SAFELY REDUCING RE-HOSPITALIZATIONS & ANTIPSYCHOTIC DRUG USE

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Outline of today

- Very interactive – lots of small group work
- Evidence based practices to safely reduce
  - Rehospitalization (morning sessions)
  - Antipsychotic medications (afternoon sessions)
- Strategies to successfully implement new practices
- At the end of each segment, jot down reflections on your worksheet to build a take-home plan
Learning Objectives

- Participants in this session will:
  - Understand the evidence base for reducing re-hospitalizations and antipsychotic drug use
  - Explore attitudes about re-hospitalizations and antipsychotic drug use
  - Become familiar with the INTERACT program and tools
  - Learn to apply the QI process to achieve practice change
  - Plan strategies to implement practice change

Polling Technology

- Throughout the day, we will ask you to answer questions using an online polling technology.
- Respond by sending standard text messages – please have your cell phone handy
  - If you have unlimited text messaging, this will be free
  - If not, it may have a small cost per message
- Your information is private - we cannot see your phone numbers, and you’ll never receive follow-up text messages outside this presentation
How To Vote via Texting

1. Standard texting rates only (worst case US $0.20)
2. We have no access to your phone number
3. Capitalization doesn’t matter, but spaces and spelling do
Technical vs. Adaptive Change

- For technical change to succeed, need adaptive changes that address attitudes/beliefs and processes
  - Technical change – new form
  - Adaptive change – changes in workflow to incorporate new form
- Education is necessary but not sufficient
- Technical changes often do not work because the adaptive changes needed to get staff to adopt and utilize the technical change have not been addressed.
Safely Reducing Avoidable Hospital Readmissions

AHCA quality initiative goal:
Safely reduce hospital readmissions by 15% by March 2, 2015
Why does this issue matter?

- Triple Aim: Better Care, Better Health, Lower Cost
- Complications, poor health outcomes and decline for older adults
- Many readmissions are avoidable
- 30-day readmissions from SNFs cost Medicare $4.34 billion (Mor, 2010)
- Payment incentives changing from volume to value: ACA, VBP, ACOs, etc...

AHCA Members 30d Rehospitalization Rates (1-year, as of March 2012)

Average: 18.1

Targeted for 15% reduction
State Rankings 30d Rehospitalizations

State Averages – 1-year, as of March 2012

New Jersey (20.3%)

Distribution of NJ Facilities
SNF 30-day Re-hospitalization

New Jersey Average 20.3
What steps do you need to take now?

- A plan is critical:
  - Identify the tools
  - Develop the process
  - Execute & evaluate
  - Refine and sustain

A quality improvement program designed to improve the care of nursing home residents with acute changes in condition.
INTERACT Goals

- Prevent conditions from becoming severe enough to require hospitalization (early identification, assessment & management)
- Manage conditions in the nursing facility without transfer when feasible and safe
- Improve advance care planning and use of palliative care plans when appropriate

Why INTERACT?

- Comprehensive package:
  - Evidence-based clinical tools
  - Implementation strategies
  - Educational & quality improvement resources
- Simple, feasible, efficient
- Consistent with regulations & surveyor guidance
- Publicly available at no cost: [www.interact2.net](http://www.interact2.net)
Why INTERACT?

- Proven effectiveness:
  - 3-state, 25-facility, 6-month intervention & evaluation
  - Average reduction in hospital admissions – 17%
  - Reduction in the 17 facilities “fully engaged” – 24%

INTERACT Tools - Summary

- Acute care transfer log
- QI Review Tool
- STOP & WATCH
- SBAR – Nurse/Physician Communication tool
- Transfer Form & Checklist
- Care Paths
- Change in Condition Cards
- Advance Care Planning Tools
Integration with daily workflow

- Critical to work with staff and champions to identify where & how tools fit YOUR processes.
- Goal - do not duplicate! Enhance, complement, replace.

What you don’t measure won’t matter
Why measure your rehospitalizations?

