



MLN ConnectsTM

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services
National Partnership to Improve Dementia Care in Nursing Homes
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

Announcements and Introduction	2
Presentation.....	2
Role of Surveyors	3
Keypad Polling.....	5
Importance of Leadership	5
Proper Pain Assessment.....	10
Next Steps and Resources.....	16
Question-and-Answer Session	16
Additional Information	29

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

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

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

The CMS National Partnership to Improve Dementia Care in Nursing Homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identifies approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications, in nursing homes and eventually other care settings, as well.

During this MLN Connects National Provider Call, a CMS subject-matter expert will discuss the critical role of both State and Federal surveyors in the implementation of the partnership. Additional speakers will be presenting on the importance of leadership, as well as strong correlation that exists between proper pain assessment and antipsychotic medication use. A question-and-answer session will follow the presentation.

You should have received a link to the slide presentation for today’s call in previous registration emails. If you have not already done so, please view or download the presentation from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page select “National Provider Calls and Events,” then select the February 26th call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

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

Presentation

Michele Laughman: Hello and welcome. As Leah mentioned, our call today will focus on the role of surveyors, the importance of leadership, and also proper pain assessment in relation to the national partnership. I’m not sure if Thomas Hamilton is on; he was meant to do the welcome today, but instead I think I’m going to be doing it.

So I would just like to say that CMS is grateful for your time, your energy, and your dedication to the mission of this partnership. We have these national calls to provide an opportunity to share new information about innovations in dementia care and also to highlight successful strategies that are being utilized around the country.

It's a new year and a new phase of our collaborative work. CMS is increasing our focus on those facilities and States that have not gotten engaged in this mission yet. And we've learned so much from the best-practice homes and States. We're eager to apply these successful models in States and regions where there are still big opportunities for improvement. We've continued to integrate the national partnership with the Nursing Home Quality Care Collaborative and Advancing Excellence. All of these initiatives have really come together and aligned their goals, and positive synergies have been achieved as people are working together.

Your work is a critical component of the National Alzheimer's Strategic Plan. Specifically, you're helping to implement initiatives by partners such as the Institute of Medicine that has convened an expert panel on advanced dementia care across settings, and the Alzheimer's Association and others that continue to campaign for more and better research, caregiver support, and consumer engagement.

We recognize that many of you are also working on Quality Assurance/Performance Improvement, or QAPI, plans and program development. Many of you have told us that you are using dementia care and antipsychotic reduction as topics for Performance Improvement Plans, or PIPs, as well as highlighting this critical issue to begin an open dialogue about QAPI.

We look forward to hearing from those of you who are sharing your stories today. It is only through your efforts that we will succeed in improving dementia care for people living in our nursing homes.

And now I would like to introduce Karen Tritz, the Director of the CMS Division of Nursing Homes. Karen will discuss the role that surveyors have in this effort. Karen?

Role of Surveyors

Karen Tritz: Thank you, Michele. Welcome to all of you from the Division of Nursing Homes. Over the past several months we've been speaking with CMS regional office staff in addition to State survey agency directors and managers. We've been hearing about their work in making dementia care a top priority for surveyors during all annual surveys, and the importance of citing poor practice based upon the recent interpretive guidance revisions.

During these discussions we demonstrate the importance of having surveyors ask specific questions related to the home's dementia care plan and their approach to reducing antipsychotic medication use during every entrance conference. We are also determining whether or not surveyors are aware of which nursing homes have high rates of use when

they are out surveying. This often relates to how connected a particular State's survey agency is with their State partnership coalition.

State agencies have been following up with CMS, informing central and regional offices about how many surveyors have also completed the three mandatory trainings that we've released, and their plans to ensure that all surveyors view them as soon as possible. Both CMS central office and our regional teams are reviewing enforcement patterns for citations at both F309 and F329 across the country. And we are discussing these trends with the State survey agencies.

We've also been working closely with professional associations such as the National Association of Activity Professionals, the Gerontological Advanced Practice Nurses Association, the American Psychological Association, and others to leverage their expertise in clinical practice, mental health, research, and education to work with nursing homes, surveyors, and families in a number of States. We continue to work closely with AMDA, AGS, and other advocacy organizations in individual States as well.

Thomas Hamilton, the Director of the Survey and Certification Group, and I are very grateful for the efforts of so many people and organizations. Because of you, we are pleased to announce that we have seen a 13.1-percent reduction in the rate of antipsychotic use in long-stay nursing home residents in less than 2 years. However, you may remember that our target was for a 15-percent reduction at the start of the initiative.

With your help, we're confident we can achieve that goal. We are very close, and we will continue moving forward to reach even bigger goals beyond that. But we do need everyone to focus on and communicate the importance of individualizing care for residents who are on antipsychotic medications now. This means reviewing each of those residents and determining with your interdisciplinary care team who might be a good candidate for a gradual dose reduction and beginning that process.

It also means carefully scrutinizing residents who come into your facility already on an antipsychotic medication and questioning whether or not that medication could be discontinued, opening up that dialogue with the medical providers at the hospital and on your staff as well.

Finally, it means stressing the use of QAPI principles to ensure that non-pharmacological approaches to residents with manifestations of distress are put into place, that staff receive continued training and support, that families are involved, and person-centered care approaches are evaluated and modified to meet the needs of each resident. We thank you very much for your participation in today's call and look forward to the continued collaboration and partnership.

And now I will turn it over to Leah for a keypad polling question.

Keypad Polling

Leah Nguyen: Thank you, Karen. At this time we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there'll be a few moments of silence while we tabulate the results. Victoria, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

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

Leah Nguyen: Thank you, Victoria. I'll now turn the call over to Michele Laughman.

Importance of Leadership

Michele Laughman: OK. We will now hear about the importance of leadership. Kathleen Lynch is the Director of Nursing Services at Genesis Lebanon Center. A write-up about her perspective on antipsychotic medication reductions in long-term care settings can also be found on the Advancing Excellence website. Kate?

Kathleen Lynch: Hello, everybody. Good afternoon. And I want to thank CMS for inviting me to speak today. I thank all of you for taking the time out of your busy day to listen and to engage in this process. So, as you can see, I do have a PowerPoint that people can follow along on if they would like.

So on today's call, we will be reviewing a couple different things, the first of which is the importance of leadership with all CMS initiatives, not just antipsychotic reduction. We're also going to review hands-on advice that leaders can put into place to move initiatives forward. We're going to discuss the foundations for building for success, and we're going to review leadership's role using antipsychotic – excuse me, antipsychotic medication reduction as an example. We're also going to talk a bit about information transparency: Is this a good thing or a bad thing? This presentation is not meant to have all the answers of leadership. It is simply going to give practical advice and steps a leader can take to get the job done to ensure our elders get the best care possible.

So we all know that a good leader can take a bad building and make it great. We also know that a mediocre leader with mediocre energy will have a mediocre outcome. We can all name a leader who is simply calling it in, and then name a dynamic leader who is getting the job done, even at times making it look easy. So leaders must be many things

to many people. And I have listed just a few. We have to be available, most of us, 24/7; know our stuff; think outside the box; find the funny in things; and come up with imaginative solutions. And this is usually before the second cup of coffee.

