – I mentioned earlier that we were charged to put together this results dashboard. And as we looked at those key measures, we began to identify and we did identify 13 measures that we felt represented the needs of the business and the needs of the people that we serve and put that in a visual graphic display for all workforce members to see how we were doing with performance improvement and the areas that we needed to monitor.

We had in place already the Plan-Do-Check-Act methodology. But we wanted to refine that a bit more. So, on slide 44, you see in front of you the circle of success model from Advancing Excellence, which we were a part of at that time. And so we combined both of those and we used this process for improvement.

We standardized our Performance Improvement Project tools—very important, again, across the organization—and conducted education on those, as well as root cause analysis. We developed recently a new prioritization matrix tool and a data monitoring matrix tool that helps us be more intentional with our – analyzing our opportunities and decisionmaking, honestly.

And then, lastly, we started, in every one of our staff town hall meetings that the CEO and myself conduct, quality as a key topic. And so, we present the dashboard results. We talk about our quality priorities. We share how we're doing with improvement and some of those challenges or successes.

On slide 45, I just wanted to highlight a few of the challenges that we've experienced. Hopefully, they resonate with some of you. Education, you know, I mentioned standardizing the education and rolling that out. Well, we



– all of us know that it takes more than once when you’re hearing new ideas, new concepts, new processes or procedures. And so, you know, I have this mantra where it takes 21 times to learn new behaviors and really hardwire it. So, as we rolled out PIPs and root cause analysis, we knew that we needed to do more education than just one.

Data analysis is an area that we have found ourselves struggling a bit. We have a few key staff that feel comfortable in data analytics. But the majority do not. And so, we’ve had to spend time helping them with data analysis and learning how to use the tools and present data in a way that helps them to understand what the data is telling us.

With our Performance Improvement Projects, or PIPs, as we fondly call them, having a facilitator that has the key facilitation skills is also really critical. And we found that out and had to go back and re-educate people on how to facilitate and use the tools. What was really key—and I know my colleague will share her experience with this—is identifying a champion. It’s really critical that during those – when you’re implementing PIP projects, you have a champion that can inspire and motivate and bring the resources to the table to keep the group going. And then, I firmly believe that the success of every PIP is around leadership. Leadership, leadership, leadership is our mantra in that it really takes that leadership support, the leadership vision, and then the champion and the team to achieve the result that you’re looking for.

And then, the importance of the improvement mindset—you know, I often listen to presentations by Dr. David Gifford. And, you know, I recall fondly how he said, you know, we have to think differently. If we’re going to say, well, we’re going to reduce antipsychotic drug use, but, well, it’s not really possible. Well, that’s not the mindset that we need to go in to Performance Improvement Projects. We need to think about that we can do it and, as a team, figure out how. So, that’s been a little bit of a challenge, turning that mindset around in the last 6 years.

And then, some of our successes – we’ve had some wonderful successes. And, you know, we have best-in-class resident and family satisfaction results conducted by an outside vendor. We – all of our facilities have the Silver Level Quality Award, demonstrating achievement in quality. And 2 years ago, one of our facilities actually achieved the Gold Level of Quality Award from American Health Care Association, 1 of only 34 in the country since the program’s inception in 1996. Four of our five nursing facilities are at a Five Star level. And this year, we were recently recognized as one of the best places to work in Maine.

On slide 46, there’s also a graphical display of one of our measures on our dashboard. And that’s the Long-Stay Residents Antipsychotic Drug Usage. And I just wanted to show this because we have been really working diligently on this measure, working as a team. We have some PIP projects in place. And this is the type of graphical information and data that we firmly believe the staff need in their hands so that they can be effective too in doing their job. So we were very pleased to see the trends and to see our results. At this time, we’re ahead of our goal. We’re ahead of State and national benchmarks. And so we plan to continue that journey.

On slide 47, I would just say next steps for us have been conducting the facility assessment and figuring out how to link QAPI and our plan that we currently have and program along with our emergency operations program and then continuing to hardwire the systems that we need to sustain excellence and decrease variability. And then lastly – and I know sometimes, in the rush of trying to get everything done and all the



new requirements, we forget that we need to take the time to celebrate and acknowledge the achievements and successes.

