This document has been edited for spelling and grammatical errors.

Centers for Medicare & Medicaid Services
National Partnership To Improve Dementia Care in Nursing Homes
National Provider Call
Moderator: Leah Nguyen
January 31, 2013
1:30 p.m. ET

Contents

Operator: At this time, I'd like to welcome everyone to today's 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, ma'am. You may begin.

Introduction and Announcements

Leah Nguyen: Thank you, Holley. I am Leah Nguyen from the Provider Communications Group here at CMS, and I will serve as your moderator today. I would like to welcome you to the CMS National Partnership To Improve Dementia Care in Nursing Homes National Provider Call. Today's national provider call is part of the Medicare Learning Network, your source for official CMS information for Medicare fee-for-service providers.

CMS has developed a national partnership to improve the quality of care provided to individuals with dementia living in nursing homes. This partnership is focused on delivering health care that is person-centered, comprehensive, and interdisciplinary. By improving dementia care through the use of individualized person-centered care approaches, CMS hopes to reduce the use of unnecessary antipsychotic medications in nursing homes and, eventually, other care settings as well.

The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. While antipsychotic medications are the initial focus of the partnership, CMS recognizes that attention to other potentially harmful medications is also an important part of this initiative. During this national provider call, CMS subject-matter experts will discuss the mission of the national partnership—its goals, quality measures, and ongoing outreach efforts. A question-and-answer session will follow the presentation.

Before we get started, there are a few items that I need to cover. The presentation was hosted last week on the CMS Fee-For-Service National Provider Calls Web page, at 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 January 31st call from the list. A link to the presentation was e-mailed to registrants earlier this afternoon.

This call is being recorded and transcribed. An audio recording and written transcript will be posted soon to the National Provider Calls and Events section of the CMS Fee-For-Service National Provider Calls Web page.

At this time, I would like to introduce our CMS speakers for today, from the Center for Clinical Standards and Quality. We are pleased to have with us Dr. Shari Ling, Deputy Chief Medical Officer, and Alice Bonner, Director of the Division of Nursing Homes. And now it is my pleasure to turn the call over to Dr. Shari Ling, who will begin our presentation.

Presentation

Introduction to the Initiative

Shari Ling: Good afternoon, and thank you, Leah. And on behalf of the Center for Medicare & Medicaid Services, we'd like to thank you for your participation in today's call and for your

partnership in this important endeavor. This initiative demonstrates strong collaborative efforts by a broad array of organizations and people. We're amazed by the energy, the expertise, and the commitment of clinicians, advocates, nursing home providers, caregivers, surveyors, residents, and families who remain passionate about this issue.

What began as an issue identified by the advocacy community and others has grown into a national partnership of valued stakeholders. This endeavor is ensuring that the voice of individuals with dementia is always heard and that their needs are never forgotten. Together, we believe that we can improve the comprehensive person-centered care that we provide for persons with dementia living in nursing homes. CMS continues to embrace a culture that values interdisciplinary, system-focused interventions, and one that is grounded upon solid evidence and data-guided improvement.

We emphasize a person-centered approach that utilizes nonpharmacologic strategies as part [of] an ongoing treatment plan, and that may also include medications in some cases, to meet the individual needs of each person. The efforts we are continuing to discuss today are critical to fulfilling our goal of improving the safety, health, and well-being of nursing home residents, a highly vulnerable segment of our population. We still have a tremendous amount of work to do in order to reduce all the unnecessary uses of antipsychotic medication.

This focused strategy and engagement of all of you, our partners, provides emphasis that CMS is fulfilling a responsibility as a trustworthy partner in achieving this goal. We must continue to put interventions in place, such as staff and prescriber training; team communication; and resident, caregiver, and family engagement. By working together, we can accomplish our goal of reducing antipsychotic use in long-stay nursing home residents by 15 percent. Our goals for 2013 are currently being finalized and will be shared very soon.

We continue to appreciate all of your efforts and your commitment to improving the care of nursing home residents, and your dedication to this initiative, and, of course, your partnership. So thank you. And I will turn it over to Alice Bonner.

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

Keypad Polling

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine. Please hold while we complete the polling.

Again, please continue to hold while we complete the polling. Thank you for your participation in today's polling session. I'll turn the conference call back over to Leah to proceed.

Leah Nguyen: Thank you, Holley. At this time, I will turn the call over to Alice Bonner, who will continue the presentation.

Presentations

Overview of the National Partnership

Alice Bonner: Good afternoon, everyone, and thank you for taking the time to be with us today. We know you're all very busy and have many demands on your time and resources. I'm going to talk about the slides as I go through them so you can follow along. So slide 2 is just an acknowledgment about the Medicare Learning Network. On slide 3, you can see our objectives for today, and they include that we want to provide a brief overview of the national partnership. We'll discuss multidimensional approaches to dementia care, including updates from around the country and best practices. We're going to share some current work by state coalitions, including work on surveyor, provider, prescriber, and consumer education. We'll review updates to surveyor guidance, and discuss future goals related to measurement, ongoing research, outreach, and next steps.

So if you look at slide 4, we wanted to start today, first and foremost, to echo the thanks from Dr. Ling and on behalf of all of us here at CMS. I've had the privilege of traveling to a number of states and conducting conference calls, hearing from many of you about the work that you're doing to improve dementia care and reduce unnecessary antipsychotic use. And today's a wonderful opportunity to recognize some of that work, the successful partnerships that have emerged, and to hear from you about how CMS can continue to support these grassroots networks, facility-based programs, and how we can continue to partner to achieve new goals as we move forward together

If you turn to slide 5, I'd like to start off by highlighting just a few of the positive changes in dementia care practices that have been observed by various partners from around the country. CMS receives calls and e-mails on almost a daily basis from many of you. Now, here's an example sent to us from a surveyor in the Northeast, who noted these positive care practices while she was in the field conducting complaint surveys. This is a direct quote. She says, quote, "I was at a facility and observed an incredibly astute CNA who was in charge of supervising residents on a dementia unit, and I saw her interacting with residents. Two of the residents paced frantically. One picked up things off the floor and would place them in her mouth. Since the items usually were non-edible, the staff would try to curb the behavior, and the woman would become very upset when staff attempted to intervene. When the woman entered the activities room, the CNA handed her an empty plastic coffee cup and a cloth napkin, which the resident took and continued on her way. I asked the CNA what she was doing, and she told me she always handed these items to the woman because it kept her hands busy and stopped her from picking [up] non-edible items, which it did. I was amazed that it was so simple, and all it took was taking the time to watch and learn from the resident.

"On the next slide is the second woman. And this is someone who would pace and rummage into other persons' belongings, which, naturally, caused conflict. I watched the same CNA hand her a pocketbook, which the woman kept in the crook of her arm as she paced around. Again, I asked the CNA why, and the CNA responded that she noticed the woman was anxious quite often and walked with her arm slightly bent, and decided to ask the woman's husband about it. The husband said his wife never went anywhere without her purse, so the husband was asked to bring purses in, and the CNA made sure the resident had a purse with her whenever possible. As a result, the woman was calmer and less frantic. She spent less time going through others' belongings—she was probably looking for her pocketbook—and all the related conflicts. Again, it was really wonderful to witness." End of quote from our surveyor.