More is being asked of us every day, and many of us are being asked to reach higher levels of excellence with less resources. And then, there will be a flu epidemic in your organization. Leadership in health care is like playing Whac-a-Mole. You look at one thing, get it under control, but look away and it pops up again. It is a changing, challenging environment, but we love it.

So, as you can see, there are multiple initiatives challenging what we thought the limits of our abilities were. It is overwhelming and occasionally very stress-inducing. So how do we do it?

The first thing leaders must do is to stop worrying about how you're going to get it all done. What you have to get done is still going to be there whether you're worrying or not. The real issue is that we are being asked to do what – is that being asked to do so much is paralyzing. And our fear brings inertia and questions our ability to even get to the finish line and reach our goals. So you may hear leaders say something else: "There's no way we're going to get that done." But we must start, even just a little bit, to break the cycle of fear and inertia.

So the following slides are going to attempt to illustrate the philosophy as it regards to antipsychotic reduction. However, I will also be discussing how each step applies to multiple initiatives. So we all know that antipsychotics are not good drugs. We know they increase morbidity and mortality in the elderly population; we know they are overused, controversial, and simply not the best care we can provide.

First, decide if this initiative is a priority. If it is not a priority, decide when it *will* be and assess what you need to accomplish to get ready for it to be a priority. As leaders, one of our duties is to ensure that our staff have the tools and resources available to complete the job. If we do not, we are asking them to do the impossible, tantamount to making a four-course meal while blindfolded and watching a 2-year old.

We must then communicate that belief that it is a priority to facilitate buy-in. How often have we as leaders blamed the State or Government for a regulation? For example, I have heard, "Listen guys, I know that we should be able to keep our coffee on the desk but the State says no." The State says no because there is a very real infection control guideline that must be followed for best practice. The same is true for antipsychotic reduction.

We cannot communicate the initiative in a way that says we do not believe in it. We cannot say it's what the State or – we cannot say it's what the State or – sorry, I just lost my place. So if we as leaders do not communicate that initiative, that it's the right time for the right population for the right reasons, we are undermining this initiative before it even starts.

So let me tell you a little bit more about Lebanon Center. Lebanon Center is a 110-bed facility located in rural New Hampshire. Our population consists of a mix of rehab patients: We have Medicaid and private-pay patients as well as the Medicare population. We are not a locked facility; we are alarm-free. And we have a strong resident-centered philosophy with a heavy emphasis on maximizing the capabilities of our residents.

In October of 2012, we decided that this antipsychotic reduction would be a priority for our facility. And 24 of our 110 residents at that time were prescribed antipsychotics for multiple diagnoses. Only two of these were acceptable according to the CMS guidelines of schizophrenia, Tourette's, or Huntington's. At that time we began a project for improvement which included education, monitoring, increased communication, and accountability. So we said, "This is important and this is why, and we believe in this."

But all – as all team members need education about the initiative and the positive impact that it's going to have on the residents' well-being. And by all team members, I do not mean just direct care staff. All team members from housekeeping to dietary, to transportation, to maintenance, to business office personnel. Each team member has the ability to move the initiative forward.

For example, there's just been a gradual dose reduction of Risperdal for Mr. Abbott. Noise is known to trigger his behaviors. Housekeeping needs to vacuum the room. If they vacuum with him in the room, it may trigger behavior that will lead to believing that the reduction was not successful. The reduction was successful, but we were not successful in managing the environment. Everyone has a part to play in every initiative.

Think of fall reduction. At Lebanon Center, the housekeepers have primary assignments and get to know the residents around them. The extra set of eyes, which alert the direct care staff that Marge is trying to climb out of her chair, are just as important as the nurse passing meds.

So again, setting the foundation is the most important part of any initiative. So at Lebanon Center, all team members underwent education about quality dementia care, end-of-life care, and effective communication skills. We talked about why antipsychotic medications are not always an effective treatment option and why gradual dose reductions and elimination of these medications should be considered. We talked about what consequences, both positive and negative, may come from this change. Then we put in tools and resources and discussed how to use them.

So the foundation—again, I can't stress it enough—is the most important part. How can you reduce antipsychotics without having extensive training in dementia? And further, how can you reduce antipsychotics if there are chair alarms ringing disrupting the environment? How can you reduce falls and reduce antipsychotics if there's no consistent caregivers to know residents' needs and routines? Each of these things are related. Nothing operates in a silo.

So leadership must ensure that a system is in place to pursue these goals. In this case, of antipsychotics, the system should be developed by an interdisciplinary team and be open to revision if things are not moving in the right direction. Now, reinforcement of that system is key. If someone is circumventing the system, go back. Educate and ensure that they know how to work within the system.

This may sound rather like a dictator. However, when a staff member does not complete a task as it should be, they must be educated in real time and taught how to do it the right way to ensure the safety and success of the population. For example, you're attempting a dose reduction on a resident and behaviors escalate. The nurse does not try non-pharmacological techniques outlined in the care plan but instead calls the doctor to increase the antipsychotic. Stop the process in its tracks and redirect to a way that it should have been done in the first place.

It's impossible to work on this initiative unless you have accurate data in real time as to what is actually happening. So on slide 17 we talk about looking at the trends and tracking each resident's antipsychotic use, but also tracking where the resident is, what room, what wing, what the diagnosis is, who the prescriber is, and who the primary care staff are, and look for trends in that. Is there one wing that has heavy antipsychotic use? Well, then we need to look at that.

So in our case we started a simple line list of residents on antipsychotics. It was updated daily in morning meeting. We later came to include the last social work and pain assessments as well as the last GDR and when the resident was visited by a psychiatrist. But we started it as a simple list.

At Lebanon Center we decided that for our population, each resident on antipsychotics would be seen regularly by a psychiatrist or a psychiatric nurse practitioner. We then kept track to ensure this was happening, and we kept track every day, every time. At Lebanon Center, anybody on an antipsychotic is seen at least once a month even if they have the proper diagnosis in place of schizophrenia or Tourette's.

Now, we began with the easy ones, gained success by picking the low-hanging fruit to reinforce buy-in with the staff. Start with one. Start with the little-used PRN, that as-needed Haldol that one patient has. Get rid of it. Those little successes will give the courage to move forward and tackle the big ones.

Now, as was said previously, review each new resident for antipsychotic medication use and discontinue antipsychotics upon admission if they are new and there's no reason for their use. Many acute care settings are now prescribing antipsychotics for sleep. Discontinue them before they are started in the building.

If you're not sure why the potential admission is on an antipsychotic and the acute care setting does not have a good reason for it, ask that it be discontinued 24 hours before you accept the patient to get a better idea of patient needs. Also, place a hard stop on all antipsychotic prescriptions. Before any antipsychotic prescription is written in this

facility, I am called as the Director of Nursing. Now this is not to say no. It is to ensure, though, that the staff have the tools they need to avoid it and to ensure that the staff has utilized each and every non-pharmacological intervention before utilizing an antipsychotic.

