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RELIAS LEARNING

PARTNERING TO REDUCE:

Minimizing the use of antipsychotics in today's senior care facilities.

DID YOU KNOW?

- As much as 80% of all antipsychotics prescribed in nursing facilities are for off-label conditions.
- Antipsychotic drug use cost Medicare over $309 million in 2007.
- Almost half of all individuals on antipsychotics in nursing facilities today were admitted with a prescription already in place.

Source: American Health Care Association (AHCA) www.ahcancal.org

According to the Centers for Medicare and Medicaid Services (CMS), more than 20% of long term care residents in today's 16,000 nursing homes are given antipsychotic medications. This number rises to approximately 40% among those with dementia to whom the meds are known to cause increased harm.

"Psychotropics, specifically antipsychotics, have side effects and can be harmful in the elderly, particularly for those with dementia," said David Gifford, MD, MPH, Senior Vice President of Quality and Regulatory Affairs at the American Health Care Association (AHCA, www.ahcancal.org). "We know it increases the risk of falls; people are more likely to have strokes and be hospitalized as well as more likely to be sedated and sleepy."

Dementia can be the cause of very disruptive and distressing behavior for those that it affects. This behavior can often be confused with hallucinations or psychosis, for which antipsychotics are rightly prescribed. It is this fine line between memory decline and psychosis that has given rise to the prevalence of the off-label use and over prescribing of antipsychotics today.

"We need to rethink our approach to dementia care and use person-centered care approaches to improve the quality of life. This will happen through non pharmacological approaches, staff education and training and gradual dose reduction and elimination."

- Karen Tritz, Director of Division of Nursing Homes, Survey and Certification Group, CMS

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A HISTORICAL PERSPECTIVE

OBRA '87

At the time of the first quality of care legislation, or the **Omnibus Budget Reconciliation Act (OBRA)** of 1987, the use of physical restraints to detain patients was a common practice.

"It was the only way we knew how to respond to the wandering behaviors of residents," said Barbara Frank, M.P.A., co-founder of RI-based B&F Consulting (www.bandfconsultinginc.com), which helps nursing homes across the country become better places to live and work.

But, OBRA's focus on the "highest practicable well-being of each resident" ushered in a new era of individualized care, calling for the correction of inappropriate care practices, including a campaign to "untie the elderly" which led to congressional hearings and brought the use of physical restraints down from 50% to less than 5% over the last 30 years, according to Frank.

While this challenge to physical restraints led to the design of locked courtyards and new, safe walkways inside LTC/SNF facilities, alternative restraints surfaced in its place. "When physical restraints were taken off, in some cases staff used alarms and antipsychotic medications in their place," said Frank.

A spirited campaign reminiscent of that of the late '80s is needed once again to curb the rate at which off-label antipsychotics and other psychotropics are prescribed for the country's elderly. "The same steps we went through then are the same steps that will help us now," said Frank. "As practitioners did then, we need to take an individual look at each person and learn how to understand and address residents' unmet needs."

like people get a little bit better while on them, but later on when randomized trials were conducted, they found no clinical evidence that antipsychotics improved the patients' behavior or dementia," said Gifford. "In our culture, we tend to believe that medications cure everything."

In response, CMS launched the National Partnership to Improve Dementia Care in 2012, a program aimed at reducing antipsychotic drug usage by 15% by the end of 2013. Working together with clinicians, home health caregivers and LTC/SNF communities, the Partnership aims to reduce inappropriate use of antipsychotics by enhancing training for nursing home providers and state surveyors, increasing transparency by making antipsychotic usage data available online at Nursing Home Compare (www.medicare.gov/nursinghomecompare), a website that provides the public consumer with quality measures for nursing homes across the country, while emphasizing non-pharmacological, person-centered care. Overall, the National Partnership was intended to improve quality of life for those with dementia.

13.1%

REDUCTION IN USE OF ANTIPSYCHOTICS

nationally between Q4’11 - Q3’13

And it has. Since the last quarter of 2011 (the Partnership’s benchmark) the use of antipsychotics has been reduced by 13.1% to 20.75% nationally as of the third quarter of 2013, the last publishable data at printing time, with more than 11 states already hitting or exceeding the 15% target and approximately 30,000 fewer nursing home residents on psychotropics than just two years ago.

