Healthcare Information Network

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CMS Initiative:
Reduce Antipsychotic Meds

The attached handout was prepared by:

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Disclosure Regarding Conflict of Interest(s):
There is no conflict of interest declared by planners and presenters of this program.

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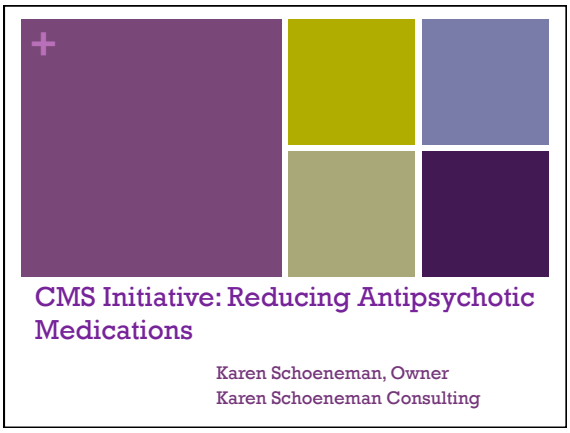

CMS Initiative: Reducing Antipsychotic Medications

Karen Schoeneman, Owner
Karen Schoeneman Consulting

Objectives of the Day

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- Attendees will be able to describe key aspects of:
  - The new CMS initiative to reduce antipsychotic medications
  - What the regulation and interpretive guidelines say about these medications
  - What can and should be done to discern the root cause of "behaviors" and effective non-pharmacological tools to alleviate resident upsets
  - How culture change fits in
  - How the new CMS Hand in Hand training fits in
  - How the soon-to-come QAPI regulation fits in

CMS Antipsychotic Initiative: Introduction

Brand New CMS Initiative is on a Fast Track

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- "CMS National Initiative to Improve Behavioral Health and Reduce the Use of Antipsychotic Medications for Nursing Home Residents"
- Began March, 2012, first goal – reduce antipsychotic drug use by 15% by end of 2012.
- Meeting of experts April, 2012 to discuss the
- Rate of antipsychotic use currently is 20%, initiative seeks to move it down to 17% by end of this year – means 18,000 fewer residents off these drugs by then
- New targets will be set for 2013

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Or You Can Find It Here

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- http://surveyortraining.cms.hhs.gov/pubs/Archive.aspx
- That site contains many dozens of CMS broadcasts on all sorts of topics, you can look for it by name of the initiative on the previous slide

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CMS Actions

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- July – each home's antipsychotic drug rate came out on Nursing Home Compare
- CMS is developing training, small podcasts and longer in-depth trainings for clinicians, providers, and surveyors
- Working with medical and pharmacy experts, and culture change and person centered care experts to tackle this issue, provider orgs will also offer trainings

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CMS Introduced the Project on You Tube

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- http://www.youtube.com/watch?v=U1_rpO0bwbM&list=LPZyM8HFAOlnM&index=6&feature=plcp
- Or just search this title on You Tube: "CMS National Initiative to Improve Behavioral Health and Reduce the Use of Antipsychotic Medications for Nursing Home Residents
- You will see a 50+ minute lecture from CMS introducing the initiative – here are the key points

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Issue is off label use for residents with dementia "behaviors"

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- Residents who are having a "behavior" are expressing an unmet need
- Person centered care practices are highlighted by CMS as a solution
  - Teaching staff how to anticipate issues and how to interact and approach in gentle ways, can alleviate many of the "behaviors"
  - New Hand in Hand training is highlighted

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Comments from CMS Deputy Chief Medical Officer – Shari Ling, MD

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- In April 2005, FDA issued black box warning of increased risk of death associated with use of atypical (second generation) antipsychotics in older population with dementia
- In 2008, FDA extended black box warning to conventional (first generation antipsychotics.

Shari Ling, MD (continued)

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- Antipsychotic drugs are not approved for the treatment of dementia-related psychosis. Furthermore, there is no approved drug for the treatment of dementia-related psychosis. Health care professionals should consider other management options.
- Physicians who prescribe antipsychotics to elderly patients with dementia-related psychosis should discuss this risk of increased mortality with their patients, patients' families, and caregivers.

