



Dementia Care: Person-Centered Care Planning and Practice Recommendations Call


Moderated by: Leah Nguyen
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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.

Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS and I am your moderator today. I would like to welcome you to this Medicare Learning Network Call on Dementia Care: Person-Centered Care Planning and Practice Recommendations.

During this call, gain insight into the Phase 2 changes for person-centered care planning and discharge planning. Also, learn about the new Alzheimer's Association dementia care practice recommendations.

Additionally, CMS shares updates on 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.

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

Presentation

Michele Laughman: Thank you, Leah. As Leah mentioned, our first presentation will be on person-centered care planning and discharge planning.

Our speaker for this presentation will be Debra Lyons, a Health Insurance Specialist within the Division of Nursing Homes here at CMS. Deb, I now turn it over to you.

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

Debra Lyons: Thanks, Michele. Hi, everyone. My name is Debra Lyons. As Michele said, I work in the Division of Nursing Homes here at the Centers for Medicare & Medicaid Services.

Today I want to share with you highlights of recent changes to the person-centered care planning and discharge planning requirements for nursing homes.

If you go to slide 5, as most of you know, the final rule of the reform of the requirements for long-term care facilities went into effect on November 28, 2016, with Phase 2 of the final rule being implemented on November 28, 2017.



Among the overall changes that went into effect this past November was the renumbering of the F-tags and interpretive guidance to surveyors related to each of the F-tags was revised, which included person-centered care planning and discharge planning. Today I will highlight some of those changes.

But first, let's talk about what person-centered care is. If you go to slide 6, person-centered care means to focus on the resident as the locus of control and supports each resident's choice and gives them a sense of control over their daily lives.

According to the authors of the final rule, person-centered care was a central theme that was woven throughout the final long-term care rule. The authors of the final rule said that the focus of person-centered care was intended to improve residents' quality of life and quality of care.

F655 Baseline Care Plan—New Requirement

Person-centered care is supported both directly and indirectly by many of the regulatory sections in the requirements for participation. Now we'll walk – now we'll talk about the changes to care planning and discharge planning if you go to slide 7.

F655 is a new requirement for a baseline care plan. The regulations state the baseline care plan must be developed within 48 hours of the resident's admission and must contain the minimum health care information necessary to care for the resident. Additionally, a written summary of the baseline care plan must be provided to the resident or their representative, if applicable.

Guidance to surveyors clarifies that the written summary must be provided to the resident and/or his or her representative by completion of the comprehensive care plan and include any changes in the resident's goals or interventions and submissions.

Slide 8. And this new requirement is intended to promote the continuity of care and communication among staff, increase resident safety, safeguard against adverse events, and ensure the resident and/or representative are informed of the initial plan of care.

F656 Comprehensive Person-Centered Care Plan

Slide 9. At F656, or comprehensive person-centered care plan, which was formerly F279, here you'll find requirements for facilities to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and describes individualized resident goals, preferences, and desired outcomes.

The guidance at F656 has been greatly expanded to define measurable objectives and provides examples of individualizing care plan goals and preferences.

Slide 10. In addition to addressing residents' needs, goals, and preferences, the comprehensive person-centered care plan must address the resident's desired outcomes, including a description of preferences related to discharge, which would include referrals to any local contact agency, a discharge plan if applicable, and any specialized services from PASARR recommendations.



F657 Care Planning

Slide 11. F657 contains the requirements for care plan timing and/or revision as well as new requirements for the composition of the interdisciplinary team, or the IDT. This was formerly F280.

In addition to the attending physician and the registered nurse with responsibility for the resident, there is a new requirement for a nurse aide with responsibility for the resident and a member of food or nutrition services to be on the IDT.

The resident continues to be a required member, but there is a new requirement for the representative to be included, if applicable. And, as previously required, other appropriate staff must be on the interdisciplinary team.

But a new requirement that other professionals, as determined by the resident or their need, has been added. Guidance has been expanded to address participation of the interdisciplinary team members and, in particular, the attending physician.

Slide 12. F657 continues with surveyor guidance acknowledging the importance of physician input into the development of the care plan and provides flexibility for participation.

Guidance at F657 explains that if the attending physician is unable to participate in the development of the care plan, he or she may delegate participation to a nonphysician practitioner who is involved in the resident's care to the extent permitted by State law or arrange alternative methods of participation, such as one-on-one discussions, videoconferencing, and conference calls with the IDT.

F660 Discharge Planning Process

Slide 13. F660 contains the requirements for discharge planning. This was formerly F284. The regulations and guidance have been significantly expanded in an effort to ensure facilities have an effective discharge planning process that is person centered. This means the discharge plan focuses on the resident's goals and prepares the resident to safely transition to post-discharge care by reducing factors which may lead to rehospitalizations or readmissions.

Slide 14. Guidance at F660 clarifies the discharge care plan is part of the comprehensive care plan and must be developed by the interdisciplinary team and involve direct communication with the resident and, if applicable, the resident representative. It must address the resident's goals for care and treatment preferences. And it must identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education.

Slide 15. Continuing the guidance at F660, the discharge care plan must be reevaluated regularly and updated when the resident's needs or goals change. It must document the resident's interest in and any referrals made to the local contact agency. And it must identify post-discharge needs, such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance required.



F661 Discharge Summary

Slide 16. At F661, you see the requirements for the discharge summary. The requirements and guidance have been expanded in an effort to ensure facilities communicate necessary information to the resident, their continuing care provider, and any other authorized persons at the time of discharge.

At slide 17, we see the guidance that F661 explains, that a discharge summary must include an accurate and current description of the clinical status of the resident, must provide individualized care instructions to ensure the resident transitions safely from one setting to another. The discharge summary may help reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident's care.

And here on slide 18, we have included some resources for providers, including a link to the surveyor guidance which I spoke of as well as to a website that contains many helpful resources for nursing homes.

I want to thank each of you for your time, and I'm going to turn it over to Michele Laughman to introduce our next speaker.

Michele Laughman: Thank you, Deb. Our next presentation will focus on the new Alzheimer's Association dementia care practice recommendations. Our speaker for this presentation will be Douglas Pace, Director of Mission Partnerships within the Alzheimer's Association. Doug, I turn it to you.