Now being – the facility must be transparent regarding the initiative. And we have to learn from the failures. As the slide says, learning from failure is essential for success. There are 10,000 ways that don't work before sometimes you find the right one. So also, what the – you have to be transparent on what the data is and more importantly, what the goals are. And communicating that to each and every staff member is very important. That transparency is essential to not only let people know how you are doing but to build trust.

So, be transparent and communicate regarding all new initiatives. Be honest and open with the staff about the data even if it does not put you in a great light. Celebrate your successes. For example, today we're providing pizza and cookies to each shift to celebrate having a great month in regard to the falls in January.

Now when a GDR fails, discuss why that GDR failed. Look at it from every angle, remembering to include who was there, what was happening at the time, the environmental and social factors. For example, if a resident's negative behavior escalates whenever the family visits, this is not a good reason to keep antipsychotics. This is a family education issue.

And finally and probably most importantly, engage the front line staff in every decision. The person closest to the bedside should have the loudest voice. Care-planning decisions should always be made as close to the bedside as possible.

So a good foundation in the basics will allow each initiative the best chance for success. And the basic foundation makes bringing other initiatives easier. And this is an intersecting highway; this is not a parallel road. For example, good dementia education will allow for further success in alarm reduction. Better communication will also result in the ability to spot illness early, resulting in decreased hospitalization. Remember, leaders must be ready to reinforce the *right* way. If we allow the wrong way to be accepted, it will be replicated. Always expect excellence.

So today at Lebanon Center we have only eight residents on antipsychotics that do not have CMS-approved diagnoses. Each of these are evaluated frequently and continue to have reductions whenever possible. We have maintained this while having a stable if not reduced number of falls. We have no increase in anxiolytics and actually have a decreasing depression rate.

We also have not had any increases in the category of behaviors that affect others located on the CASPER report. Currently, our rate of Behavior Symptoms that Affect Others is only 2.2 percent, compared with the State average of 25 percent.

So I want to thank you for the opportunity to speak today. But I also want to make it clear, I am simply the mouthpiece for an amazing team at Lebanon Center, and I'm so very proud to work with them every day.

So at this point I'd like to see if there's any questions.

Michele Laughman: Actually we will, we'll have the Q&A session at the end, Kate, but I do appreciate that. So if people would like to ask questions, we will do that at the very end.

So thank you. Next up we will have Michelle Carlson. She is the Project Coordinator with HealthInsight, which is the quality improvement organization in Utah. And she will be discussing the topic of proper pain assessment and how it correlates to the reduction of antipsychotic medication. So, Michelle?

Proper Pain Assessment

Michelle Carlson: Yes. Thank you so much for having me today, and I want to thank Michele for giving me the opportunity to speak. I'm really happy to be on the call even though it's hard to be inside here today. It's 60 degrees and sunny and beautiful in Utah, which – that's a heat wave for us here in February. So we're enjoying that.

So I am speaking today on are we doing enough to address pain for our dementia residents in our nursing homes? I think we're all aware by now that seniors are the fastest growing population worldwide. And currently, it is estimated that of people 65 years or older, 5 percent have a dementia diagnosis. But for folks 90 years or older it's estimated that over 50 percent of them have dementia.

And I have a real special place in my heart for folks with dementia. I began my health care career 21 years ago, sad to say, as a CNA working on a dementia unit. And it was at that time I came to realize how vulnerable that population is. And, you know, 21 years later we've made some really great progress. I used to be the CNA tying residents to a geri chair with a Posey vest, and I'm glad to say that we don't see that here anymore. But we still have a lot of room to grow with reducing these antipsychotic medications. And knowing how far we have come with reducing physical restraints, I think it's definitely possible and on the horizon.

Globally, it's estimated that 35 million people have dementia and that 50 percent of them experience regular pain. I started to become aware of the issue and possible relationship between pain and antipsychotic medication use here in Utah when I realized last year that Utah was the second highest in the nation for long-stay pain according to the MDS 3.0 CASPER quality measure report, so I started doing a little bit of investigation to see if I could figure out if there was a correlation there. And some of this information has come from making that an effort here on our part in Utah.

According to the American Geriatric Society on Persistent Pain in Older Persons—this was back in 1998—persistent pain can be defined as “an unpleasant sensory and

emotional experience that continues for a prolonged period of time that may or may not be associated with a recognizable disease process.”

Current research estimates that 35 to 48 percent of older adults living in the community experience pain daily, and that this is compared to 45 to 80 percent of folks with dementia residing in nursing homes. I’m fairly confident that we’re not treating 45 to 80 percent of our dementia residents in our nursing homes for pain, whether that’s pharmacologically, non-pharmacologically, or both.

There’s a quote here that says, “Dementia increases the risk of inadequate pain treatment; even severe and persistent pain goes untreated in many patients with dementia.” “International epidemiological research has shown that elderly in general, but especially those with dementia, receive less pain medication than their cognitively healthy counterparts, even in the same painful situations—for example, after a hip fracture.” And why is this? Because often, more often than not, they cannot verbalize their pain, and we’re not yet proficiently skilled at assessing nonverbal signs and symptoms of pain. We’re just watching for those signs if we are skilled at assessing them.

Why is this? Well, in nursing homes here in Utah, and I believe it’s probably the same nationwide, we have a lot of new nursing graduates that care for our residents in nursing homes, and it takes time to develop some of those skills. I’m also not sure that we’re doing enough to mentor those nurses on the front line. An example that I would like to give also is, are we set up in our nursing homes and especially in our memory care units, if we have such a thing—we do still have memory care units here in Utah—is the physical environment set up so that we can properly observe our residents?

A colleague of mine and I were in a nursing home here in Utah last year, and we were offering some technical assistance during an onsite visit, and we were in the dementia unit, or the memory care unit. And the way that it was set up, there was a nurse on staff responsible for more than a handful of residents, but the majority of them were in a social living area.

Before we got there they had nothing to do, but we brought them some sensory stimulation tools that we were kind of testing out, so we were hanging out in this area. And where the nurse was set up to do documentation on her laptop computer, she could not see the residents except for maybe from the shoulder up because they were sitting in chairs and they were sitting on sofas so that she couldn’t see the remainder of their bodies. And we happened to observe one resident constantly rubbing her knees and kind of shuddering. And so we had mentioned to the nurse that it looked like she was uncomfortable and possibly could have been in pain and could they, you know, look into that.

And after some time and another prompting, the nurse did get up and did give her something for pain, but, you know, it led me to start to think about how are we set up to actually be able to observe these residents. The resident was not capable of verbalizing, “Hey, I’m in pain. My knees hurt.” And if we hadn’t observed that she had been in pain, I

don't know how long she would have gone in pain before somebody would have attended to her needs.

So pain manifests in many different ways. It can be associated with increases in behavioral disturbances, agitation, depression, anxiety. And it can also be associated with declines in functional and mental capacity, social interaction, quality of life, appetite, and sleep, to name a few.

So what does all of this mean so far? So far we've learned that chronic pain affects 45 to 80 percent of nursing home residents with dementia, that chronic pain may or may not be associated with a recognizable disease process, so they don't necessarily have to have a diagnosis that you would automatically assume that they would have pain for. They could have pain and not have a diagnosis that is usually associated with having chronic pain. We also know that pain can lead to an array of behavioral disturbances.

