Dementia Care & Psychotropic Medication Tracking Tool Call

Moderated by: Leah Nguyen
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Announcements & Introduction

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

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

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS and I am your moderator today. I'd like to welcome you to this Medicare Learning Network Call on Dementia Care and Psychotropic Medication Tracking Tool.

During this call, gain insight on the tracking tool, a free, publicly available electronic tool that facilitates a structured approach to tracking preference-based care and psychotropic medication use among residents living with dementia. Also, learn about a recently released, Nursing Home Staff Competency Assessment Toolkit. Additionally, CMS provides updates on the Phase 3 Requirements for Participation and the progress of the National Partnership to Improve Dementia Care in Nursing Homes. A question and answer session follows the presentations.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL, go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the question and answer session. If you have inquiries, contact press@cms.hhs.gov.

For today's event, I have Michele Laughman, Jay Weinstein and Debra Lyons here at CMS Central Office with me. And we also have David Reynolds and Yolanda Jones joining us by phone to talk about the National Nursing Home Quality Improvement Campaign.

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

Presentation

Michele Laughman: Thank you. As Leah mentioned, our first presentation will be on the Dementia Care and Psychotropic Medication Tracking Tool. Our speakers for this presentation will be David Reynolds, Project Manager for the National Nursing Home Quality Improvement Campaign; and Yolanda Jones, a Registered Nurse with CMS Center for Clinical Standards and Quality and is working with the National Nursing Home Quality Improvement Campaign, Contracting Officer Representative.

Please note that Adrienne Mihelic from the National Nursing Home Quality Improvement Campaign was not able to be with us today. David, I will now turn it over to you.

David Reynolds: Thank you, Michele. This is David Reynolds with the National Nursing Home Quality Improvement Campaign. So, before we begin, I wanted to go over our learning objectives, those are on slide 5.

So, participants in this session will be able to, describe four uses for the Dementia – for the Campaign's Dementia Care and Psychotropic Medications Tracking Tool. Know how to finalize monthly results and get trend graphs. And finally, give examples of three implementation strategies.

So, by the end of this call, all of you are going to know everything you need to know, to go out to our website, download the Dementia Care and Psychotropic Medication Tracking Tool and get started both putting information into the tool. And also getting information out and using it as part of the quality improvement project.

At this time, I'd like to turn it over to Yolanda Jones with CMS and she'll provide a little bit of background and motivation for the call.

Yolanda Jones: Hi, everyone, my name is Yolanda Jones from CMS. Today, I'll go over some of the CMS priorities that are reflected in this project. We have individualized, person-centered care. Also, reducing the use of psychotropic medications, and – sorry, I'm on slide 6, and supporting each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Lastly, involving all staff in continuous quality improvement.

Now, I'll turn it back over to you, David.

David Reynolds: Thank you, Yolanda. So, this really does align very well with some of the objectives and priorities of CMS.

Okay, now I'm on slide 7. And before I jump in, I'm going to first share a brief overview of the agenda of what I'll be talking about for this presentation. So first, I'm going to just provide a little bit of background. So, bear with me through that, that will just take 5 minutes or less. And then, we will actually jump in and look at the Dementia Care and Psychotropic Medications Tracking Tool. We'll look at it step-by-step, we'll understand what it is and how its use. Then thirdly, we're going to look at reports and outcomes, what you as a user can actually get out of the tool, what it can tell you about your resident population, what it can tell you about psychotropic medication use at your home. And then finally, we'll talk about implementation. What does it actually look like to use the tool within a long-term care community? And I'll also share some feedback and quotes from nursing homes who have already started using this tool.

So here on slide 7, I want to provide a very brief overview of the National Nursing Home Quality Improvement Campaign or NNHQIC for those of you who aren't familiar. We provide free quality improvement resources for long-term care.

And we changed our name in 2016, so you may be familiar with us as Advancing Excellence. We have 3 main types of tools. We have Quality Improvement Resources; our website has a great selection of curated resources for a variety of quality improvement areas. We have Tracking Tools and those are Excel files or Excel tools that enable long-term care communities to track data for their resident. And then finally, we have Graphs and Reporting, and those can be used to track progress and quality improvement.

Throughout all of our work, we focus on the individuals who are receiving long-term care, the staff members who are interacting with and getting to know those individuals on a daily basis and involving everyone in creating a culture of quality improvement.

Okay, slide 8. So, here's a little bit of motivation for the tool. Why did we create this tool? What it is? Who uses it? So, what it is? It is an Excel-based tool for recording and displaying individual information and aggregate trends. Who? It's used for tracking individuals living with dementia and any resident with a psychotropic medication. So, any resident that falls into one of those two categories whether they're living with dementia or they are prescribed a psychotropic medication, they're the target audience for this tool.

The emphasis is on pleasant moments and meaningful activities. It's on learning communication, how does the resident express himself. And then, how can we meet those needs? And the why is the support and prompt individualized care. We want to document key processes and provide information to identify opportunities and drive improvement.

So, when we're talking about motivation, I wanted to share a little story from a nursing home, who was part of our pilot test group and was implementing this home. And they said, we discovered when completing the tool that a particular resident strength has decrease since returning from a Geri psych hospital stay. She was verbalized for – she was hospitalized for verbal aggression, insomnia, resisting care and confusion. And she was placed on an antipsychotic medication while at the Geri psych hospital.

Although, her combative and resisting care symptoms improved, she doesn't seem to enjoy others now. We also learned that she lost her Bible at some point during the last few months, so we will get her another one. We may not have found out about this without interviewing her CNA for this tool.

So, I think that story really sums up the motivation in a nutshell. This tool by itself is not going to create any improvement in any long-term care setting. What's going to create improvement is long-term care staff members, the entire team working together to create quality improvement and what we hope is that, this tool can be a way to make that more effective and more focused.

Okay slide 9, Subject Matter Advisors. So, before we jump into the tool, I just wanted to note the broad array of Subject Matter Advisors that provided input and feedback into this tool. We had representatives from the Alzheimer's Association, Consumer Voice, CMS, QIN-QIOs, a consumer and educator and more. So, we had a very broad group of stakeholders represented. As far as education and training, we had a Nurse, a Pharmacist, a Physician, Nursing Home Administration, all of that background and thought went into this tool.

Slide 10. So, this is a fun part. This is where we actually get to jump in and look at the Dementia Care Tool. So, like I said before, this is an Excel file, but it's not necessarily quite an Excel file that you're used to seeing. So, I was talking with another of our team members this morning who was a Director of Nursing for quite a while and she said that her experience with looking at some of the NNHQI Campaign tools was that after looking at other Excel files all day, she thought, oh here's another Excel file.

And Excel files can be very valuable, but we want to make it as easy as possible for long-term care communities to implement this. So, this is in a little bit different format, everything is button-based. So, there's no standard

grid. You click on the buttons, you enter data in field. And so, based on the feedback that we've heard so far from nursing homes who have implemented this, this is a very good format.