Alzheimer's Association Dementia Care Practice Recommendations

Douglas Pace: Thanks, Michele, and good afternoon. I appreciate the opportunity to be with you. And on behalf of the Alzheimer's Association, I want to thank all of you for the work you do to advance quality dementia care.

So today I thought it would be helpful to remind us of the tremendous impact of this disease by looking at some of the latest facts and figures, talk about the risk factors, introduce you to our new dementia care practice recommendations that were just released in the February special supplement of *The Gerontologist*®, and discuss our next steps. And my hope is that the information that I share with you today will help you in your work in improving the quality of care and the quality of life for those with dementia.

And on slide 31, and most of you know about the Alzheimer's Association. We are the world's leading voluntary health organization in Alzheimer's care, support, and research. And we work on a global, national, and a local level through our home office and our 71 chapters nationwide to provide care and support for all those affected by Alzheimer's and other dementias.

Our mission is to eliminate Alzheimer's disease through the advancement of research, to provide care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. And our vision is a world without Alzheimer's.

So each year the Association publishes our Facts and Figures report. And I'm glad to announce that the 2000 Facts and Figures report was just released today. And this is a great resource. You can download a copy



of it at [alz.org/facts](https://www.alz.org/facts). So Facts and Figures is one way to put a face on this disease and for all of us to understand why Alzheimer's should be a national priority. And the rapid aging of America as baby boomers enter the greatest risk of Alzheimer's means a dramatic rise in the number of cases in the coming years. So let's take a look at some of these statistics from the 2017 report.

But before we do, on slide 23, I thought it would be helpful to remind us that dementia is an umbrella term used to describe a wide range of symptoms associated with cognitive impairment. And while Alzheimer's disease comprises the majority of dementias, there are other types, such as vascular, Lewy bodies, and frontotemporal. So the number of Americans living with Alzheimer's disease is growing.

And it's growing really fast. There's an estimated five and a half million Americans living with Alzheimer's dementia today. About 5.3 million of those are age 65 and older, and 200,000 are under age 65 with younger-onset Alzheimer's. So by 2050, this number could reach as high as 16 million. And among those 65 and older, 1 in 10 has Alzheimer's. And among those 85 and older, 1 in 3 has Alzheimer's.

So on slide 25, you can see that Alzheimer's disease is currently the most expensive disease in America, with costs soaring past a quarter of a trillion dollars for the first time for paid care.

And as you know, most of these costs are borne by Medicare and Medicaid. And in 2017, Medicare and Medicaid spent an estimated 175 billion caring for those with Alzheimer's and other dementia, and that represents about 68 percent of the total cost.

And on slide 26, we know that Alzheimer's disease is a major driver of these health care costs. So Medicare payments for a senior with Alzheimer's or another dementia are more than three times as great for a senior without these conditions. And Medicaid payments are 23 times as great.

Slide 27 gives us a way to look at cost for Medicare beneficiaries with or without Alzheimer's and other dementias. And as you can see, the per-person payments are about \$33,000 a year higher per year for people with Alzheimer's.

Why Is Alzheimer's Such a Cost Driver?

So why is it such a cost driver? Nearly 30 percent of people with Alzheimer's or other dementias are dual eligible—they're on both Medicare and Medicaid—compared to 11 percent of people without dementia.

Another reason that Alzheimer's is such a cost driver is that people with Alzheimer's are more likely than people without dementia to have other chronic conditions. And the dementia complicates the management of those conditions. And we also know that medication adherence is a big issue for this population and can be a cost driver.

So slide 30 provides two good examples that a person with diabetes and Alzheimer's costs Medicare 81 percent more than a person with only diabetes. And a senior with Alzheimer's and cancer costs Medicare 57 percent more than a person with only cancer.



And costs will continue to grow. The cost for caring with people and other Alzheimer's and other dementias are projected to increase from 259 billion in 2017 to 1.1 trillion in 2050 unless we have some groundbreaking medical science research between now and then.

Alzheimer's Doesn't Just Happen to Individuals—It Happens to Families

And on slide 32, we see, besides the cost of Medicare and Medicaid and other long-term services and supports, Alzheimer's disease affects families significantly. In 2016, more than 15 million family members and friends provided more than 18 billion hours of unpaid care.

And the economic value of that unpaid care totaled 230.1 billion in 2016. Now our 2016 Facts and Figures report, which is still available on our website, featured a special report on the personal impact of Alzheimer's on families.

The – and you can see on slide 34, the 2016 report highlights that Alzheimer's just doesn't happen to individuals; it happens to families. Caregivers had almost \$11 billion in additional health care costs due to their own tremendous physical and emotional burdens of caregiving.

And nearly half of care contributors, those who are caregivers with someone with Alzheimer's and/or contribute financially to their care, cut back on their own expenses, including food, transportation, and medical care, to pay for dementia-related care of a family member or a friend. And care contributors are 28 percent more likely than other adults to eat less or go hungry just because they simply can't pay for food. And 1 in 5 care contributors cut back on their own doctor visits because of their care responsibilities. And amongst caregivers, 74 percent report that they are somewhat to very concerned about maintaining their own health since becoming a caregiver. And on average, care contributors lose over \$15,000 in annual income as a result of reducing or quitting work to meet the other demands of caregiving.

So slide 35 shows another way to look at the impact. If Alzheimer's and dementia caregivers were the residents of a State, it would be the fifth-highest populated State in the country. And if you combine that with the 5.5 million people living with the disease, it would be the third-highest populated State in the country today. I mean, those are just truly staggering numbers.

So slide 36 reminds us that Alzheimer's is now the sixth leading cause of death in the U.S. and the fifth leading cause of death for those age 65 and older. And it's important to remember that this is a fatal disease and the only disease in the top 10 that can't be prevented, slowed, or stopped. And an estimated 700,000 Americans died with Alzheimer's disease in 2017.

So you can see on slide 37, from 2000–2014, Alzheimer's disease deaths have increased by 89 percent, while you can see from the slide that other deaths from other diseases have been declining. And part of the reason for the decrease in deaths from other conditions is due to increased funding in medical science research.

In 2012, an expert panel of scientists concluded that annual Alzheimer's and dementia research funding was far short of what was necessary to achieve breakthroughs and developing preventions and effective treatments. But the good news is, thanks to bipartisan efforts in Congress, funding to the National Institutes of Health, NIH, has been increasing. And NIH is expected to spend 1.4 billion on Alzheimer's and dementia



research in 2017. And encouragingly, for fiscal year 2018 funding levels, the House Appropriations Committee passed a \$400 million increase and the Senate Appropriations Committee a \$414 million increase. And the final funding level for fiscal year '18 is still pending before Congress. But we expect action on that actually by March the 23rd, so, very soon.

