



mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

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

March 20, 2018



Acronyms in this Presentation

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



Agenda

Person-Centered Care Planning
and Discharge Planning: Highlights
of Phase 2 Changes

Debra Lyons, CMS

Alzheimer's Association Dementia
Care Practice Recommendations

Douglas Pace, Alzheimer's Association



Person-Centered Care Planning and Discharge Planning: Highlights of Phase 2 Changes

Debra Lyons, RN
CMS



Reform of the Requirements for Long-Term Care Facilities

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



Person-Centered Care

Person-Centered Care:

- Supports each resident's choice and gives them a sense of control over their lives
- Is a central theme to the Final Rule
- Will improve Quality of Life and Quality of Care



F655 Baseline Care Plan – New Requirement

Baseline Care Plan:

- Develop within 48 hours of admission
- Contain the minimum healthcare information necessary to care for resident

Facility must provide a written summary of the baseline care plan to the resident/ representative.



F655 Baseline Care Plan – New Requirement

Intent of the Baseline Care Plan requirements:

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



F656 Comprehensive Person-Centered Care Plan

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

New guidance at F656:

- Defines measurable objectives
- Provides examples of individualizing care plan goals and preferences



F656 Comprehensive Person-Centered Care Plan

The care plan must describe:

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



F657 Care Planning - Interdisciplinary Team

Interdisciplinary team must now include:

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



F657 Care Planning - Physician Involvement

- Physician input into the development of the care plan is important
- Physician may delegate participation to a non-physician practitioner who is involved in the resident's care
- Facility may arrange alternate methods of physician participation



F660 Discharge Planning Process

- Expanded new requirements **and** guidance
- Focuses on the resident's goals
- Prepares the resident to transition to post-discharge care by reducing factors which may lead to re-hospitalizations or readmissions



F660 Discharge Planning Process

Guidance at F660 clarifies that the discharge care plan:

- Is part of the comprehensive care plan
- Be developed by the interdisciplinary team which includes direct communication with the resident/resident representative
- Address the resident's goals for care and treatment preferences
- Identify needs that must be addressed before the resident can be discharged



F660 Discharge Planning Process

Guidance at F660 continued:

- Be re-evaluated regularly and updated when the resident's needs or goals change
- Document the resident's interest in, and any referrals made to the local contact agency
- Identify post-discharge needs, such as nursing and therapy services, medical equipment or modifications to the home, or Activities of Daily Living (ADL) assistance



F661 Discharge Summary

- Expanded new requirements **and** guidance
- Intends to ensure facilities communicate necessary information to the resident, continuing care provider, and other authorized persons at the time of discharge



F661 Discharge Summary

The discharge summary :

- Must include an accurate and current description of the clinical status of the resident
- Must provide individualized care instructions to ensure a safe transition to another setting
- May reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident's care



Resources

- [State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities](#)
- [CMS Website for Nursing Home Laws and Regulations](#)



Contact Information

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Alzheimer's Association Dementia Care Practice Recommendations

Douglas Pace, NHA
Alzheimer's Association





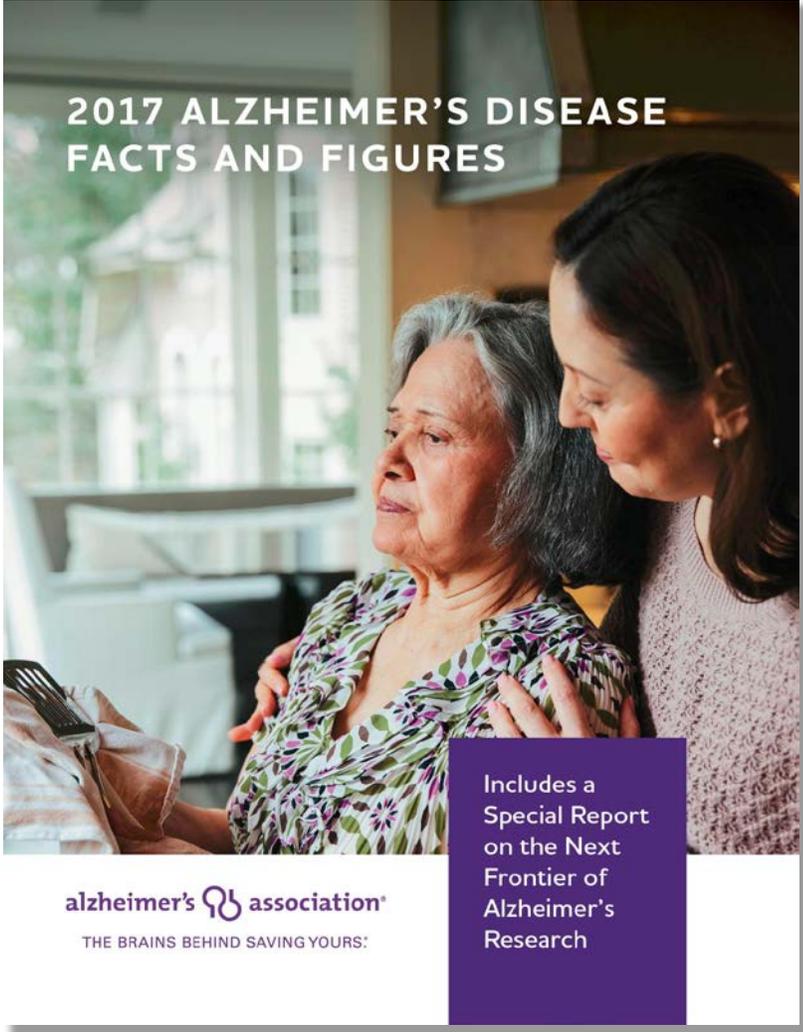
OUR VISION:

A world without Alzheimer's disease®.