Source: Information for Healthcare Professionals: Conventional Antipsychotics FDA ALERT [6/16/2008]
http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm124830.htm

Ling (continued)

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- CMS continues to develop a national action plan to improve dementia care, behavioral health management and to safeguard nursing home residents from unnecessary antipsychotic drug use.
- CMS efforts are underway to evaluate, monitor and reduce inappropriate anti-psychotic medication use in nursing homes and other care settings.
- The agency is placing greater emphasis on non-pharmacologic therapies for those nursing home residents who do not have a diagnosis of psychosis, and who may not be candidates for antipsychotic drugs

Hand in Hand is the CMS training tool to teach person centered care

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Important Role of the Pharmacist

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- Should track patterns of antipsychotic and related drug use and report back to the quality committee
- Pharmacist should educate clinical staff on interpreting behavior changes that might be due to drug use, change of drug, good effects, side effects
- Pharmacist can review total drug picture for a resident to see if a drug such as new eye drops is causing a psychotic reaction (hallucination) or combo of drugs is badly interacting

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Surveyors are being taught to ask:

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- Was a non-pharmacological intervention tried first before instituting a drug?
- If a resident is on a drug, was it ordered for a valid clinical indication and specific behaviors?
- Does the care plan reflect the indication for the drug, the time period, how the effects will be monitored
- If a resident is already on a drug, was gradual dose reduction tried?

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CMS recommends:

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- Prescriber training on guiding home to trying non-pharmacological interventions first, and training on person centered care
- Interdisciplinary teams should work together to determine root causes of "behaviors"
- Residents and families need to be engaged and educated
- Review policies and procedures and update to direct that non-pharmacological interventions should be tried before instituting a drug for a resident with dementia

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Who else is involved in initiative?

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- CMS is working with:
  - Advancing Excellence – putting material up on their site
  - AHCA and Leading Age – who are also developing their own trainings
  - QIOs, who are gearing up to assist nursing homes
  - AMDA, Alzheimer's Asso., Consumer Voice are all developing materials

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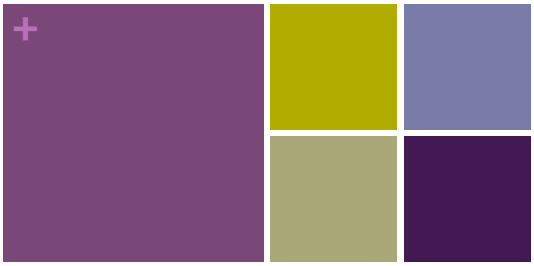

What do the regulations and interpretive guidelines say about drugs?

The regulation for Unnecessary Drugs – Tag F329:

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- For all drugs, not just antipsychotics – written 1990
- Regulation language:
  - "Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
    - In excessive dose (including duplicate therapy); or
    - For excessive duration; or without adequate monitoring; or
    - Without adequate indications for its use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
    - Any combination of the reasons above."

The Interpretive Guidelines

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- Apply to all drugs – but we will look at applicable portions of the lengthy guidance which was written in 2006
- CMS used a large, expert panel to develop the guidance and surveyor and provider training, based on best practices and research

Intent of F329

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- General intent of the regulation: Each resident's drug/medication regimen be managed and monitored to promote goals:
  - Promote each resident's highest well-being
  - Try non-pharmacological interventions instead of, or in addition to, medication
  - To ensure only necessary meds. In dose and duration clinically indicated
  - Adverse consequences minimized

Examples in Guidelines of Non-Pharmacological Interventions

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- Increasing exercise and intake of liquids and fiber
- Identifying underlying causes of upsets (such as pain, boredom, constipation)
- Encouraging individualized activities [more on activities guidance later]
- Providing preferred foods, enhancing taste and presentation of foods

Consider Before Prescribing:

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- Whether other causes for behavioral distress have been ruled out
- Whether the symptoms are serious enough to warrant use of the drug
- Whether non-pharmacological interventions were tried first
- Whether the intended benefit is sufficient to justify the potential risks or adverse consequences associated with the drug
- Whether resident goals have been considered (especially at end of life)

What if a Resident Already is on a Drug?

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- Prescriber and team evaluate:
  - Reason why the drug was instituted
  - What is the diagnosis that is related to use of the drug
  - What are the effects (good and bad) on the resident and how does the drug interact with other meds?
  - What are the goals for the use of the med?