So, from this home page on slide 10, if I were to click the My Residents button there in the middle, that would take me to the screen on the next slide.

So now I'm looking at slide 11. So, this is kind of the – the central place where data is entered. So, you can see at the top we had Bruce Lee, he's our demo record and all of the information. It's a fictitious and we've got kind of a fun Bruce Lee that you may be familiar with and you'll see him themed throughout this presentation.

And there's two main components of – two main types of data that are in this tool. There's information about the individual, and then there's information about psychotropic medication. And I think those two really go together. You can't improve – you can't truly improve psychotropic medications without taking a look at the individual. And one great way to reduce the unnecessary use of anti-psychotropic medications is to say, what are these individuals' needs that aren't necessarily being met? So, having those two components I think is key.

So, the first 3 tabs, the Individual's Information tab, the Preferences & Joys tab, and the Communication tab, all relate to the individual. And what is the information about the individual? What do they like to do? In what ways they communicate?

And then the last tab that we'll look at Psychotropic Medications is obviously all about medication. And you'll see some connections between those two types of data as we go through.

So, like I said, this is an Excel file, but all of the information is entered in these fields. So, we're just looking at Bruce Lee right now. And here at the top, in this top section above that horizontal line, you can see some basic information about Bruce. His name, his date of birth, the most recent admission, type of care, service area, structured medication reconciliation, I'll talk about that in a moment, so kind of some basic information to start out. And then below the horizontal line, we have information about diagnosis. So obviously since this tool is all about dementia care, we've got, does this individual have a diagnosis of dementia?

And then in addition to that, we feel that mental health diagnosis is a very important component of this, and so we've also got that, a variety of different mental health diagnosis that can be indicated for each individual.

Okay, and moving on to slide 12. This is where I'll talk a little bit about that structured medication reconciliation. So, throughout the tool, there are these little question marks. And so, you can see there to the right of structured medication reconciliation, there's that little blue box with the question mark in it. There is so much information that would be helpful to users as they're working through this tool. Way more than we could fit in to this screen.

So, anytime you see a little question mark, you can click on them and they'll bring up more information related to that component of care. So here when I click on that for structured medication reconciliation, I've got a lot of information about what that looks like, I've got a link to JCAHO Sentinel Event Alert. And I also have a worksheet for structured medication reconciliation. So that – those pieces are kind of beyond the scope of this tool. But we want to make sure that we have plenty of links within the tool, so that those are all easily accessible as users are using the tool.

Okay, slide 13. So now I'm still on the Individual's Information tab, but I've scrolled down a little bit, so you can see the scroll bar on the right. This is the only tab of the 4 that has a scroll bar. So, you can see here, we've got Strength, Dislikes, Fears and Phobias and Adverse consequences. And this is where we're really getting to the heart of individualized care. So, for Strengths on the left, what we're trying to do here is prompt staff to build days and use approaches to maximize abilities and exercise strength.

So, for Bruce, his strengths might be expresses preferences, mobility, and likes to be in control. And so, when we're building days with Bruce, we want to keep those strengths in mind, how can we build the day that's going to emphasize those strengths?

Okay, Dislikes, Fears and Phobias. Bruce intensely dislikes dirty clothes, especially sweat stains. Okay, this is an easy one. We can – as we're building days for Bruce, we can make sure those are things that be avoid.

And then on the right side, we have adverse consequences. And these are listed here on this first page for maximum visibility. Anything that selected here is also automatically going to show up on the Psychotropic Medications tab, so that when we're entering psychotropic medication, we can see, okay, Bruce may have been experiencing drowsiness or sleepiness. Could that possibly be related to any of the medications that Bruce has been prescribed?

So throughout this on both Strengths and Adverse consequences, you see there's a variety of check box option. And there are also some options for other. So, there's really an infinite number of Strengths, there's an infinite number of potential adverse consequences. There's no way we can capture them all. So, we've listed a number of them here and then we've also left some spaces for other. And then you can see below adverse consequences, there's a little link there that says, other adverse consequences. And that just brings up another list of ideas.

So that when you're thinking about Bruce, you can think, okay, does Bruce experience drowsiness or sleepiness? You don't have to necessarily be thinking, okay, is medication that Bruce is taking causing drowsiness or sleeping – sleepiness. All we're thinking about right now is, what is Bruce's experience?

Okay, slide 4 – 14, excuse me. And once again, we see another example of those question marks. So, when I click the question mark next to the Adverse Consequences, I get a pop-up message. And this pop-up message takes information from the RAI, the Resident Assessment Instruction. So, throughout this tool, this tool uses Minimum Data Set, MDS Resident Assessment Instruction Definitions to emphasize consistency. So, we really want to be a consistent in the way that we approach all of these things. So those – that information is there. And that you'll see that in other pop ups as well.

Okay, slide 15. So now we're moving on from the Individual's Information tab. You can see that we're on Preferences & Joys. And this is a very simple tab, it's all about one concept, which is preferences and joys. So, you can see at the bottom of the screen, we've got 6 boxes and if you want, you can click that add another button to – add more than 6 if your resident has more than 6. But here we're describing what the individual enjoys. So, I'm looking at that first box, pleasant greeting, Bruce enjoys returning a small bow. If you speak a bit of Cantonese, even hello brings a big smile.

So, these are the types of things that can be really helpful for anyone who's involved in care, whether it's direct care staff, anyone who's involved in caring for Bruce Lee, these are really helpful thing to know. And so, we want to focus on this, we want to emphasize this, and we want to use this when we're working with Bruce.

All right, slide 16. So, we're still here on the same Preferences & Joys tab, and you can see once again, we've got 3 buttons on the right, we've got Survey Guidance on Individualizing Care, we've got Getting to know Me Resources and we've got Creating A Good Day Resources.

And each of those, some of them will take you directly to other resources. Some of those resources are on the web. And others they'll bring up a – a pop up with more information. So, throughout the tool, we want to make sure that we are connecting the information that the users of the tool are entering with ways to use that information, ways to use understand that information.

Okay, slide 17. Communication and I think this might be my favorite tab, because what the tab does is helps the user walk through a thought process. So, this tab starts out really simple. At the top we have, What do you see? A very simply question. What do you see that may signal emotion, perceptual differences, unmet needs or distress? So, for Bruce, it might be – we see exit-seeking, we see crying, we see restlessness, delusions or confabulation, and maybe in other option jumps and kicks.

So, these are just things that we see in Bruce and when we're checking these, we don't necessarily have to be thinking deeply about them or what they mean. But then, when we get to the bottom of the slide, the bottom of slide is going to help us walk through a thought process of understanding what might be communicated and how we might be able to meet the need.

So, the way this work is every time you check the box at the top, they will automatically create another row at the bottom. So, you can see at the bottom we have exit-seeking, crying, restlessness and if you were to scroll a little bit, you see the others. So, if I were to come into Bruce Lee's record here and check another one, say wandering that would create another row above exit-seeking that I could then fill in.