So that – those are my slides for today. And at this time, I'd like to turn it over to my colleague, Sarah.

Sarah Schumann: Thank you very much, Deb, for that great information. And our – in our community, we took several steps very similar to Deb's community.

So on slide 49, Brookside Inn is an independently owned Skilled Nursing Facility in Colorado where we serve 120 residents. And we've been fortunate that we've had a commitment to quality since its inception. We've had monthly QAA meetings with the involvement of the board, the administrator, director of nursing. We've been also a recipient of the Silver Award through American Health Care Association. And I also highly recommend this process because it really creates a pathway for the QAPI process in our communities. It was a wonderful experience to do this program. And we're also a CMS Five-Star quality rating.

Going to the next slide, we've had an evolution of the QAPI process. And so one thing that we've had a lot of success in our community is when there is a new initiative by CMS or a new regulatory change, we identify a champion, someone in our community who could lead that. And a good quality of a champion that I've seen is someone who has desire. And then it's our responsibility as management to give that individual the education. So we had one individual really steer and pioneer the QAPI plan for our organization, and it was utilizing the CMS requirements. And then, we reviewed it as a team together.

So one thing that's changed a lot in our world as Skilled Nursing Facility operators is we have so much data. There is so much data, whether it's electronic medical records, CMS Five Star Compare, for those of you who are members of American Health Care Association, Long-Term Care Trend TrackerSM. There is so much data about us. And the question is, now, what do we do with all this information?

So for 6 years, we've been fortunate that we've had a QAPI dashboard. On this dashboard, we state our goals for each initiative. What's the score we want to have for each of the quality measures? And if we start to vary from those goals, how we do get back to our goals? So we would do then a root cause analysis or performance improvement plan, if appropriate. We have a commitment to review things on a daily schedule as needed, a weekly schedule as needed, or monthly, so whether that's reviewing things at subcommittees in morning IDT meetings or at the QAPI monthly meeting. And of course, communication: communicating involving all the staff, the residents, and the family about what your goals are and your performance improvement plans.

On slide 51, these are some resources that we utilized for the QAPI process in our independent community. We were very fortunate that our QIO, Telligen, did a huge QAPI education where you could actually send staff members to work on a QM and actually have concrete results to improve the outcome of a particular quality measure.

I'm very happy to be a member of American Health Care Association and Colorado Health Care Association. And these trade associations—and there're others out there—have lots of resources and tools, education, forms, templates for you as a member to tap into.



For about the past 5 years, Colorado Medicaid Program Pay for Performance has had a QAPI section on it that involved doing the CMS self-assessment and actually performance improvement plans. Of course, CMS has resources as well. And we've done a lot of training either by the board members, each other, and by consultants.

In Colorado, we're very fortunate that there's an Epidemiology Division at the Colorado Department of Public Health and Environment. And they actually came out into our community and did an assessment for infection control and antibiotic stewardship. And that was an invaluable resource for us. And of course, now with all of our electronic medical records and our software systems, all of our data is at our fingertips, which can really help us track and trend.

The next slide, number 52, I'd like to talk a little bit about our process for medication review and reduction and the success we've had in that. It's really – we've had a lot of success by establishing a process and educating to that process. And we've used this in the off-label use of antipsychotics, in antibiotic stewardship, and also for opioid use.

So in this process, once again, we identify a champion. And this champion needs to understand the initiative. What is the goal here? So for off-label use of antipsychotics, which diagnoses are being tracked in these numbers? How does the MDS trigger this information? What does it look like for a long stay vs. a short stay? Once we have this champion, there is a constant communication and education to staff. So, our champion was available 24/7 to provide support. So, at a Saturday night at 8 p.m. when you have your p.r.n. nurse working and you have an individual who needs some – a resident who needs some more support, that nurse could call the director of nursing, and the director of nursing could walk them through nonpharmacological interventions available to them, walk through the care plan, help educate that nurse into options because we know our caregivers desire to do something. And so, we're giving them options of nonpharmacological interventions before they make that immediate call to the physician.

In our community, we've also had a commitment to nonpharmacological interventions. So, we have a high psychosocial staffing pattern. We also, in our community, use complementary and alternative modalities, such as aromatherapy and acupuncture. And we have a strong spiritual services program.