So let's spend on slide 38 a couple of minutes talking about risk factors. So here's a picture of German physician Alois Alzheimer in 1906, who was a pioneer in linking symptoms to microscopic brain changes. And the picture above is a 50-year-old patient who he describes had a peculiar disease with profound memory loss, unfounded suspicions about her family, and other worsening psychosocial changes. And in her brain at autopsy, he saw dramatic shrinkage and abnormal deposits in and around nerve cells.

And since then, scientists have identified several hallmark brain abnormalities, including plaques, which are those microscopic clumps of the protein fragment called beta-amyloid; and tangles, which are twisted, microscopic strands of the protein tau; and loss of connections among brain cells that are responsible for memory, learning, and communication. And these connections or synapses transfer information from cell to cell. And then we know there's the eventual death of brain cells and severe tissue shrinkage. So while scientists know that Alzheimer's disease involves the progressive failure of brain cells, we still don't know why this happens.

But we have identified certain risk factors that increase the likelihood of developing Alzheimer's, and I'm now on slide 39. And we know that age is the greatest known risk factor for Alzheimer's.

Another risk factor is family history. So research has shown us that those who have a parent, brother, or sister with Alzheimer's are more likely to develop the disease.

And the risk increases if more than one family member has the illness. But when diseases tend to run in family, either heredity—genetics—or environmental factors, or both, may play a role. Now scientists have identified one gene that increases the risk for Alzheimer's, but it doesn't guarantee an individual will develop the disease. Research has also revealed certain rare genes that virtually guarantee an individual will develop Alzheimer's. But those genes have been found in only a few hundred extended families worldwide and account for less than 5 percent of all Alzheimer – all cases of Alzheimer's worldwide.

Most experts also believe that the majority of Alzheimer's disease is – occurs as a result of complex interactions between genes and other risk factors. So age, family history, and heredity are all risk factors we can't change. But now research is beginning to reveal clues about other risk factors we may be able to influence through general lifestyle and wellness choices and effective management of other health conditions. There may be a strong link between serious head injury and the future risk of Alzheimer's, especially when trauma occurs repeatedly or involves the loss of consciousness.

And growing evidence links brain health to heart health. So our brain is nourished by one of our body's richest networks of blood vessels. Our heartbeat pumps about 20–25 percent of our blood to our head, where brain cells use at least 20 percent of the food and oxygen that your blood carries. So the risk of developing Alzheimer's or vascular dementia appears to be increased by many conditions that damage the heart or blood vessels. And these include high blood pressure, heart disease, stroke, diabetes, and high cholesterol. And other lines of evidence suggest that strategies for overall healthy aging may help keep your brain as well as



your body fit. And these strategies might even offer some protection against developing Alzheimer's or related disorders, like keeping your weight within recommended guidelines, avoiding tobacco and excess alcohol, staying socially connected, and exercising both your body and your mind.

And now on slide 40. We know also that women are at the epicenter of this disease. Today, nearly two-thirds of Americans living with Alzheimer's are women, and over 60 percent of Alzheimer's and dementia caregivers are women. For a woman in her 60s, the estimated lifetime risk of developing Alzheimer's is 1 in 6 compared to 1 in 11 for breast cancer.

On slide 41, we also know that African-Americans are twice as likely as Whites to have Alzheimer's or another dementia, and Hispanics are one and a half times as likely. And although the rate is higher, they are like – they are less likely to have a diagnosis of the condition. And when they are diagnosed, African-Americans and Hispanics are typically diagnosed in the latter stages of the disease when they are more cognitively and physically impaired and therefore need more medical care.

Now, genetic factors don't appear to account for the greater prevalence of or the greater risk of developing Alzheimer's. But high blood pressure and diabetes are suspected risk factors, and these are more prevalent in these communities. And these conditions, among others, may contribute to the greater prevalence in these groups.

But as you can see on slide 42, there's some good news that early evidence shows us that modifiable risk factors may make a difference. There's a lot of unanswered questions and significant uncertainty with respect to the relationship between individual factors in dementia. But there are research studies underway that have shown that regular physical activity and management of cardiovascular risk factors may reduce the risk of cognitive decline and may reduce the risk of dementia. So also, lifelong learning and cognitive training and a healthy diet may reduce the risk of cognitive decline. So we've developed 10 ways that we are promoting to help love your brain.

But the main reason for our call today is to talk about the Association's updated dementia care practice recommendations. The Association has a commitment to quality care.

In the early '90s, we published "Guidelines for Dignity," followed by "Key Elements of Dementia Care." And our most recent recommendations were published between 2005 and 2009, with distinct recommendations for nursing homes and assisted living, end-of-life care, and working in a home care setting.

But as you can see on slide 45, our new recommendations are peer reviewed and evidence based, published in a special supplement of *The Gerontologist* in February. And there's 56 recommendations by 27 nationally recognized experts that now provide a foundation for quality person-centered dementia care.

And you could see on slide 46 that the new recommendations are intended for health care professionals working in long-term care and community-based settings and are applicable to all settings.

The recommendations are anchored in person-centered care, and the additional topic areas are detection and diagnosis; assessment and care planning; medical management; information, education, and support; ongoing



care; workforce; supportive and therapeutic environment; and transition and coordination of services. Now all of these recommendations are available and free for you to download at alz.org/qualitycare.

So on slide 47, let's look at the first recommendation, which is integral to all of the recommendations. And that's know the person. Knowing the person with dementia means gathering information on that person both present and past. It means including the individual, family, and friends to understand the person's reality and including the knowledge gained in the care plan and ongoing reassessments and, very importantly, sharing that knowledge of the person with all staff.

And opportunities for meaningful engagement include creating a supportive environment, looking beyond traditional and planned activities, and educating staff on how every interaction can become an activity. It's about building and nurturing authentic, caring relationships, the kind of caring relationships that is about being present and concentrating on the interaction, rather than the task. It's about doing "with" rather than doing "for" and creating and maintaining a supportive community for individuals, their families, and the staff. It's a community that values each person; respects individual preferences; celebrates accomplishments; provides opportunities for autonomy and shared experiences from the community and, very importantly, engagement with the community at large; and, finally, evaluating care practices regularly and making appropriate changes.