“Psychotropics, specifically antipsychotics, are sedating so it looks like people get a little bit better while on them, but later on when randomized trials were conducted, they found no clinical evidence that antipsychotics improved the patients’ behavior or dementia. In our culture, we tend to believe that medications cure everything.”

- David Gifford, MD, MPH, Senior Vice President of Quality and Regulatory Affairs at the American Health Care Association

But, there is still more to be done.

“We need to rethink our approach to dementia care and use person-centered care approaches to improve the quality of life,” said Karen Tritz, Director of Division of Nursing Homes, Survey and Certification Group, CMS. “This will happen through non pharmacological approaches, staff education and training and gradual dose reduction and elimination. Ultimately, the goal is to arrive at a building-wide approach to interdisciplinary care. With any good intervention, this takes strong leadership, nursing staff and pharmacist involvement. It takes a village.”

Survey Guidelines

To further the objectives of reducing the use of antipsychotics led by the Partnership to Improve Dementia Care, revised survey guidelines to F-309 (Quality of Care) and F-329 (Unnecessary Drugs) released in May 2013 are now in effect.

F-309 updates amend the survey sample to include residents with dementia specifically, asking surveyors to now request a list of residents who have been diagnosed with dementia and who are taking, have taken or currently have an as-needed prescription (PRN) for an antipsychotic medication. Additionally, the revised guidelines add four more drugs to the list of antipsychotic medications: asenapine (Saphris), iloperidone (Fanapt), lurasidone (Latuda) and paliperidone (Invega).

RECOGNIZING DELIRIUM

Once the basic triggers have been ruled out, it's important to consider any potential medical causes for the patient's behavior. Oftentimes if there's a quick or significant change in behavior, it could be something as simple as a urinary track infection (UTI), a new medication or the resident could be experiencing a delirium.

Unlike dementia, delirium has a sudden onset, causing an immediate change in behavior and signaling a real medical emergency. Usually caused by an acute illness, an elder with delirium can be either restless or lethargic, confusing day or night and, in some cases, can even experience hallucinations or delusions. Known to surface especially during times of physical or emotional change, developing delirium during a nursing home stay can significantly increase the risk of rehospitalization.

See the white paper, *Puzzle of Prevention*, Relias Learning, 2013, for more information on delirium, its signs, symptoms and prevention.

"We also provided a new severity example that talks about unnecessary drugs in F-329," said Tritz. "We talk with surveyors about what they should look at to determine compliance. In cases of non-compliance, we've given examples to better inform the surveyors as well."

These additions are likely the result of increased citations in both F-309 and F-329 over the last few years. According to AHCA, the number of facilities cited during CMS surveys for the use of unnecessary medications (F-329) has increased nearly 75% since 2006.

But, for the 33% of today's nursing home residents who actually suffer from mental illness, antipsychotics and other psychotropic-classified drugs can be necessary.

To account for this, CMS provides diagnosis exclusions for the use of psychotropics for both short and long term stay nursing home residents. Exclusions for a short term stay (considered to be 101 days or less) include diagnoses of Schizophrenia, Tourette Syndrome and Huntington's Disease as well as for those who entered the nursing home on antipsychotics, as reported on the initial minimum data set (MDS). Long-term stay exceptions include Schizophrenia, Tourette Syndrome and Huntington's Disease.

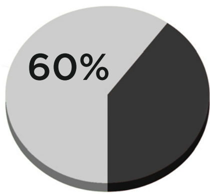
To further prevent the off-label use and over prescribing of antipsychotics, each LTC/SNF is required to initiate annual gradual dose reductions (GDR) for long-term residents who do not fall into the above-mentioned diagnoses during two separate quarters each year while in residence.

Understanding the Meaning Behind the Behaviors

Of the 1.5 million nursing home residents today, 60% suffer from some form of dementia, which leads to progressive cognitive decline. This decline in turn lowers the resident's stress threshold, which can increase anxiety and dysfunctional behaviors, including

wandering, yelling, agitation, repeating questions, hitting, hoarding, exit-seeking, refusing care and more.