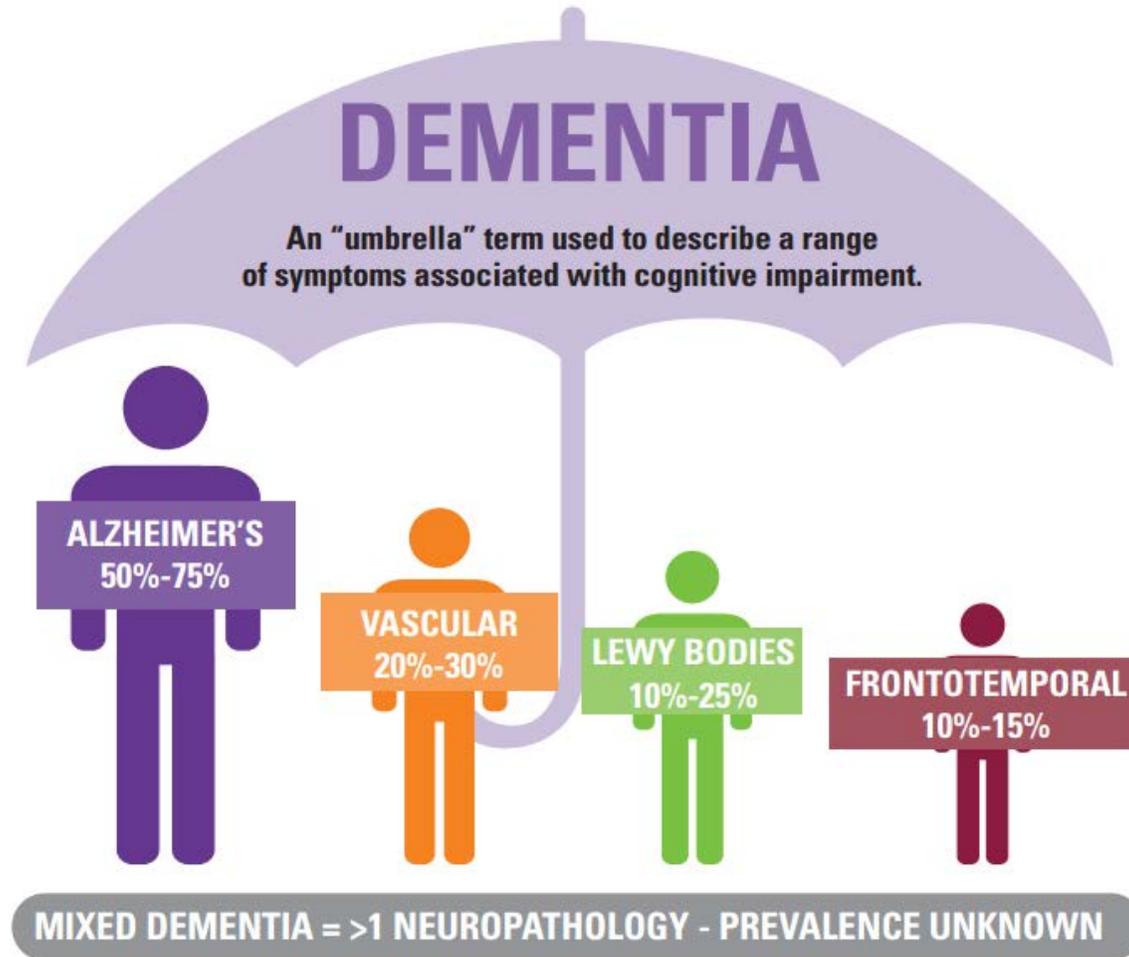
OUR MISSION: To eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.



2017 Alzheimer's Disease Facts and Figures



Alzheimer's Disease & Related Dementia



Millions of Americans are Living with Alzheimer's

- An estimated 5.5 million Americans are living with Alzheimer's dementia today — 5.3 million people age 65 and older and 200,000 under age 65 with younger-onset Alzheimer's
- Among those 65 and older, 1 in 10 has Alzheimer's, and among those 85 and older, 1 in 3 has Alzheimer's