The only way to know if you're making a difference is to regularly evaluate your practices and models, study and share findings, and make changes to interactions, programs, and practices as needed.


The next area is detection and diagnosis. So in addition to updating and enhancing previous recommendations in areas familiar to the dementia care community, the recommendations break important new ground.

Most notably, the recommendations offer guidance to community-based and residential care providers on detection and diagnosis and ongoing medical management. Those topic areas are typically reserved for clinicians. But recommendations in these two areas are written specifically for nonphysician care providers and address what these providers can do to help with the important aspects of holistic person-centered dementia care.

Our recommendations outline appropriate action dementia care providers can make to complement and enhance the work clinicians are doing. It's about providing information about brain health and cognitive aging, educating staff about the signs and symptoms of cognitive impairment, and developing a process for referral to a qualified professional for a diagnostic evaluation. Now, using a brief mental status test to detect a cognitive impairment if the testing is within the scope of practice of the nonphysician care provider, then referring the person to a physician for a diagnostic evaluation and offer additional resources for a better understanding of the diagnosis.

Slide 49, Assessment and Care Planning. So comprehensive, person-centered assessments are performed on intake and at least every 6 months and/or when changes occur. Use the assessment as an opportunity for information and relationship building.

It's important to approach the assessment with a collaborative team approach, including the person living with dementia, their care partner, and the care plan team, which should include a front-line caregiver, then using a



documentation and communication system to make sure that it was shared with all staff for use in planning and evaluating care.

Now, as I mentioned earlier, in the previous recommendations, we had one set of recommendations focused on advanced care planning and end-of-life care. But with these new recommendations, you will see the importance of early and ongoing discussion of what matters, including values, quality of life, and goals for care, and essential for person-centered care planning, including palliative care and hospice throughout all of the recommendations.

I'm now on slide 50, Medical Management. So nonphysician providers must adopt a holistic approach to providing care and ongoing support to work to reduce barriers to coordination of medical and nonmedical care and support. So it's about educating staff around common comorbidities, developing a protocol for when the physician should be contacted, and let the physician know about difficulties they are encountering managing acute and chronic conditions at home or in a residential care community.

Increasing evidence suggests that nonpharmacological interventions are effective at managing behavioral and psychosocial – psychological symptoms of dementia. These interventions should be used first before considering pharmacological treatments. And although nonpharmacological interventions are preferred, there are times when pharmacological treatment is warranted for behavior and psychological symptoms. But providers must understand the principles for starting and, more importantly, for ending pharmacological treatments, asking the medical provider for regular medication review, and having a plan to discontinue the medications when appropriate.

It's important to have a plan in place should a medical or social crisis occur such as an illness, a hospitalization, or maybe the death of a caregiver. And again, encourage persons living with dementia and their families to start end-of-life care discussions early.

Information, education, and support. So discussing the individual's care values and preferences early in the disease can aid in planning the middle and late stages as well as end of life. So by discussing important care-related issues earlier on, the individual with dementia's desires and wishes for their own care will remain an important part of the caregiver's decisionmaking process as the care situation changes.

And as a care provider, it is also important to build culturally sensitive programs that are easily adaptable to special populations, such as minority, LGBT, or other socially disadvantaged populations. Highlighting multicultural issues when training professionals will lead to more effective programs that embrace the unique needs of all care partners. So there's many transitional points throughout the trajectory that have variable effect on care partners.

So progressions to the various stages of dementia brings about many transitions, such as changes from in-home care to community-based care. And ensuring resources are available during times of transition will be reassuring to individuals with the disease and to their care partners. And we know that technology can be a tremendous resource for education, information, and support, and technology can be especially useful for people living alone or in rural communities. And also, you can find a lot of great information on our website, again, at alz.org/livewell.



Ongoing care. I'm on slide 52. Ongoing care is such an important topic that we actually included two separate articles and sets of recommendation.

So support for ADL function must recognize the activity, the person's functional ability, and their cognitive impairment. Not only are dignity, respect, and choice a common theme, but providers must attend to the individualized abilities, likes, and dislikes of the person with dementia. For example, people living with dementia are more able to dress themselves independently if they're in a safe and comfortable area, provided a selective choice, and given simple verbal instructions.

In general, people living with dementia are more able to be continent if, for example, they are monitored for signs of leakage or incontinence, have regularly scheduled bathroom visits, and have access to a bathroom that is clearly evident and avoid caffeine and fluids in the evening, and also engaging in constipation prevention activities.

So we all know that one of the most important times of the day is mealtime. And people living with dementia are more likely to eat if, for example, they're offered choice; dine with others in a quiet, home-like environment; and maintain oral health; and they're provided adaptive food and utensils; and offered nutritionally and culturally appropriate foods.

I'm on slide 53 and talking about our second section in ongoing care, which is behavioral and psychosocial symptoms of dementia. It is important to identify situations for social or the physical environment triggers of behavioral response, produces stress, or evokes a behavior that expresses an unmet need.


As we've discussed earlier, it's important to implement nonpharmacological practices that are person centered, evidence based, and feasible in the care setting. Antipsychotic and other psychotic medications are generally not indicated to alleviate BPSD, and so nonpharmacological practices should be the first-line approach.

Now different practices require a different amount of investment in terms of training and implementation, equipment and capital resources, and many are feasible in both residential and home care settings. And protocols of administration assure that there is a guideline for care providers as they try to alleviate BPSD. And these protocols will evolve over time. That's why it's necessary to routinely assess the effectiveness of the practice and if necessary, adapt it or implement other evidence-based practices.

I'm now on slide 54, and we're on the topic of workforce and staffing. One of the most important components of delivering high-quality dementia care is having trained staff.

It's important to have comprehensive orientation and training for new staff on person-centered dementia care as well as a dedicated plan for ongoing education for all staff members. It's important that all staff know the person living with the dementia as an individual. And procedures must be established that collect information on choices, preferences, and life history, and a mechanism for sharing that information for all staff. Interdepartmental and interdisciplinary collaboration is crucial as well as ensuring that training is provided, again, to all shifts.