So if nursing home residents are unable to communicate that they're experiencing pain, and many of the behavioral disturbances discussed are common with dementia residents for whatever reason or reasons, what is the likelihood that we are looking at pain as contributing to or responsible for many of these behaviors?

I would imagine that more than a few of us have sat in an IDT meeting that went something like this: Jane has decreased social interaction. We think she's depressed. We probably ought to put her on an antidepressant because she's not coming out of her room as often as we think she should or she's not attending as many activities as we think she should.

My question to that would be, do we have an activities person or a social services person at the table at this IDT meeting to say, "Jane does not enjoy group activities. She never has. She likes one-on-one activities. I go in and visit with her and she really enjoys that, but her family says she's never enjoyed large groups of people. Therefore, we don't feel like she has a decreased interaction in her social life. This is normal for her." If somebody's not there that knows this resident's history and to advocate for the resident, a lot of times and specifically, historically she would end up on an antidepressant.

Here's another example. Fred has a decreased appetite and some weight loss. So what do we do? Put him on an appetite stimulant. He needs a little bit of Remeron, right? Has anybody asked how his dentition is? Does he have teeth? Does he have dentures? Should he have dentures but he no longer has dentures because they're lost?

What foods did he enjoy at home? Could he possibly have some type of an infection or not feel well? Does he have an adverse reaction to the texture of the food or the temperature of the food? Those are questions that should be asked before we put somebody on an appetite stimulant.

Wanda has decreased sleep; she's not sleeping as much as she used to sleep. She's not sleeping as many hours or during routine that we think most people should sleep,

sometime in the, you know, evening hours 'til sometime in the morning hours. We – a lot of times, we put them on a sleeper or do put them on a sleeping medication. My question to that would be, is somebody asking what her nighttime routine was? Not everybody sleeps on the same schedule. Is she comfortable? You know, some nursing home beds that I've seen when I've walked around, there's no way I'd be able to sleep in some of those beds. Nursing home beds, I can compare to hotel beds. Some are a lot more comfortable than others.

Is she able to reposition herself? Is she becoming uncomfortable and not able to reposition herself, so she's waking and not being able to make herself comfortable again and therefore unable to go back to sleep? Those are some things that we should look at before we automatically jump to medication.

Here is another example: Joe has increased agitation. What does that mean? He's refusing care. He's combative with staff. My questions would be, which staff? Is this a new staff that he's becoming agitated with? If this is an increase in agitation which is unusual for Joe, is it possible he could have an infection or not feel well? You know, how many of us have not felt well but didn't realize it for a day or two – you become a little bit agitated, a little bit irritable, maybe short with people, maybe not quite yourself, and then a day two – a day or two later, you find out that you have a UTI or an upper respiratory infection or some other type of illness.

This happens to our residents I believe quite often, and we look at the behavior before we find out what the cause is. And once we find out what the cause is, such as they have a UTI, we don't often go back and look at, "Oh, that must have been what the reason for the agitation was," so we no longer need to have possibly medicating for agitation or regression even on the docket. We'll just completely forget we even talked about that, for this particular instance anyway.

So then we have Mary. And Mary has increased anxiety. Well, what does that mean? A lot of people would say, "Well, she paces and wanders." Well, what – define pacing. Define wandering. Is she doing both or one or the other, and why do we think she's doing it? Are we providing her space to ambulate? Do we take her outside for walks if that's something that she likes to do? Are we really looking at what we're considering to fall into the category of anxiety, what this anxious behavior actually is? And are we looking into why somebody's behaviors might be exhibiting before we put somebody on an anxiolytic or an antipsychotic?

You probably noticed, if you have the slides, all of these stars next to these signs and symptoms of behaviors, and all of these are signs and symptoms of BPSD. So what is BPSD? BPSD stands for Behavioral and Psychological Symptoms of Dementia, which are symptoms of disturbed perception, thought content, mood, or behavior that frequently occur in patients with dementia. Subject-matter experts say that we should replace the term "behavioral disturbances" with "BPSD."

I still see behavioral disturbances as diagnoses all over the place here in Utah. So we've got a lot of education to do on this issue. BPSD encapsulates cognitive impairments, mood disturbances, and sleep disturbances associated with dementia, including disinhibited behavior, delusions and hallucinations, verbal and physical aggression, agitation, anxiety, and depression. So what this means is we can expect any of these mood disturbances, sleep disturbances, and behavioral disturbances for any person that has any form of dementia.

What is BPSD continued. Considerations that we need to think about when we are having residents that are having some of these signs and symptoms is that pain may be a major contributor. They are just not able to verbalize it. They're becoming aggressive or, you know, having anxiety or even depressed because they're in pain and they can't communicate that to us.

Symptoms change with different stages of dementia; what happens in one stage of dementia may not happen as they go through the declines in stages. Agitation and aggression are often symptoms of pain and can be inappropriately treated with antipsychotic medications. BPSD manifestations have one of the highest impacts on quality of life and are often very disturbing to family members and caregivers. It's when these signs and symptoms start to manifest that most residents with dementia end up being placed in nursing homes, because these behaviors are so disturbing to family members and caregivers and they're not educated.

They're not educated enough on dementia in general, let alone how to intervene once some of these behaviors are occurring and what to do about it, what might be causing it, and having ideas on how to care for people. And they just become exhausting. So they end up placing their loved ones in care facilities, and then it becomes our job to try and take care of them.

So what can we do when it comes to pain for our dementia residents? Well, I wish that I had a silver bullet, but it's a very complex issue. According to the few studies that have been done on this issue, there are dozens of subsets of dementia which we know, dozens of different types. And pain affects these differently. Depending on what is going on in the brain that is causing the different subset of dementia, pain that they may have (and there are different kinds of pain) may affect every individual differently, and it may have something to do with what's going on neurologically in the brain.

So a few suggestions that I do have are that you could view "The Principles of Pain Assessment and Management in Older Nursing Home Patients," which is a presentation by an MD here in Utah. She actually did a presentation at a Utah QIO with our trade association education day last fall. And there's a link here on the slides to her presentation; it contains all of her slides and some good examples of assessments to use and other treatment ideas.

Always, always, always use an interdisciplinary approach involving direct care staff, as previously mentioned, and caregivers and family members whenever possible for observations and input into pain assessment and management.

One of the best things that we can do for our residents whether they have dementia or not is to keep them moving and keep everyday activities consistent to reduce agitation and anxiety. One of the ways that we can do this is to use resident profiles. For example, we as a QIO suggest to all of our nursing homes that they do a resident profile for every nursing home resident they have that is existing, and prior to the admission if possible when they have a new resident coming in, so that they can gather as much information about that resident as they can so that they can provide the highest quality of care.

Some examples of questions or answers here that I'll give you that would be on a resident profile would be something like this: Michelle enjoys walks outside on sunny days. She loves to feel the sun. She does not enjoy group activities other than musical performances and bingo. She will become agitated if too warm, if it's too crowded, and if she's thirsty. She'll fidget at night until her face is washed and moisturized and she has lotion on her feet. Hot showers help her relax. She enjoys aromatherapy. She enjoys pet visits, and so on and so forth.