Guidance Has Tables of Drugs for Prescribers to Review

24

- Table 1: List of meds with their issues and concerns
- Table 2: Medications with Significant Anticholinergic Properties

Surveyor Observations

25

- Table provides a long list of adverse consequences surveyors will check for residents on a drug, such as:
  - Ususual behavior patterns, dizziness, headaches, sedation, seizure activity, falls, new cognitive decline, unplanned weight loss or gain, and many others
  - If any are present, surveyors will review how the facility managed the medications in light of these findings

Interviews

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- Surveyors will ask residents or families about
  - Participation in planning care and their goals for the medication
  - Whether other approaches were tried before using medication
  - Their opinion of the results of medication therapy

More Interviews

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- If surveyors note a concern, they will ask the pharmacist about results of their monthly reviews and recommendations
- Ask clinical staff about what they did to identify root causes for resident upsets, what was tried before a drug was requested, the specific reasons for the drug, the goals, monitoring, what results they have observed
- Ask prescriber what was their rationale for the drug

CMS Broadcast on Unnecessary Drugs

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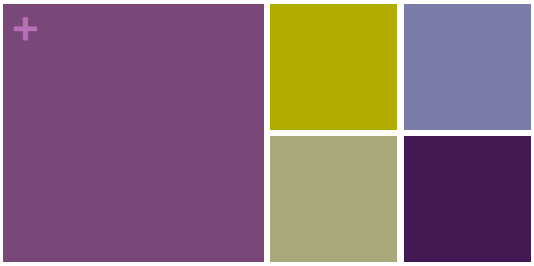
- http://surveyortraining.cms.hhs.gov/pubs/VideoInformation.aspx?cid=1055
- This is about an hour long introduction to the drug guidance done in 2006,that is still appropriate for clinical staff and prescribers to view.



CMS RECOMMENDS PERSON CENTERED CARE – WHAT IS IT?

Person Centered Care is the Goal of the Culture Change Movement

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- The culture change movement began in 1997 and has spread coast to coast and also in many nations
- The movement seeks to move nursing homes from institutional practices to individualizing care via a set of principles
- Research shows clearly that individualizing care and using consistent staff assignment makes residents, families, and staff happier and saves money too

What is the Culture Change Philosophy? The Pioneer Principles are the Basics:

31

Know each person

Each person can and does make a difference

Relationship is the fundamental building block of a transformed culture

Respond to spirit, as well as mind and body

Risk taking is a normal part of life

Principles (continued)

32

- Put person before task
- All elders are entitled to self-determination wherever they live
- Community is the antidote to institutionalization
- Do unto others as you would have them do unto you
- Promote the growth and development of all

Principles (continued)

33

- Shape and use the potential of the environment in all its aspects: physical, organizational, psycho/social/spiritual
- Practice self-examination, searching for new creativity and opportunities for doing better
- Recognize that culture change and transformation are not destinations but a journey, always a work in progress

What is it Like to Visit a Culture Change Leading Home?

34

- Sounds of laughter, people hugging each other as friends and family
- Cat napping, dog looking to be petted
- Children and babies from the home's day care center being held on laps of elders
- Smells of good cooking, toast popping in the toaster, ice cream in the fridge – many flavors
- A glass of wine with dinner

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+ Person Centered Care Leads to Many Excellent Outcomes

45

- Residents who were losing weight, gain weight
- Relationships develop, residents are happier and staff enjoy consistent assignment once they get used to it
- Turnover drops significantly, occupancy rises
- Residents are healthier, use less supplements when they eat food they enjoy, use less Depends when staff know them better and take them to the bathroom timely, USE LESS ANTIPSYCHOTIC MEDS

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CMS NEW HAND IN HAND TRAINING TOOLKIT TEACHES PERSON CENTERED CARE

Hand in Hand – What is it?

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- Training toolkit: 6 hour-long training classes
  - 4 on person-centered dementia care
  - 2 on abuse recognition and abuse prevention
  - Instructor orientation guide
- Consist of video clips shot in a nursing home, along with instructor notebook to guide discussions
- Focus is nurse aides but all staff would benefit
- CMS is distributing the kit to all nursing homes

Hand in Hand

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Examples of Hand in Hand scenarios

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- Good and bad interactions, battles or good approaches
- Teaches what goes on in the brain as dementia progresses
- Being alert to possible abuse (physical, verbal, sexual)
- Increasing level of ADL help as resident declines

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Hand in Hand Teaches How to Interact and How Not to