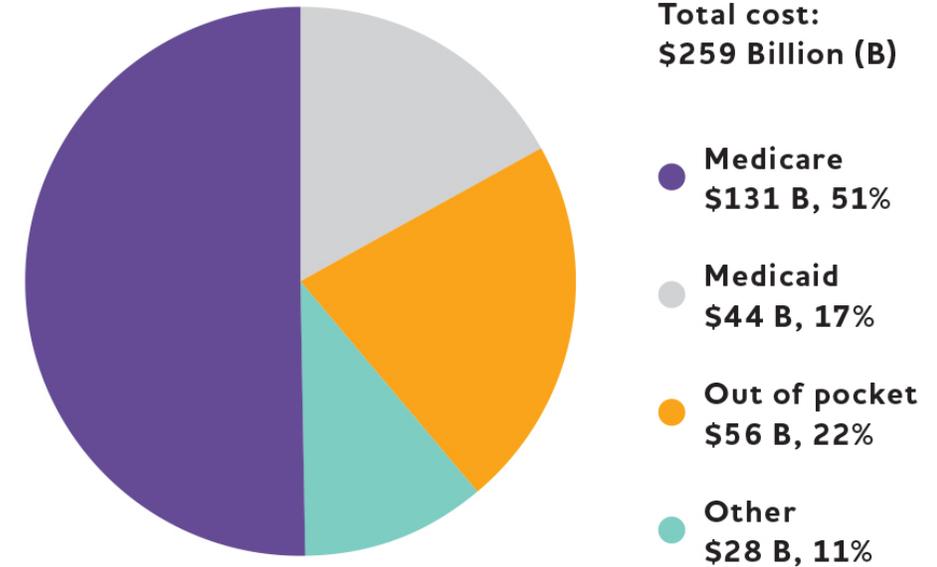


Cost of Care

- In 2017, caring for people with Alzheimer's and other dementias will cost the United States an estimated \$259 billion, including \$175 billion paid by Medicare and Medicaid

FIGURE 11

Aggregate Cost of Care by Payment Source for Americans Age 65 and Older with Alzheimer's and Other Dementias, 2017*



*Data are in 2017 dollars.

Created from data from the Lewin Model.^{A21} "Other" payment sources include private insurance, health maintenance organizations, other managed care organizations and uncompensated care.



Alzheimer's is a Major Driver of Health Care Costs for Older Americans



- Medicare payments for a senior with Alzheimer's or other dementias are more than 3 times as great as those for a senior without these conditions. Medicaid payments are 23 times as great



Average Annual Per-Person Payments for Health Care and Long-term Care

TABLE 10

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

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

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

Created from unpublished data from the Medicare Current Beneficiary Survey for 2011.³⁸⁰



Why is Alzheimer's such a Cost Driver?



- Nearly 30 percent of people with Alzheimer's or other dementias are on both Medicare and Medicaid, compared with 11 percent of people without dementia



Why is Alzheimer's such a Cost Driver?



- People with Alzheimer's are more likely than people without dementia to have other chronic conditions, and dementia complicates the management of these other conditions



Why is Alzheimer's such a Cost Driver?

- A senior with diabetes and Alzheimer's costs Medicare 81 percent more than one with diabetes and no Alzheimer's
- A senior with Alzheimer's and cancer costs Medicare 57 percent more than one with cancer but no Alzheimer's



And Costs will Continue to Grow



- The costs of caring for people with Alzheimer's or other dementias are projected to increase from \$259 billion in 2017 to more than \$1.1 trillion in 2050



Alzheimer's doesn't just Happen to Individuals - it Happens to Families



- More than 15 million family members and friends provided more than 18 billion hours of unpaid care to those with Alzheimer's or other dementias in 2016



Alzheimer's doesn't just Happen to Individuals - it Happens to Families



- The economic value of the unpaid care provided to those with Alzheimer's or other dementias totaled \$230.1 billion in 2016



Alzheimer's doesn't just Happen to Individuals - it Happens to Families

- In 2016, Alzheimer's and dementia caregivers had \$10.9 billion in additional health care costs of their own due to the tremendous physical and emotional burden of caregiving



If Alzheimer's and dementia caregivers were the residents of a state, it would be the 5th highest populated state in the country.