So I'm sure many of you on the phone have similar stories about successful approaches you've found that work with residents. What's been so wonderful about the partnership has been the ability to share these best practices and to use these examples and others to demonstrate that improved care for people with dementia and certain behavior is possible.

Of course, it's true that not all behaviors have specific interventions that will work, such as in these examples, or that will work all of the time. And, yes, it does take enough staff, and staff with adequate training, and we know that can be a challenge in some facilities. But there are too many people out there right now like these residents for whom non-medication strategies may be effective, but in many cases these are people who are placed on antipsychotic or other medications, even though they only have mild symptoms or behaviors. These are individuals for whom medications may not be necessary and put them at risk. And this partnership is about finding these people and coming up with the best solutions for their individualized care.

If you turn to slide 7, I'm going to briefly review a few slides now that provide an overview of the partnership, as I believe many of you may have participated on some state, regional, or national calls and are familiar with the purpose, our goals, and objectives by now. But just to review, this initiative began over a year ago when a group of advocates visited with the CMS administrator, Dr. Donald Berwick, and asked if CMS could do more to address the high rates of antipsychotic use in people with dementia living in nursing homes.

An OIG report and Senate Aging Committee special hearing also highlighted these issues. A group of us was charged with bringing HHS agencies and CMS components together, identifying and recruiting public and private partners to examine this issue and come up with strategies to improve care. We note that the advocacy community in several states, and through their national network, has been a driving force in the partnership. They have developed consumer and other materials and have rallied groups around the country to help us think together about these issues. In addition, the nursing home provider community and professional associations, the geriatric community, including physicians, nurses, pharmacists, social workers, ombudsmen, researchers, and others, have come together in every state and have dedicated resources to this effort.

People have asked, "How can we do this together?" If you go to slide 8, you'll see our summary. And it quickly became apparent that this work was not primarily a medication issue. It was much broader than that. As a nation, we didn't have a clear, comprehensive approach for the care of persons with dementia living in nursing homes. So while the initial description and name of the

initiative was focused on reducing the use of inappropriate medications when we began, through shared discussions we've renamed this the Partnership To Improve Dementia Care. We're still focused on reducing unnecessary medication use, and CMS has chosen to focus its initial goals on antipsychotic medication use in nursing homes. However, consistent with our HHS national Alzheimer's strategic plan, we plan to examine other medications and, more importantly, other aspects of dementia care in nursing homes and other settings as well. And please note in the last bullet here that the focus is on all medications. Because any medication may be beneficial if used and monitored appropriately, and any medication may be harmful if used without an appropriate clinical indication and careful monitoring.

If you go to slide 9, this slide shows that our first-year goal was to reduce the overall prevalence rate of antipsychotic use in long-stay nursing home residents by 15 percent by December 31, 2012. This would mean that the rate would decrease from the baseline of 23.9 percent nationally. This was the baseline rate using MDS data from December 2011, averaging the previous three quarters, to about 20.3 percent, which is still one in five residents. We're still analyzing the data to determine whether or not we hit that target. However, there are encouraging trends, and we'll discuss those a little bit more a little later.

Slide 10 talks about the three Rs, and the three Rs provide an easy way for all of us to communicate with legislators, community leaders, residents, families, and others about what this initiative is really about. It can be part of your elevator pitch. It's what you might say to someone if you're sitting next to them on an airplane who asks, "So what do you do for work? What do you do in your daily life on your job?" And you can talk about how you and your colleagues are working to rethink our approach to dementia care, reconnect with residents via person-centered care practices, and restore good health and quality of life. So it's a way of thinking and talking about this initiative.

Use of Antipsychotic Medications in Nursing Homes

On slide 11: This includes some background data, and we've shared this previously—the high rates of use of antipsychotic medications in nursing homes, particularly in residents with dementia and without other psychiatric diagnoses, as well as the cost of these medications.

But there are other potential quality issues related to the prescribing of antipsychotic medications beyond just whether or not there's a clinical indication. So on slide 12 you'll see some examples. There could be an inappropriately high dose, such as noted in this study, or the use of multiple antipsychotics, where the rationale for that clinical decision is not clear.

The likelihood of being placed on an antipsychotic medication in one large study was independently related to the prescribing culture in that facility, even after controlling for other factors. In other words, given two facilities with the same characteristics and similar populations, one facility might have a high rate of antipsychotic use for persons with dementia, while the other would not. I suspect that some of you working in multiple nursing homes see this in your practice as well. It strongly suggests that if we pay attention to this issue there are opportunities to reduce unnecessary use of these medications, such as use in certain people with only mild symptoms or expressions of distress.

Research has demonstrated that comprehensive dementia care programs work. You have asked us to provide tools and resources on these types of programs. Many resources are now available on the Advancing Excellence Web site, and we'll share more on that in a few minutes.

Slide 13 shows you some state-to-state variability in the rates of antipsychotic use in nursing homes, and it's helped many of you in your regional groups focus on states with higher rates, as well as best practice states with the lower rates.

Outreach efforts to individual facilities in many states are helping us all gain a better understanding of the challenges that each state and each facility face. In some cases, high facility rates may be driven by a large percentage of mental health residents, not people with dementia, in a particular facility. In other cases, outreach to facilities with a high population of people with dementia allows state coalitions, professional associations, quality improvement organizations, or QIOs and others to identify opportunities to appropriately reduce medication use in persons with dementia by providing support, tools, and resources to those facilities.

You've shared your experiences that, in some instances, facility teams, including their medical director, director of nursing, and consultant pharmacists thought that they had already done what they could to minimize antipsychotic use. And yet they found that they were able to do even more.

Partnerships and State-Based Coalitions

The next few slides will provide a brief status report on some of the various dimensions of the national partnership and the work that many of you are already doing in your facilities. So if you turn to slide 14, this shows you some of the partnerships and state-based coalitions. We mentioned these state coalitions and the opportunities they have to open up an ongoing dialogue, and get people talking together who don't always have that opportunity to be included in conversations—advocates and providers, physicians and pharmacists. It's been fruitful and productive. And in many cases these informal grassroots coalitions are just getting started. In Region 4, many outreach efforts have been conducted, and these are going on in other areas as well.

So peer-to-peer learning is the goal. Can these coalitions function as learning organizations, sharing challenges and best practices, helping and supporting one another in this work? State coalition partners and QIOs have also reached out to facilities with very low rates of medication use in residents with dementia to learn about these best practices. What have those facilities done differently? How did they transform? How long did it take? Were there increased costs, such as related to staffing or other resources? You may be wondering about some of these issues, too.