So, I'm looking at the exit-seeking row and we've got four columns here. First, we have what this means or triggers – okay, exit-seeking happens when Bruce doesn't get outside time in the morning. That's pretty simple once we put that way. Okay, this helps, prevent it by keeping a daily routine. If exit-seeking occurs, gently offer an excursion to the outside. So, here's how we can address it. And this one is a very simple example but in other situation, this thought process may help us see and understand more.

Then we also have a Try next column. So, for exit-seeking, we understand a very good way to help Bruce and make sure that that need is met, so that he's not just trying to express it with exit-seeking, that his needs are already met. But if we didn't have that, if we were not sure about how to meet that need, we might have a Try next column that within, say okay, here's what we're going to try. And then finally, a Notes column, so for exit-seeking, this is working well, there's an infrequent occurrence with routine.

So, you can see how we've now been on a journey of a thought process. From a very simple question, what do you see all the way through – okay, what does that mean for Bruce? What does – he may be trying to express. And then finally, what are we going to do in order to meet that need?

Okay, slide 18. Psychotropic Medication. So, this is probably the most complicated slide, but it's really simple once you know a couple of things. So, the first one is up in the upper left-hand corner, we've got a list of medications. These are all of Bruce's medication. And anytime you select the medication at the top, the information down below is going to correspond to that medication. So, you can see in the lower-left of the screen, we've got the information for Geodon, what's the start date, who is the prescribing clinician, et cetera, et cetera.

But if we were to go back up to the top and then switch that to Zoloft, then all the information below would then change to reflect what we're looking at for Zoloft. Another thing I'll highlight here is the Target Symptom. That's got that big circle around it, in the middle. So, if you remember from the previous slide, the Communication slide, we indicated that some of the things that we see and Bruce are exit-seeking, crying, restlessness, delusions, jumps and kicks.

And so now those are populated here on Medications tab. So anytime we're thinking about a medication, we can say, okay, was this medication prescribed for that – has a target symptom. So, for Geodon, delusions or confabulation is a target symptom. And what this allows us to do is make a connection from the communication that we look at on the last tab all the way through to, potentially reducing the unnecessary use of psychotropic medication.

So, on the previous tab, we thought about delusions or confabulation, what does that mean for Bruce? How can we meet that need? And now when we at here, we can see if Bruce is doing well with that and he is no longer having any expressions that indicate that he still has that unmet need. Well maybe, we might even consider looking at gradually reducing the use of this medication, because delusions or confabulation is under control.

Okay, and now I'm looking on the right side of the screen. The same slide 18. Possible adverse consequences. So, this is something that we entered a long time ago on the Individual's Information tab. For Bruce, it was muscle spasms, tics or rigidity, seizures or tremors and drowsiness or sleepiness.

So, like I said before, when we check those, we weren't thinking about how they might relate to medication, all we were doing and saying okay, what possible adverse consequences do we see in Bruce? But now that we're here, we can then make a connection. okay, is there any possible way that Geodon might be connected to drowsiness or sleepiness. And so now we can see, okay, here's the target symptom that it was prescribed for maybe we're getting those needs under control. Here's the medication and here are the possible adverse consequences. So, if we can get Bruce to a point where he no longer needs that medication, then maybe we've also eliminated the adverse consequences of that medication.

Okay, on the lower right-hand corner of the screen. We've got Gradual Dose Reduction or GDR tracking. So, throughout the tool, you'll see this referred to in a few different ways, you'll see GDR which stands for Gradual Dose Reduction. You'll see reduction attempt. So, here we've got a list of dates for Upcoming review and reduction attempt. And these are automatically populated within the tool based on the start date. And I'll actually talk a little bit more about that on the next slide. But there's nothing that the user needs to do in order to get these. It just automatically creates a schedule. And this doesn't mean that the staffs have to then create a GDR right then, but it's a time to look and review, is now a good time to be doing a GDR for that medication.

And for the – and at the bottom, you can see for the Geodon that we're on. We're actually in the middle of a reduction attempt right now. So, this bottom box will change depending on where we're at in the – in the cycle.

So, if there was no Gradual Dose Reduction attempts active, this would give you the option to start one. And since we have already started one, it tells you about what's going on right now.

Okay. Now I'll move on to slide 19. So, here's where I'll talk a little bit more about that Gradual Dose Reduction schedule. So, once again as we discussed throughout the tool, if I could click those little questions marks, they're going to bring up more information. So, in this case, it's going to tell me how is this Excel tool actually calculating those recommended date? And so that's based on this date operations manual and I want to emphasize here, these are not requirements. These are recommendations that are based on this date operations manual.

And so, we leave it up to each long-term care community to ensure that they're fulfilling those requirements. But we hope that this recommended schedule is going to make it easier for them to do that.

So, one other final thing that I'll say about this, is you – when you get to that point where the tool is recommending a Gradual Dose Reduction, you've got a few options. First, you could obviously go ahead and jump in and start that Gradual Dose Reduction. Second, you could say it's contraindicated. So instead of starting the dose reduction, you'll have an option to say this is contraindicated and then indicate the clinical rationale for why it's contraindicated. Or third, you could change the due date.

So, the tool produces – automatically produces those recommended dates, but you can also enter your own. So, if you see that the tool is producing an automatic recommended date that's maybe at a bad time for Bruce, maybe it's the time of where something is going on in his life, that there's a change and maybe it's not a good time to be shaking up his medication regimen. You can say, okay, we're going to do this in two weeks. You change that due date and then it will come up again in two weeks.

All right, slide 20, Printable Quick View. So, as you're looking through this, you probably have a lot of questions already and one of those questions maybe, great David, this sounds good, but a lot of my staff don't have access to a computer. So that's what the Quick View is all about.

So, this is something that is created for each resident. It's prints in black and white, so you see that kind of grayish background, that's not going to print when you print this. So, it won't use up too much ink. And it provides all of the information that's pertinent to direct care staff.

So, you can see we have dislike, fears and phobias, pleasant moments and meaningful activities. We have whether Bruce is currently on any reduction trials, possible adverse consequences, strength and expressions of distress and communication notes.

So, like I said before, some nursing homes have already started using this tool. And so here are few examples of how those nursing homes have been able to integrate the Quick View into their processes so that it's easy for staff to access. The one nursing home said that the – they would print it out and that the information will be available in a binder at nurse stations. Another said that our direct care staffs have clipboards, where we can put the Quick View print off or we might post it inside the resident closet door along with our care cards and therapy updates for individual resident.
So maybe they have – they already have a place where they have other similar information, this is a good place to put that. And then another home said, that copies of care plans have been included with ADL Activities of Daily Living Record for easy access for staff members.