CALIFORNIA
Population:
39,250,017



TEXAS
Population:
27,862,596



FLORIDA
Population:
20,612,439



NEW YORK
Population:
19,745,289



ALZ/DEMENTIA CAREGIVERS
Population:
15,975,000

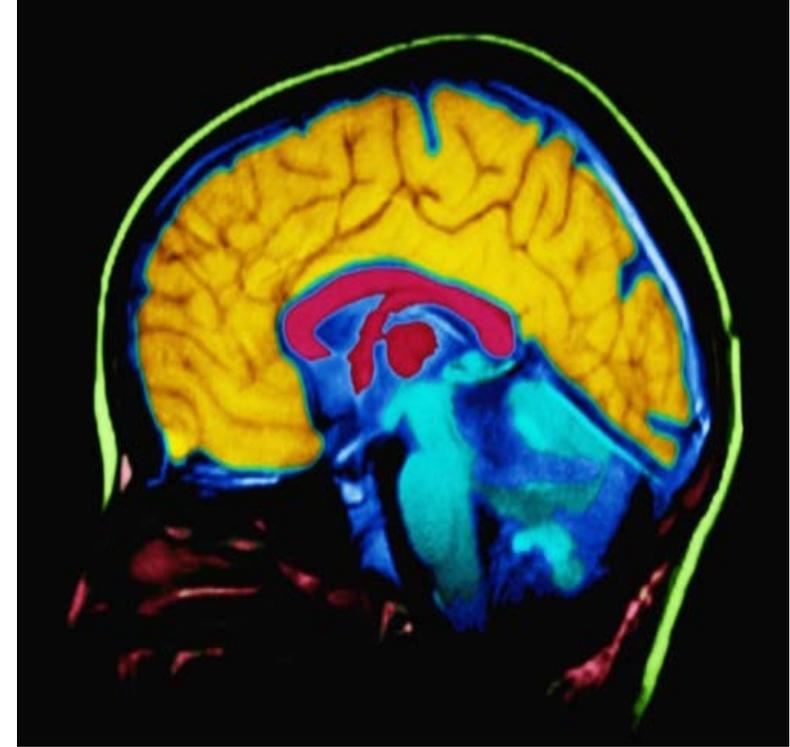


ILLINOIS
Population:
12,801,539



Alzheimer's is More than “a Little Memory Loss”— it Kills!

- Alzheimer's is the 6th leading cause of death in the U.S.
- It is the only disease in the top 10 that cannot be prevented, slowed, or stopped
- An estimated 700,000 Americans will die with Alzheimer's disease in 2017



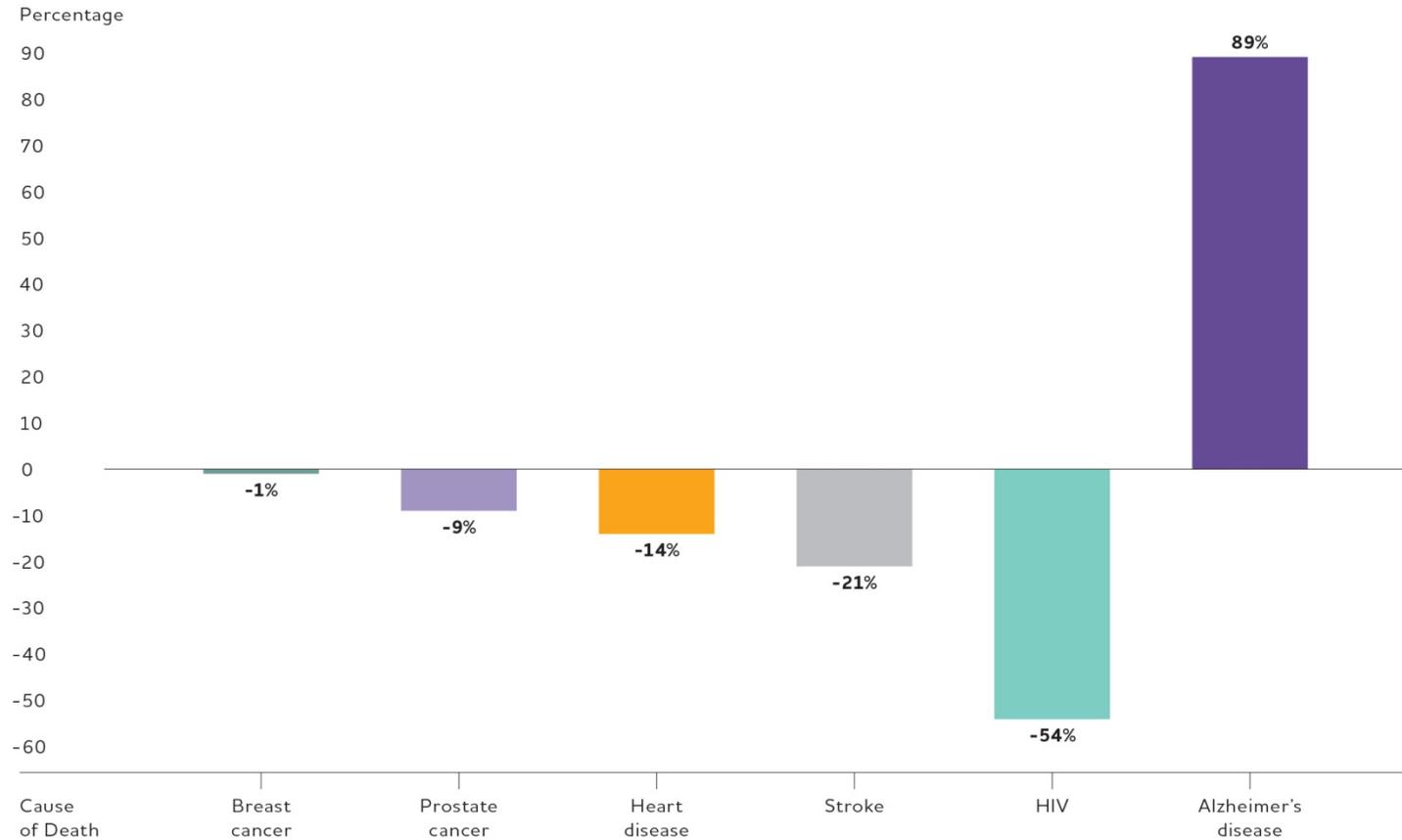
From 2000–2014, Alzheimer’s Disease Deaths Increased 89% While...