We'd like to point out that our QIO colleagues and partners are embarking on a major new initiative in the second phase of the 10th Scope of Work by establishing nursing home quality care collaboratives in each state. They're going to be continuing to work with nursing homes on these and other quality issues. We anticipate that state coalitions established in 2012 through the partnership will continue to work closely or even merge with some of these new nursing home collaboratives, optimizing time and resources devoted to this work.

On slide 15, you will see some state highlights. So far, we're seeing successful collaboration in a number of states, and those are shown on this slide, as well as there are many others. Nursing home residents themselves have been involved in a number of these efforts, giving us the most critical perspective of all. We need to ensure that nursing home residents and family members are on all of the state and regional calls as much as possible, and continue to be engaged in this work.

On slide 16, you'll see that many of you have been active in helping CMS to develop provider, prescriber, and consumer training. And this shows you the Advancing Excellence homepage, with the big blue button for the partnership resources on the lower right. Professional associations and advocates have played a significant role in helping to develop training materials, many of which are available online right here. Some of you have done individual trainings in your facilities or around the state. The American Health Care Association, Leading Age, the American Society of Consultant Pharmacists, American Medical Directors Association, and many others, working with Advancing Excellence, have developed new tools and resources for provider, prescriber, and consumer training.

Training and Resources

On slide 17: In the interest of time today you'll see that we're not going to be presenting detailed information on dementia itself, such as how to identify and screen residents. However, there is detailed information available on assessment, cause identification, care plans, treatment, and monitoring. And this is available through a number of these resources, including Hand in Hand, the DVD series for direct care providers that was developed as part of the Affordable Care Act and was delivered to every nursing home in the country last month. This series of six DVDs and an instructor's manual provide experiential learning for nursing assistants and other nursing home staff through a model that can be used and adapted by facility staff, educators, or other trainers. The focus is on environmental modification to meet the needs of residents, understanding behavior as a form of communication, identifying and reporting acute change in condition, and staff approaches that are most effective in working with people who have dementia. If your facility did not receive the Hand in Hand program, we've provided contact information so you can contact us here at CMS in this program.

So in addition to Hand in Hand, there are many other resources on the Advancing Excellence Web site, which we hope provides one-stop shopping for all of you. Most of these resources emphasize a few key points that we wanted to mention here, such as Number 1: For people with dementia, antipsychotic drugs have limited efficacy. They may work in the short term but are much less effective long term. And they're generally more effective in certain subpopulations with severe symptoms, not in those with mild symptoms.

Number 2: There is an FDA black box warning. These drugs are dangerous unless they're prescribed after a systematic process involving the interdisciplinary team and physician, and with careful monitoring in place.

Number 3: The resident and family representative need to be educated and involved.

And Number 4: Nonpharmacologic approaches work. Evidence-based resources are available.

So those are the kinds of major points that you'll find in the resources available. And now I'd like to show you a few screen shots briefly so you get a sense of what's available on the Advancing Excellence Web site to share this and other information. So on slide 18: This is where you can find the initial kickoff video that CMS produced back in March that also has some useful information about the partnership.

If you look at slide 19: These are the PowerPoints and other resources that you can use in working with physicians and prescribers, nursing home staff, pharmacists. But these are PowerPoints that have been shared so you don't need to go out and develop your own. You can use these, and they're free on the Advancing Excellence Web site.

On slide 20 you'll see categories such as state initiatives and presentations. What are other states doing? You can learn about that from the information posted on the Web site.

Individual tools: We have self-assessment tools for nursing homes, provider checklists, and flow diagrams. These are easy ways for you to see where you are right now in terms of your program, and give you suggestions about how to get started. There are sample resident assessment forms shared by physicians and others, questions on how to get started with your interdisciplinary team, management of residents in your facility.

On slide 21 you'll see sample medication policies. So again, you don't have to develop it from scratch. You can use an example, and it may help you to develop your own facility policy. There are practice guidelines and comprehensive toolkits from some of the associations and other organizations.

On slide 22: There are a variety of programs here with consumer information, some evidence-based research, and reviews, and other books and articles. So we hope you'll take a look at some of those resources and that you'll find them helpful in the work that you're doing.

The Survey Process

Slide 23 reviews our surveyor training. And we've developed surveyor training and guidance. We have three mandatory training videos that provide information on care of persons with dementia, the regulations related to unnecessary medications at Tag F329, and how to evaluate facilities for compliance in these areas. Two of those trainings are now posted on the surveyor training Web site. A third training will be released later this spring in conjunction with revised guidance for surveyors.

We anticipate that updated guidance will be released within the next 1 to 2 months, and this will include some revisions to F329 and new guidance for dementia care. The trainings also discuss best practices and what compliance looks like in the care of persons with dementia.

On slide 24, you'll see that surveyors will be looking closely at this issue, and will be looking to see that a systematic, comprehensive process was followed. And facilities that follow a systematic process do the following:

On slide 25: Those facilities get details about the residents' behavioral expressions of distress and the risks of those behaviors, and they discuss potential underlying causes with the care team and the family. They exclude potentially remediable causes of behavior—things such as delirium, infection, or medications—and they determine if symptoms are severe, distressing, or risky enough to adversely affect the safety of residents.

Slide 26: They try environmental and other approaches that attempt to understand and address behavior as a form of communication in persons with dementia, and modify the environment and daily routines to meet the person's needs. They assess the effects of any intervention, pharmacologic or nonpharmacologic, and identify benefits and complications in a timely fashion and adjust treatment accordingly. There are a few more slides here about the systematic process.

And for those residents for whom antipsychotics or other medications are warranted (slide 27), these facilities are using the lowest effective dose for the shortest possible duration, based on findings in that specific individual. They are monitoring for potential side effects and therapeutic benefits with regard to specific target symptoms. And they are trying to taper the medications when symptoms have been stable, or adjusting the doses to obtain benefits with the lowest possible risk.

So other things that you may see people doing during the survey process (slide 28) is the surveyors will be asking for input from nursing assistants, nurses, social workers on all three shifts and on the weekend as well, trying to tell the story about what's happening with individual residents. Surveyors will look at communication, as I said, between shifts and between nurses and practitioners or prescribers. Surveyors will also look at whether medications prescribed by a covering practitioner in an urgent situation are reevaluated by the primary care team, and discontinued when possible.

And surveyors will look at whether or not other psychopharmacologicals are prescribed when, and if, antipsychotic medications are discontinued or reduced. So there will be an examination of whether or not when antipsychotics are eliminated or reduced is there a different type of psychopharmacologic agent prescribed at that time.

Public Reporting

Slide 29 moves on to public reporting, and there are two new measures on Nursing Home Compare.

The partnership goal, as we said earlier, relates to the prevalence measure here. While we're focused on reducing the unnecessary use of antipsychotic medications in residents with dementia, the residents here include all residents on antipsychotics, except those with schizophrenia, Tourette's, or Huntington's disease. Hopefully, a reduction would reflect that

those people who no longer need the medication, or who did not have an appropriate clinical indication to begin with, were able to be taken off the medication safely.