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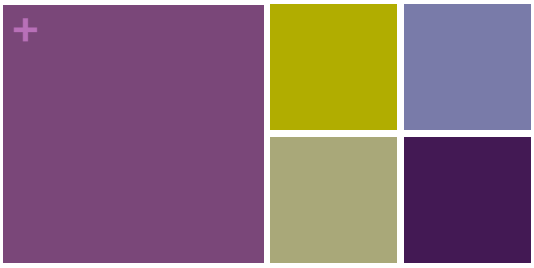

CMS RECOMMENDS INDIVIDUALIZING ACTIVITIES OF CHOICE

CMS Regulatory Guidance on Activities is Comprehensive

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- Developed with a panel of long time experts in provision of Activities, Therapeutic Rehabilitation, Occupational Therapy, plus AHCA and Leading Age experts
- The main point is that it is not possible to provide individualized activities unless:
  - Your staff know your residents
  - Everyone working there is part of the team, not just an Activity Department

F248 Activities

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- "The intent of this requirement is that:
- The facility identifies each resident's interests and needs; and
- The facility involves the resident in an ongoing program of activities that is designed to appeal to his or her interests and to enhance the resident's highest practicable level of physical, mental, and psychosocial well-being."

Activities - Continued

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- "Activities can occur at any time, are not limited to formal activities being provided only by activities staff, and can include activities provided by other facility staff, volunteers, visitors, residents, and family members. All relevant departments should collaborate to develop and implement an individualized activities program for each resident."

Activities - Continued

55

- "Surveyors need to be aware that some facilities may take a non-traditional approach to activities. In neighborhoods/households, all staff may be trained as nurse aides and are responsible to provide activities, and activities may resemble those of a private home. Residents, staff, and families may interact in ways that reflect daily life, instead of in formal activities programs. Residents may be more involved in the ongoing activities in their living area, such as care-planned approaches including chores, preparing foods, meeting with other residents to choose spontaneous activities, and leading an activity."

Activities - Continued

56

- Nursing should help – transporting, providing ADL assistance at activities, leading activities in evenings/weekends
- Everyone can and should be part of the team, residents, families, hairdresser, pastor, administrator – everyone has talents to share

Activities - Continued

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- Large groups may not work out for many residents.
- CMS does not count how many activities a week are on calendar
- Care plan for three activities a week is institutional and says nothing individual

How Activities Fits with Antipsychotic Initiative

58

- Guidance has a section on use of activities for residents with behavioral symptoms:
- For the resident who is constantly walking:
  - Providing a space and environmental cues that encourages physical exercise, decreases exit behavior and reduces extraneous stimulation (such as seating areas spaced along a walking path or garden; a setting in which the resident may manipulate objects; or a room with a calming atmosphere, for example, using music, light, and rocking chairs); aromatherapy

Activities - Continued

59

- For the resident who engages in name-calling, hitting, kicking, yelling, biting, sexual behavior, or compulsive behavior:
  - Providing a calm, non-rushed environment, with structured, familiar activities such as folding, sorting, and matching; using one-to-one activities or small group activities that comfort the resident, such as their preferred music, walking quietly with the staff, a family member, or a friend; eating a favorite snack; looking at familiar pictures;

Activities - Continued

60

- For the resident who disrupts group activities with behaviors such as talking loudly and being demanding, or the resident who has catastrophic reactions such as uncontrolled crying or anger, or the resident who is sensitive to too much stimulation:
  - Use task segmentation; occupation-related; physical exercise;

Activities - Continued

61

- For the resident who goes through others' belongings:
  - Using normalizing activities such as stacking canned food onto shelves, folding laundry; offering sorting activities (e.g., sorting socks, ties or buttons); involving in organizing tasks (e.g., putting activity supplies away); providing rummage areas in plain sight, such as a dresser; and
  - Using non-entry cues, such as "Do not disturb" signs or removable sashes, at the doors of other residents' rooms; providing locks to secure other resident's belongings (if requested).

Activities - Continued

62

- For the resident who has withdrawn and isolates self in room:
  - Providing activities just before or after meal time and where the meal is being served (out of the room); providing in-room volunteer visits, music or videos of choice; encouraging volunteer-type work that begins in the room and needs to be completed outside of the room; having the resident assist another person;
  - Inviting to special events with a trusted peer or family/ friend; inviting resident to participate on a facility committee;
  - Inviting the resident outdoors; and involving in gross motor exercises (e.g., aerobics, light weight training) to increase energy and uplift mood.