Part of this process is to review daily the telephone orders, see what's being prescribed, and looking at behavior sheets or labs, as appropriate, depending on the initiative, and then, looking at this data at the QAPI process, comparing our outcomes to our goals, doing root cause analysis, and adjusting our processes.

On the next page, 53, some of the challenges that we've had. In all communities, it's very interesting to communicate 24 hours a day, 7 days a week across all shifts. And so, that's something that's definitely been a challenge for us: how to get the communication out, the training out. We also have an abundance of data. And how do we prioritize, and what are we looking at, and what's the most important for quality in our community? As we know, we have a very demanding profession. So, how do we keep a focus on QAPI with everything else that's pulling us in a thousand directions? With the new facility assessment with the requirements of participation, right now, as a community, we're looking at: What do we need to bring from the QAPI meeting – monthly meeting to the facility assessment? And what from the facility assessment do we need to track and trend at the QAPI process? That's a pretty extensive review that we're doing. And then, of course, any time there're changes in staff or physicians or residents, you need to do continual education.



So the next slide, we'll first talk about our antipsychotic medications. And in 2012, this became a focus of our community. We created a champion who is available 24/7 to support staff and guide staff. We used our process of reviewing telephone orders and understanding the initiative, and we implemented that process. Part of this that was really important was dementia training and also training on our nonpharmacological interventions because we're caregivers. And when someone is in distress, we need to do something because we're caregivers.

So what are our other options instead of immediately getting a prescription or immediately getting a medication? And so you can see our results on the right. Our graph shows in 2015 we had a 17.15 percent. And as of the third quarter of this year, we were able to bring it down to a 9.2 percent.

The next page, slide 55, antibiotic stewardship became our focus in 2015. And if you have the opportunity to look at the Centers for Disease Control information on core elements of antibiotic stewardship in long-term care, that's the template we used for our community. And it is very comprehensive, and it was a wonderful resource for us. And in our community, we implemented the McGeer Criteria for what an infection is.

And so if you're looking at our results, in 2015, we had a 4.33 percent usage – or UTIs, excuse me. And as you go down to the third quarter of this year, we had a 0.8 percent usage. And through implementing this process, we were able to prevent unnecessary antibiotic use in our community.

The next slide. Right now, we're starting the opioid medications. We're looking at this. We're beginning to track and trend this. Once again, we have a champion. And we're utilizing a similar process of tracking like we did for antipsychotics and antibiotic stewardship. Using the CMS and CDC resources, what are we tracking? What are we calculating? What do we need to know about this initiative and the population we serve? It's a daily process where we're reviewing TOs or any concerns with pain management. It's something we're doing on a daily basis. And our pharmacist has been fantastic in assisting us with this initiative. And a lot of pharmacies actually have a lot of resources. So year to date, we've actually had a reduction of five prescriptions in our community with the pain still being managed.

So thank you very much. And on slide 57 is my contact information should anybody have any questions.

National Partnership Updates

Michele Laughman: Okay. Thank you, Deb and Debra and Sarah. Before we begin the Q&A portion of our call, I'd like to share some updates related to the – excuse me, the National Partnership. I'm on slide 60.

CMS is tracking the progress of the National Partnership by reviewing publicly reported measures. The official measure of the partnership is the percentage of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's disease, or Tourette syndrome. In 2011 quarter four, 23.9 percent of long-stay nursing home residents were receiving an antipsychotic medication. Since then, there has been a decrease of 35 percent to a national prevalence of 15.5 percent in quarter two of 2017.

Slide 61 depicts the decline by CMS region from quarter two of 2011 through quarter two of 2017. The rates of two regions and several states have increased this quarter, and we're working closely with them to determine



what may be causing these increases. Our efforts include collaboration with the State Dementia Care Coalition, CMS regional offices, and state survey agencies with a focus on those nursing homes that have a utilization rate higher than that of the current national average.

Slide 62. CMS recently announced that the partnership met its goal of reducing the national prevalence of antipsychotic medication use in long-stay nursing home residents by 30 percent by the end of 2016. It also announced a new goal of a 15 percent reduction in those homes with currently limited reduction rates. Nursing homes with low rates of antipsychotic medication use are encouraged to continue their efforts and maintain their success while those with high rates of use are to work to decrease antipsychotic medication use by 15 percent for long-stay residents by the end of 2019. These homes are – we’re referring to them as late adopters – would be nursing homes that remain above the national average and have had little change in their antipsychotic medication utilization rate.