On slide 30, we've provided some additional detail on the Nursing Home Compare measures. A technical expert panel has provided input on this measure and, through ongoing dialogue, we've discussed other possible exclusions. CMS anticipates bringing new measures to the National Quality Forum to be put through the endorsement process. Now, you'll note that these are not what we might call appropriateness measures, and should not be interpreted as applicable to individual residents or facilities. These are broad-based national measures to help all of us achieve national goals similar to the Million Hearts campaign or the Partnership for Patients.

However, facility-specific data that you may be able to obtain—for example, from your pharmacy vendor or other sources—may be very helpful. If you take a look at slide 31, this is an example that was shared through our partnership of facility-specific data. That's what's presented on the slide. Now, note that the state and national averages are not the same as the ones we mentioned earlier. And that's because there may be differences in date ranges or types of exclusion, depending on the source of the data you may be using.

Even with CMS data sources, there could be differences, for example, between the CASPER reports that facilities that may run themselves, or what is reported in the three-quarter average on Nursing Home Compare. So it's important not to focus too much on the exact numbers, but to really focus on tracking and trending, and measuring your own facility's improvement over time. And many of you have shared a number of strategies that you're using to do that.

Frequently Asked Questions

Slide 32 reports a question that we get asked frequently, which is what will happen if we don't achieve the 15 percent reduction in our quality measure in our facility? The answer is that there's not a specific consequence that's tied to the quality measure; it's not currently part of the five-star rating system, although we do anticipate there will be an antipsychotic measure eventually as part of the five-star rating system. However, surveyors will be evaluating the clinical care of each individual resident, and the sample of residents on the annual survey will include residents with dementia who are on an antipsychotic. Therefore, facilities and other organizations may find it particularly helpful to track and trend their own data as much as possible.

So what are some of the ways that facilities can begin to improve dementia care and reduce rates of unnecessary antipsychotic use? On slide 33 we provide a few suggestions. Consider focusing on the bigger picture. Share resources on dementia care principles. Focus on each individual resident, and use a careful, systematic process to evaluate his or her needs. This is what the surveyors will be looking for.

During off-site preparation, the surveyors will also review the antipsychotic rate in the facility. So that's something to be familiar about and to know what your facility's rate is, because surveyors are going to ask about the home's approach to people with dementia on the survey.

On slide 34, you may want to consider forming a behavioral health committee or team for dementia care practices, or include it in your existing committee structure. Consider including the consultant pharmacist, the medical director, administrator, director of nursing, recreational therapy and other therapy staff, social worker, and direct care partners and staff, such CNAs. You may be able to include a behavior health specialist or consultants when possible, and certainly consider residents and family members in terms of policies and practices, not when individual data is being discussed. Begin by looking at each resident with dementia who's on an antipsychotic and considering the case in some detail. Look for underlying causes of the behavior, and consider whether a gradual dose reduction may be indicated, and communicate with the practitioner about that.

We mentioned the tools on the Advancing Excellence Web site. And in addition to that, national experts may be available to assist. On slide 35: Use the teams to examine the nursing home practices related to dementia care and behavioral health. Consider programs such as Hand in Hand, and there are other available programs. One is called Oasis—that is used fairly widely in a number of states. Habilitation therapies—and those are available on the Advancing Excellence Web site as well. And engage your medical director and consultant pharmacist.

I'd also like to add that some of you have gotten back to CMS and said what are you all doing to engage hospital partners? And as of just last week, we've had some follow-up and additional work that we've been doing with the Society for Hospital Medicine. And the American Society for Hospital Pharmacists is working with the American Society for Nursing Home—or Consultant Pharmacists as well, and they've been trying to identify issues of antipsychotic prescribing in hospitals since many skilled nursing facilities tell us that a high percentage of residents in their facility come to them already on an antipsychotic prescribed in the hospital.

So we recognize this is an important issue. Several states and regional groups include hospitalists and hospital administrators so that discussions about care transitions can lead to improved communications across settings.

On slide 36, we are sharing with you some aspects of research. And our contractor is in the final stages of data analysis for a project in which researchers conducted 200 case studies, both chart reviews and individual interviews with clinical team members, family members, and others, to determine how decisionmaking led to the use of pharmacologic or nonpharmacologic interventions in residents with dementia. This was done in five states in a stratified random sample of 25 nursing homes. CMS anticipates reviewing the draft report in December. And we've also shared with you that, as a result of this partnership, there have been a number of additional small research grants approved, and a number of groups of researchers have sprung up and are really working on different aspects of this national partnership.

Goals, Next Steps, Helpful Web Sites, and How To Reach Us

On slide 37, we're—as we draw to a close here, we do have a discussion and some next steps in mind. So we are planning to finalize our 2013 goals for the national partnership. If it turns out that we have not yet hit that target of a 15 percent reduction in the prevalence rate, we're going to continue toward that goal. And if we have, then we're looking at adding some other measures

as well. We're going to continue to engage partners at the local, state, regional, and national level. And as we mentioned, this may roll into a number of other initiatives that we know many of you are involved with as well. Things such as Advancing Excellence, Quality Assurance Performance Improvement, or QAPI, and the QIO Learning and Action Networks, and the new nursing home collaboratives that we spoke of earlier. We're going to continue to develop and refine quality measures, and continue to conduct the wonderful outreach that so many of you are doing right now and to measure the success of all of these programs.

On slide 38, we've provided a number of additional Web sites particularly for folks who may not have providers who have a lot of geriatric expertise. These are organizations that have stepped up and made a real commitment to providing tools, resources, national experts, etcetera. So please check out their Web sites as well.

On slide 39, this is how to reach us here at CMS. And there's also the way to reach us through our direct contact information, or you have our names as well and can reach us through our e-mails.

So the final slide, 40: Again, we just really want to thank you for all that you're doing, for your optimism and partnership, as Dr. Ling said in the beginning. We have a tremendous opportunity to continue to work toward meaningful and positive change. And this is a dynamic process, and we continue to seek feedback and insights from all of you. So we want to hear about the issues facing you in your work, and how CMS can continue to be a trustworthy partner in your care of people living in nursing homes.

And with that, I'm going to turn this back over to Leah, as the moderator for the Q&A portion of the program.

Question-and-Answer Session

Leah Nguyen: Thank you, Alice. We will now take your questions about the CMS National Partnership To Improve Dementia Care in Nursing Homes. Let me take this time to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a follow-up question, or have more than one question, you may press star one to get back into the queue, and we'll address these additional questions as time permits. Holley, we're ready to take our first question.

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

Your first question comes from the line of Adrienne Mims.

Adrienne Mims: Hi, this is Dr. Adrienne Mims, Atlanta, Georgia, Georgia Medical Care Foundation Alliance. And my question is regarding the work that we've done over the last **6** months to reduce antipsychotics. It's been focused on that higher group of nursing homes who had challenges. When do we think we'll be able to see that as part of the national data so we can see true response statewide?

