National Partnership to Improve Dementia Care in Nursing Homes & Quality Assurance and Performance Improvement (QAPI)

March 20, 2018
Acronyms in this Presentation

- ADL - Activities of Daily Living
- ADRD - Alzheimer’s Disease and Related Dementia
- PASARR - Pre-Admission Screening and Resident Review
Agenda

Person-Centered Care Planning and Discharge Planning: Highlights of Phase 2 Changes  
Debra Lyons, CMS

Alzheimer’s Association Dementia Care Practice Recommendations  
Douglas Pace, Alzheimer’s Association
Person-Centered Care Planning and Discharge Planning: Highlights of Phase 2 Changes

Debra Lyons, RN
CMS
Reform of the Requirements for Long-Term Care Facilities

- Phase 2 implemented on November 28, 2017
- F-tags renumbered
- Guidance to surveyors revised
Person-Centered Care

Person-Centered Care:

• Supports each resident’s choice and gives them a sense of control over their lives

• Is a central theme to the Final Rule

• Will improve Quality of Life and Quality of Care
Baseline Care Plan:

• Develop within 48 hours of admission

• Contain the minimum healthcare information necessary to care for resident

Facility must provide a written summary of the baseline care plan to the resident/ representative.
F655 Baseline Care Plan – New Requirement

Intent of the Baseline Care Plan requirements:

- Promote continuity of care and communication among staff
- Increase resident safety
- Safeguard against adverse events
- Ensure the resident/representative are informed of the initial plan of care
F656 Comprehensive Person-Centered Care Plan

Develop and implement a comprehensive, person-centered care plan that includes measurable objectives and timeframes to meet a resident’s needs and describes resident goals, preferences, and desired outcomes.

New guidance at F656:

• Defines measurable objectives
• Provides examples of individualizing care plan goals and preferences
The care plan must describe:

- Preferences related to discharge, with referrals to local contact agency
- Discharge plan if applicable
- Specialized services from Pre-Admission Screening and Resident Review (PASARR) recommendations
Interdisciplinary team must now include:

- A nurse aide with responsibility for the resident
- A member of food/nutrition services
- The resident or, if applicable, their representative
- Other appropriate staff or professionals as determined by the resident or their needs
F657 Care Planning - Physician Involvement

• Physician input into the development of the care plan is important

• Physician may delegate participation to a non-physician practitioner who is involved in the resident’s care

• Facility may arrange alternate methods of physician participation
F660 Discharge Planning Process

• Expanded new requirements and guidance
• Focuses on the resident’s goals
• Prepares the resident to transition to post-discharge care by reducing factors which may lead to re-hospitalizations or readmissions
F660 Discharge Planning Process

Guidance at F660 clarifies that the discharge care plan:

• Is part of the comprehensive care plan

• Be developed by the interdisciplinary team which includes direct communication with the resident/resident representative

• Address the resident’s goals for care and treatment preferences

• Identify needs that must be addressed before the resident can be discharged
F660 Discharge Planning Process

Guidance at F660 continued:

• Be re-evaluated regularly and updated when the resident’s needs or goals change

• Document the resident’s interest in, and any referrals made to the local contact agency

• Identify post-discharge needs, such as nursing and therapy services, medical equipment or modifications to the home, or Activities of Daily Living (ADL) assistance
F661 Discharge Summary

• Expanded new requirements and guidance

• Intends to ensure facilities communicate necessary information to the resident, continuing care provider, and other authorized persons at the time of discharge
F661 Discharge Summary

The discharge summary:

• Must include an accurate and current description of the clinical status of the resident

• Must provide individualized care instructions to ensure a safe transition to another setting

• May reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident’s care
Resources

- State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities
- CMS Website for Nursing Home Laws and Regulations
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OUR VISION: A world without Alzheimer’s disease.

OUR MISSION: To eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.
2017 Alzheimer’s Disease Facts and Figures
Alzheimer’s Disease & Related Dementia

DEMENTIA

An “umbrella” term used to describe a range of symptoms associated with cognitive impairment.