Data for homes with high rates of use has been collected and has been shared with the State Dementia Care Coalition leads, the State survey agencies, and the CMS regional offices for outreach purposes. We plan to collaborate in an effort to provide direct outreach and resources to these nursing homes. Some of the late adopters may have already been contacted by their State coalition. Others may not be aware that they are considered a late adopter. If you are one of the nursing homes identified, information will be shared via the Nursing Home Provider Preview on Nursing Home Compare this month.

Slide 63. A few months ago, we facilitated regional calls with the State Dementia Care Coalitions. With the participation of many States, we were able to develop a State Dementia Care Best Practice Strategy document. The link to this resource is located on the bottom of this slide. I have also included some of the frequent responses. Direct outreach to facilities that continue to have high rates of antipsychotic medication use through letters, phone calls, and onsite visits. Many of the States have been continuously holding workshops and conferences. The provision of training opportunities – many States mentioned the use of CMS Hand in Hand, which I will mention is currently under revision. And also, a lot of States talked about State and CMP funds which are being utilized for education and training, conferences, and implementation of specific nonpharmacological approaches. And many States have also mentioned the Music and Memory program.

So what’s ahead? With the release of the 2019 goals, we plan to collaborate closely with the State coalition, the regional offices, and the State agencies in providing support and outreach to the late adopters. Additionally, we are continuing the focused dementia care surveys and are also doing more of the schizophrenia surveys this year to monitor the increase in schizophrenia diagnoses in nursing home residents.

We also held an MLN call dedicated to the topic of appropriate diagnosis of schizophrenia. That call was held on June 15th of this year if you would like to review that call information. A Federal contractor will be conducting those types of surveys as they have for several years.

The Hand in Hand training series is currently under revision, which I mentioned on the last slide. And most of the revisions will take place in the abuse modules, which are modules 2 and 5.

We will continue to track the success of the partnership and release data publicly on a quarterly basis. And we are also embarking on a new Federal CMP fund initiative. It’s just getting under way now, so I’m not able to say



a lot about it. However, I can mention that dementia care will be a component of this initiative in collaboration with State Dementia Care Coalitions and their work with the late adopters as planned.

On slide 65, I shared screenshots and the web address for the National Partnership resource and tool repository. We completed a website overhaul last year with the assistance of an advocate who is living with dementia. He helped us in making the web site more user-friendly and also to improve the navigational capabilities. It was enlightening to work closely with this advocate. He really provided us with a lot of insight and also guidance that – on things that we hadn't really thought of.

And that brings me to the last slide, which is, again, the link to the National Partnership website. And then if you have questions, you can send them to the DNH Behavioral Health mailbox.

So I want to say thank you to everyone for participating in today's MLN call and, also, thank you very much to all of our speakers. I'm going to now turn it over to Leah and our moderator, Dorothy, for the question and answer session.

Question & Answer Session

Leah Nguyen: Thank you, Michele. We will now take your questions. As a reminder, this event is being recorded and transcribed. All right, Dorothy, we are ready for our first caller.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you're asking your question, so anything you say or any background noise will be heard in the conference. If you have more than one question, press star 1 to get back into the queue, and we will address additional questions as time permits.

Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Donna Thorson.

Donna Thorson: Hello. This is Donna Thorson. I work at HealthInsight in Nevada. And my question is for the representatives from the nursing homes about QAPI. Congratulations on the great work that you're doing with that. But my question is how do you engage the front-line staff in actually implementing Performance Improvement Projects?

Michele Laughman: Deb Fournier, do you want to start? And then, Sarah can add to that.

Debra Fournier: Sure. I'm happy to do that. This is Deb Fournier with Maine Veterans' Homes. We are engaging our front-line staff in a couple of different ways. But first and foremost, I would say that when we have Performance Improvement Projects, we are encouraging them to participate on the team. So for example, we have – in all of our facilities, we have work going on reducing resident falls. And we – our teams consist



of direct care workers, you know, housekeeping staff, dietary, leadership, etc. So we're – providing the time for them to participate is key—and not always easy, I must say, but very important to us. We also encourage them to participate in the improvement programs that we're doing directly on their units, so with mini-huddles and daily huddles at morning report and the latter, not to mention that they all participate frequently, if not almost always, now in care planning sessions and looking at individual opportunities for improvement. I hope that's helpful.