- Measurement is a critical part of any QI effort
  - Determine baseline
  - Set goals for improvement & track progress
  - Identify patterns and opportunities to improve
- Facilities that measure and set targets outperform their peers who do not
- Hospitals and Managed Care Companies expect you to be tracking the data

Rehospitalization Measures

- Based on Claims (Hospital and SNF Part A), exclude:
  - ER visits & observation stays
  - Medicare Advantage & private insurance

\[
\% = \frac{\text{Numerator}}{\text{Denominator}} = \frac{\# \text{ of persons sent to hospital}}{\# \text{ of persons admitted to SNF}}
\]

- Numerous Existing National Measures: AHCA, CMS, MedPAC
- Internal measures – hospitals, managed care companies
Where Can I Get Data on My Rates?

- AHCA – Long Term Care Trend Tracker
  - Free AHCA member benefit
  - [www.ltctrendtracker.com](http://www.ltctrendtracker.com)
  - Now includes claims-based measure
  - By end of 2012, will have MDS-based, risk adjusted Point Right measure
- Many MDS vendors include in their systems
- Real-time internal data collection & analysis

Tracking in Real Time

- To determine your own rates, you need to track:
  - Name
  - Date of admission to facility
  - Admitted from (home, hospital (name), IRF, LTCH, SNF)
  - Date of transfer to hospital
  - Reason for transfer (i.e., planned or unplanned)
How do you know where you stand?
New SNF Rehospitalization Measure

- AHCA partnering with PointRight for MDS-based, risk adjusted 30-day SNF readmission measure
  - PointRight provided measure to AHCA for free
  - AHCA member facility rates in LTC Trend Tracker
- CMS TEP working on risk adjusted 30 day SNF measure based on claims

AHCA SNF 30 Day Rehospitalization

**Numerator**: # of individuals sent back to any hospital (excluding ER-only visits) from your facility within 30 days of admission, as indicated on the MDS discharge assessment

**Denominator**: All residents admitted from an acute hospital to your facility who have an MDS admission assessment

**Risk adjustment**: Logistic regression-based adjustment for 33 different clinical variables. Compares your observed rate to your expected rate

**Data Source**: MDS 3.0 admission & discharge assessments
Risk Adjustment Variables Used

- **Demographic**
  - Age ≥65
  - Male
  - Medicare as Primary Payor

- **Functional Status**
  - Total Bowel Incontinence
  - Eating dependent
  - Needs 2 person assistance in ADLs
  - Cognitive Impairment (Dementia)

- **Prognosis**
  - End Stage prognosis poor
  - Recently rehospitalized
  - Hx of Respiratory Failure
  - Receiving Hospice Care

- **Clinical Conditions**
  - Daily pain
  - Pressure Ulcer Stage ≥2 (split into 4 variables)
  - Venous Arterial Ulcer
  - Diabetic Foot Ulcer

- **Diagnoses**
  - Anemia
  - Asthma
  - Diabetes Mellitus
  - Hx of Viral Hepatitis
  - Hx of Septicemia
  - Hx of Heart Failure
  - Hx of Internal bleeding

- **Services & treatments**
  - Dialysis
  - Insulin prescribed
  - Ostomy care
  - Cancer Chemotherapy
  - Receiving Radiation Therapy
  - Continue to receive IV Medication
  - Continue to receive oxygen
  - Continued tracheostomy care

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Advancing Excellence

- Acute Care Transfer Log is available as excel file on Advancing Excellence website
Tracking hospital transfers

Analyzing Data & Looking for Opportunities

- Percent re-hospitalizations
  - Identify a time period (e.g., within 30 days of admission)
  - Calculate: # of hospital re-admissions within time period/total # of admissions in time period

- Days between events:
  - # of days since most recent hospital transfer
  - Avg # of days between hospital transfers

- Patterns & trends
  - Types of hospitalizations
  - Unit or time of day/week of hospitalization
  - Attending Physician
Exercise – What are the data saying?

- Review the example tracking log at your table
- What patterns do you observe in the data that you may want to explore further?
- What additional questions does this data raise?