Deaths from:

- HIV**
Declined 54%
- Stroke**
Declined 21%
- Heart disease**
Declined 14%
- Prostate cancer**
Declined 9%
- Breast cancer**
Declined 1%

FIGURE 5

Percentage Changes in Selected Causes of Death (All Ages) Between 2000 and 2014

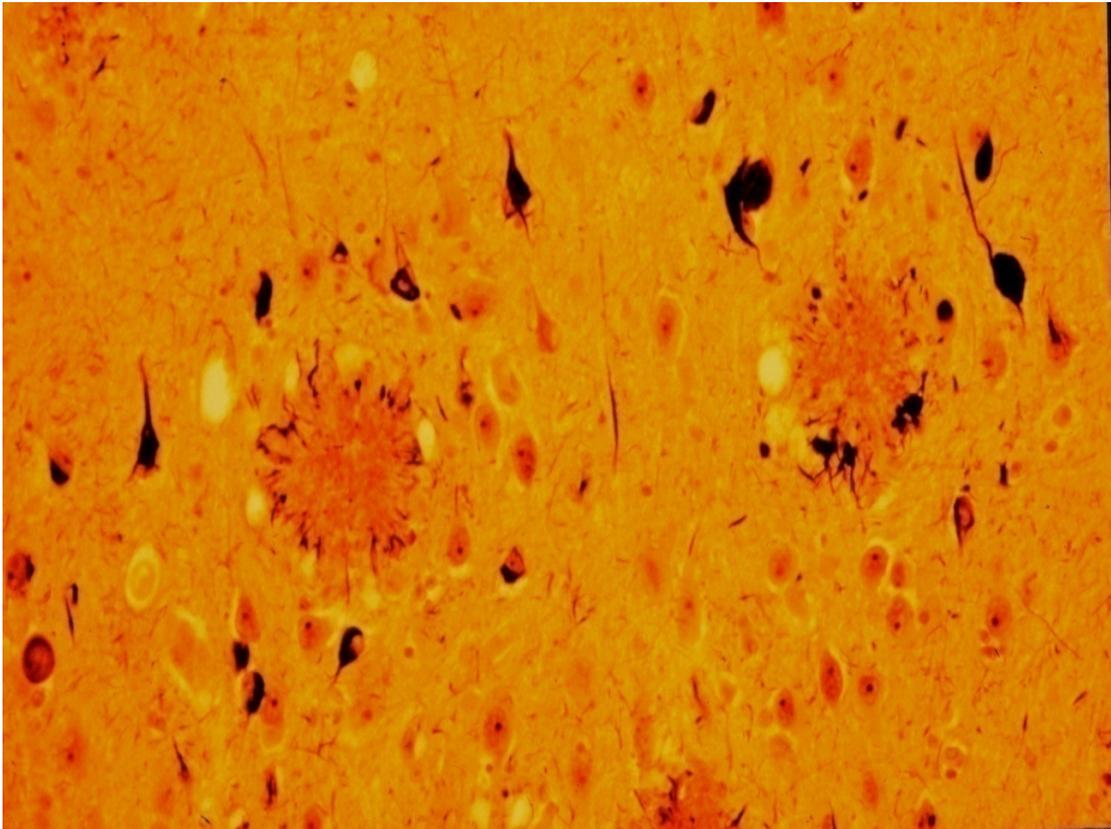
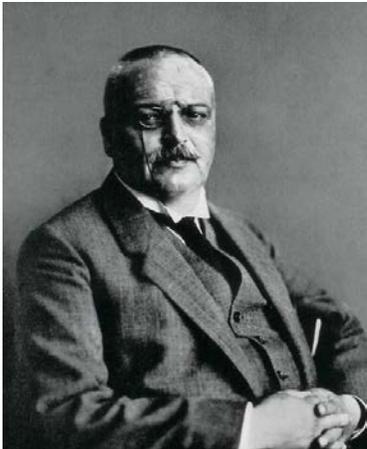
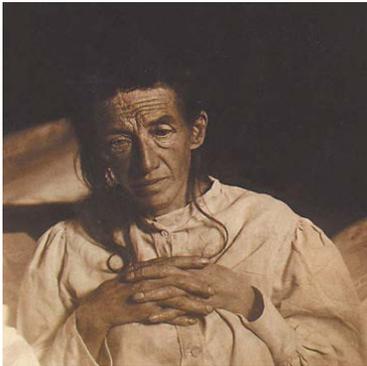