Donna Thorson: It is, but clarification, I guess, on how you engage them. Like, you're saying huddles, but do they actually meet to develop the PDSA cycles and that sort of thing after they've been given a team charter? I guess that's more what I'm looking at. How do you get them engaged in that way?

Debra Fournier: Okay. I would say, at this point in time for our organization, that generally there is a leader or a champion, most often from leadership, that is helping to facilitate that. But they – the direct care staff and others are more team members and not doing the direct leadership roles or facilitation.

Leah Nguyen: Sarah, do you have any more insight?

Sarah Schumann: I am so sorry. I got kicked off the line and just rejoined, so I did not hear the question.

Leah Nguyen: That's okay. Do you want to – the caller, do you want to briefly repeat your question?

Donna Thorson: Yes, thank you. This is Donna Thorson in Nevada. I was just trying to figure out how you engage the front-line staff in the actual Performance Improvement Projects. So there's a team charter; you have a team lead. But how do the staff actually engage in the PDSA cycles and implementation?

Sarah Schumann: That's a great question. And that is certainly a challenge. A few of the things that we've had success with is we have a great participation in our all-staff meetings. So we do those twice a month. And those are each an hour long where we're able to really disseminate information and have conversations. We do post our performance improvement plans in our breakroom or throughout our community so our residents and our staff can be involved. And we also provide just a lot of education. So for example, on the antipsychotic reduction measure to reduce the off-label use, we provided a lot of dementia training and crisis prevention intervention training. And so that's how we've really engaged.

One thing we can do better and we're striving to do that—it's a goal of 2018—is really have some more structured ways for staff to get feedback. We have an open-door policy in our community where direct care staff can come speak to any manager at any time. How can we make that more structured? So, that's our goal for 2018.

Leah Nguyen: Thank you. Dorothy, can we take our next question?

Operator: Your – as a reminder, in order to ask a question, please press star, then the number 1 on your telephone keypad.

Your next question comes from the line of Jeff West.



Jeff West: Hi. This is a question I'm not sure if I have the right people on the line to answer this. But is there any consideration for changing the antipsychotic measure – the long-term antipsychotic measure so that the denominator includes residents with a diagnosis of dementia? It currently has exclusions for people with schizophrenia, Tourette's, Huntington syndrome, and so forth. But it also includes people who don't really fit the black box warning kind of reasons for the concerns about antipsychotics at this point.

Karen Tritz: Hi. This is Karen Tritz from the Division of Nursing Homes and Survey and Certification. Thanks very much for your question. We have not considered putting the residents with dementia in the denominator portion of the antipsychotic measure. I think the result of doing that would essentially – or as an exclusion, for example, that would essentially remove the intervention as a whole from being captured. And I think what we are trying to do, which Dr. Nazir talked about very eloquently, is really encourage community – nursing facility communities to look at how antipsychotic medications are being used among residents with dementia. And so if you exclude them from the measure altogether, then that essentially makes that measure meaningless for those residents with dementia that are being, you know, one of the focus of this intervention. So, that's not, I think, being considered.

Jeff West: No, I – well, that was not what I was asking. I was saying including dementia as the only – in the denominator – including it, not excluding it. So right now, you have a lot of people in the denominator who don't have dementia. They have head injuries, or they're younger folks on Medicaid and – who got into the nursing homes that are driving up a lot of these rates in some States. And it's they – you know, they're included in the measure even though they're not really the target for – the reasons for looking at antipsychotics for treating behavioral and psychological symptoms of dementia. If – in other words, making sure that the people in the denominator do have dementia. That's what I was actually asking about.

Karen Tritz: Understood. So, your question is about essentially limiting the measure to just residents with dementia?

Jeff West: Correct. Yes.

Karen Tritz: Understood. Yes. So that's not something that we've really put on the table in terms of changes to the measure. But I appreciate your comments on that. And we'll – we can talk about it.

Jeff West: Okay.

Leah Nguyen: Thank you.