Questions, Reflections

- Any questions?
- Take a moment to reflect on this segment and make some notes on your worksheet.
BREAK

What’s the real issue here?
Transfer decisions are complicated

- Multi-factorial
- Early review process can be uncomfortable as you explore what might have been handled differently
- Current incentives favor hospitalization
- INTERACT QI tool facilitates, systematic root cause analysis process:
  - What happened?
  - Why did it happen?
  - What can be done to reduce likelihood of recurrence?

What’s the Real Issue Here?

- INTERACT Quality Improvement Review Tool
- To be completed following each unplanned hospital transfer
- 5 Sections:
  - Background information
  - Change in condition
  - Evaluation & management
  - Transfer Information
  - Opportunities for improvement
Quality Improvement Tool

The growth process:

“My initial determination was based on the fact that ... if the patient was admitted ... I automatically felt it was unavoidable ... but I’ve had a culture change with my thought process ...”

Exercise - What’s Mrs. Smith’s story?

- You and your tablemates are a staff team.
- Use what you know about Mrs. Smith to complete the INTERACT QI Tool (30 min)
- Each person has an assigned role
- You each have several kinds of information:
  - Facts the entire team knows
  - Facts only you know that you may share at any time
  - Facts only you know that you may share only if someone asks you a relevant question
Exercise Debrief

- What factors contributed to this transfer?
- What opportunities for improvement did your team identify?
- Did you decide the transfer might have been prevented? How?

Using the Transfer Log & QI Tool

- Integrate into facility’s regular QI & education processes – provides a structured approach:
  - Look for common situations, patterns and trends
  - Identify situations you believe can be safely managed without transfer
  - Work together to develop strategies for these situations
  - Develop and implement education on key topics
- Focus on systems that need to change – not individuals to blame.
Questions, Reflections

☐ Any questions?
☐ Take a moment to reflect on this segment and make some notes on your worksheet.

Early Identification of Acute Changes
Stop & Watch – early warning tool

**Purpose:**
- Guide front-line staff through brief review of **early, often subtle**, indicators of change in condition
- **Improve communication** between frontline staff and the nurse in charge

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**Why is it important?**

- **Staff** who know resident best often need permission & mechanism to communicate what they observe
- **CNAs** notice early signs of change as much as 5 days before other clinicians (Boockvar, JAGS 2000)
- Helps staff know what is important to report
- Helps nurses recognize the importance of the information and take action

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**INTERACT®**

EARLY WARNING TOOL

“Stop and Watch”

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

- **S**eems different than usual
- **T**alks or communicates less than usual
- Overall needs more help than usual
- **P**articipates in activities less than usual
- **A**te less than usual (Not because of dislike of food)
- **N**eeds less than usual

- **W**eighted change
- Agitated or nervous more than usual
- **T**ired, weak, confused, or dehydrated
- Change in skin color or condition
- Help with walking, transferring, toileting more than usual

Staff: ____________________________
Reported to: ____________________________
Date: ______/____/______ Time: ________

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3/13/2013
Exercise – Part 1

- Refer back to the case study we just completed
- Pair up at your tables – each pair must include one of the individuals in the following roles:
  - Housekeeper
  - Day Shift CNA
  - Evening Shift CNA
  - Physical Therapist
- Using the information these individuals have about the case, complete a Stop & Watch form for about 1-week prior to Mrs. Smith’s transfer back to the hospital

Exercise – Part 2

- Share your 4 Stop & Watch forms and discuss:
  - Nursing perspective:
    - If you were a nurse getting this information, what would you do to follow up?
    - Might his have changed Mrs. Smith’s outcome? How?
  - Leadership perspective:
    - What first steps could you take to implement Stop & Watch?
    - What challenges might you have and how could you respond?
Stop & Watch implementation tips

- PILOT TEST!
- Make it accessible – where will it work best for your staff?
- Engage everyone with resident contact: CNAs, housekeeping, activities, therapists…
- Engage family— they also have valuable observations
- PILOT TEST!
- Nurse buy-in: “Please fill this out so I am certain not to forget what you just told me.”
- Create feedback loop so staff see impact of their reports
- PILOT TEST!