Dan Andersen: This is Dan Andersen, responding from CMS. We will not know how we are doing as far as the national goal until April, when we receive Quarter 4 of 2012 MDS data when it's actually processed and creates the QM. So we will not know, from a national standpoint, how we're doing. But we know—we know, from certain providers, that we're on track.

Adrienne Mims: April 2013? And then that'll be released to us when?

Dan Andersen: It'll be the same—the same month, April 2013.

Adrienne Mims: Thank you.

Operator: And your next question comes from the line of Denice Cragg.

Dana: Yes, my question is—this is Dana at the Shepherd's Center. I want to know if psychosis is a diagnosis that will cover us for the use of antipsychotics.

Alice Bonner: So this—that's a great question, thank you. It really—what we're stressing in the partnership, and in this work, is, it's going to depend on the individual resident. There are residents—the systematic process that would be looked at would be: What is the clinical indication?

And it's not just about a diagnosis alone. It's also about the effects of the psychosis, the effects of something like the hallucinations or the delusions. We've had a lot of discussions about that. Are they—are they causing tremendous anxiety and anguish? Are they pleasant delusions? Are they frightening delusions? And with the psychosis, is it—you know, has there been a careful and systematic analysis and evaluation by the medical team and/or the psychiatric team to determine whether there is possibly an underlying cause for the symptoms, an underlying cause for what appears to be the psychosis? And has there—have there been efforts to see if there are other ways that that might be treated to improve the symptoms?

But following the systematic process, if there is a psychosis in a resident—and, again, a careful evaluation has been done and it's been determined by the medical team that an antipsychotic is the appropriate intervention for that resident, then that's what we'll be looking for. Does that answer your question?

Dana: Yes, ma'am. Thank you very much.

Alice Bonner: Thank you.

Operator: Your next question comes from the line of Eric Sokol.

Eric Sokol: Good afternoon, Ms....

Operator: Eric, you line's open.

Eric Sokol: Hi. Good afternoon. This is Eric Sokol with the Alzheimer's Foundation of America. Thanks for this great program, and we appreciate your time today.

There was a recent *New England Journal of Medicine* study about halting the use of antipsychotics and its relapse in patients. And I just wonder if there's been any discussion of that, and if there's been any alternatives in training in regards to patients who—coming from the hospital or who are already in the nursing home setting who have been on antipsychotics and then, because of some restriction or other situation, abruptly gets halted and then they're subject to possible relapse.

Alice Bonner: So that's—so there's a number of parts of that question. Thank you very much. And let me just address the second part: The issue of care transitions and how critical it is for patients or residents that when they're transitioning from the hospital to the skilled nursing facility that there is good communication between the teams is really, I think, what you're talking about. So that if there is a clinical indication for someone to be on a medication, that that information is communicated in a way that the staff in the skilled nursing facility understand enough about the case that they can make a decision about whether or not that medication should be continued or could be gradually reduced or discontinued.

And very often—and this was the discussion we were having with our colleagues at the Society for Hospital Medicine this week—very often it may involve a telephone call between the provider in the nursing home and the provider in the hospital, to say why is this person coming out on an antipsychotic? And when the rationale is explained, then it's clear what the best clinical decision is for that resident. But it sometimes does not come across in the paperwork, and that's something we all need to work on, whichever side we're on.

It works in both directions. Sometimes when a resident goes from a skilled nursing facility to the hospital for an evaluation in the emergency room, similarly, there's not adequate information passed along so that that next set of providers can really care for that resident well. So it's imperative that anyone caring for someone for any medication—this doesn't just go for antipsychotics, it's really true for any medication—that it's clear in the documentation why the person needs that medication. And if it's not completely clear, then there needs to be a conversation among the providers.

There have been a number of articles lately in the literature, and I'll let Dr. Andersen here address the Devanand article which you referenced. There was also an article, I'll just mention briefly, in JAMA that was shared pretty widely among a lot of folks in the partnership. It was—Laura Gitlin was the lead author, and it was back in November. And it had a very good review of the evidence base for dementia care programs, and some of both the pharmacologic interventions

and the nonpharmacologic interventions. So that may be useful to people on the phone as well. But, Dan, do you want to address...

Dan Andersen: Yes, this is Dan Andersen again. I would only add that the Devanand article, while it had some merit, did not really alter our approach to training surveyors or the way we approach dementia care for methodological reasons, since it was a community and long-term-based sample mixed together. The sampling methodology would not really—the people that were left in the sample would not be our typical nursing home residents necessarily. And we would argue that relapse is probably going to happen if the underlying causes haven't been addressed when you take someone off antipsychotic medication with no other intervention.

Eric Sokol: Well, thank you very much.

Alice Bonner: Thank you.

Operator: And your next question comes from the line of Matt Brauss.

Matt Brauss: I'm at the different location. I just wanted to get the Web site on—where I could get those slides that you presented today.

Leah Nguyen: Oh, sure. The URL is www.cms.gov/npc, which stands for National Provider Call. And then you'll see a list of calls. So you'll click on Upcoming Calls and Events on the left-hand side, and then select the January 31st entry from that list. And if you scroll down, you'll see the presentation materials.

Matt Brauss: Great. I appreciate that.

Leah Nguyen: You're welcome.

Operator: Your next question comes from the line of Marina Katsap.

Marina Katsap: OK, hi. Basically, you responded to my question already, when you responded to the question regarding psychosis. I did have—I wanted to ask the same about bipolar and dementia with paranoid ideation or hallucinations. Is it appropriate for the use of antipsychotics? Because we tried to taper it and we failed, and quality of life of the resident was affected by this.

Alice Bonner: Thank you. So I'm glad that we're getting these types of questions because they're so important. This entire approach that all of us are taking collaboratively is really about the systematic evaluation of each resident. So if someone has paranoid ideation, delusions, bipolar disorder, what we're looking to see—and, again, to work on in each case—is why is that behavior occurring or why are those symptoms occurring that present in that way? And is there a possible underlying cause?

So there's a very careful assessment and cause identification by a team that has the skill to evaluate. And many of these patients are complex, and have appropriate nonpharmacologic interventions been attempted when that's the right thing, when it's not such a risk and so severe

that a different approach is needed right away? And so all of that is evaluated, and if nonpharmacologic approaches are attempted—or in the case you describe, there's been a taper but it has not been successful—and it's, again, careful monitoring and evaluating of why it hasn't been successful. Was it done slowly enough? Were other things put in place during the taper? So in other words, if we're taking away an antipsychotic medication, were there—were there ways that the staff changed their approach to this person to try to help to reduce the paranoia and those kinds of symptoms?