Operator: As a reminder, in order to ask a question, please press star, then the number 1 on your telephone keypad.

Your next question comes from the line of Erin Silber.

Erin Silber: Hi. My question is about something that you briefly mentioned regarding aromatherapy. What different things have you done with using essential oils in aromatherapy with residents?

Michele Laughman: Dr. Nazir, I think that question is meant for you.



Dr. Arif Nazir: Yes. Sure. Sorry, I was on mute. Personally, my experience to aromatherapy is limited to a couple of patients who I saw benefited from this. But I am not the expert on this. And the literature I have followed kind of is very iffy at this point. So, I'm not sold that aromatherapy is going to work for everybody. I think the studies have been very, very small and those patients have had certain attributes, just a few patient case studies. So, I'm not very comfortable speaking confidently about it.

I mean, of course, there are examples where some patients did amazingly well. And if that's the case, if the family gives us a history and their stories all described by the team that they do respond well to aromatherapy, you know, absolutely, I think it's, honestly, one of the safer things you can do in regards to nonpharmacological measures, so, absolutely. But I would not invest at a facility level on aromatherapy at this point because I don't think the data is that generalizable at this point.

Erin Silber: Okay. Thank you.

Dr. Arif Nazir: Sure.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Melody Malone.

Melody Malone: Hi. This is Melody. And I want to echo the other speak – or the other gentleman's comment. I agree with him that you need to look at those residents on – with dementia who are on an antipsychotic. That's what I see as what you're really trying to get at. And I think that would be a much better measure.

And then, Dr. Nazir, I had a question for you regarding this issue of contraindications for a GDR. As I'm working with my facilities—and I am at the CMS QIO – CMS Health Quality Institute, one of the things that I'm suggesting that they consider: instead of just taking that contraindication for another GDR as a be-all end-all for the rest of the resident's life, but until or if the time the resident has a significant cognitive change of condition or some kind of brain insult—TIA, CVA, you know, fall and knock themselves out for a while. And I'm not getting much traction on that, and I wondered if you could speak to this issue of contraindications and when is it going to be okay to come off that contraindication for GDR?

Dr. Arif Nazir: Well, that's an interesting question. And I don't know if – it's very hard to kind of specify that, you know, with a guideline or a measure because – you know, I mean, I do that all the time. I mean, I do have patients who appear to be contraindicated to be taken off from lipid medications. And they seem to be that they are contraindicated to be take off – taken off from PPI. And you know what? You just make that individual distinct decision based on knowing that patient, and you call the consultant, if there's a consultant on the team, and make that decision.

So, I think as a clinician, that is one responsibility you should feel, that every single medicine that you're prescribing, regardless of what the chart or the sign says around contraindication or indication or what does CMS ask you to do, I think that's an inherent role of a prescriber to consider that nothing is contraindicated to be stopped, you know, forever, because there is going to be a certain point which may not just be researched enough where you know as a clinician that your patient is really, honestly, not benefiting from it. So, I think it's a very important issue.



But it only can happen if, as a clinician, as a prescriber, you know your patient, you're spending enough time, and you have a proactive, holistic approach to care. I don't think I would recommend guiding, you know, those kinds of decisions under guidelines or under CMS requirements or so forth, because I think that can get us in trouble. But, as a geriatrician, I take pride in kind of challenging myself to really, really question what the consultant said even. Like, if a consultant said that this patient cannot be taken off this medicine, I always kind of question why. But, why? I mean, I know this patient better. And as a – you know, based on what I got from his daughter, which the consultant never got to see, I think this patient can be taken off this medication.

So, I think it's a very, very individualized approach. It requires a whole lot of effort of investment of time and prescribe – from prescribers. So, I think we should leave it that way. But you know, we need to empower our clinicians to spend more time with their patients. We just cannot put so much on them so that they're spending more time doing other things rather than spending time with their patients. I think that's where the key is.

Leah Nguyen: Thank you.

Dr. Arif Nazir: I'm sorry. And I'm sorry I don't have an accurate – I mean, a specific answer. But you know, that's all I have at this point.

Operator: Your next question comes from the line of Jeena Mathews.