ALZHEIMER’S 50%-75%
VASCULAR 20%-30%
LEWY BODIES 10%-25%
FRONTOTEMPORAL 10%-15%

MIXED DEMENTIA = >1 NEUROPATHOLOGY - PREVALENCE UNKNOWN
Millions of Americans are Living with Alzheimer’s

• An estimated 5.5 million Americans are living with Alzheimer’s dementia today — 5.3 million people age 65 and older and 200,000 under age 65 with younger-onset Alzheimer’s

• Among those 65 and older, 1 in 10 has Alzheimer’s, and among those 85 and older, 1 in 3 has Alzheimer’s
Cost of Care

- In 2017, caring for people with Alzheimer’s and other dementias will cost the United States an estimated $259 billion, including $175 billion paid by Medicare and Medicaid.
Medicare payments for a senior with Alzheimer’s or other dementias are more than 3 times as great as those for a senior without these conditions. Medicaid payments are 23 times as great.
## Average Annual Per-Person Payments for Health Care and Long-term Care

### Table 10

Average Annual Per-Person Payments for Health Care and Long-Term Care Services, Medicare Beneficiaries Age 65 and Older, with and without Alzheimer’s or Other Dementias, in 2016 Dollars

<table>
<thead>
<tr>
<th>Payment Source</th>
<th>Beneficiaries with Alzheimer’s or Other Dementias</th>
<th>Beneficiaries without Alzheimer’s or Other Dementias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$23,497</td>
<td>$7,223</td>
</tr>
<tr>
<td>Medicaid</td>
<td>8,182</td>
<td>349</td>
</tr>
<tr>
<td>Uncompensated</td>
<td>364</td>
<td>365</td>
</tr>
<tr>
<td>Health maintenance organization</td>
<td>1,205</td>
<td>1,475</td>
</tr>
<tr>
<td>Private insurance</td>
<td>2,152</td>
<td>1,358</td>
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<tr>
<td>Other payer</td>
<td>895</td>
<td>231</td>
</tr>
<tr>
<td>Out of pocket</td>
<td>10,315</td>
<td>2,232</td>
</tr>
<tr>
<td>Total*</td>
<td>$46,786</td>
<td>$13,351</td>
</tr>
</tbody>
</table>

*Payments from sources do not equal total payments exactly due to the effect of population weighting. Payments for all beneficiaries with Alzheimer’s and other dementias include payments for community-dwelling and facility-dwelling beneficiaries.

Created from unpublished data from the Medicare Current Beneficiary Survey for 2011.
Why is Alzheimer’s such a Cost Driver?

• Nearly 30 percent of people with Alzheimer’s or other dementias are on both Medicare and Medicaid, compared with 11 percent of people without dementia
Why is Alzheimer’s such a Cost Driver?

- People with Alzheimer’s are more likely than people without dementia to have other chronic conditions, and dementia complicates the management of these other conditions.
Why is Alzheimer's such a Cost Driver?

• A senior with diabetes and Alzheimer’s costs Medicare 81 percent more than one with diabetes and no Alzheimer’s

• A senior with Alzheimer’s and cancer costs Medicare 57 percent more than one with cancer but no Alzheimer’s
And Costs will Continue to Grow

• The costs of caring for people with Alzheimer’s or other dementias are projected to increase from $259 billion in 2017 to more than $1.1 trillion in 2050
Alzheimer’s doesn’t just Happen to Individuals - it Happens to Families

• More than 15 million family members and friends provided more than 18 billion hours of unpaid care to those with Alzheimer’s or other dementias in 2016
• The economic value of the unpaid care provided to those with Alzheimer’s or other dementias totaled $230.1 billion in 2016
In 2016, Alzheimer’s and dementia caregivers had $10.9 billion in additional health care costs of their own due to the tremendous physical and emotional burden of caregiving.
If Alzheimer’s and dementia caregivers were the residents of a state, it would be the 5th highest populated state in the country.

- **California**
  - Population: 39,250,017

- **Texas**
  - Population: 27,862,596

- **Florida**
  - Population: 20,612,439

- **New York**
  - Population: 19,745,289

- **Alzheimer's and Dementia Caregivers**
  - Population: 15,975,000

- **Illinois**
  - Population: 12,801,539
Alzheimer’s is More than “a Little Memory Loss”— it Kills!