So changing, again, the staff training sometimes or the staff approach: If all of those things are done, and the person continues to have paranoid ideation or other symptoms, and they were better on the medication—as you describe, their quality of life is better—then all of those steps will be outlined in the documentation, and it will be able to support that the antipsychotic medication for that individual person was the best approach, led to the best quality of life.

And so it's that individualization and looking for underlying causes and trying to understand any symptoms as possible communication that we're looking for. So thank you for the question.

Marina Katsap: You're welcome. I just wanted to add that sometimes, after tapering, conditions worsened in 1 or 2 months. It's not like right away. It's some cumulative effect of the medications, and then they suffer relapse. Thank you very much.

Alice Bonner: Yes, thank you.

Operator: Your next question comes from the line of Constance Kenes.

Constance Kenes: Our question is related to the 15 percent reduction across the board, and where—what number is that referring to? National, state, or combination?

Dan Andersen: That 15 percent reduction is in the national—the national prevalence measure. So that's the percentage of long-stay residents who are receiving antipsychotic medication. And the 15 percent is 15 percent from the 23.9, which was set as the baseline. It included Quarters 2 through Quarters 4 of 2011.

Constance Kenes: OK, thank you.

Dan Andersen: You're welcome.

Operator: Your next question comes from the line of Vivian Del Toro.

Vivian Del Toro: Hi. This is Vivian from Willow Creek Healthcare Center, and the question we had I believe has been answered. But it was dementia with behavior, even if other pharmacological interventions have been done and were not successful, at that point, is this—like Haldol, antipsychotics OK?

Alice Bonner: So the answer would also be that it depends on the individual case. And we're hoping that some of the—that a lot of the folks on the phone, the providers, will look at some of

the resources on the Advancing Excellence Web site, which really have a tremendous—a very rich amount of information about different approaches that are effective, ways to train staff. And again, I would refer also back to Hand in Hand, which is a terrific resource for any of the nursing homes about these nonpharmacologic interventions. So it really depends on the individual case, and it depends on evidence that there's been an effort with some good education, and that there's—that people have consulted some of these available resources in all of these cases. And, again, there's these resources in terms of how to conduct interdisciplinary rounds, making sure your medical director, the consultant pharmacist is needed or available. Behavioral health professionals can be involved. And we've had some very interesting discussions with folks, in particular, in some of our more rural states, where there have been issues with access to behavioral health providers.

And there are a number of programs we've heard about where psychiatric services or geriatric psychiatric services at major medical centers are using telemedicine and video conferencing to work with nursing homes in outlying rural areas so that the geriatric psychiatrist at an academic health science center, for example, can actually visualize what's going on with individuals in a remote nursing home and can give really good advice, consultation, recommendations. So I just wanted to mention that because it's something we've heard about. And behavioral health care providers, psychologists, geriatric psychiatrists can be a really valuable member, obviously, of the interdisciplinary team in these cases.

Vivian Del Toro: Thank you very much.

Operator: Your next question comes from the line of Janet James.

Janet James: Hello. I was curious if you have plans in the future of possibly indicating on the MDS the diagnosis—the psychiatric diagnoses for the patients that are associated with the antipsychotic usages. We have a high referral rate from a geriatric psych unit—that they tend to come to us with, obviously, a psychiatric need for their antipsychotic usage.

Alice Bonner: Thank you. Are you asking about the specific types of psychiatric diagnoses that are currently on the MDS, and finding that the places where you check the boxes don't always have the diagnoses that you're dealing with because they are coming from a psychiatric hospital?

Janet James: Well, our rate of antipsychotic usage is high at our facility, based on our population, because of the high referral rate from the geriatric psych unit. And that is their treatment modality due to their psychiatric diagnosis.

Alice Bonner: So we do review the MDS periodically in terms of the specific items on there, and …

Dan Andersen: It sounds like the question is more related to exclusions than the actual antipsychotic quality measures.

Janet James: Yes.

Dan Andersen: I think the answer to that is, for now, what will be on Nursing Home Compare is the schizophrenia, Huntington's disease, and Tourette's as exclusions.

Janet James: So those are your only three diagnoses as exclusions.

Dan Andersen: Correct.

Janet James: OK. Alright, thank you.

Operator: And your next question comes from the line of Chris Crouch.

Chris Crouch: Yes, hello. We are doing well with our antipsychotics, decreasing them, but I'm noticing an increase in some anxiety in hypnotic medication use, and I wondered if anybody else was experiencing that.

Alice Bonner: We can—we can answer from CMS that the folks that have the calls, our regular calls with states and the regional coalitions. A number of people have expressed concerns about that. We are only hearing about that anecdotally. We're not seeing it in the data. And we are going to be looking at that because we recognize it is a potential unintended negative consequence, and we're concerned about that. I would encourage anyone who is seeing that in your individual facility to really bring that up at your behavioral health meetings with your medical director. It's a perfect opportunity for either the medical director or the consultant pharmacist to get involved and share the literature and the data back with the people who are prescribing. And you may have to even in an individual case, as the director of nursing or the nurse who's taking the order from a nurse practitioner or a physician may need to say something if the order is to just stop an antipsychotic or taper an antipsychotic and instead use a different psychopharmacological.

What we're looking to see happen is to attempt nonpharmacologic, non-medication interventions first in a variety of approaches. Not to substitute one class of medication for another. Now having said that, if there's a thorough evaluation by a geriatric psychiatrist or by the primary care provider, it's possible that in some cases that's an appropriate change in therapy for an individual person. But in general, there should not be a trend back to anti-anxiety agents or, in other cases, mood stabilizers and other agents that you may see used in your facility.

So these are just really important discussions to have with the medical director, consultant pharmacist, the nurses, and the entire team. And the surveyors will be looking at that specifically. So thank you for the question.

Chris Crouch: Yes, thank you. Our data does support that, and we are just getting a chance to drill down into the data and the residents involved, and try to figure out what happened. I don't think that they actually prescribed another drug, but it was surprising that it was trending up. So I don't really know the answer, but you've been very helpful. Thank you.

Alice Bonner: And we're very glad that you're looking at the data, and working with your pharmacy and looking at your pharmacy data. That's very encouraging. And it's—certainly one

of the things we've seen during this partnership is more and more providers looking at pharmacy or other quality data as part of this. So thank you for doing that, and we hope and want to encourage others to do it as well.

Chris Crouch: Thank you.

Operator: And your next question comes from the line of Jacqueline Davidson.

Jacqueline Davidson: Yes. My question is twofold. I'm from Gentiva Hospice, and I'm certainly wanting to help our patients with dementia, both in the home setting as well as in the nursing home, and help comply with these requirements. One question is, would patients that are routine homed that are going into the nursing home for respite fall into that short-term stay category?

And the second question is, more specifically, dealing with the systematic approach. Certainly, our hospice has a dementia program in place. But when I'm looking at the survey process, that they'll be looking for the approach to be consistent and the same within the facility, and so it sounds to me like we might need to certainly adopt their approach for each individual facility instead of having a different approach.