Jeena Mathews: Hi. This is Jeena from Presence Maryhaven Nursing Home. I would like to check with someone's opinion. If my unit – if a resident with dementia with behavioral disturbances or nonbehavioral disturbances with a condition of hoarding, how you can prevent or eliminate those behaviors? Anybody have any suggestions?

Dr. Arif Nazir: Well, I mean – this is Dr. Nazir. I mean, I have, of course, have had, I would say, a handful of patients who were just – absolutely want to hoard everything and hide everything in their rooms, and not very, very common issue but not rare either. And I'll tell you that every single patient had to be addressed differently. I mean, again, the ultimate issue was why did mom or why did dad, you know, get into that habit? And knowing that and, you know, what anxiety led for them to hold on to things was something which we had to get at too. And then, you know, in the end, you had to see was the hoarding harmful for them?

Dr. Arif Nazir: If yes, then you have to bring in a consultant because, you know, more often than not, you are basically – when you're bringing a consultant in, unless they're doing a lot of talk therapy, they are going to start medication. And I think, at this point, you have to have a discussion with the family. Like, this hoarding issue is harmful for mom; it is leading to risks for other residents, and we are going to try some pharmacological method at this point and be it an antipsychotic, psychotropic, or (Venzor) or Depakote. But it has to be tried in the realm of that discussion and communication, understanding the risk, and then very closely monitoring if there's a benefit, and, if there's not a benefit, then moving along.

Jeena Mathews: Okay. Thank you.

Dr. Arif Nazir: Sure.

Operator: Your next question comes from the line of Carmen Bowman.



Carmen Bowman: Hi. Can you hear me?

Leah Nguyen: Yes, we can.

Carmen Bowman: Oh, thanks. I just wanted to make sure. I thought people might be interested in a little bit of research that we did collect in the early 2000s to answer Erin's question about aromatherapy. I had the privilege to work with CMS on the Artifacts of Culture Change measurement tool. And we found a home back in about 2003 in South Carolina who was able to help all the people living with dementia on a locked environment to get off the antipsychotics way back then and they attributed it to essential oils.

I'm also hearing, around the country, everyone that – nursing homes that are utilizing different blends are having great outcomes in preventing things like the flu. There's a blend of essential oils called Thieves that actually started way back during the Black Plague. People would wear it on handkerchiefs over their mouth, and you can diffuse it into the air. And it's got – many of these different blends have antibacterial and antiviral properties. And there's really two ways to think of aromatherapy: that it can be done personally, that it's on the person—maybe lotion is one way to think of it; lavender lotion has an effect on some people for calming. And then it can be done in a – excuse me, in a public way where it has those other properties.

And then I also wanted to ask, I think, Michele – forgive me, Michele, I lost contact. I'm in Colorado like Sarah and did not hear what you had to say about the updates to the dementia care survey, the schizophrenia surveys, and the Hand in Hand series. I'm sorry. If you could repeat that, please.

Michele Laughman: I just stated that we're continuing to do the focus surveys, those types. And they are being conducted by our contractor, as they have been for a couple years now. And then, I mentioned that Hand in Hand is under revision, and the revisions are predominantly in modules 2 and 5. Those are the abuse modules.

Carmen Bowman: Very good. Thank you so much.

Michele Laughman: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Crystal Haze.

Crystal Haze: Hi. This is Crystal Haze with Great Plains QIN in Nebraska. And I just wanted to say as well that I agree with Jeff West and Melody Malone regarding the measure itself only including those residents with dementia in the denominator. But my question is for Michele Laughman. When you were discussing the late adopters, you mentioned something about that information would be shared on Nursing Home Compare. And I was wondering if you could just clarify what information you were talking about.

Michele Laughman: It's general – in general, it's a notification to the provider that they have been identified as a late adopter.



Crystal Haze: So are you saying that that would be identified on Nursing Home Compare if I'm a consumer that goes into the site?

Michele Laughman: No.

Crystal Haze: No. That's just a ...

Michele Laughman: It's strictly for the provider.

Crystal Haze: Okay. Thank you.

Michele Laughman: You're welcome.

Leah Nguyen: Thank you. Dorothy, we have time for one final question.

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

Additional Information

Leah Nguyen: Thank you. For information on evaluating today's event, see slide 68.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on the National Partnership to Improve Dementia Care and QAPI. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.