- Alzheimer’s is the 6th leading cause of death in the U.S.
- It is the only disease in the top 10 that cannot be prevented, slowed, or stopped
- An estimated 700,000 Americans will die with Alzheimer’s disease in 2017
From 2000–2014, Alzheimer’s Disease Deaths Increased 89% While...

Deaths from:
- HIV Declined 54%
- Stroke Declined 21%
- Heart disease Declined 14%
- Prostate cancer Declined 9%
- Breast cancer Declined 1%

Created from data from the National Center for Health Statistics.208,213
Risk Factors

Alzheimer’s – Plaques & Tangles
Risk Related to Cognitive Decline & Alzheimer’s

- Age: The greatest known risk factor
- Heart-head connection
  - Increased risk suspected if high blood pressure, heart disease, stroke, diabetes, and high cholesterol
- Head injury
- Family History
  - Risk and deterministic genes
OVER 60% of Alzheimer's and dementia caregivers are WOMEN.

Women are at the epicenter of the Alzheimer's epidemic.

In her 60's, a woman's estimated lifetime risk of developing Alzheimer's is 1 IN 6. For breast cancer, it is 1 IN 11.

More WOMEN than MEN stopped working to provide care for someone with Alzheimer's.

Today, nearly 2/3 Americans living with Alzheimer's are WOMEN.
The Facts: Alzheimer’s is an Epidemic in America

African-Americans are about twice as likely as whites to have Alzheimer’s or another dementia, and Hispanics are one and a half times as likely.
10 WAYS TO LOVE YOUR BRAIN

START NOW. It’s never too late or too early to incorporate healthy habits.

HIT THE BOOKS
Formal education will help reduce risk of cognitive decline and dementia. Take a class at a local college, community center or online.

BUTT OUT
Smoking increases risk of cognitive decline. Quitting smoking can reduce risk to levels comparable to those who have not smoked.

FOLLOW YOUR HEART
Risk factors for cardiovascular disease and stroke – including high blood pressure and diabetes – negatively impact your cognitive health.

HEADS UP!
Brain injury can lead to all cognitive decline and dementia. Wear a seat belt and use a helmet when playing contact sports or riding a bike.

FUEL UP RIGHT
Eat a balanced diet that is higher in vegetables and fruits to help reduce the risk of cognitive decline.

TAKE CARE OF YOUR MENTAL HEALTH
Some studies link depression with cognitive decline, so seek treatment if you have depression, anxiety or stress.

CATCH SOME ZZZ’S
Not getting enough sleep may result in problems with memory and thinking.

BREAK A SWEAT
Engage in regular cardiovascular exercise that increases heart rate and increases blood flow. Studies have found that physical activity lowers risk of cognitive decline.

STUMPS YOURSELF
Challenges your mind. Build a piece of furniture. Play games of strategy, like bridge.

BUDDY UP
Staying socially engaged may support brain health. Find ways to be part of your local community or share activities with friends and family.

Visit alz.org/10ways to learn more.
Defining Quality Care: Dementia Care Practice Recommendations
Quality Care: History

• Guidelines for Dignity
• Key Elements of Dementia Care
• Dementia Care Practice Recommendations
Quality Care: Today

• Evidence-based practices
• Peer-reviewed
• 56 recommendations by 27 expert authors
• Published as a supplement to Feb 2018 issue of The Gerontologist
• Foundation for quality person-centered care
Dementia Care Practice Recommendations
Recommendations:
• Know the person
• Person’s reality
• Meaningful engagement
• Authentic, caring relationship
• Supportive community
• Evaluation of care practices
Detection and Diagnosis

Recommendations:
• Information about brain health and cognitive aging
• Signs and symptoms of cognitive impairment
• Concerns, observation and changes
• Routine procedures for assessment and referral
• Brief mental status test when appropriate
• Diagnostic evaluation follow-through
• Better understanding of diagnosis
Recommendations:
• Regular, comprehensive, person-centered assessments and timely interim assessments
• Information gathering, relationship building, education, and support
• Collaborative, team approach
• Documentation and communication systems
• Advance planning
Medical Management