And a person-centered delivery system is not possible without a vision-driven leadership team, leadership that believes in complete system transformation, leadership that knows that a well-trained, informed, and



empowered staff who feel valued, recognized, and involved in decisionmaking is the foundation of person-centered care. So there's many ways the staff can get to know the person, such as consistent assignment and involving residents, staff, and families to cultivate successful relationships. And with all of these areas, evaluation is key.

Analysis of the data should be used to evaluate the effectiveness of all the programs, identify areas for improvement, share information with all staff, and make changes as needed. And leadership must encourage a culture that staff welcome, serve, and respond.

And now on slide 55, Supportive and Therapeutic Environments. Supportive environments, both in long-term care and community settings, are very important. The environment should support building relationships.

And comfort and dignity are at the core of person-centered care. Comfort is about how a person feels. But dignity is more about how they are treated. And another essential tenet of person-centered care is respect for others. And there are environmental correlations as well.

Settings should be pleasant, with visual and physical access to engaging in safe outdoor activities, supporting privacy and security of personal space. It's really about balancing safety and autonomy.

And it's about opportunities for meaningful engagement in both the residential or home setting and in the broader community. Spaces should allow for both individual activities and group activities.

And so while the environment is the backdrop in front of which real life takes place, caregivers and care partners must be trained and understand how things like turning on a light or closing a curtain to reduce glare or reducing unnecessary background noise can make a tremendous difference in the quality of life for someone living with dementia.

And now to slide 56. Our last area is transitions. Transitions and care for persons living with dementia include movement across settings, between providers, which can increase the risk of fragmented care and poor outcomes, like hospital-acquired complications, morbidity, mortality, and excess health care expenditures. Transitions in care are often unnecessary, unplanned, and stressful, not just for the person living with dementia, but for the family as well.

Preparing and educating persons living with dementia and their care partners and caregivers about transition in care should occur before, during, and after transitions. And when transitions in care are necessary, it is important to assure a safe hand-off. After any hospitalization or significant change requiring a transition in care or level of care, there should be a review and a reassessment of the preferences and the goals of the person living with dementia. Every person – every member of the health care team must be accountable and responsive to ensure the timely and appropriate transfer of responsibility to the next level of care or setting. And clinicians from the sending site should maintain responsibility for individuals with dementia until the caregivers at the receiving site assume clinical responsibility.

Now the article shows that there's several evidence-based models of care that are focused on avoiding unnecessary transitions or delaying or supporting placement in residential care settings. So targeting avoidable



hospitalizations or rehospitalizations for persons living with dementia has the risk or the potential to reduce poor outcomes that are more common with this population, such as the risk of delirium or falls. Excuse me.

And now on slide 57. So each of the practice recommendations provides a person-centered framework for improving the quality of care and the quality of life for those living with dementia and their caregivers and care partners. And policy can be a powerful driver in the promotion of standards and practices for Federal and State Governments. And while we have limited time today, I did want to mention one important policy initiative that many of you are aware of. But I think it's important to see how it aligns with the recommendations.

The National Alzheimer's Project Act was signed into law in 2011. It creates an Advisory Council on Alzheimer's Research, Care, and Services and has a National Alzheimer's Plan, which is updated annually.

Five goals are the foundation of the plan with Goal 2, "Enhance care quality and efficiency," as being the most closely aligned with care and support.

And now on slide 58. So you can see how the emphasis on person- and family-centered care from detection and diagnosis through the end-of-life care in health care settings and long-term services and supports coordinate with our practice recommendations.


And if you look at slide 59, you can see how the strategies for Goal 2 also align with our recommendation. It talks about building a strong workforce, having a timely and accurate diagnosis, making sure that you identify guidelines and measures across care settings, making sure that you have safe and effective transitions, you have coordinated and integrated care, and working on how you improve care for populations that are disproportionately affected.

And on slide 60, along with our release of the dementia care practice recommendations, we also at alz.org/qualitycare have another report from the perspectives of people living with dementia. And I think it's important to see again, how these themes for people living with the disease—and most of these are people that are currently in the early stage of the disease—from their perspective, what is important to them and think about how that crosswalks with the National Alzheimer's Project Act and with our recommendations.

And you can see it's around early detection and diagnosis, making sure they have all the information and education that they need and getting to know the person, where you can maximize independence, where you can practice patience and compassion, and that adjusting those care practices daily to reflect the needs and abilities of the person.

And then on slide 61, continuing on with their priority list, it's around opportunities for engagement that have meaning and purpose, ensuring coordination among those who provide care, making sure that they – that we have a trained staff on the most, latest, up-to-date information, and that we are creating a safe and supportive environment that reflects the person's characteristics, personality, and preferences.

So I'm now on slide 62. So the dementia care practice recommendations are the foundation of how the Association believes quality care in long-term community-based settings should be delivered. But that's just the beginning.



We're hopeful that our influence can be – continue to work with CMS around Federal and in our State partners as well, and through national and provider membership organization partnerships, and through your relationship with those organizations as you're delivering that care daily, and also with accreditation bodies. We're working closely with the Joint Commission and CARF™ and doing a crosswalk with their standards against our new updated dementia care practice recommendations.

And we're in the process of developing several new programs or product lines. And I'll just mention a couple briefly. One is Curriculum Review, where you will have an opportunity to submit your training curriculum to go through a crosswalk of our dementia care practice recommendations. And once that is done, if approved, then you would have an opportunity to have your staff go through essentiALZ® certification, which is a program where we test on knowledge and give staff a 2-year certification around meeting those requirements.

We're also launching something called Project ECHO, which is a new learning platform that's gaining traction in the clinician and physician community, but it's around an all-teach, all-learn platform where we'll use a Zoom videoconferencing platform to do sort of that case – peer-to-peer learning. And so those are just some of the things that we're really excited about in the future.

And our goal is to increase the number of covered lives, that people know the information they need to know, not only the people with the disease, their care partners, but also that communities can have the best resources that are available to them.

And hopefully, with all of this work, we will start working on some more outcomes research and have more evidence-based care around what good dementia care looks like. So with that, I will turn it over to Michele. Here is my contact information. Feel free to reach out to me. And Michele, I'll turn it over to you.


National Partnership Updates

Michele Laughman: Great. Thank you so much, Doug. Before I turn it over to Dorothy, the moderator for the Q&A session, I'd just like to provide a few updates about the National Partnership To Improve Dementia Care.