Alice Bonner: So the residents you're talking about who are going in for respite would be short-stay, and therefore would not be included in—would you like to respond?

Female: Well, they may not even have an over-assessment completed.

Alice Bonner: Yes, they may not have an over-assessment completed. So the bottom line is, they're not going to be included in the long-stay prevalence measure. The issue about the approach in hospice in the community, and whether or not it makes sense to have the same approach, I would agree with you. I think it does make sense to have an approach in all settings, and this is why we mentioned the National Alzheimer's Strategic Plan. It makes sense across all settings to have a systematic process, where you're doing assessment, cause identification, care planning, involving the family, involving all the care providers, etcetera, and targeting appropriate nonpharmacologic interventions as a first line whenever possible for these residents who are dementia residents in hospice programs.

We do recognize that there are cases of delirium very often near the very end of life, and that that is something that, again, hospice providers are sharing stories with us, saying that they are finding that in some cases nonpharmacologic interventions are effective, and in other cases pharmacologic interventions with antipsychotics are much more effective. And so, again, I think it just gets back to the individual case and making the best determination for that resident or person.

Jacqueline Davidson: OK, thank you.

Operator: And your next question comes from the line of Mary Compton.

Mary Compton: Hi, I'm an independent dementia care consultant, and I had requested a copy of Hand in Hand from the CMS Web site. Do you know when those will be available to those of us that aren't in facilities?

Chris Allen: Yes, hi. This is Chris Allen. The Hand in Hand—if you contact Michelle, we will forward your information to the contractor that is supplying Hand in Hand. There are limited copies left. It is available. It will be available to download, and also there will be availability to purchase it if we do run out.

Mary Compton: OK, thank you.

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

Rosene Dunkle: Hi. I had a question as to why there's a difference in the statistics for antipsychotic use in the CASPER report quality measures versus the Five-Star Nursing Home Compare. What was the reasoning behind that?

Dan Andersen: I think that you're referring to the CASPER, what's called the psychoactive medication use. It's a long-stay, antipsychotic measure as well. This was constructed a long time ago, before this national campaign was created, and we created the short-stay and the long-stay measures that are now in Nursing Home Compare. So the measures will differ because of the number of exclusions.

We are in the process of switching out those measures so that the CASPER report will—the CASPER report measure will match exactly, in specification at least, the measure that's on Nursing Home Compare currently, and that's slated to happen at the end of March of this year.

Rosene Dunkle: Oh, good. So right now, it probably would be best to go with the Nursing Home Compare measure?

Dan Andersen: Yes.

Rosene Dunkle: Thank you.

Operator: And your next question comes from the line of Helen Van Horn.
Helen, your line's open. And that question has been withdrawn. Your next question comes from the line of Gail Crump.

Gail Crump: Yes, I was able to figure this out earlier on the call, but I initially didn't get the slides to coordinate with the audio. So I'm fine now. I was able to find them, so I appreciate it.

Leah Nguyen: You're welcome.

Operator: And your next question comes from the line of Vincent Davis. Vincent, your line is open. And that question has been withdrawn. Your next question comes from the line of Victor Molinari.

Victor Molinari: Yes. I just wanted to mention that I very much applaud you for broadening the initiative to include better mental health care for all nursing home residents rather than the more narrow reduction of antipsychotic medications. Because it has to be taken, really, as an overall general program of improvement of mental health care.

Along those lines, I just wanted to check. Has there been any thought to going ahead and sort of designating mental health champions for each nursing home so that they could coordinate the type of care? The way I see it, there has to be broad general training for all nursing home staff. And then you also have to have good mental health consultants for the more difficult cases.

Alice Bonner: So that's a wonderful point, and thank you. So there's a number of programs that are quality improvement programs that use that methodology of identifying a champion for particular clinical areas or staff support. And there's been reports in the literature that that can work quite well. One of the programs is—that you may know about—is to reduce unnecessary hospital readmissions. And they identify champions to look at change in condition. And nursing assistant champions, nursing champions, and sometimes social workers and others.

So the idea is a very good one. And in many of the different programs that are on the Advancing Excellence Web site that is a component of the training and of the implementation. So I would encourage your colleagues on the phone to think about that. I think it can be very effective. It sometimes can be challenging if you have a champion for pressure ulcer reduction and then a champion for dementia care and then a champion for falls prevention. You sort of get a lot of champions in the mix, and it can—so it needs to be thought out. And it really depends on the structure within the facility, I think, of their risk teams and how their teams are set up.

But through our work on quality assurance and performance improvement that CMS is doing, and through a lot of the work that the quality improvement organizations are doing, your point is well taken, and that is an element in many of these kinds of programs. So it's a very good one for people to think about.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jennifer Scaffidi.

Jennifer Scaffidi: Hi. I know that we have already addressed assessing the resident thoroughly and having the team collaborate to go over what could be the underlying cause for someone in their behavior. And once pain, physical, sensory, and environmental stresses have been addressed, and we find out that they've never had any behaviors at home and no pharmacological/nonpharmacological interventions have worked—they're not effective—we usually get a psych referral. And after they come in and evaluate, they might not have a diagnosis of psychosis or hallucinations. It might just be physical, aggressive behavior. And so the diagnosis that will go along with the psychotropic med will be Alzheimer's dementia with behavioral disturbances. So I understand all those other diagnoses are OK as long as you have done a complete, thorough assessment. Is Alzheimer's dementia with behavioral disturbances OK?

Alice Bonner: Again, it will really depend on the case. Historically, a lot of people with dementia who only have a diagnosis of dementia with behavioral disturbances have been able to be managed more safely and effectively without a medication intervention. And so it depends on the individual case.

I hear you sharing that in some cases these people have violent behaviors, aggressive behaviors—for example, they're hitting or kicking or spitting, some of these things. But it really gets back to what is the underlying cause. And, again, I know you're talking about evaluating for pain and different things. We're very interested in looking at daily routines and the environment. Is there something in the environment that is setting this person off or changing their behaviors, where they did not have those behaviors at home? Did we change something in their daily routines that is so different from what they did their whole life that just by virtue of upsetting their daily routines it's led to this kind of behavioral disturbance? Does it have to do with being hungry or thirsty or other physical discomfort that's not pain per se, but has led them to just not be a fit, a proper fit, with their environment?

And that can take a lot of detective work. It's very complex to figure out what to change in the daily routines. Is it the bedtime, the time they get up in the morning, the mealtime, the routines of taking them to the bathroom?

Was the family involved? That's another very important point here is when a team says, a clinical team says, we've done everything, we think, to evaluate this person, and we've tried all these different interventions. If you have not involved the family—when a family member is available, because there is not always a family member—but if there's a family member available who knows the person, it's critical that that person in the family be contacted and a discussion and some sharing of information happen with that person.

So the kinds of things that we see sometimes, the surveyors sometime see, is cases where there's a diagnosis of dementia with aggressive behavior, for example, with no evaluation by the medical team to rule out medical causes, no consultation with the family, no clear documentation of other attempts to change the approach to this person and really evaluate whether or not the different approaches work.