The more we can find out about a person's daily routine before they came to reside in one of our buildings, what triggers them and what comforts them—a little bit of information can go a long way when it comes to preventing behaviors or offering some type of intervention or interaction with the resident that may reduce the likelihood of the behaviors or de-escalate once the behavior occurs.

Also, you can determine if your building has a discrepancy with cognitively impaired residents receiving pain management. If you go in and you look at your – you know, how many of your cognitive residents receive pain medication versus how many dementia residents receive pain medication, and look at their diagnoses and see if there may be something that would lead them to have chronic pain, or, as we know, they may not have a correlating diagnoses. If there's a huge discrepancy just in the number of cognitive versus cognitively impaired residents who are being treated for pain, whether it's pharmacologically or non-pharmacologically, you probably want to look at how you're assessing for pain.

Become involved in research if given the opportunity. We need a lot more research in this area. There are a lot of articles out there that address pain and proper assessment of pain with dementia residents, but they're all inconclusive as to what we absolutely need to do, how valid the pain assessment tools are. There are some good examples, like I said, on our website. But the best thing that we can do is, if we are aware of a study opportunity or a research opportunity with this issue, is to get involved and to get our residents involved so that we can further our education and understanding of properly treating these residents for pain.

So that's all I have today and again, I thank you for the opportunity to speak.

Next Steps and Resources

Michele Laughman: Thank you, Michelle. We appreciate that. We've really had some enlightening presentations today. Our efforts continue to be focused on outreach with individual nursing homes, States, and regions. We are trying to gain stories of success like those that we heard about today to share with States that continue to have high rates of use.

On a recent call with Arkansas, we learned how the QIO and Arkansas AKA Chapter are partnering to give providers across the State access to a virtual dementia tool. This tool will not only benefit direct care staff but also nursing home staff in an effort to encourage empathy when caring for persons with dementia.

Another best practice example is a video that was created by the Oklahoma Quality Improvement Organization and shared with us recently. The video captures a nursing home in Oklahoma providing individualized dementia care. This video will soon be posted to the Advancing Excellence website, but in the meantime can also be viewed on YouTube under the title "The Villages of Southern Hills: A Champion for Change." Again, that title is "The Villages of Southern Hills: A Champion for Change."

As Karen mentioned earlier, the original target for this national partnership was for a 15-percent reduction. We are very close to reaching this goal and are currently discussing future goal setting. With all of your efforts we will continue to pursue the successful implementation of this critical partnership.

Thank you. And now, I will turn it over to Leah for the question-and-answer session.

Question-and-Answer Session

Leah Nguyen: Thank you, Michelle. Our subject-matter experts will now take your questions about the National Partnership to Improve Dementia Care in Nursing Homes. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization.

In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one. If you'd like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits.

All right Victoria, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard into the conference.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Chris Crouch.

Christine Crouch: Yes. This is for Michelle. Michelle, can you give me a couple examples of some of the non-pharmacological interventions? We're struggling with some of those here at our home.

Michelle Carlson: Sure. They probably would be different for different people, and things that would provide comfort for that individual. I know you have to be super, you know, careful with certain things such as heat packs, massages, aromatherapy massages. Some people like a whirlpool bath when they're feeling kind of achy – maybe not in, you know, real acute pain but maybe more of a chronic, achy kind of a pain.

One of the best things I think that we can do is talk to family members and ask, you know, before they got to the point where they could not communicate to us when they were in pain and they happened to have pain, how did they find relief? It's not always pharmacological that provides relief, oftentimes it is and a lot of times it's in conjunction with a non-pharmacological approach such as a massage, like I said, a hot tub bath. Sometimes it's just a change in positioning. People get into a position and they become – they have some pain. Sometimes we just don't get them up and moving enough, and they become stiff, and when we try to start getting them moving again then it becomes painful for them.

So, again it's different for each individual, and I would talk closely to the family and the caregivers to find out what may or may not have worked in the past. There are those people that, you know, it's going to be pain medication that's going to be effective for their pain, but it depends on the individual and the type of pain and where the pain is.

Christine Crouch: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Sandra Stimson.

Sandra Stimson: Hi. Excellent speakers. This is Sandra Stimson with the National Council of Certified Dementia Practitioners. My question is if they could give more information specifically on what type of in-service was provided to the staff to recognize pain, and if you personally developed it, if that could be shared with the community.

Michelle Carlson: The presentation that we provided at the education session here in Utah was more kind of an overview of pain assessment and treatment. If you look at the slides that are provided on our link, there are some examples of specific things to look for and also some examples of some nonverbal pain scales that Dr. Talebreza thought were fairly effective, again, for folks that can't communicate. So I would look at that presentation. It contains the slides for her presentation and also her contact information,

and she probably would be more than happy to answer questions. She just is extremely busy, and sometimes it takes a while for her to get back with you.

Sandra Stimson: Thank you.

Operator: Your next question comes from the line of Jeff Hilock.

Jeff Hilock: Yes. Hi. One of the things that I was looking for, a possible outlet, is we have many residents that are Spanish speaking, and we have several that are nonverbal and ambulatory. What is the best – I don't know, approach, I guess, on how to make their needs known? Because sometimes their nonverbals even don't even let us know that there might be something brewing.

Kathleen Lynch: Hi, it's Kate.

Jeff Hilock: Hi.

Kathleen Lynch: I think that one really good resource is actually having the family make a communication board. And the communication board, you can use things from clipart to, you know, there's all sorts of things on the Internet, with just simple pictures. And those pictures can be hot, cold, comfortable, not comfortable, smiling, the FACE scale. It can be a cup of coffee. It can be any of those things. But also by including the family in that, you're also doing a lot of education with the family, and there'll be a lot of cross learning.

Jeff Hilock: Thank you.

Operator: Your next question comes from the line of Norwu Wesson.

Norwu Wesson: Hi. Are facilities going down the road of having a psychoactive medication policy, or are people just using guidelines? What have you seen in the field?

Kathleen Lynch: So I work for Genesis, and Genesis has very clear policies regarding antipsychotics and the use of them. And we also have very clear policies in terms of how we document behaviors and how we assess things going forward. However, some of these are very new. So I would say if you don't have these, sometimes you do have to develop your own, but make sure that they're in – they're within the guidelines of your State rules and regulations.

And like I said, we started very small. We started with a simple line list, and then as we learned more and as CMS came out with more and more information, we added more. And it became a much more complete program.

Norwu Wesson: Thank you very much.

Operator: Your next question comes from the line of Melissa Randler.

Melissa Randler: Hi, we were wondering what the staffing ratio was at your facility?

Kathleen Lynch: At Lebanon Center we have – so I'll just describe typical days. On days we have, for 55 patients we have either 2 or 3 nurses, depending on the population – if it's – the acuity, and then we have anywhere from 6 to 8 LNAs. And that's just that. We usually have a ward secretary, and we also have a unit manager for each floor. Now, I want to, though, include – I think the activities departments are wholly underutilized in this initiative. And your activity staff is going to be some of the most important people that you have.