Okay, so now I'll move on to slide 21. And now we're getting into the data. So, in the process of quality improvement, I think many of you are probably familiar with the way that works, but anytime we make a change, or any time that we do something, we want to be tracking to make sure that, that change is taking effect. So that's what all of the data is about here, and the tracking tool has two types of data that it outputs. The first is what we call report and the second is what we call outcomes.

So, the graph that we're looking at right now is on slide 21, this is what we call report. And these are designed to help you understand your resident population and what's going on in your home. So, reports aren't necessarily measures where higher is better, or lower is better they're here to help you understand. And then later we're going to look at outcomes, and these outcome measures are the things where you do want to say, okay, am I doing better than I was before? Am I – they're the types of things where you say okay, higher is better, lower is better, where's there's a clearly defined objective.

And I also want to make a note about how these reports and outcomes are recorded. So, after the end of every month a screen will come up within the tool that asks if you want to finalize your reports and outcomes for the previous month. So, once you finished entering all of your data for that month, you go ahead and click that finalize button, and then your reports and outcomes become available.

So, looking at the reports here, I'm going to talk through a little bit about how what I might think if this were my home looking at this data, what I might think could potentially be going on and then next steps that I might want to take. So, the first graph here in the upper left, it's a pretty simple graph, it's saying what – when we look at our resident population what is the demographic as far as dementia and mental health diagnosis?

So, you can see that 75 percent of our residents have dementia diagnosis. And then a few have mental health diagnosis and then a small number in both and neither. So, I can see my home has a very high proportion of residents with the dementia diagnosis. And keep in mind that this is specific to the individuals who you've entered within the tool. And so, if individuals aren't on psychotropic medication aren't on dementia – don't have a dementia diagnosis, those aren't the target audience for the tool, they may not be in here. So, this graph isn't saying – isn't explaining your resident population over all, it's just those that are in the tool.

In the lower left, we've got top 10 Target Symptoms for Prescribing Psychotropic Medications for Individuals Living with Dementia. So, what the question that we're answering here is what are the top reasons why we're prescribing psychotropic medication?

So out of all the psychotropic medications prescribed in our community, 20 percent are prescribed for anxiety, 18 percent for delusion, 16 percent for hallucinations. So maybe as someone who's working on quality improvement I want to dig into those areas across my resident population. Are there things that we can do for those areas, and you'll see that these percentages don't add up to a hundred, that's because any particular medication could be prescribed for more than one thing.

And then on the right side we've got PRN orders by category of psychotropic medication. So, when I look at this, the first thing that jumps out to me is that 36 percent of hypnotics, sedatives and sleep agents are prescribed on a PRN basis. So that definitely jumps out at me right away.

But maybe I want to look closer at that, maybe a lot of them are PRN sleep agents and that's just fine. Or maybe a lot of them are PRN medications that we really might not want to be prescribing PRN. This helps me understand what's going on in my community as far as prescribing.

Slide 22. We've got two more graphs that I want to talk through. So, on the left we've got Informed Choice. So, within the tool, within the tracking tool, there is a question about Informed Choice that is asked for each medication. So, for each medication, it asks three things. Was the resident informed of the risks and benefits of the proposed care? Was the resident informed of treatment and treatment alternatives or options? And then finally did the resident choose the option that they prefer?

So, when I look at this, I can see that out of the medications prescribed in my home, 70 percent are – this question is not being recorded for 70 percent for the first question and the last question. So that tells me maybe there's a process opportunity to make sure that that question is being asked.

Another thing that I can see from this draft for the middle question informed of treatment and treatment alternatives, or treatment options, that's not happening in 34 percent of psychotropic medication. So, for more than a third of those medications, we're not informing the resident about what other treatment we might provide. So that also is a process opportunity.

And then on the right-hand side, we have documentation and process completion. So, this corresponds to the diagnosis. So, whether for individuals living with dementia whether diagnostic criteria was documented, the same for mental health whether those diagnosis are being documented with that diagnostic criteria. And then finally for individuals with mental health diagnosis, whether the PASRR, the Preadmission Screening and Resident Review is being completed.

So, I can see that only 22 percent of the individuals with mental health diagnosis are getting that PASRR 2. So once again that's something I might want to look at.

Okay and now we'll look at slide 23, Monitoring Outcomes. So now we've looked at reports, those were things that tell me about my home what is going on, what does the resident population look like, what do the prescriptions look like. And the outcomes that we're looking at now are things that I want to improve. So, we've got two categories in outcomes and these correspond to the two types of information that we talked about when we were looking at the data entry screen.

So, we've got Individualizing Care and we got Psychotropic Medications. So, there's a variety of outcomes here, I'm not going to read through all of them, but I will say for those of you that have been using campaign tracking tools, you'll be very familiar with the process. At the end of each month, once these are finalized you can enter those outcome measures on to the campaign website and then you will automatically get graphs and reports about those.

Okay. And then on slide 24. This is showing Monitoring Progress. This is what those graphs look like that you'll get from the website.

Implementations & Integration: Experience from Pilot Testers and Early Adopters

Okay slide 25. So now we're moving into implementation and we'll take a little bit of a look at experience from pilot testers and early adopters. So here there's two links, Is This Tool for You and Implementation Tips. So, if you're multitasking go ahead and open up those links and check them out, otherwise take a look at them after the presentation.

Slide 26. So, the first Implementation Strategy that I want to talk about is starting small. Based on the feedback that we've gotten, in a lot of the cases it takes about 5 minutes per resident to start entering the information. Now once you've got all that information initially entered, it's going to be a lot easier in the next month to then come in and update it. But that first data entry process can be a little hard.

So, some of you are saying, okay, my home has 30 beds, this isn't going to be too bad. Some of you are saying my home has 200 beds this is going to take a long time. So, what I would recommend to you is start small, start with just a few residents, you could choose to start with residents from one particular floor or unit. You can try to start with a representative sample of 25 percent of your resident but start small.

And I will say that there are other communities who said that it takes as long as 30 minutes to enter the data for one resident the first time. That is a long time and that is a big ask. But in those situations, often the community is looking up a lot of the information for the very first time. And they found that the process was extremely valuable as they went and got that information.

Slide 27, Implementation Strategy number 2. Leverage existing processes and systems to collect and share information. So whatever existing processes you've got in your community, in your home where this type of information is being passed around, use those. In your cross over or shift change huddles, use those. Interdisciplinary Team Meetings, we've heard that one home is using that. Some of the information may already be in your EMR. Some may be in pharmacy reports or some may be in previously collected About Me Information.

Slide 28, involve your whole team. So, this tool is really not something that's going to be successful if the administrator and the director of nursing sit down by themselves and say we're going to do this. This is going to be the most successful when the whole team all the way from the leadership to nursing, direct care staff, even housekeeping, cooks, all of these people who are involved in resident care touch the individual in some way. Whether it's doing their laundry, whether it's cooking their meals, all of these people are interacting with the resident in some way. So, all of those people are critical in order to make this tool a success.