Created from data from the National Center for Health Statistics.^{208, 219}



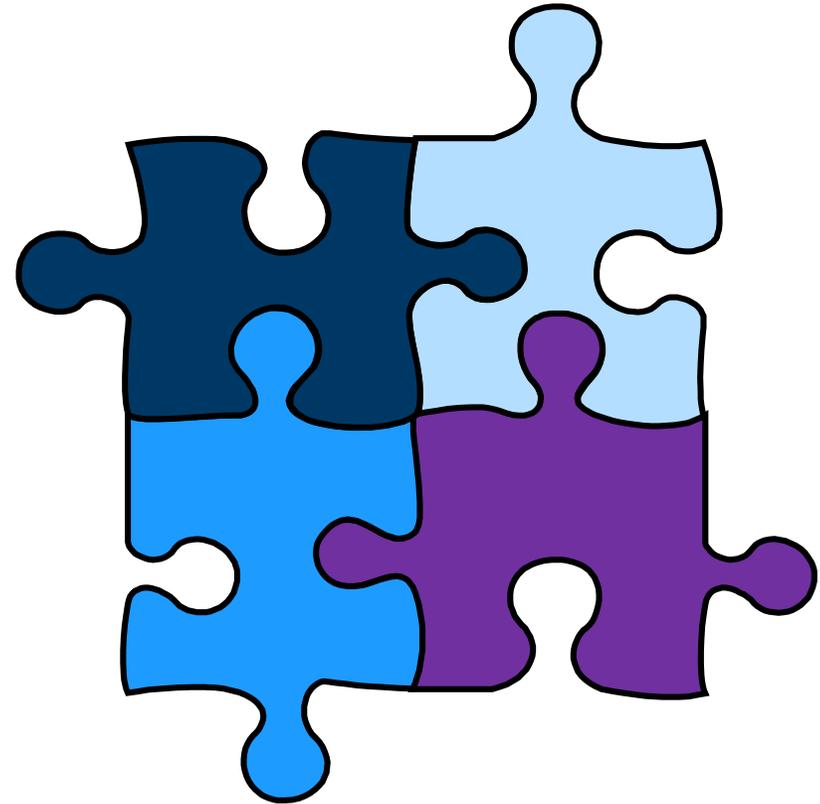
Risk Factors

Alzheimer's – Plaques & Tangles



Risk Related to Cognitive Decline & Alzheimer's

- Age: The greatest known risk factor
- Heart-head connection
 - Increased risk suspected if high blood pressure, heart disease, stroke, diabetes, and high cholesterol
- Head injury
- Family History
 - Risk and deterministic genes

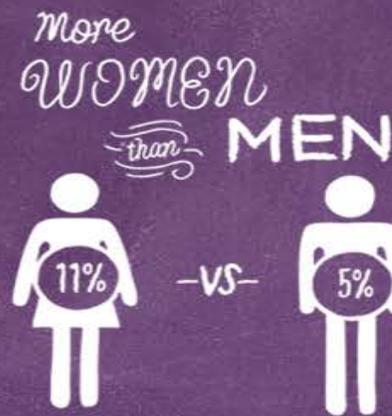


OVER
60%
of
ALZHEIMER'S AND DEMENTIA
— CAREGIVERS —
are **WOMEN**

IN HER 60's
A woman's estimated lifetime
RISK OF DEVELOPING
ALZHEIMER'S
IS **1 IN 6**
FOR BREAST CANCER IT IS
1 IN 11

WOMEN
ARE AT THE EPICENTER
of the **ALZHEIMER'S**
EPIDEMIC

TODAY, **2/3**
NEARLY
of
AMERICANS
LIVING WITH ALZHEIMER'S
are **WOMEN**



STOPPED WORKING
TO PROVIDE CARE FOR
Someone with
ALZHEIMER'S

The Facts: Alzheimer's is an Epidemic in America

African-Americans are about twice as likely as whites to have Alzheimer's or another dementia, and Hispanics are one and a half times as likely.



10 WAYS TO LOVE YOUR BRAIN



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



Visit alz.org/10ways to learn more.

alzheimer's association

THE BRAINS BEHIND SAVING YOURS.

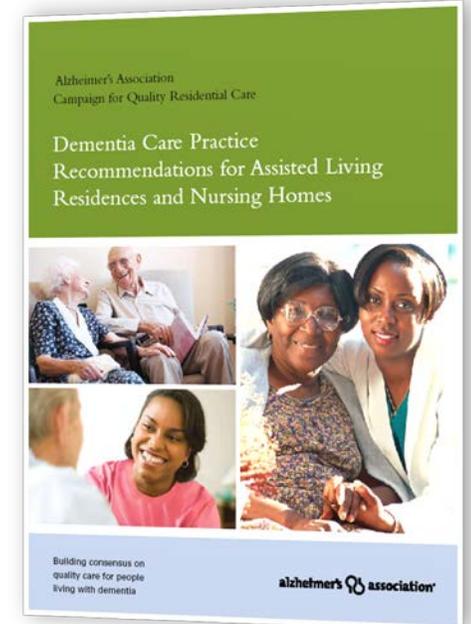
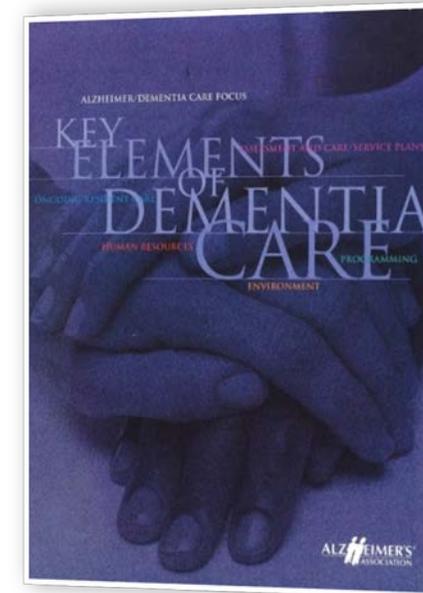


Defining Quality Care: Dementia Care Practice Recommendations



Quality Care: History

- Guidelines for Dignity
- Key Elements of Dementia Care
- Dementia Care Practice Recommendations