Those are just some of the ideas

63

- Beyond the CMS guidance, there are many resources for individualizing activities
  - Key is to know each person, find out what they want and need, what they used to like, what activity is a part of their quality of life.

Drug and Activity Guidelines are part of State Operations Manual, Appendix PP

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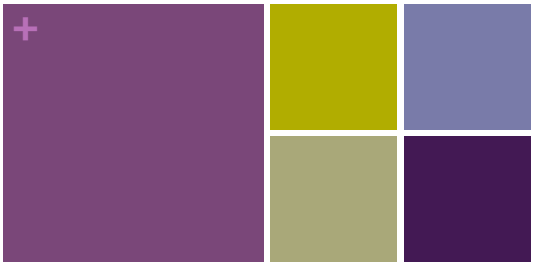
- On the internet for free viewing or download, just highlight what you need. Drugs = F329, Activities = F248 and F249
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf



HOW DOES QAPI FIT IN?

QAPI

Quality Assurance & Performance Improvement

QAPI Background

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- Affordable Care Act of 2010 mandated CMS develop a regulation for Quality Assurance and Performance Improvement for all nursing homes, similar to QAPI for other providers (hospitals, hospice, etc.)
- But the law gave CMS time prior to issuing a regulation, to develop tools and resources for nursing homes to get ready
- CMS is currently in the second year of a demonstration project with 17 homes.

QAPI Official CMS Definition

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- Quality Assurance and Performance Improvement is a data-driven and pro-active approach to quality improvement. Activities of this comprehensive approach are designed to involve all members of an organization to continuously identify opportunities for improvement, address gaps in systems through planned interventions in order to improve the overall quality of the care and services delivered to nursing home residents.

QAPI – The Five Elements of a Comprehensive Plan

69

- Design and Scope
- Governance and Leadership
- Feedback, Data Systems, and Monitoring
- Performance Improvement Projects (PIPs)
- Systematic Analysis and Systemic Action

Keys to QAPI

70

- You are already doing QAA. QAPI is more global, uses data on ongoing basis to find problems and areas for improvement, involves whole facility from the board to all the staff, the residents, and families.
- Communication chain is key – issues are surfaced, plans are made known, successes are celebrated by all
- Helps a nursing home be effective and also be compliant with the regulations.

Law Mandates that:

71

- Nursing homes must have a written QAPI Plan that addresses the five elements. It must be designed to balance a culture of safety with individual choice and rights.
- Nursing homes will get a full year AFTER the CMS regulation is issued in final, to turn in their plans to CMS. The regulation is not even out in draft yet, so final not expected until sometime 2013.

Meanwhile, Help is on the Way

72

- CMS is testing out tools and resources with the 17 Demonstration Homes. And is conducting an evaluation what happened in each home ,which is receiving technical assistance.
- CMS plans to open a website sometime later in 2012 with initial helpful materials for nursing homes to review to begin their thinking about turning their QAA to QAPI.
- QIOs are being trained to go out and teach QAPI to nursing homes in their states.

More on QAPI Demo

73

- Homes are in California, Florida, Massachusetts, and Minnesota
- In QIS and non-QIS states, half large, half small homes
- Half in multi-home groups (chains)
- Half with little QAPI experience
- Rural and urban, varied 5 star ratings, a few with substantial culture change

How Does QAPI Fit with the Antipsychotic Initiative?

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- QAPI tools that will become available to nursing homes will include a variety of topics, including reduction of unnecessary drugs
- The systematic analysis part of QAPI involves ROOT CAUSE ANALYSIS
- You do this every day – why did Mr. Smith fall? Why does Mrs. Connolly cry out? But QAPI makes it more global and systematic

What is Root Cause Analysis, Really?

75

- It is basically asking the "Why?" questions deeper and deeper and using all information that can be obtained to find the answers – it is detective work.
- Can be applied to any issue, clinical, procedural, staff-related, building-related.
- It is a style of thinking that I'll bet you are already doing in some areas of practice, like using the CAAs in the MDS process

Root Cause Resources are Everywhere

76

- CMS will not mandate use of specific resources, homes are free to go to any authoritative sources
- QIOs are super at Root Cause, they have a lot of material, go to your QIO website
- The CMS QAPI contractors include both the University of Minnesota and the Minnesota QIO – Stratis Health, which will train the QIOs to teach using a common curriculum

Root Cause, Common Questions for a Problem that Happened

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- What happened?
- Who was involved, when did it happen?
- Is it happening often?
- What happened before and after?
- What is already known about why it happened?
- Who knows information we need? And on and on, until the story is told.