And on slide 28 here, I'll make a little plug. There's a link that says, try a story board and share your successes. If you've implemented this tool and it's going well in your home, you can click that link. It's going to take you to our website. You can answer a few questions about how did your quality improvement project go? And then, we will be able to feature your home's quality improvement success story. And we'll also give you a one page or a two-page plaque that you could then print off and frame and put in your nursing home or your community to share what you've accomplished.
Okay, learning objectives, slide 29. Describe four uses of the Campaign's Dementia Care & Psychotropic Medication Tracking Tool. So, the first two are those two categories of information that we talked about. The first one is individualizing care, these needs to be about the resident. The second is about psychotropic medications. We want to make sure that we are prescribing appropriately and reducing the use of unnecessary medication. The third is exploring patterns and identifying opportunities. Those are the charts and graphs that we talked

about. And the fourth are – is monitor continuous quality improvement through trending outcomes calculated by the tool.

Slide 30, Objective number 2. Know how to finalize monthly results and get trend graphs. So, I talked a little bit about this earlier. When you're done with each month, there's that Finalized Outcomes button. And if you don't remember to do it, it's okay, the tools are going to automatically remind you. When you click that, it's going to take a snapshot of your data for that past month. And then all of that information will be available.

And then slide 31, Learning Objective 3. Give examples of three implementation strategies. So, start small. This is often a big ask to get started. It gets a lot easier once the ball is rolling, just start small. Second, leverage your existing processes. You don't need to create any new processes around these. You can use what you've already got where you already discussing this information in your home. And then third involve your whole team. Everyone who touches the resident needs to be involved in this process in order for it to be a success.

Slide 32 provides a few links. There is the link to the Tracking Tool right there, you can download it right now if you want and start checking it out, looking at, looking at it and seeing if it's something that you like to implement in your home. On that same page with the tracking tool, there's a lot of great information. There are some PDF files that have screenshots that show you how to use it. Or if you prefer, we also have some short three to six minutes recorded webinars that talk about how to use it.

So, I will wrap it up there. Once again, there will be a question and answer session at the end of this call. So, I hold questions for now. But I did want to say, thank you all for joining and thank you for making a long-term care community, great place to live, work, and visit. So now I turn it back to Michele.

Nursing Home Staff Competency Assessment

Michele Laughman: Thank you, David and Yolanda. Next up, we had Jay Weinstein, a Health Insurance Specialist with CMS, Division of Nursing Home. He will be discussing a recently release nursing home, Staff Competency Assessment Toolkit. Jay?

Jay Weinstein:Thank you, Michele. Good afternoon, everyone. I just want to mention the information that I'm going to go over today is on CMS's website. And you can find it under cms.gov Centers for Medicare and Medicaid Services. And it would be under Home Medicare Quality and Safety Oversight. General information, and it would be under the tag Civil Money Penalty Reinvestment Program. And that's a program that's taken CMP funds that were collected from facilities and used to help the residents out to increase the quality of care in nursing homes.

So today, I want to talk a little bit about some of the toolkits that are on this website. It's important to know that any of these toolkits that are on the website, you have to save the documents to your desktop in order to use all functions of the document. So, I'm first going to talk about the very first one that was developed several months ago, Nursing Homes Staff Competency Assessment. And if you have any questions, you can email the CMPRP team at cmp-info@cms.hhs.gov.

So quality care is very complex. That's why with CMPRP competency assessments helps nursing homes break down and self-examine some of the most important building blocks of quality care. Use the competency

assessment to identify areas where your nursing home is doing well. First, is where you – facility might need support. Once you know where you need support, CMPRP can provide funding, technical assistance and learning opportunities to help address some of your facility's toughest challenges, and in order to offer the best possible care to your residents.

There are 3 competency assessments that we have both in print form and electronic form. The first one is the Certified Nursing Assistance CNA, Certified Medication Technician CMT kit. Second one, is Licensed Practical/Vocational Nurses, LVN/LPN and Registered Nurses RN. And the third is Assistant Director of Nursing, ADON; and Director of Nursing, DON and administrators. The assessment poses questions about behavioral, technical, and resident-based competencies and should be completed as needed.

This toolkit, number one, which includes the competency assessment and support materials to support your nursing home's existing learning and development standards of practice. The toolkit also includes an instruction manual to support managers in implementing the assessment. The guide provides resources, including videos, talking points, emails, memos, a poster, an assessment, and a completion tracker. Also, a manager's guide to meeting one-to-one with staff and assessment result worksheet to compile and analyze the results.

I am a nursing – I have been a Nursing Home Administrator for over 35 years. I just wish that this - these tools were available when I was administrating nursing homes. They were very helpful and would solve a lot of the issues in today's world.

Just recently, we published the Nursing Home Employee Satisfaction Survey which was actually put on the website on February 15th. The same instructions that I gave you for toolkit 1 must be applied to this toolkit as well. We save the documents to your desktop in order to use all functions of the documents. If you have questions, you email the same email address that I gave you.

The employee satisfaction survey can help your nursing home to recruit, motivate, and retain staff. After all, nursing home employees are critical to better resident health and quality of life. These free anonymous surveys offer facility employees and opportunity to share their perceptions about nursing homes workplace. Survey topics include, Employee Engagement and Team Building, Job Satisfaction, Management and Leadership, Scheduling and Staffing, and Training.

Supporting resources are available to support managers in implementing the survey as well as aggregating and interpreting survey results including, implementation guide with talking points, an email memo and posters. Data collection and analysis tool to compile and analyze survey results. Videos, watch these two videos to get started. Introduction to the Nursing Home Employee Survey can be found at the link, https://youtu.be/9WE40dUELpw.

Data collection and analysis tool tutorial, the link there is https://youtu.be/wXN3bNJzZ6A. Not sure if the staff satisfaction is your biggest issue. Use the CMPRP free competency assessment, also available in a download section to find out.

In the months to come, CMS will be putting on their website, A Guide to Improve Nursing Home Employee Satisfaction. So, once you finish giving the Nursing Home Employee Satisfaction Survey, this guide will analyze the results and tell you how to best improve your nursing home. Thank you very much.

Phase 3 -Federal Requirements for Participation

Michele Laughman: Thank you Jay. Next up, we'll have Debra Lyons, a registered nurse and Technical Director with CMS, Division of Nursing Homes. She will be providing updates on the Phase 3 Requirements for Participation from the Reform of Requirements for Long-Term Care Facilities final rule. Deb?

Debra Lyons: Thanks, Michele. Thanks, Michele. Good Afternoon everyone. And thanks for taking time out of your – we're moving the microphone. Thanks for taking time out of your busy day to join this call. As Michele said, my name is Debra Lyons and I'm a Registered Nurse in the Division of Nursing Homes.