A few weeks ago, I released two quarterly data reports. One was the standard report that we have released throughout the partnership. The other report was specific to the nursing homes that have been identified as late adopters. The standard report announced that we have seen a decrease in antipsychotic medication use for long-stay nursing home residents of 35.4 percent to a national prevalence of 15.4 percent in quarter three of 2017. So I just wanted to note that, that that was the recent data that was released.

Additionally, I wanted to share that we are collaborating with Deloitte Consulting on a Federal civil money penalty contract. One of the objectives under this contract focuses on the improvement of dementia care and reduction of antipsychotic medications in nursing homes across the country. Through this contract, we are gearing up to work with nursing homes that have been identified as late adopters through outreach and technical assistance opportunities.

We hope to gain a better understanding of the specific barriers these homes are facing and offer resources and tools to assist in resolving those barriers. This effort includes close collaboration with the State dementia care coalitions, which have really been a vital component of the National Partnership.



So I'd like to say thank you to everyone for your participation in today's call. And I would like to give a big thank you to both of our speakers. I'm now going to turn it over to Leah and Dorothy for the Q&A portion of the call. Thank you.

Question & Answer Session

Leah Nguyen: Thank you. Thank you, Michele. We will now take your questions. As a reminder, this event is being recorded and transcribed. All right Dorothy, we are ready for our first caller.

Operator: To ask a question, press star followed by the number 1 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 are 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 1 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 Denise Kitzman.

Ms. Kitzman, your line is open.

Denise Kitzman: I didn't have a question.

Operator: Your next question comes from the line of Marian Hollingsworth.


Marian Hollingsworth: Hello. This is Marian Hollingsworth. I was wondering – two quick questions. Under the F-tag 657, it says the facility may arrange alternative methods of doctor participation. It just seems like that this kind of waters down the facility's requirement to have a doctor involved and therefore increases the likelihood that there will be noncompliance with 657. Is there anything to ensure that?

And then, secondly, why use the term "late adopters" for facilities who are not following the guidelines? Would it be more effective to have more assurance from the local health department that they will be disciplined or fined if they're not in compliance? It just seems "late adopters" is like someone who just didn't know, as opposed to making them accountable for not following State and Federal law.

Michele Laughman: Debbie, do you want to take the first question and then I'll follow up with the second one?

Debra Lyons: Yes.

Michele Laughman: Okay.



Debra Lyons: Yes, so this is Debbie Lyons. And thank you for the question related to physician – the attending physician requirement to participate in the interdisciplinary team. We – as you can – as you know, the regulation does require that the attending physician be a part of the interdisciplinary team. We, you know, felt that we had to incorporate into the guidance an allowance for situations when the physician is simply not able to participate in person. So that's why we built in guidance around alternatives to participating.

Additionally, we – I think we felt that, you know, if a nonphysician practitioner will attend in place of the physician, it has to be someone who has had responsibility for the resident. So again, keeping in mind the intent that the physician who has responsibility for the resident participate, we feel like we've addressed that in the guidance and allowed, you know, some flexibility for when physicians cannot attend the meeting.

Marian Hollingsworth: Okay. As long as the person is, you know, definitely responsible, is not just a CNA who was brought in to be kind of a poor substitute.

Debra Lyons: Oh, no. And I – we agree with you. No, the CNA is another person who is required to be there. The CNA does not take the place of the attending physician.

Marian Hollingsworth: Okay. They were there. Thank you.

Debra Lyons: Yes.

Michele Laughman: Okay. And this is Michele Laughman, I'll just comment on the second question that you had. Appreciate that.


I think you know – our – the term that we're using as far – just as a way to identify the group of homes that our new goal – you know, that surround, basically, what our goal is about and what we're kind of focusing on through 2019. I would say, you know, we can't – like, just – we can't put a blanket response that every nursing home that's been identified as a late adopter is not following Federal regulations. I would say, you know, we're trying to put emphasis on that and ensure that they are looking at each resident individually to see if there, you know, are clinical indications where gradual dose reduction should be done, you know, if non-pharms are contraindicated. So I wouldn't want to put a blanket statement that every nursing home that is identified as a late adopter is not following Federal guidelines. It's just a way that we're able to identify which homes we're referencing.

Leah Nguyen: Thank you.

Marian Hollingsworth: Okay. So those would be the ones that you would focus on more than.

Michele Laughman: Yes, we – the 15 percent – the new 2019 15-percent goal that's going to go through the end of 2019 is – involves the late adopters. It's – we're looking for a reduction by 15 percent from that specific cohort of nursing homes. So it's just a way to identify the homes that we're working with. It's about 1,500 nursing homes across the country.

Operator: Your next question comes from the line of Edward Tu.



Edward Tu: Hi, everyone. Thank you very much for having me. I have a quick question regarding the F-tag. We are critical access hospital, and we utilize the swing bed program to provide long-term care. We also have assisted living facility. My question is, does F-tag apply to us on both swing bed long-term care program and assisted living? If not, where is the guideline for swing bed program that utilized as a long-term care? Thank you.

Leah Nguyen: Hold on a moment.

Michele Laughman: Debbie, would that be for you?

Debra Lyons: I'm going to have to take a few minutes to get back to this gentleman about the applicability of swing bed regulations. I know that they're very limited. And I was – if it's at all possible, can I get back to him or he can submit his question to my email address?

Leah Nguyen: Yes. I think if he submits it to your email address, that would probably be the easiest.

Debra Lyons: Okay.

Edward Tu: Okay. Thank you.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star, then the number 1 on your telephone keypad.

Your next question comes from the line of Richard Mollot.

Richard Mollot: Hi. Thanks. This is Richard Mollot. I was wondering in regards to the question that was asked earlier, just as a followup, how are you going to ensure that the CMP funds are not used to provide the level of services for which nursing homes have already paid, as that's prohibited under Federal law?


Michele Laughman: We're – this is Michele Laughman. Hi, Richard. Thank you for the question.

Richard Mollot: Hi, Michele.

Michele Laughman: We are – you know, we're taking that into consideration. We know that there can be duplicative effort. So – and this is a Federal CMP fund versus – it's a little bit different than the funds that the states individually have. But we are, you know, making note of that and we are being very diligent to ensure that there's no duplication in efforts as far as what's currently going on in the various states.

Richard Mollot: Well, no, it's not a matter of duplication of what's going on in the various states. It's a matter of paying nursing homes to achieve the level of care and including dementia care and avoiding the use of antipsychotics and chemical restraints for which they're already being paid.