60% of today's 1.5 million nursing home residents suffer from some sort of dementia



This leads to progressive cognitive decline.

"Behavior is a form of communication for people with dementia," said Barbara Frank, M.P.A., co-founder of RI-based B&F Consulting (www.bandfconsultinginc.com). "If it's an outward oriented push, kick or stop, that's a form of communication saying, 'Stop what's happening here—it's not working for me.' The most important thing a caregiver can do in that case is to stop, step back and determine what is causing the person's distress and what can be done to alleviate it."

These negative behaviors can be the result of internal, environmental or caregiver triggers. Internal triggers include medical, social or psychological causes. Is the resident hungry or thirsty? Does he/she need to use the bathroom? Are they experiencing discomfort?

"Individuals with dementia have a hard time expressing themselves," said Gifford. "Think of kids who get really hungry at the end of the day—they might be having a melt down in the mall. This goes on with adults, too. When you have enough cognitive function you can handle it, but when you have dementia, you've lost your cognitive reserve."

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Environmental triggers, on the other hand, can be prompted by the temperature in the room, noise, lighting, unfamiliar surroundings or people, too much or not enough stimulation. But, by far the greatest number of problematic behaviors witnessed in residents with dementia occurs during personal care, when the resident can become combative or refuse help.

"Imagine you woke up in your home and found a complete stranger undressing you?" said Jennifer Moore, RN, content developer, for Relias Learning (www.reliaslearning.com), online training provider for senior care staff. "Would you scream, hit or kick? If you did,

would your actions be considered inappropriate? Would the incident warrant you being placed on a psychotropic medication?"

"The goal is to shift our thinking from: 'How do I stop the behaviors?' to 'What is the resident trying to tell me?'"

- Jennifer Moore, RN, Content Developer, for Relias Learning

Communicating with previous home health caregivers as well as the resident's family about unique behavior as issues arise will provide an invaluable look into the person and their habits and will be key to understanding how to respond in a timely manner.

"All behavior has a meaning," said Moore. "The goal is to shift our thinking from: 'How do I stop the behaviors?' to 'What is the resident trying to tell me?'"

CASE STUDY:

A New Jersey resident was constantly waking up at night and being redirected back to bed. Each time, the resident would resist the staff and was eventually put on antipsychotic medication until the home held a meeting with the man's son who told them that for years his father used to pace the house at night, have a hot bowl of oatmeal and then slept late into the morning. Allowing the man to continue his long-time routine resulted in the removal of the antipsychotic medication soon after.

Behavioral Interventions

Behavioral interventions, or non-pharmacological approaches to person-center care, can help minimize or eliminate the resident's negative behavior and need for antipsychotic medication. While there is no way to know when a behavioral intervention will be needed, it is possible to train home health caregivers or LTC/SNF staff to anticipate a variety of different situations.

The first step in instituting behavioral interventions in any home is to form a behavior management team responsible for reviewing the resident's medications, reasons for usage, dosage and

QUICK BEHAVIORAL INTERVENTIONS

- Redirect the resident
- Provide stimulating, interactive exercise or activities
- Provide one-to-one care
- Allow the resident to make simple decisions or choices on their own
- Eliminate physical factors, including pain and hunger
- Reduce external triggers, including loud noise

Excerpt from Relias Learning online training module, "Understanding the Meaning behind Behaviors: Actions and Reactions."

diagnosis so the appropriate infrastructure is in place to question, manage, supervise and serve as a resource for staff. This group can help create individualized care or distress behavior response plans for residents as needed as well as tracking and analyzing behavior to see if there's a particular behavioral pattern or trend with a patient that should be noted. The committee should make sure to document their efforts and keep a list of tried interventions in each resident's file. This will serve as a reference when talking to family members, surveyors and future caregivers.

Frank's advice is to make this a hands-on committee. "You can sit in the conference room and make a plan of action, but the best thing is to have the committee make rounds themselves," said Frank. "Go to the areas where the staff is working with the residents; find out from the staff closest to the residents what's going on and involve them in thinking through a plan of action."