I'm going to give two updates actually related to nursing home. First, an update on the Phase 3 Implementation of the Reform of Requirements for Participation in Medicare and Medicaid for Nursing Homes. As you may recall, this overhaul of the nursing home regulations went into effect on October 4th of 2016. And those changes were implemented in 3 phases.

Phase 1 generally involves no change to the regulatory language and was implemented on November 28th, 2016. Phase 2 involved some regulatory language change. And some changes to the interpretive guidelines. And those were implemented on November 28th, 2017. We are quickly approaching implementation of Phase 3 which will occur on November 28th, 2019.

CMS plans to take a similar approach as we did with Phase 2 by releasing an advance copy of the interpretive guidelines. This advance copy will include both Phase 3 Regulations on Interpretive Guidelines, and changes that we've made to some, some select Phase 2 guidelines.

So, let me explain the changes to Phase 2. In more than a year since implementation on Phase 2, we have answered numerous inquiries from providers and surveyors alike and made – and have made decisions to clarify or modify some of those Phase 2 interpretive guidelines based on the number of inquiries we've received. CMS will make available an advance copy of the new Phase 3 regulations and guidelines along with any Phase 2 guidance that has been revised.

Additionally, as we did with Phase 2, CMS will release training related to these changes that will be available to the public as well as the surveyors. The advance copy of the interpretive guidelines and the training will be released this summer to give nursing home providers, state survey agencies, and other nursing homes stakeholders time to view the training and implement these changes. And as we did this Phase 2, we will issue an advance copy via the QSO policy memo.

For additional information on where you can find CMS updates related to the survey process or any changes to interpretive guidelines you can go to the Nursing Home Information hub at get ready for it, it's a long web address. I mean we will also – this link will be available in the transcript following this presentation. Http – I'm going to go with www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawAndRegulations, all one word, /nursing-home.html. Again, this link will be available in the transcript.

The second update that I'm going to announce is the long awaited Specialized and Infection Prevention and Controlled Training for nursing home staff in the long-term care setting. The Centers for Medicare and Medicaid Services CMS, and the Centers for Disease Control and Prevention CDC, collaborated on the development of a free online training course in infection prevention and control for nursing home staff in the long-term care setting. The training provides approximately 19 hours of Continuing Education Credits as well as a certificate of completion.

The Nursing Home Infection Preventionist training course and additional information is available by reviewing the policy memo. You can find the memo by searching for QSO-19-10-NH.

And that's all I have for this announcement today. Again, if any of those links will be included in the transcript. And we will try to get those in ahead of time when the slides come out next time.

National Partnership Updates

Michele Laughman: Thank you, Deb. Before I turned it over to the moderator for the Q&A session, I'd like to talk a little bit about the National Partnership to Improve Dimension Care.

Recently, we released quarterly data reports for the partnership. In 2011, Quarter 4, 23.9 percent of long stay nursing home residents were receiving an antipsychotic medication. Since then, there has been a decrease, a 38.9 percent to a national prevalence of 14.6 percent in 2018 Quarter 3. I'll note that the national prevalence remained the same from 2018 Quarter 2.

Additionally, in 2011 Quarter 4, 21.4 percent of long stay nursing home residents living in a nursing home that has been identified as a Late Adopter were receiving an antipsychotic medication. Since then, there has been decreased of 5.2 percent to a national prevalence among Late Adopters of 20.3 percent in 2018 Quarter 3. We note that there was an error in earlier versions of the Late Adopter report related to the prevalence rate for Late Adopters for Quarter 3 of 2012 and earlier. But this has been corrected.

As we continue to make progress to achieve our goal of a 15 percent reduction in the use of antipsychotic medication for nursing homes identified as Late Adopters, we also want to acknowledge that circumstances exist where clinical indications for the use of antipsychotic medications are present. And we do not expect that the national prevalence of antipsychotic medication use to decrease to zero. The National Partnership continues to be committed to improving the quality of care for individuals living with dementia in nursing home. And has a mission to deliver healthcare that if person-centered, comprehensive, and interdisciplinary.

We continue to conduct with focus dementia care and focus schizophrenia surveys in an effort to examine antipsychotic medication prescribing practices, study appropriate assessment and diagnosis of schizophrenia, assess compliance and also improve surveyor effectiveness.

Additionally, the work of the Civil Money Penalty Reinvestment Project or CMPRP has progress. Under the CMPRP, we are working with nursing homes that had been identified as Late Adopters by the National Partnership. Through a breakthrough community model, the participating homes are focused on implementing small plan do study act cycles to improve quality of life and quality of care for residents living with dementia while reducing inappropriate antipsychotic medication use.

Additionally, the CMPRP is providing dementia care technical assistance. Participating nursing homes learn root cause analysis technique. Evaluate the skills of their staff. Have the opportunity to hear from experts and develop performance improvement plans to reduce the inappropriate use of antipsychotic medication. And improve person-centered care for residents living with dementia.

I'd like to thank you for your participation in today's call. And give a big thank you to all of our speakers. I will now turn it over to Leah Nguyen for some additional announcement. Thanks.

Question & Answer Session

Leah Nguyen: Thank you, Michele. We will now take your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many questions as possible. Each caller is limited to one question. To allow more participants the opportunity to ask questions, please send question specific to your organization to the resource mailbox on slide 37, so our staff can do more research.

Preference will be given to general questions applicable to a larger audience, and we will be mindful of the time spent on each question.

All right, Dorothy, we are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization. Please note, your line will remain open during the time you're asking your question, so anything you say, or any background noise will be heard in the conference.

If you have more than one question, press star one to get back into the queue and we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

Your first question comes from the line of Melody Malone.

Melody Malone: Thanks so much. This is Melody Malone at TMF Health Quality Institute. My question is for David. On slide 13 under Adverse Consequences, both that are checked are red, so do they turn red when they are check?
David Reynolds: Hi, Melody. Yes, great question. When you check Adverse Consequences, they do turn red and when you uncheck them, they will turn back to black. So that's just a way to easily visually scan to see what the potential adverse consequences might be. But note that that red and black color changing is not necessarily the case with other areas such as strength.

Melody Malone: Thank you so much.

Operator: Your next question comes from the line of Susan Battaglia.

Susan Battaglia: Hi, this is Susan Battaglia at Tara Cares. Just a quick question for Debra in regards to the Infection Preventionist Training Course. That course that's being offered does meet the requirements of participation education, correct?

Debra Lyons: Well, I can tell you that this – this has been offered and you're going to have to refer to the requirements. I am not actually the infection preventionist subject matter expert. So, I think what I would suggests is that you first look at the regulations for the Infection Preventionist. And, you know, make a determination as to whether if, you know, if it will meet the requirements.

And you can also submit a question to our dnh_triageteam mailbox and we will get you an answer. And I apologized for that, I'm not the subject matter expert but, you know, please submit your question to our email box, we will get you that answer.

Susan Battaglia: Okay, thank you very much.

Leah Nguyen: And that's on slide 37. Thank you.