So my concern is – as it's always been, you know, we've been working on CMPs for over a decade now. It's that the Federal regulations, you know, or the law – excuse me – requires – at least I know it's on the State level, but I would assume that even if it doesn't apply to the Federal CMPs that CMS itself retained, that you



would not want to cross – I think it's a pretty important line – that facilities are already paid to provide dementia care, as the lady mentioned earlier. It's important that they be held accountable for meeting that standard, or those standards. And they certainly shouldn't be given money from CMPs with the result of resident harm to meet those basic standards. So, I was just wondering – to make sure that that wasn't going to happen, or isn't going to happen with the delayed funds, how it will be applied.

Michele Laughman: We will certainly make sure that doesn't occur. I can't speak to the specifics on how we're going to make that happen in this type of forum. But it's something that we're taking into consideration very closely.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Ginger Davidson.

Ms. Davidson, your line is open.

Your next question comes from the line of Sandra Stimson.

Sandra Stimson: Hi. This is Sandra Stimson, National Council of Certified Dementia Practitioners. I have a two-part question. One, are you able to tell us where we can get a list of the nursing homes who are classified as the late adopters? And what do you mean exactly when you classify them as late adopters? What does that mean exactly?

Michele Laughman: In a nutshell – this is Michele Laughman. Thanks for the question. Hi. I'm not sure why you didn't get the data. I believe you're on my mailing list. But if you send me a direct email, I will make sure that you get that information.

The late adopters are in – generally speaking, it's homes that have made little to no progress since the beginning of the Partnership and homes that remain above the national average. We also excluded homes that had a higher percentage of residents with a schizophrenia diagnosis. But I don't have the breakdown of the percentages of those three group of factors. But that's generally how we came to get that 1,500 homes, you know, and the homes that we identified as late adopters.

Sandra Stimson: Thank you.

Operator: As a reminder, ladies and gentlemen, in order to ask a question, please press star, then the number 1 on your telephone keypad.

Your next question comes from the line of Natasha Frazier.

Natasha Frazier: Hi. I just had a question about the IDT. Our physician attends a Medicare meeting weekly where we discuss everybody and all of their ADL and just things that are pertinent to their care. Would that count as him being involved in the IDT?



Debra Lyons: I would – this is Debbie Lyons. I think I would say that, you know, if you have documentation of that and you can show evidence of that to the surveyors, absolutely. I mean, you know, there are many different ways that we think that their physicians provide input into development of the care plan. And so, what I would suggest is that you maintain evidence of that. You know, that would certainly would include when changes occur, so that that input is used when the care plan is developed.

Natasha Frazier: Okay. So we have a signature page for each meeting. That would be adequate documentation that he was involved in the meeting and the talking of the patient?

Debra Lyons: You know, I, without seeing the evidence that you have and the types of information that's discussed, it's difficult for me to say, "Yes, that would be considered in compliance."

Natasha Frazier: Okay.

Debra Lyons: What I would say to you is that, you know, the important aspect is that there's evidence that the physician is looking at any changes that are occurring with the resident and it's that physician's input – that you have some ways to document the physician, you know, is contributing and providing input into the development of the care plan.

Natasha Frazier: Okay. Thank you.

Debra Lyons: Yes.

Operator: Your next question comes from the line of Linda Koepplin.

Ms. Koepplin, your line is open.


Your next question comes from the line of Ginger Davidson.

Ginger Davidson: Can you hear me now? Hello.

Leah Nguyen: Yes, we can hear you.

Michele Laughman: Yes, we can hear you.

Ginger Davidson: Okay, okay. I have a question about the participation of certain individuals in the care planning process, including the nursing assistant and nutritional staff members. What I am reading in the regulatory language is that they are to be contributing to the development of the plan of care. I am trying to find where – whether or not there is regulatory language that says they must be attending the actual meeting with the resident because there are times – you know, there's other examples other than the physician to where there's other ways to collect this information from those participants, you know, by interviewing the nursing assistants who care for the resident on a regular basis, that type of thing. So that's my question.



Debra Lyons: Correct. And this is Debbie Lyons. I think that's a reasonable approach. Again, as long as you have evidence that can support that the CNA who has responsibility for the resident has – been able to provide input into the development of the care plan because – I mean, obviously...

Ginger Davidson: Okay.

Debra Lyons: ...that person who tends to the resident on a daily basis is going to know and be able to provide, you know, very, very helpful information when it comes to, you know, developing the care plan. So again, I would emphasize you have to maintain some sort of evidence so that the surveyors...

Ginger Davidson: Right.

Debra Lyons: ...you know, have something to base their assessment on.

Ginger Davidson: Okay. Well, that was it. It's very clear the way you explained it. And that's the way I understood it from reading the regulatory requirements and the guidance. But I just wanted to be sure about that, thank you.

Operator: Your next question comes from the line of Kathy Bradley.


Kathy Bradley: Hi. I have a great concern about the push from the long-term care industry to roll back regulations that they assert are burdensome. The regulations targeted are the very ones that provide protections for the health and safety of residents and really have little or nothing to do with burden. And the examples of burden offered by the industry often aren't even actually a part of the so-called burdensome regulation.

For example, they design care plans within 48 hours, designating a person to be responsible for investigating consumer complaints, and retaining documentation for 3 years, staff training, and specifically including dementia training, facility evaluation and analysis for quality improvement – and I'm also concerned that CMS, in response to this pushback, has announced that it will reform the regulations by June of this year, apparently completely ignoring the process that the newly implemented regulations underwent over a period of years during their development and then not even subjecting the reform to the same process that is required for developing Federal regulations. And I wondered what the current position of CMS is towards this so-called reform.

Debra Lyons: Hi. This is Debbie Lyons. I'm actually not going to be able to address that – your concern. But it is very – we absolutely understand your concern. You know, what we have on this call right now are subject matter experts around, you know, comprehensive care planning and dementia care. What I would recommend is that you perhaps, you know, send your concern. You can send it to my email address and I will forward it on to our Director, you know. But we certainly cannot address that – your overall concern right now on this call. But we definitely appreciate the thought that you conveyed.

Kathy Bradley: Thank you.

Operator: Your next question comes from the line of Wanda Placheki.