So we don't have, you know, the best staffing in the world. I mean, we struggle with staffing like every other center in America. But we do, you know, we do the best we can, and we do try to keep our staffing as high as we can.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of David Flores. David, your line is open.

Your next question comes from the line of Michelle Webb.

Michelle Webb: Yes. Good afternoon. Thank you, this call has been so informative, so I'd just like to thank the speakers so much for doing this. I have two questions. I actually have one for Kathleen and one for Michelle.

Kathleen, in your facility at Genesis Lebanon, what, if any, environmental modifications did your facility make to ensure that the home – that there was a home-like setting? Because we know that sometimes an institutional type of environment really can increase some of the BPSDs that we see.

And Michelle, for you, as far as pain assessments, do you have any particular assessment that you would recommend to the field? Thank you, ladies.

Kathleen Lynch: So thanks for your question. It's a really good question. The environment is everything. First, I would say it's not just what you see for furniture. You have to look at what the auditory environment is as well. If you have a lot of overhead paging – I'm a big believer that if you have alarms, like chair alarms or bed alarms, I think reducing antipsychotics in that environment is going to be even more difficult because remember, you know, we've always been taught you run away from alarms. So alarms can actually be disturbing and can actually increase those behaviors.

Now, what – we didn't do any physical changes to the plan; for example, the nursing station stayed where it was. What we did, though, is really concentrate on having an active living room. Having things for people to do, having different, you know, activities and having different things that could be interactive for them. But then also not just in that living room, making sure that people could go to a different dining room, because I

know I wouldn't want to be in my one living room and then my bedroom all day every day. So trying to make sure that residents got that changed environment as well.

The third thing regarding environment is I cannot say enough about primary caregivers and consistent staffing. When you have somebody new on a block, you know that really they're just worried about when somebody is going to be going to the bathroom; they certainly don't know what their behaviors are when they need to go to the bathroom. So it's really important to have that consistent staffing. So it's not just the physical environment that's so important. I hope that helps.

Michelle Webb: It did, thank you.

Michelle Carlson: Hi. Yes. This is Michelle. Some of the pain scales that have been recommended by Dr. Talebreza that we have worked with on this issue are the numeric rating scale, if a person is cognitive and able to rate their pain on a scale of 1 to 10; as well as a mapping scale, if they're able to look at an image of a body and kind of point or locate on a map of the body where their pain is located. They – if they're cognitive but they just have difficulty communicating, these can be good scales to use because they can just point to the map of the body or the map of the number where they would fall on a scale of 1 to 10.

And for non-cognitive people, probably the FACES pain scale is one that is fairly valid and reliable, where you have – you can look it up on, you know, on the Internet, but it has faces that indicate different types of pain on a severity scale of 0 to 10, and what somebody's facial expression would look like according to the level of pain that they're feeling. There's also the Wong-Baker FACES scale—excuse me, pain scale assessment that was developed for pediatric patients that basically follows the same concepts.

And then there's a couple of other pain scale assessments called the NRS and the FPS-R that are feasible for use in most patients that are cognitively impaired. I don't know the real specifics on each one of those pain scales, but there's information on them, again, on the link to our website, and they are readily available on the Internet.

There's also a couple of promising tools that are listed on this presentation. And they're just acronyms, so again you would probably need to look them up. But they're the PACSLAC and the Doloplus 2. And then there's also the PAINAD scale, which is mentioned in quite a bit of the literature that I've been reviewing, which is a scale that is endorsed and used by American Academy of Hospice and Palliative Medicine. But again, these are listed on the link for the presentation on our website.

Leah Nguyen: Thank you.

Michelle Carlson: You're welcome.

Operator: Your next phone question comes from the line of Marvin Byard.

Marvin Byard: Hello. I'm a pharmacist and I do consulting for long-term care. So one of my questions is as far as a gradual dose reduction on antipsychotics, what seems to work the best? I'm guessing like a 25-percent decrease in the dose once a month or is it every 2 months, every 3 months? What, you know – I don't like to hurry – see doctors hurry it up because they're setting it up to fail if they try to do it too fast. So I wonder what the experience was.

Kathleen Lynch: You know, you bring up a great point, and I really appreciate your question because one of the people I didn't mention was our pharmacist consultant, who is absolutely integral. And I have to say, you kind of nailed it on the head. What we tend to do—and there's no cookie cutter approach—is about a 25-percent reduction about every month. Now, that may change. For example, we may find from previous experience that we have to bring somebody down 10 percent every 6 weeks, or that we can do it a little bit more quickly. But...

Marvin Byard: Thank you.

Kathleen Lynch: But again, there's no cookie cutter approach to that.

Marvin Byard: OK.

Operator: Your next question comes from the line of Thomas Smith.

Thomas Smith: Yes, thank you for the presentation. I was wondering, in the target group to reduce the antipsychotic drugs, were hospice patients included in that study or that effort?

Kathleen Lynch: Yes, they were. We do recognize Haldol as an end-of-life drug. And we do include that in our antipsychotic numbers because of course they trigger just like any other antipsychotic. However, we don't – our hospices do not put Haldol in place unless it's absolutely necessary. So for example, have we done the environmental modification? All the same steps that apply to every other resident on antipsychotics also applies to the patient that's actively dying or on hospice. Have we treated the pain, have we attended to all the comfort needs, have we treated anxiety? All of those things.

So I believe the same steps really apply to each population group. But I do understand that Haldol is a, you know, very well-known medication for end-of-life use. Now, I will say, though, I think that since we did this – since we did this reduction, the amount of times we've use Haldol for end-of-life care has dropped dramatically, because we were ensuring that all the other steps took place.

Thomas Smith: OK. Thank you.

Operator: Your next question comes from the line of Samantha Zaporojan.

Samantha Zaporojan: Hi, this is Samantha, and I'm with Volunteers of America as the activity director. And there was a question asked about staffing and the response back, and I can't remember who said it, about the activity staff being a key role and underutilized. As the activity director, I just want to know what have you guys done with the nursing staff to incorporate the activity team and utilizing them, and kind of getting on the same page of how important it is to have activity staff on board, and working with the nursing staff?

Kathleen Lynch: So our activities staff, I mean, they're absolutely brilliant. I am so impressed with our activities staff. I think that the culture of this building has always been one where the activities staff were always seen as equals. The activities director is a director and they're at every morning meeting. Their input is very welcome. And also, we included them in the weekly meetings that we have for anybody who's having any problems. So for example, they're included on all the care-planning decisions. So it's not separated out. It's not a secondary thought.

And I think that by doing that, the administrator, myself as the nursing director, dietary direction, we've all projected the importance of them from the top. And we've also addressed it if there was something that happened, maybe a negative interaction or maybe there wasn't the respect that needed to happen, that was addressed on a person-to-person basis. And we've celebrated everything that activities does. And we actually have very large activities calendars. We have – they're very visual and very present in our building.

So, I think it comes from the top, that mutual respect that has to happen. But again, they're very close to the bedside, and they need to be a piece of this puzzle.

Samantha Zaporojan: Right. Thank you.