Operator: Your next question comes from the line of Este Pomell.

Este Pomell: Hi. I am calling from Washington Odd Fellows Home and this is the skilled nursing facility. My question has to do with the tracking tool. And I'm wondering if the information we enter into the tracking tool will be considered an official part of the resident's medical chart, so that it counts when surveyors are looking for documentation?

David Reynolds: Hi, this is David Reynolds. So the first thing that I'll say is I cannot speak to exactly what a surveyor will need or be looking for, but I will say that we hope that using this tool and having documented, the types of care actions provided in the tool will help you be able to demonstrate the quality of care and the type of processes that you're following.

So, I can't say for sure how any particular surveyor or how CMS would look at this, but the idea here is that this can be used as supporting documentation to document the processes that you are using in your home.

Leah Nguyen: Thank you.

Operator: Again, as a reminder, if you would like to ask a question, please press star then the number one on your telephone keypad.

Your next question comes from the line of Lisa Barton.

Lisa Barton: Oh hi, this is Lisa from HealthInsight Org. And I'm actually asking about the infection control, infection prevention training that was recently released. So, I – myself as well the nursing home try to create accounts on that, and there seemed to be some confusion about what to select during the account creation process where it asks for the community. And then the next step is what best applies as far as the type of community. And so, there wasn't an option for nursing home or at least direct that seemed clear to apply to nursing homes, so I kind

of played around with it and try to find which option to select. And they all took me to the hospital option where there was only hospital.

Leah Nguyen: Oh, I'm sorry, we really can't hear, is there a way for you to speak up?

Lisa Barton: Oh. All right, can you hear me now?

Leah Nguyen: Yes.

Lisa Barton: Okay, very well. So, I'm referring to the infection prevention training that was recently released. So there came an issue that myself as well as a nursing home user discovered when creating an account, so that way we can get into the training. During the process you're asked to create – select your community as well as then select the type of business, I guess, is the other question.

And neither of them seemed to apply for nursing homes, they were directed for other kind of like hospitals and dialysis and other kind of settings, but didn't apply to nursing home, but I try to play around with it and try to find something for nursing home. But they all directed me to hospital. Do you know the correct option or is that something I should send an email to that email address that you reference earlier?

Debra Lyons: Yes, you're going to have to send an email to the dnh_triageteam@cms.hhs.gov …

Lisa Barton: Okay.

Debra Lyons:… and we can get to the technical assistance you need.

Lisa Barton: Okay, will do, thanks.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Susan Whitaker.

Susan Whitaker: Hi, this is Susan Whitaker with Rennova Health in National Tennessee. I was just wondering, is there any plans to incorporate on a more much broader perspective of pharmacogenetic testing for residents in senior facilities. Since so many psychotropic antidepressant drugs have a genetic component in regards to how well or how poorly they're metabolized?

Debra Lyons: Are you – are you asking if CMS will require this testing? The answer to that at this point …
Susan Whitaker: Or …

Debra Lyons: Go ahead.

Susan Whitaker: Oh, I was just – well, I was just wondering if there was a broader application than what's currently approved for pharmacogenetic testing with all of the efforts to manage psychotropic drugs in the dementia population whether there was any consideration to expanding the guidelines for coverage?
Debra Lyons: Are you talking about for Medicare to pay for that?

Susan Whitaker: Well yes.

Debra Lyons: Yes. We're not aware of any efforts underway at this point.

Susan Whitaker: Okay.

Leah Nguyen: Thank you.

Susan Whitaker: My company had recently participated in all small study at a senior facility here in town and we actually found that a third of the patients that we tested were actually on a medication that were either – they were poorly metabolize in it or an intermediate metabolizer of anti-psychotropic.

Debra Lyons: What I would say is that, you know, CMS is one of our requirements is that the practice reflect the standards of practice. And I think as we move forward and we learn more about this, you know, especially dementia care as relates to as, you know, pharmacology. I'm sure, you know, there'll be efforts in the future but at this point, you know, I think that we're not there at this point. But thank you for the suggestion and the question.

Leah Nguyen: Thank you.

Susan Whitaker: Thank you.

Operator: Your next question comes from the line of Jennie McDougal.

Jennie McDougal: Hi, it's – I was just wondering, I'm also using the hospitalization tracking tool and I saw when clicked on residents that, you can pull info from one tracking tool to the other on the nursing home campaign site. Will this pull over my whole resident list?

David Reynolds: Hi, this is David Reynolds. Yes, that will pull over your whole resident list. And if you have any other questions on the hospitalization tracking tool, go ahead and send us an email at help@nhqualitycampaign.org. I don't want to – I distract the focus-- from the focus of this call but yes, that will pull over your whole resident list.

Jennie McDougal: Okay, thank you, that gives us a good start.

Operator: Your next question comes from the line of Lisa Birdwell.
Lisa Birdwell: Hello, can you hear me?

Leah Nguyen: Yes, thank you.

Lisa Birdwell: Okay, just making sure. So, my first question goes back to our presenter on the competency on substance and I know you have the onset satisfaction. And then it started with the CMPRP team, it says you guys had said, once you know where you need support CMPRP can provide funding, technical assistance and learning opportunities to help address some of your facility's toughest challenges. Can you give me a little more

detail on what that is? How you can provide funding, the technical assistance and learning opportunity? Thank you.

Jay Weinstein: So, I ask you to address that to the mailbox because they would be able to address that this and it would be the cmp-info@cms.hhs.gov. I would need a little bit more – we would probably need a little more information. And I'm sure a lot of it would be involved in the competencies that you give to your staff.

And then following the employee satisfaction survey, how to analyze that. So, I would send that email to that mailbox and we can answer the specific question.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Hilda Nucom.

Hilda Nucom: Yes, can you hear me?

Leah Nguyen: Yes, thank you.

Hilda Nucom: Okay, thank you. Back on the tracking tool, whenever you are documenting your diagnosis, they have Alzheimer's, they're listed first. And then they have 3 types of dementia listed. Do you want to specifically choose dementia and if it's not listed as a vascular dementia or a mixed by the physician? Do you just type in the dementia in the other slot that you have there? Does that still count or how do you do that?

David Reynolds: This is David, can you repeat the question one more time please?

Hilda Nucom: Sure. When on the tracking tool, it has Alzheimer's listed first which I'm assuming that if they have Alzheimer's, you would still want to put the dementia versus the Alzheimer's as a diagnosis since this tool leans towards dementia. And also, if they're just simply – their diagnosis is simply dementia unspecified, do you need to put that in the other spot?

David Reynolds: Yes, thank you. So, I think the idea here is that you indicate whichever type of dementia it is, so if it's dementia from Alzheimer's disease, you'd indicate that, vascular, et cetera or mixed. And then with regards to unspecified dementia, we intentionally left that option off of here, we discussed that with our advisory panel. If you do have a situation where there is an unspecified dementia, you can put that in the other box.