Once there is an established infrastructure committed to pursuing behavioral interventions, a variety of interventions/techniques can be taught to the staff for facility-wide implementation. These include:

1. **Consistent staff assignments** have been shown to decrease the frequency and intensity of behavioral episodes in cogitatively impaired residents who benefit from a familiar face, by allowing the resident to become more comfortable with the caregiver and visa-versa. While easier to implement in home health care cases, when consistent assignments are implemented in the LTC/SNF, the "staff huddle," or a quick discussion among knowledgeable team members when an issue arises with a particular resident, can lead to an immediate, effective behavioral intervention.

2. **Meaningful activities** can be a welcome distraction for those with dementia. Headphones programmed with classical music can provide an alternative for a resident who is disturbed by loud noises or a stimulated environment, while a basket of clothes to fold might be calming for another elderly homemaker. Other ideas can include: books or books-on-tape for the more academic resident, or participation in group games like bingo for the social resident.

3. **Provide one-to-one care** whenever possible. While this is a given in home health care, it can be much more challenging to schedule in the LTC/SNF facility. But, when possible, and the staff member identifies themselves to the resident, makes eye contact, moves slowly, using simple words and positive terms, it can be just what the resident needed to eliminate anxiety or soften a mood or behavior. Often times one-to-one care will help the resident break down overwhelming, complex tasks into single steps.

"It's hard to teach nursing home staff specific individualized interventions to manage behaviors because every individual needs something different. What works for one person may not work for another. However, you can show, by scenario or example, how knowing the individual person will allow the staff to identify individualized interventions, which in turn can reduce negative behaviors."

- Jennifer Moore, RN, content developer for Relias Learning

"It's hard to teach nursing home staff specific individualized interventions to manage behaviors because every individual needs something different. What works for one person may not work for another," said Moore. "However, you can show, by scenario or example, how knowing the individual person will allow the staff to identify individualized interventions, which in turn can reduce negative behaviors."

CASE STUDY:

The CNA walks into Mrs. Tate's room only to find her crying, which could be for any number of reasons. It could mean she is in pain. It could mean she's upset that her daughter is going on vacation and will not be able to visit for two weeks. It could mean Mrs. Tate's roommate is in the hospital and she is worried or lonely. It could also mean she suffers from depression.

What should the staff member do about the crying? A variety of interventions can be initiated depending on the cause of the behavior. If she is in pain, pain relief interventions should be started. If Mrs. Tate is crying because her daughter is on vacation or her roommate is in the hospital, increasing social

interventions and or more frequent staff visits are in order. If the cause of her crying is depression, consulting with the home's social services for counseling is the best option.

Without identifying the meaning of Mrs. Tate's crying, the staff will be unable to implement the most appropriate intervention.

But, even after interventions have been employed, monitoring behavior and improvement is still critical because something that works once may not work again or may need to be reevaluated as the dementia progresses.

Training plays a tremendous role in the learning and implementation of behavioral interventions as in this example with Mrs. Tate. For all levels of LTC/SNF and home health staff, from administration down to the nurses aides, training can go a long way to help the staff do the necessary critical thinking needed to institute behavioral interventions that prevent resident stress and institute true person-centered care.

"Training is essential to help people do the critical thinking to understand what is causing the distress and come up with a way of responding that helps prevent resident stress," said Frank. "But, it's only helpful as long as it's in the context of the whole nursing home's process.

- Barbara Frank, M.P.A., co-founder of RI-based B&F Consulting

But, Frank warns that training will only be successful when what staff is taught about behaviors is supported by the nursing home's practices. Only when there is support can the front line staff incorporate new techniques and theories they have learned.

"Training is essential to help people do the critical thinking to understand what is causing the distress and come up with a way of responding that helps prevent resident stress," said Frank. "But, it's only helpful as long as it's in the context of the whole nursing home's process. If you provide training for your CNAs to do something and then you have management practices that are contrary, then the well-trained staff will be caught in that distressed moment without the ability to respond in a non-pharmacological way."