Recommendations:
• Holistic, person-centered approach
• Role of medical providers
• Common comorbidities of aging
• Non-pharmacologic interventions
• Pharmacological interventions when necessary
• Person-centered plan for possible medical and social crises
• End-of-life care discussions
Recommendations:
• Preparation for the future
• Work together and plan together
• Culturally sensitive programs
• Education, information, and support during transition
• Technology to reach more families
Ongoing Care – ADLs

Recommendations:
• Support for ADL function
• Person-centered care practices
• Dressing — dignity, respect, choice; process; environment
• Toileting — also health and biological considerations
• Eating — also adaptations and functioning; food, beverage and appetite
Ongoing Care: Behavioral and Psychological Symptoms of Dementia

Recommendations:
• Social and physical environmental triggers
• Non-pharmacological practices
• Investment for implementation
• Protocols
• Evaluation of effectiveness
Staffing

Recommendations:
- Orientation and training and ongoing training
- Person-centered information systems
- Teamwork and interdepartmental/interdisciplinary collaboration
- Caring and supportive leadership team
- Relationships
- Continuous improvement
Supportive and Therapeutic Environment

Recommendations:
• Sense of community
• Comfort and dignity
• Courtesy, concern, and safety
• Opportunities for choice
• Meaningful engagement
Recommendations:
• Education about common transitions in care
• Timely communication of information between, across, and within settings
• Preferences and goals of the person living with dementia
• Strong inter-professional collaborative team to assist with transitions
• Evidence-based models
Practice to Policy

- National Alzheimer’s Project Act
- Signed into law in 2011
- Advisory Council on Alzheimer’s Research, Care and Services
- National Alzheimer’s Plan – annually updated
- Five goals are the foundation of the plan:
  - Prevent and Effectively Treat Alzheimer’s Disease by 2025
  - Enhance Care Quality and Efficiency
  - Expand Public Supports for People Living with the Disease and their families
  - Enhance Public Awareness and Engagement
  - Track Progress and Drive Improvement
Goal 2 - “Enhance care quality and efficiency”

“All persons living with Alzheimer’s disease and related dementias, regardless of location, race, ethnicity, sexual orientation or socioeconomic class, should receive high quality person/family-centered by well-trained practitioners and workers from detection and diagnosis through end-of-life, across all health care and long-term services and supports.”

2025 Endpoint

Alz. Association National Plan Care and Support Milestone Workgroup
Strategies for Goal #2

- Build a workforce with skills to provide high quality care
- Ensure timely and accurate diagnosis
- Educate and support people with Alzheimer’s Disease and Related Dementia (ADRD) and their families upon diagnosis
- Identify high quality dementia care guidelines and measures across care settings
- Explore the effectiveness of new models of care for people with ADRD
- Ensure that people with ADRD experience safe and effective transitions between care settings and systems
- Advance coordinated and integrated health and long-term services and supports
- Improve care for populations disproportionately affective

Alz. Association National Plan Care and Support Milestone Workgroup
Quality Care: Perspectives from People Living with Dementia

Themes:
• Encourage early detection and diagnosis
• Share appropriate information and education
• Get to know the person
• Maximize independence
• Practice patience and compassion
• Personalize care to meet individual needs and preferences
• Adjust care approaches to reflect day to day needs and abilities
Themes

• Provide ongoing opportunities for engagement that have meaning and purpose
• Ensure coordination among those who provide care
• Train staff on the most current disease information and practice strategies
• Inform and include the individual in new interventions as appropriate
• Create a safe and supportive environment that reflects the person’s characteristics, personality, and preferences
Next Steps

Quality Care in Long-Term & Community-Based Care

**Dementia Care Practice Recommendations**

**INFLUENCERS**
- Federal and State Policies
- National Provider Member Organization Partnerships
- Accreditation Bodies

**PRODUCT LINES**
- Organization-Wide Consultative Coaching
- Curriculum Review
- essentiALZ® Certification
- Project ECHO
- Dementia Care Provider Roundtable
- Dementia Care In-Person Training

**IMPACT**
- Number of Covered Lives
- Number of Organizations
- Outcomes Research
Contact Information

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National Partnership Updates

Michele Laughman, CMS
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