Wanda Placheki: Hello. My question really centers around best and promising practices for new models of care related to residents with dementia that might be in crisis. I feel that in the work that I do that we often see people in crisis. And that could be crisis in their current supportive living environment. It could be crisis in their medical piece. But it sort of happens at a point of time, and then there aren't a lot of services that are affordable that may be wrapped around that resident and their caregiver. And so I'm looking for, I guess, just best and promising practices across the Nation, and I'm wondering if you could point me in any direction.

Debra Lyons: That would be Doug.

Michele Laughman: Yes, I think – Doug, do you want to take that one?

Douglas Pace: Sure.

Michele Laughman: Thank you.

Douglas Pace: So Wanda, I would say, you know, go into alz.org/livewell. We just have a tremendous amount of online resources that are there. And those are primarily for care partners, for those – for who are caring for people living at home and those unpaid caregivers. And so I think you'll see a lot of great information that's there and then – at alz.org/qualitycare, again, just reviewing the dementia care practice recommendations that I spoke of and then looking at each one of the articles to see the evidence behind all these recommendations, I think, should give you quite a bit of great information as well.

Wanda Placheki: All right. Thank you.

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

Ms. Teet, your line is open.

Your next question comes from the line of Linda Koeplin.

Linda Koeplin: Yes, I would like to have the information also about the – sorry – the critical access hospitals if I could, please.


Debra Lyons: Could you please send an email to me directly and I will get back with you. Again, I apologize, that's a specialty area that, you know, we don't have a subject matter expert on the line right now. But we will get back, and we will get you an answer if you send an email.

Linda Koeplin: Which email do I need?

Leah Nguyen: And that's on slide 19 of the presentation.

Linda Koeplin: Okay.

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



Ms. Teet, your line is open.

Elizabeth Teet: Can you hear me now? Hello.

Leah Nguyen: Yes, we can.

Michele Laughman: Yes, we can hear you.

Elizabeth Teet: Awesome. Slide 10, the F656 comprehensive person-centered care plan – I have a question regarding the PASARRs and specialized services. As the OBRA specialist that works with nursing homes on doing their level 2s and significant changes and specialized services for ID or related conditions, in the care plan, do you think the best place to incorporate specialized services as a separate tag or, as I'm working with the facilities, just to ensure they're greatly incorporated – do you have any suggestion on that?

Debra Lyons: Hi. This is Deb. So what the requirement says is that the comprehensive care plan – well, actually, the baseline care plan include the minimum health care information necessary, including, but not limited to, PASARR recommendations. So, you know, I think we've been pretty clear in our guidance that we did not really go into a lot of detail as to how the baseline care plan is formatted. But, again, if there – you know, based on the PASARR recommendations, it should be very clear what the – you know, the particular interventions would be.

Elizabeth Teet: Okay.

Debra Lyons: You know what I'm saying? So we are leaving the format up to the individual facility.

Elizabeth Teet: Thank you.


Debra Lyons: You're welcome.

Operator: Your next question comes from the line of Diane Wood.

Diane Wood: Hello. I'm Diane, and I'm from Oklahoma Foundation for Medical Quality. We are a CMP contractor for nursing homes, helping them improve their quality of care. And my question comes kind of from the standpoint of our stakeholders group where we see hospitals sometimes discharge dementia residents back to the home, of course on an antipsychotic, when there's been some sort of behavior problem that's just escalated. And often, it seems like there's a disconnect between the hospital's knowledge of the home's responsibility to reduce antipsychotic medications.

So my question is, has there been any larger discussion with hospital – national hospital discharge planners or hospital – national hospital groups about regulations with long-term care and antipsychotic medications?

Michele Laughman: Hi, Diane. This is Michele. I can say, you know – and it would just be through my efforts with the National Partnership. But we have included hospitalists on – you know, within our stakeholders for the Partnership. I would say we need to do more in that area as far as care transition – care transitions, and, like you mentioned, discharge. That's really – I have limited information. I can just say that we have tried to have



inclusion of hospitalists. But we definitely need to do more in that area. I don't know if – Doug, if you have any insight as far as the transitioning process from hospitals to long-term care, if you have any information that you could add.

Douglas Pace: Sure. And this is Doug Pace. I would just, again, go back to the article in *The Gerontologist* around transitions. And you will see there several evidence-based practices that I think would be good for you to work with. And, and we know that this is a huge issue. We know that these hand-offs are not always handled well.

And I would also recommend you going to another site on our website called alz.org/careplanning. There, we've developed a tremendous amount of resources for the physician community and how for them to best be educated around, not only transitions, but around detection and diagnosis.

Diane Wood: Okay. Doug, is the article in *The Gerontologist* – is it something that I could access for free or do I have...

Douglas Pace: It is. Yes. No, no. We have them all...if you go to alz.org/qualitycare, we have all of the...all of – the entire supplement is available there and we have split up each one of the articles.

Diane Wood: Okay.

Douglas Pace: There's an overview article at the top that lists all 56 recommendations. But then you can download each separate article as well.

Diane Wood: Okay. Great. Thank you very much.

Douglas Pace: Sure.

Operator: Your next question comes from the line of Colleen Graff.


Colleen Graff: Hi. We do some of the dementia training for our nursing facility. And how much time is recommended per year and on new hire do you recommend giving to all staff? Currently, we really just treat – do the nursing assistants – but do nurses have to have yearly recommended training as well?

Michele Laughman: I can't say that I'm – I don't know – this is Michele. I can't say that I'm an expert on the training requirements. That's not my area of expertise. And I'm not – I don't want to misspeak on that. So if you could send your specific question to me...

Colleen Graff: Okay.

Michele Laughman: ...that would be greatly appreciated. My email is "Michele with one l" dot laughman@cms.hhs.gov. And I can...

Colleen Graff: Okay.



Michele Laughman: Yes. And I can work with you offline to get the answer that you are looking for.

Colleen Graff: Great. Thank you.

Operator: Your next question comes from the line of Ala Moll.

Ala Moll: I just want to know where to get the handout.

Leah Nguyen: Hi. This is Leah. Are you – if you're referring to the slide presentation, you can get it from our Medicare Learning Network Calls and Webcasts webpage. So it's go.cms.gov/npc. And that's N as in Nancy, P as in Paul, and C as in Charlie. And then just select today's event from the list and you will see it posted in the Event Materials section.

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. 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 the National Partnership To Improve Dementia Care in Nursing Homes. Have a great day, everyone.

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