A CASE STUDY:

In November 2013, CASPER data revealed that 20% of the residents at the John Knox Village Care Center (JKV, www.jkv.org/vcc) 430-bed facility were using antipsychotic medications. While comparable to the national average, JKV's Director of Nursing Tami Hoversten, RN, felt that the facility "was at a higher level of antipsychotic use than was appropriate." Together with Meda Hernandez, RN, manager of clinical services and Sandy Stearman, LPN, memory care unit support nurse, they pledged to make JKV's memory care unit as antipsychotic free as possible. Of the 85 residents in the unit at the time, 39 were on antipsychotics.

"The first thing we did was look at everyone on PRN antipsychotics which was 10," said Stearman. "We immediately eliminated those that hadn't used them in 90 days and worked with our in-house doctor and psychiatrist or with the resident's individual doctors as necessary to see if we could decrease the others. We came up with individualized interventions for each resident that had to be exhausted first before an antipsychotic could be given. Just four months later, we have only 13 residents on antipsychotics. Our PRNs are now down to two and of the 13, we've reduced dosage for eight of them."

But, it is not just a numbers game for JKV. Hernandez and Stearman instituted an activity program on the memory care floor separate from that of the home's regular activities schedule in which every staff member in the unit conducts a

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The Numbers Game

Once there's a plan in place to minimize the use of psychotropics and maximize the quality of care for LTC/SNF residents, analyzing the home's minimum data set (MDS) will be key to real, long-term lasting improvement.

"You may have been doing a great antipsychotic program for a year, but if your numbers haven't decreased, you may be meeting the minimum standard for quality assurance, but you are not demonstrating performance improvement," said Theresa Schmidt, manager of education, Ohio-based eHealth Data Solutions (www.ehds.biz), a healthcare data management software company. "Quality assurance says 'We're putting in place interventions consistent with what we think needs to happen,' while performance improvement says 'We're measuring the effectiveness of our interventions to see if performance is really improving.'"

Initially, MDS data should be analyzed for internal benchmarking purposes to uncover any triggering issues and to ensure documentation for any red flags that might arise. If assessments are reviewed for inconsistencies

A CASE STUDY continued:

20-minute activity of their choice sometime during the day, depending on their schedule. The result is several different activities are going on in the unit at a time. They also created resident activity books. Assigning each memory care staff member to a particular resident to interview them and their families about their life story, the staff documented the names of parents and siblings, where the resident was born, how and where they grew up, their hobbies and funny stories and kept it catalogued and readily handy in the resident's activity book.

"We wanted our staff to know our residents really well, including what has happened in their life that makes them stressed or what makes them happy," said Stearman. "Now, we have these activity books so when someone is agitated or looking for their parents or children, the staff can grab the book and ask them questions, redirecting them before turning to medication. With these books, we can share in that piece of their life with them."

JKV finds that even the simplest of behavioral interventions work well for their mid-to-late stage memory care residents, including just sitting down and sharing a cup of coffee or reading a book aloud.

"I found that the CNAs are starting to relate to the residents like people instead of an assignment or task they have to get done," said Hoversten. "Now they are seeing them as individuals, even finding common ground."

JKV uses both Relias Learning's antipsychotic reduction and dementia care modules to train staff as well as eHealth Data Solutions' CareWatch® data analytics system to track progress and spot potential issues before they happen.

"We're always focused on behavior and behavior reduction and when we need to reduce meds, across the facility, we've used Relias for that. I frequently pull up Relias and have interactive

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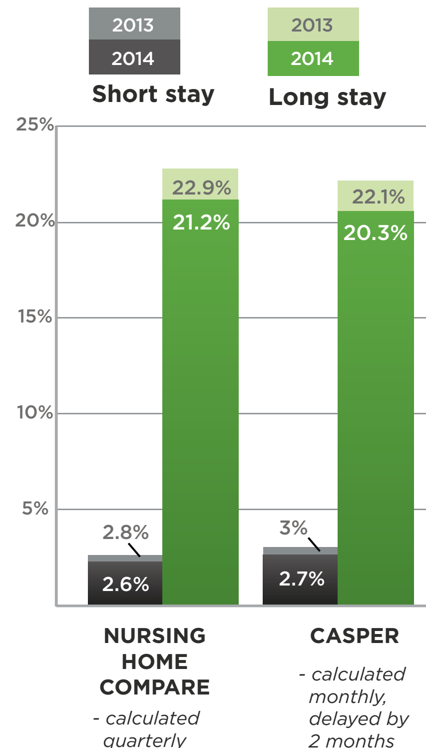
prior to submitting to CMS, many problems can be avoided later on. Following the submittal of the MDS data, CMS' public Nursing Home Compare and private Certification and Survey Provider Enhanced Reports (CASPER) reports should be examined to determine how each home compares to national averages in multiple categories. While Nursing Home Compare provides general facility comparisons and evaluations, the CASPER data, which is accessible only by the submitting nursing home, will provide specific measures down to the individual resident (see comparison chart, below).