So it isn't the fact of the diagnosis being there or not being there. It really has to get back to this issue of the systematic process. So it would depend on the case, but those would be the things that we would be looking for.

Jennifer Scaffidi: OK. And I have one other question. If you have a resident who—they are calling out, continuously calling out, and if you provide a one-on-one they will be quiet, but as soon as that person leaves their side they're continuously calling out. So, really, to not have that behavior you would have—they would have to have a private aide at all times that the resident is awake, since their calling out causes distress to the other residents if someone isn't at their side. Is that a reasonable reason to go ahead and medicate?

Alice Bonner: Again, it's so hard without understanding the context of these cases. I really don't think it's possible to say either yes or no in that situation. I think it would depend on figuring out about the reason why the person is calling out and the level of distress that it's creating, and whether or not family have been involved if possible. And that the direct care workers, the nursing assistants, that are such good detectives and can add so much to these discussions—did they have any thoughts or ideas about different approaches besides the one-on-one? And besides the medications.

I guess my response would be: Is it possible that there might be other interventions that are not a one-on-one 100 percent of the time, and not an antipsychotic medication? And have those other things been attempted and evaluated? And then it would depend on the rest of the context of the case.

Jennifer Scaffidi: Thank you.

Operator: Your next question comes from the line of Michelle Lindig.

Lynn Kemper: Hi, this is Lynn Kemper with Acumentra Health in Oregon. Great call. I just wanted to ask about—if it's possible to get permission to duplicate the DVDs. We've had some stakeholders ask for copies, and I just heard you say that there are only going to be limited copies available, although the DVDs say there are copyrighted. So is that—is that something that we'll be allowed to do?

Chris Allen: There is a way that you can go onto—and if you send an e-mail to Michelle Laughman at CMS, there is a way she can send you a link to the Hand in Hand Web site if you don't already have it, and you can download the modules and also make copies of the DVDs.

Lynn Kemper: OK, I didn't know about the DVDs. I knew that you could download the hard copy, the toolkit, but I didn't know that you could download the DVDs.

Chris Allen: There is a way to do it. I haven't tried it, but I know there is a way to do it.

Lynn Kemper: OK, alright. So that's your preference, rather than duplicating the actual DVDs that we have. We go to the Web site, and download from there.

Female: Yes.

Lynn Kemper: OK, thank you very much.

Operator: Your next question comes from the line of Beverley Laubert.

Beverley Laubert: Hi there. Just a question: Alice, you said that if you get to the 15 percent that you will work on a new goal. If not, you'll continue working toward the 15 percent. I'm wondering if an individual state achieves the 15 percent reduction, is there technical assistance available from CMS to continue our work, or maybe with individual facilities? I'm just wondering kind of what you're thinking into the future.

Alice Bonner: That is a great question. So the question is, if an individual state has hit the target, when we look next and report the data, can we help that state, working with CMS, to develop more appropriate goals for them? Which would be perhaps additional numerical goals, but also we've been talking about other kinds of process measures and things we might want to look at to determine that we're continuing to move in the right direction to reduce unnecessary drug use as much as possible.

So things like: Is there a dementia care program in place, and in how many nursing homes, and what are the components of those programs? And again, we know we've heard from the Alzheimer's Foundation on this call, and the Alzheimer's Foundation and Alzheimer's Association have done a lot of work on dementia care programs and what those look like and how to certify people in special care, and so forth.

So, Bev, it's an absolutely great question. And we would certainly work with individual states to develop a set of goals that are state goals, and I think we could share those with other states and regions as well, through the partnership. So that would be tremendous. So thank you.

Beverley Laubert: Right, thank you. And I also just wanted to say that yesterday an individual, a nurse from our Chicago regional office, reached out to me about the partnership, and we're very excited to be engaging with them. So we appreciate CMS reaching out to us. Thanks.

Alice Bonner: Fantastic. Thank you.

Leah Nguyen: Holley, it looks like we have time for one final question.

Operator: OK. Your final question comes from the line of Linda Morton.

Linda Morton: Hello. I got the answer to it. I want the audio recording of this, and it looks like I got an earlier e-mail that tells me where to go to obtain that.

Leah Nguyen: Yes, that's correct. We'll be hosting it on the call Web page, and I believe you should have that URL, and I'll be announcing it again in a few minutes.

Linda Morton: OK, thank you.

Leah Nguyen: We can go ahead and take one more question, Holley.

Operator: OK. Then that question will come from the line of Judy Ellet.
Judy, your line is open. And that question's been withdrawn.

Next question will come from the line of Paul Tatum.

Paul Tatum: Well, I better come up with something good since it's the last one. My main ones were about hospice care. So let me take the opportunity to congratulate you guys on just a wonderful set of resources, and I look forward to using them with particularly the hospice team.

In terms of appropriateness of medications, I wonder if you could comment on depression and the Star D trial and the use of antipsychotic medication for depression, particularly if I don't have access to a geriatric psychiatrist.

Alice Bonner: Thank you. So we've had some discussions about a number of areas where antipsychotics may be used and may be indicated. We've had discussions about bipolar disorder, we've had discussions about major depression, major depression with psychotic features. And, again, I think what we're trying to do with the campaign right now is really focus in on the people with dementia who have very mild symptoms, or just have the absence of a clear clinical indication, or are really missing the components of the systematic approach. They've not been evaluated, there's no clear cause identification, there's no attempt of nonpharmacologic measures, etcetera.

Again, we absolutely recognize, and certainly want to emphasize to everybody on the call: These medications can be extremely valuable when they're used appropriately, carefully, with good monitoring and good involvement of the medical and psychiatry teams. So beyond that, I guess I can't particularly comment other than to say we hope that people are continuing to individualize and look at the individual patient or resident in front of them, and making an evaluation about the use of these medications in each of those cases.

So it's very possible, in the case of someone with severe major depression with psychotic features, that an antipsychotic will be effective and will be the best intervention. And, again, that would be evaluated on an individual patient basis. So thank you for the question.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that's all the time we have for questions today. If we did not get to your question, you can e-mail it to dnh_behavioralhealth@cms.hhs.gov. That address is also listed on slide 40.

I'd like to thank everyone for participating in the CMS National Partnership To Improve Dementia Care in Nursing Homes National Provider Call. On slide 41 of the presentation you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential. I should also point out that all registrants for today's call will receive a reminder e-mail from the CMS National Provider Calls resource box within 2 business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. Please note evaluations will be available for completion for 5 business days from the date of today's call. We appreciate your feedback.

An audio recording and written transcript of today's call will be posted soon to the CMS Fee-For-Service National Provider Calls Web page. Again, my name is Leah Nguyen, and it has been my pleasure serving as your moderator today.

I would also like to thank our presenters, Dr. Shari Ling and Alice Bonner. Have a great day, everyone.

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

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