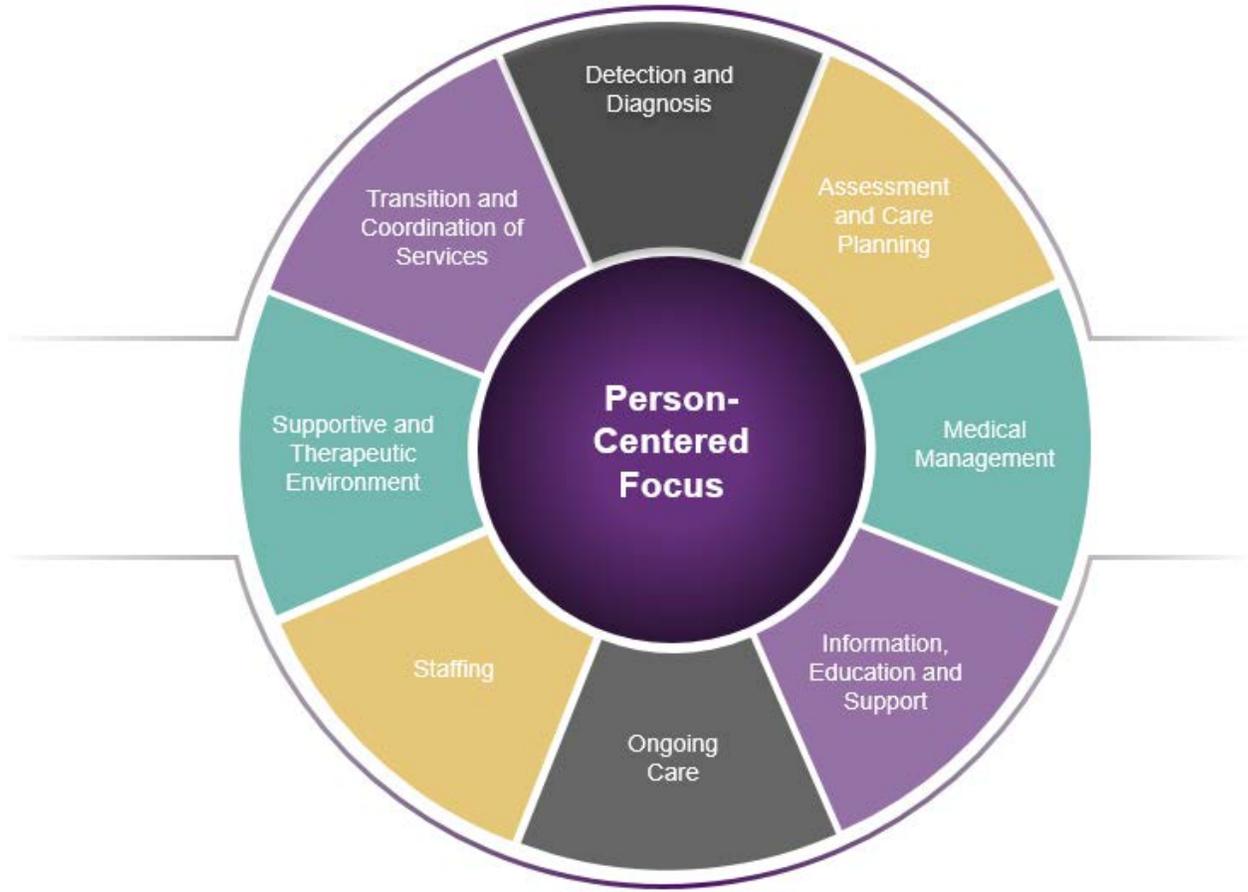


Quality Care: Today

- Evidence-based practices
- Peer-reviewed
- 56 recommendations by 27 expert authors
- Published as a supplement to Feb 2018 issue of The Gerontologist
- Foundation for quality person-centered care



Dementia Care Practice Recommendations



Person-centered Focus

Recommendations:

- Know the person
- Person's reality
- Meaningful engagement
- Authentic, caring relationship
- Supportive community
- Evaluation of care practices



Detection and Diagnosis

Recommendations:

- Information about brain health and cognitive aging
- Signs and symptoms of cognitive impairment
- Concerns, observation and changes
- Routine procedures for assessment and referral
- Brief mental status test when appropriate
- Diagnostic evaluation follow-through
- Better understanding of diagnosis



Assessment and Care Planning

Recommendations:

- Regular, comprehensive, person-centered assessments and timely interim assessments
- Information gathering, relationship building, education, and support
- Collaborative, team approach
- Documentation and communication systems
- Advance planning



Medical Management

Recommendations:

- Holistic, person-centered approach
- Role of medical providers
- Common comorbidities of aging
- Non-pharmacologic interventions
- Pharmacological interventions when necessary
- Person-centered plan for possible medical and social crises
- End-of-life care discussions



Information, Education, and Support

Recommendations:

- Preparation for the future
- Work together and plan together
- Culturally sensitive programs
- Education, information, and support during transition
- Technology to reach more families



Ongoing Care – ADLs

Recommendations:

- Support for ADL function
- Person-centered care practices
- Dressing — dignity, respect, choice; process; environment
- Toileting — also health and biological considerations
- Eating — also adaptations and functioning; food, beverage and appetite