Operator: Again...

Michelle Carlson: Yes, I would just like to add—this is Michelle—that as a quality improvement organization, we go all around the State here in Utah doing onsite visits as well as larger conferences and trainings and webinars. We always emphasize how important the activities department is and that the activities director as well as the assistants are key partners and should be involved in any care planning, and especially in the care plan meetings with the families. They have a lot to offer. They spend a lot more time with the residents than a lot of the clinical staff do, and we just cannot under – or, excuse me, we cannot emphasize enough how important they are. But I do believe that still here they're underappreciated and underutilized, and we're doing our best to try and get them more into the line of focus and being appreciated the way that they deserve to be.

Alice Bonner: That's really well said. This is Alice Bonner from Northeastern University, consultant with CMS. And I just wanted to chime in and echo those statements about activities. And also, I think, what all of us are hearing on this terrific call today is many important people on this interdisciplinary team, and I just wanted to also mention medical

directors, physicians, nurse practitioners, and other clinical providers. Part of the reason why I just wanted to make mention of that is because one of the conditions that is often under-recognized in nursing home residents is delirium. And delirium can cause a lot of the same mental status changes or behavioral manifestations that we see with dementia, but it has an underlying medical cause, very often infection or dehydration or a new medication.

And it's really important because delirium can quickly become a medical emergency. It's important that we are training staff and learning and talking about recognizing delirium as well. So the American Medical Directors Association, American Geriatric Society, and some of the geriatric nursing organizations as well as the pharmacy organizations have really got some good materials that are available on that.

And I think it's just important that – you heard in the beginning of the call, you heard Kate talk about this very systematic process of trying to determine, you know, like a good detective—I mean you're really being like Sherlock Holmes here—you know, what could be the underlying cause of a behavior. And that cause identification, that process needs to be a very systematic analysis that leads you to identify things like potential delirium, infections, and other problems, and rule them out and then really focus on, OK now, what can we do and how can we do it?

And a lot of the great interventions and ideas about the non-pharmacologic tools and resources you've heard about today. Michele Laughman asked me to mention a couple of others as well. We do have on the Advancing Excellence website a number of tools and resources that address some of the questions that are coming up here today. With respect to pain, there is a website that's called GeriatricPain.org. And that's another website where you may find some tools and resources and curricula that would be helpful.

And there is also the Nursing Home Toolkit that was developed under a grant from the Commonwealth Fund by several nurse researchers, Ann Kolanowski and Barbara Resnick, as well as Kim Van Haitsma, who's a psychologist. And that toolkit may help some of the folks who are asking about non-pharmacologic interventions. It's like a clearinghouse; it is a whole bunch of resources. And that's also available as a link on the Advancing Excellence website, but you can simply go to Nursing Home Toolkit and find that resource.

Also on the Advancing Excellence website are policies, ideas for how to develop policies. So Kate was saying that Genesis has very extensive policies on non-pharmacologic interventions and also on how to reduce – gradual dose reduction and so forth. If you do not have those policies or if you'd like to re-review your policies because of the new CMS guidance, on the Advancing Excellence website there are some sample policies that you could use to get started.

So we just wanted to mention those tools and resources as well.

Leah Nguyen: Thank you, Alice.

Operator: And again, if you would like to ask a phone question, simply press star 1 on your telephone keypad. Your next question comes from the line of Mary Peterson.

Mary Peterson: Yes. I'm sorry, Karen. I'm not sure if I heard you, but you talked about the surveyors to be cognizant obviously when they're conducting their surveys in the nursing homes if there's seemingly any abuse of psych drugs. That said, you talked about some mandatory training for surveyors. And I'm not sure if I – you named some mandatory trainings. I couldn't hear everything at that time.

Karen Tritz: Thank you for your question. Yes, we did release three mandatory trainings on dementia care and identification, appropriate use of antipsychotics, as well as when deficiencies are cited, sort of the scope – broader scope and severity determinations. Those are available for public viewing at the surveyor training website.

And I believe if you go into, I think, even Google and type in “CMS surveyor training,” you should – it should take you to the main surveyor training page, and you can log in as a guest and see those trainings. They were mandatory for the surveyor – for the State surveyors and, as said in the opening remarks, we've been talking with States and regions about ensuring that those are viewed.

So feel free to take a look at them. Michele and Alice, who both talked today—Michele Laughman and Alice Bonner—were instrumental in producing and releasing those trainings. I would see if Alice or Michele wanted to say anything more about what was incorporated into the trainings.

Michele Laughman: Well, I would say that the first training – and again all of these were released last year, between January and May of 2013. The first training was really just kind of an overview of the national partnership. The second training was an interactive training, where it actually walked through a good portion of the survey process with questions and answers throughout. And then the third was focused on, as Karen had mentioned, scope and severity. The first and third being about 35 minutes in length, and then the second one, because of it being interactive in nature, you know, took somewhat a little bit longer.

But, you know, it is mandatory for all long-term care surveyors to complete. And we've been tracking that completion as well to ensure that the surveyors are getting the information and training that's expected. Does that answer your question?

Mary Peterson: Yes. Yes.

Michele Laughman: OK. Great.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Elizabeth Gomes.

Elizabeth Gomes: Thank you. I just – I really appreciated all the practical information on this call and also agree that an interdisciplinary approach is really, really critical. I haven't heard it mentioned, and so I just wanted to bring it up, that a well-trained therapy department, particularly occupational therapy, can really contribute to this and shouldn't be thought of as something completely separate; that we bring much training involved in the assessment and understanding of the perceptual changes that happen with dementia, and also in analyzing peoples' occupational interests and history and working together with activities and nursing to develop comprehensive dementia care program. Thanks.

Kathleen Lynch: You know, I think that's a great point and I really appreciate you bringing it up. And we're lucky enough to have rehab in-house. So they can also sometimes give us a little bit of a curbside consult, and then we can get a full assessment when we need it, but I absolutely agree. And again, the more people who have the eyes on these residents can give suggestions because everybody sees something different. So I absolutely agree and thanks for bringing it up.

Alice Bonner: And I – this is Alice again, and I just wanted to reiterate a very important point that Kate made earlier about the housekeepers. And when we think about fall prevention, and we know that many of you are working on alarm reduction or eliminating alarms in your building, you know, the opportunity that we all have with the housekeeping department and even the maintenance department, you know, training everyone in fall prevention and training everyone in dementia care is a real QAPI approach.

That's when we say with Quality Assurance/Performance Improvement, that it's about design and scope, and the scope is that everyone in the building has this role to play and can be a vital part of the care of these people. That's how you create a sense of community and a sense of family in your buildings. And as you can tell from the people, you know, speaking on the call today, they've really done this. And we're hearing such incredible stories from all around the country, and it's such a team effort in these buildings. So the OT, you know, thank you so much for mentioning OT. We've heard great testimonials about the activities staff and how important they are.