But the reason that we did not include that as one of the standard option, is because we want to encourage homes and community to investigate further where possible and try not to fall back on unspecified dementia. Of course, there will be cases where that is the most appropriate, but if possible, to indicate the specific type.

Hilda Nucom: Okay. Thank you.

Leah Nguyen: Hold on a moment.

Debra Lyons: Hi there, this is Debbie Lyons and I want – our infection control subject matter expert is actually listening in and sent me a response to the earlier question that I was not able to answer. And so basically, our

intention in developing this training, the Specialized Infection Prevention and Control Training, is that it will meet the requirement for Specialized Training and Infection Prevention and Control.

The infection prevention and control training must be sufficient to perform the role of the infection preventionist at the facility and to care for the infection prevention and control needs of the resident population. Please keep in mind that more training maybe needed to meet the population's need than what's developed by CMS and CDC. There may be many other trainings currently available that would meet the regulatory requirement as well.

The quality of the trainings will have to be ensured. This may mean that training is accredited and provides continuing education, but the interpretive guidance is still in development and the final criteria for training is not yet available.

So, I hope that answers your questions if there – if it doesn't, if you're if you have other questions, please send it in to the DNH.TriageTeam email box. Thank you.

Operator: Your next question comes from the line of Virginia Fist.

Virginia Fist: Yes. Virginia Fist from New Jersey. I had a question regarding the competency, the staff competency check list, I was wondering how I could obtain that for the dementia.

Jay Weinstein: Okay so the important thing to do is you must download the tool in your computer and save it, if you do that you should be able to pull it up.

Virginia Fist: Yes, but …

Virginia Fist: Oh, go ahead…

Jay Weinstein:Okay. And once you do that – first of all, you have to – you go in our website and all of that, all the toolkits that are there so far have been approved are on the website. But the key to that is that you've got to save the document to your desktop in order to use all the functions of the document.

Virginia Fist: Thank you. So, I go to your general website to …
Jay Weinstein: Yes. If you go on to the cms.gov Medicare, Medicaid Services and you go to home page, Medicare, Quality and Safety and Oversight, General Information, under the CMP – Civil Money Penalty Reinvestment Program, it tells you everything about the program it's like a 5-page document. And then the toolkits are there. And on actually page 4 and they can be downloaded. But in order to download them, it's important to remember that you have to save it on your desktop to get all of the documents.

Virginia Fist: Okay, thank you very much.

Jay Weinstein: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of David Koch.

David Koch: Hi, this is David, I'm in South Dakota. And I have a question about the exclusion of antipsychotics in bipolar, I believe it used to be that you could use anti-psychotics for bipolar and then it was removed. Are there any discussions about putting that back in?

Michele Laughman: This is Michele Laughman, bipolar has not been an exclusion, the 3 exclusion have remained the same schizophrenia, Huntington's disease and Tourette's. So, there wasn't a change from the past, it's always been there's 3 exclusion for the antipsychotic quality measure.

Leah Nguyen: Thank you.

David Koch: Second question is, on your sheet, page 11, you get diagnosed, diagnosis documented and have diagnostic criteria been met. Where do I find the diagnostic criteria?

David Reynolds: Hi, this is David Reynolds. So that would really be to indicate whether a physician had provided that diagnosis and that that diagnostic criteria had been met for that. So, what this is trying to differentiate is situations where – based on interacting with the resident and based on the residents history without any particular specific, clinical documentation that a diagnosis of dementia is being indicated as compared with situations where a physician has come in and really identified that this is the diagnosis. Does that answer the question?

David Koch: No – I think, sometimes we get Alzheimer's disease, but I don't know if they've tested them or, you know, that's hard to prove it's Alzheimer's until after they've died.

David Reynolds: Yes. So, I think with this tool here, if it's not something that's indicated by a physician, you would indicate no. And that's not necessarily a bad thing, that the diagnosis wasn't documented in that situation. So if you remember when we talked about the report, you'll see that show up in the reports, you'll see what percent of your resident who have a diagnosis of dementia, have that diagnosis documented. And maybe that's not a 100 percent, but that's okay, because there may be situations where that's not needed.

David Koch: Okay, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jacqueline Houston.

Jacqueline Houston: (Inaudible) to that would need to be (inaudible) ...

Leah Nguyen: Hello, do you have a question?

Jacqueline Houston: If we can continue to participate in any …

Operator: Ms. Houston, your line is open.

Jacqueline Houston: (Inaudible).

Leah Nguyen: We'll take the next.

Operator: Your next question is from Melanie Malone.

Melanie Malone: Thanks so much. I was wondering what the status is on any education tools or even survey clinical pathways on the trauma informed care component of the federal requirements for participation.

Debra Lyons: Hi, Melanie, this is Debbie Lyons. As I mentioned in my announcement, we will have training – the same training that we are providing for surveyors will be available to any nursing home providers, as well as the interpretive guidance that will be, you know, released in advance copies sometime this summer.

As far as the pathways in any survey tools, they are available on the nursing home information hub that I referenced with the really long web address that we will provide, we will send out an email, is that right Leah?

Leah Nguyen: Yes, we're going to send an email out to you right after this call with the links that we've been talking about.

Debra Lyons: Yes. And you can find there – this nursing home information hub that I'm referring to is a place where on the CMS website where we have all of the surveys about pathways, we have all of the guidelines, we have, you know, all of the reference sources that the surveyors use when they're on site, we have Chapter 7 of the state operations manual, the long-term care survey procedure guide. We have all of that information in one central location; it is available to the public. And I will – that will be part of the information that we send out.

Melanie Malone: Thank you.

Debra Lyons: Does that help?

Melanie Malone: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Este Pomell.

Este Pomell: Hi. I am wondering if any mental health professionals were included in the Subject Matter Advisors.

David Reynolds: Hi, this is David. I am not recalling whether we had somebody who specifically was a mental health professional involved in there.

Este Pomell: It seems like that would have been a good idea, is there any plan to consult mental health professionals in the future regarding this type of thing?

David Reynolds: I think if we look at making changes to the tool, we may look for the types of people who we need to pull in order to make sure we consult and get the best possible set of perspectives. I think it can be challenging to get every single perspective. I could see the – I definitely see your point and the value there, but I don't think we have any immediate plans to change anything.

Este Pomell: Okay, thanks.

Michele Laughman: David, this is Michele Laughman. In your list of Subject Matter Advisors, you list Gary Epstein-Lubow and I know that he has a background in geriatric psych.

David Reynolds: Great, thank you.

Este Pomell: Thanks.

Leah Nguyen: Thank you.

Operator: There are no further questions at this time. I will turn the call back over to Leah.

Additional Information

Leah Nguyen: Thank you. We hope you would take a few moments to evaluate your experience on slide 37. See slide 37 for more information. An audio recording and transcript will be available in about two weeks at go.cms.gov/npc.

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

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