National Averages of Antipsychotic Use (as of Feb. 2014)



A CASE STUDY continued:

group sessions with the staff," said Hoversten. "We use CareWatch for our QAPI meetings and to develop our process improvement teams. It gives us all the data we need for our action plan and to measure where we're at, what we're doing well and what we can improve on, while saving us from looking through 400 separate files. Both help us be proactive rather than reactive."

Just four months after initiating this program, JKV's rate of antipsychotic use has dropped well below the national average, holding steady at 12.7%.

"Leading by example is critical. When the staff sees that the unit manager and administrative staff is on the unit participating, it encourages them to do the same," said Hoversten. "Just last week I took a potential CNA candidate on a tour of the facility without telling anyone. In one area, we found three separate CNAs in different areas doing artwork, polishing nails and making mardi gras masks with residents. Walking to the other side of the unit, there was a volleyball game going on."

The results of this analysis will not only arm administrators with the documentation and proof necessary to manage the survey process head on, but will also provide direction to the facility's future path of improvement and the required maintenance of its current program.

"When it comes to quality measures, really take time to learn how they are calculated," said Schmidt. "If you want to win the numbers game, you have to know the rules."

According to Schmidt, educated staff will use the following rules when playing the numbers game:

1. **Understand how the numbers are calculated.** Choose the most effective way to measure quality at individual facilities. Then, review the calculations for these quality measures using CASPER and a data management program like CareWatch.

2. **Find out which residents are triggering.** Make sure none of these residents have exclusions that aren't captured on the MDS. If they're triggering appropriately, then examine what conditions exist that may explain or justify why they are getting the medication. Consider if other interventions might be effective. Do it systematically—create a performance improvement project (PIP) surrounding antipsychotics.

3. **Systematically review the residents that are triggering for the quality measures.** Explore what is working and what is not. A tracking program might present a year's worth of trends. Use a statistical process control chart to determine if performance is getting better, worse or remaining the same.

4. **Plan facility and individual interventions** based on what you have learned by investigating the sources of your performance.

5. **Pay attention over time.** Track improvement over time using a statistical process control chart to see what has really changed and if it's been sustained. If the new interventions have not worked, then go back to the drawing board and try something else. This follows the Plan Do Study Act (PDSA) Cycle.

Following these principals for facility data collection will help any home make real–time improvements to a residents' quality of care on a daily, monthly and annual basis.

"Think about a new year's resolution to loose 10 pounds. You go to the gym every day and change the way you're eating. If at the end of the month, you've done all the 'right' things for quality assurance, but you've gained two pounds anyway, you still didn't meet your goal. Maybe you need to figure out what the root causes of your weight gain really are, and then you can go back and try to implement a weight change program that addresses these causes and is geared toward performance improvement," said Schmidt. "If you're not doing it with data, it's like trying to lose weight in a dark room with no scale. You're just sort of hoping what you're doing works."

What's Next?

Encouraged by the decrease in off-label use of antipsychotics over the last two years and the collaboration that has surfaced as a result of the National Partnership to Improve Dementia Care, CMS looks to strengthen its state coalitions where significant strides are still desired, while pushing the envelope to further decrease the use of psychotropics in today's nursing homes below the current 15% reduction goal.

"We're going to continue to drill down and spread the message of this effort and the overall use of non pharmacological approaches

to dementia care," said Tritz. "We have made changes to the survey process in the last year. Going forward, I see us continuing to look at where we can make additional improvements and clarifications from the surveyor's side as well."

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