After Root Cause, Comes Planning

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- Based on what we found out, what should we try?
- How will we communicate the plan?
- How will we monitor the success of the plan?
- All of this thinking is part of QAPI thinking.

Stay Tuned for More Information

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- From CMS on the initiative, from your provider groups, from Advancing Excellence, from your QIO.
- Look on the Nursing Home Compare site for your data
- Look for the new Hand in Hand materials and the opening of the QAPI resources website.

"Encouraging the Heart" by Kouzes and Posner
Self Assessment

1 Almost never	2 Rarely	3 Seldom	4 Once in a while	5 Some-times	6 Fairly Often	7 Often	8 Usually	9 Very Often	10 Almost always

1. _____I make certain we set a standard that motivates us to do better in the future than we are doing now.
2. _____I express high expectations about what people are capable of accomplishing.
3_____I pay more attention to the positive things people do than to the negative.
4_____I personally acknowledge people for their contributions.
5_____I tell stories about the special achievements of the members of the team.
6. _____I make sure that our group celebrates accomplishments together.
7. _____I get personally involved when we recognize the achievements of others.
8. _____I clearly communicate my standards to everyone on the team.
9. _____I let people know that I have confidence in them.
10. _____I spend a good deal of time listening to the needs and interests of other people.
11. _____I personalize the recognition I give to another person.
12. _____I find opportunities to let people know the *why* behind whatever we are doing.
13. _____I hold special events to celebrate our successes.
14. _____I show others, by example, how people should be recognized and rewarded.
15. _____ I make it a point to give people feedback on how they are performing against our agreed-upon standards.
16. _____ I express a positive and optimistic outlook even when times are tough.
17. _____I get to know, at a personal level, the people with whom I work.
18. _____I find creative ways to make my recognition of others unique and special.
19. _____I recognize people more in public than in private for their exemplary performance.
20. _____I find ways to make the workplace enjoyable and fun.
21. _____I personally congratulate people for a job well done.

_____**TOTAL** (add together all the ratings above; the lowest possible rating you can have is 21, and the highest is 210)

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EVALUATION

Seminar: **"CMS Initiative: Reduce Antipsychotic Meds"**

Location: _____

Your Discipline (Circle): NHA, RN/LPN, SW, Activities, other _____

Job Title (Optional): _____

Did today's program meet the following objectives:	**Circle one**	
1. Describe the CMS initiative to reduce antipsychotic meds in nursing facilities.	YES	NO
2. Identify regulatory guidance for Antipsychotic Meds and Unnecessary Meds.	YES	NO
3. Identify typical behaviors related to dementia and cognitive loss.	YES	NO
4. Define person centered care.	YES	NO
5. Discuss CMS dementia training series *Hand in Hand*.	YES	NO
6. Identify appropriate non-pharmacologic interventions for residents with dementia and cognitive loss.	YES	NO
7. Discuss QAPI and other related CMS initiatives currently in development.	YES	NO
Do these objectives relate well to the overall purpose of the program?	YES	NO
This program was fair, unbiased and free from commercial influence?	YES	NO

Disclosure Regarding Conflict of Interest(s):
There is no conflict of interest declared by planners and presenters of this program.
No commercial support was received for this educational activity.

Please evaluate speaker(s) effectiveness on the scale provided;

Karen Schoeneman, MPA, BA	**Excellent**				**Poor**
1. Presentation Content	5	4	3	2	1
2. Ability to Present	5	4	3	2	1
3. Instructor's level of knowledge/expertise	5	4	3	2	1
4. Teaching Materials Used (AV, handouts)	5	4	3	2	1
5. Appropriateness of teaching strategies	5	4	3	2	1

Comments:

_____

_____

_____

Please rate hotel service and physical facility: 5 4 3 2 1
Comments:_____

_____

What are the reasons you chose today's program? Please check all that apply:

_____ **Program Topic** _____ **CEUs provided** _____ **Speaker** _____ **Sent by Supervisor**

_____ **Hotel where offered** _____ **HIN is sponsor** _____ **other (please identify)**_____

Will the information gained at today's program be useful in your everyday work? YES NO

How do you rate this program overall? 5 4 3 2 1

Comments:_____

_____

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