Ongoing Care: Behavioral and Psychological Symptoms of Dementia

Recommendations:

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



Staffing

Recommendations:

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



Supportive and Therapeutic Environment

Recommendations:

- Sense of community
- Comfort and dignity
- Courtesy, concern, and safety
- Opportunities for choice
- Meaningful engagement



Transition and Coordination of Services

Recommendations:

- Education about common transitions in care
- Timely communication of information between, across, and within settings
- Preferences and goals of the person living with dementia
- Strong inter-professional collaborative team to assist with transitions
- Evidence-based models



Practice to Policy

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



National Alzheimer's Plan Research on Care and Services

Goal 2 -“Enhance care quality and efficiency”

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

2025 Endpoint

Alz. Association National Plan Care and Support Milestone Workgroup



Strategies for Goal #2

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

Alz. Association National Plan Care and Support Milestone Workgroup



Quality Care: Perspectives from People Living with Dementia

Themes:

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



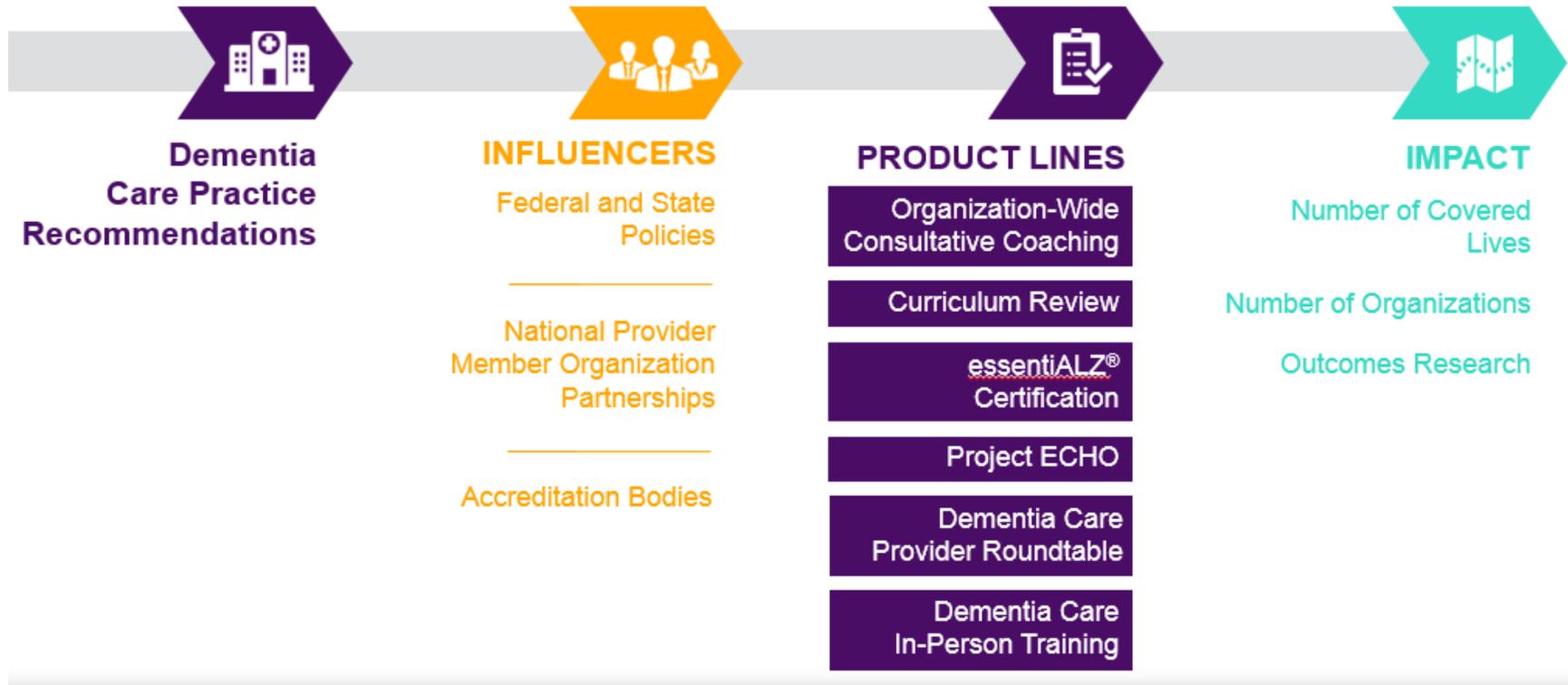
Themes

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



Next Steps

Quality Care in Long-Term & Community-Based Care



Contact Information

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National Partnership Updates

Michele Laughman, CMS



Question & Answer Session



Thank You – Please Evaluate Your Experience

Share your thoughts to help us improve – [Evaluate](#) today's event

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SEC. 524. Federal agencies funded under this Act shall clearly state within the text, audio, or video used for advertising or educational purposes, including emails or Internet postings, that the communication is printed, published, or produced and disseminated at U.S. taxpayer expense. The funds used by a Federal agency to carry out this requirement shall be derived from amounts made available to the agency for advertising or other communications regarding the programs and activities of the agency.
CONSOLIDATED APPROPRIATIONS ACT, 2017, PL 115-31, May 5, 2017, 131 Stat 135.