Many of you work with behavioral health teams, and this has been some interesting conversations that we've had because in some cases, you know, people have said, "Well, you know, they come in, they do the consults, and then they leave again. And it doesn't – you know, we don't always get that much time with them." The best-practice homes, the homes where it seems that a team has really been able to reduce antipsychotic use, in many cases, there's been a much closer relationship with the clinical nurse specialist or the psychiatric or psychologist teams that are coming in. They are not just, you know, seeing individual residents, but they are working with the nurses, working with the leadership, working with the medical directors, and really part of the team. And building that relationship is something that you may want to consider as, you know, one of the approaches that can also really help you in this work.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Ryan Simmons. Ryan, your line is open.

Ryan Simmons: Oh, OK. Thank you again for all of that wonderful information. I've got a question for Kathleen concerning the education for all team members. I think you guys really hit the nail on the head with that. My question is more to operations: What does that look like as far as time of day, length of training, as well as the source for your training material?

Kathleen Lynch: So everybody is trained upon orientation to the facility. So when we first started this we did go back and, you know, trained those who hadn't been trained. But all of our nurses, all of our LNAs, have extensive dementia education when they are oriented. We use the Hand in Hand program that is very popular. Then when the other people come in, like dietary and housekeeping and ancillary staff, we do a short dementia training with them to hit the highlights.

Now, I think the bigger thing is to have ongoing education. In this building there's dementia education of some form at least every week, 2 weeks. I think this week we've actually – this month we've had six or seven different sessions of dementia training offered to all staff, all different times of day. I think it's very important to offer it to days, evenings, nights, not just your dayshift. We tend to – we're here 8 to 4, so we tend to put our training 8 to 4. You got to come in at 6, you got to be there at 11 o'clock at night to really make sure that everybody is trained, and also that also conveys how important it is.

But I think that certainly you don't need to have the entire Hand in Hand program for your business office person. It may be abbreviated and that's OK. But I think you have to take care of it upon orientation. And you have to ensure that people understand upon orientation that this is important.

Ryan Simmons: OK.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Patricia MacCulloch.

Patricia MacCulloch: Hi there. I'm so grateful to participate in this call and learn from all of you. I'm working with a group of folks in an emergency department, a senior-friendly emergency department out in Rhode Island, Roger Williams Medical Center. And we're looking at folks with cognitive impairment that are being sent to the emergency department for an urgent assessment and finding often 60 percent of our population are being sent back to the long-term care facilities because they're not meeting admission criteria.

I'm posing a question to Genesis of Lebanon. In your trainings and in your program, was there a focus on family involvement and the facility being attuned to those geriatric assessments to best avoid the emergency department transfers?

Kathleen Lynch: Yes, absolutely. Our families are as involved as they want to be. We all know that there's some family members that are here and dedicated and very involved, very knowledgeable, and there's others that are not. So of course we take that into consideration.

Lebanon Center uses the INTERACT program. And the INTERACT program is a fabulous program that we have used that includes a watch tool, an extensive SBAR tool, and also a tool that communicates with the emergency department what our capabilities are so that they don't have to be admitted, or if they need to be admitted then there's some conversations as well. But the SBAR tool walks the ER through what we have done and what those results are, rather than just a simple – you know, a quick call, "Hey, I'm sending Mrs. Jones over. She's got chest pain." I think that that INTERACT tool has been absolutely essential.

The other thing that we've done is we have made it a priority that when somebody goes over with any psychiatric emergency—for example, an acute psychosis or something like that where they have to go to the emergency room, which we do try to avoid at all costs because the change in environment can be just so disruptive, we do send a staff member that's known to that patient with them. And then, if we have to call somebody in we do. But I really appreciate that you're looking at this from the ER because the ER is actually – was my stomping ground for years and years.

Patricia MacCulloch: OK. Thank you.

Operator: And you have followup question from the line of Sandra Stimson.

Sandra Stimson: Hi. I just wanted to give a followup to the question regarding environment. We do recommend that you do conduct a noise study. She had mentioned at Genesis great suggestions about eliminating alarms, but we also recommend that you do a complete noise study, which just means, you know, having somebody sit there on the unit or even in the homecare, even in the emergency room, and write down all the noises that you hear that we no longer hear, we're just so accustomed to hearing them. And start eliminating those noise, from scraping of chairs to alarms to phones that ring too loud, staff talking too loud. It doesn't necessarily mean you're going to spend any money doing that, but that will have a huge impact. And we recommend that's done at least annually.

Kathleen Lynch: You know, I think that's an excellent, excellent suggestion, and I would add to that to consider the overhead paging. That can really be toxic. And remember that alarms frequently—and it's well studied—cause alarm fatigue, where, you're right, we don't hear them. We don't have the same response to them. And so it doesn't bother us as much as it might a dementia resident.

So I think that's a really, really good thought. And I think that when that's done especially as part of a QA, that's very measurable. You can measure that. If you want to reduce that, you can measure that from month to month or however often you're doing it. And I think that will show people a very real improvement and give some of that buy-in that you really need.

Sandra Stimson: And the other thing I wanted to say is we do have a free in-service that you can download on noise and behavior and how it affects a dementia older person. So we do have that available on our website for free to train the staff because again, it's such a simple thing you can do. It takes 1 day to do it and has a huge impact not only on the residents, but on the staff to work in a nice, soothing environment as well. Thank you.

Alice Bonner: And this is Alice, I just wanted to add to those great comments that the noise also has a very big impact on sleep. And one of the things when we talk about dementia that we've been talking about and hearing from the field is about facilities that have really looked very carefully at the noise at night and other aspects of sleep disruption, with some very positive results that when sleep is less disrupted, and when people are sleeping better, sometimes it's been the case that the dementia-related behaviors have been less. Thank you.

Karen Tritz: Hi, this is Karen. Just one followup to the respondent that mentioned the noise inventory that could be downloaded from the web – their website. Could you give that web address for folks on the phone, please?

Operator: She already withdrew her question.

Leah Nguyen: That's no problem. It looks like we have time for one final question, Victoria.

Operator: Your final question is a followup from the line of Melissa Randler.

Melissa Randler: Hello. We're just calling to expound upon the question we asked earlier. We're questioning your activity program to see how often that you guys offer activities days, evenings, weekends, and what your staffing is like in the activity department? Thank you.

Kathleen Lynch: Hi. So right now, in our activities department, we have three – since I'm not the director, I want to make sure I give you an accurate count. We have one director who's full-time, and then we have two people that are full-time and I believe two others that are either part-time or three-quarter-time.

So there's a significant amount of activity people. We also have a very, very active volunteer program, which supplements those people quite nicely. Now, our activities run typically from either 9 or 10 in the morning. There's coffee hour every day. We have a (tell-go), which is a fabulous program with rehab that helps people stay strong, and it's also called Balance in Action. So that's a program that's run together.

But activities run basically all day. It – you know, and usually end about 8 o'clock at night. Usually at 6 o'clock, there's some music or a movie or something like that that will end about 7:30 or 8. And people can pick and choose what activities they go to. But also there's really two programs for those activities. There's those for people that are cognitively intact and for people who are not cognitively intact. We make sure that there's activities that both will enjoy or that are targeted to one population or the other.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 36. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 35 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on the National Partnership to Improve Dementia Care in Nursing Homes.

Have a great day, everyone.

Operator: This concludes today call. Presenters, please hold.

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