SBAR

Communication and Change in Condition Tool
Exercise: How Do You Handle Change in Condition?

- At your table - discuss your current change of condition process.
- Review your assessment/evaluation, notification and documentation process
- Identify how the SBAR could help
- Identify tools and processes that could be replaced by the SBAR
- Debrief

SBAR: A Change in Condition Tool

Change in Condition Process

- CNA/staff raise concern about resident status
- RN assesses resident
  - Observe, examine (review of systems), vitals signs
    - Is this an emergency, if so call 911
  - Review medical record for baseline data
    - Labs, progress notes, past vitals
  - Review MAR
  - RN discuss with other staff about past similar changes
- Likely actions
  - Monitor more closely
  - Institute nursing interventions
  - Contact Practitioner to discuss and develop plan (e.g. new orders)
  - Send resident to ER/hospital
The SBAR and Communication

- Improve communication
- Consistent language
- Standardized criteria
- Clear guidelines
- Communication that is efficient
- Communication that is effective

Do I Have to Use It For Everything”

- No
- Consider language---Change In Condition Progress Note
- Standard qshift charting for 72 hours after initial change in condition
- When there is a new order or a change in the care plan
SBAR: More than one purpose....

- Communication tool
  - Contacting MD/NP
  - Change of shift report
  - Morning meeting, huddle, change of status mtg
- Documentation tool
  - Progress note
  - Transfer note and documentation to sent to ER
- Educational tool
  - Just in time and scheduled in-service

Strategies to Reduce Hospitalizations

- Champion the Change
- Track your rehospitalizations
- Improve Communication
  - Externally (eg with hospital/ER)
  - Internally (eg between nursing & physicians)
- Identify small changes in a resident’s status
- Change Staffing
  - Consistent Assignment
  - Reduce staff turnover
  - Utilize nurse practitioners
Strategies to Reduce Hospitalization: Champion the Change

- Communicate
  - Develop a campaign with a consistent and repetitive message about re-hospitalization and INTERACT

- Sell
  - Help the staff make an informed decision based on their identified needs
  - Present information on a psychological and emotional level to spur staff to action

- Persuade
  - Help staff discover an emotionally compelling reason for them to adopt INTERACT

Identify What’s Important to the Staff

- Staff want to use evidence based best practice tools
  - INTERACT tools and process meet this need

- Staff want efficient and effective forms and paperwork
  - INTERACT tools meet this need

- Staff do not want duplicative tools and processes
  - To reduce re-work INTERACT tools should REPLACE existing tools
### Selling What’s Important to the Staff

- **Resident quality of care and life**
  - Hospitalizations often result in poor outcomes and complications

- **Staff satisfaction**
  - Feel empowered to care for own residents

- **Less “re-work”**
  - Prevent need to fix hospital acquired conditions - delirium, antipsychotics, incontinence, pressure ulcers, immobility and de-conditioning

### Questions, Reflections

- **Any questions?**
- **Take a moment to reflect on this segment and make some notes on your worksheet.**
Safely Reducing the Use Of Antipsychotic Medications
Poll: Which statement best represents your belief...

Dementia Re-Examined
Exercise – “Speed Dating”

- Stand up and form two lines, facing each other, so that each person has a partner to talk to

What would you do if…?

- Make sense of the situation – what’s going on here?
- How do you feel?
- What do you do?
How Do We Understand Behavior?

- What are “behaviors”?
  - Medical symptoms?
  - Predictable human responses to the perceived situation?
  - Attempts to communicate an unmet need?
- Our answer to above question shapes our response
  - Identifying and prescribing pharmacologic or non-pharmacologic “treatment”?
  - Focus on stopping the behavior? Or identifying the need?
  - Seeking empathy and understanding?

<table>
<thead>
<tr>
<th>Biomedical Model</th>
<th>Experiential Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>View of behavior</td>
<td>Confused, purposeless, driven by disease &amp; neurochemistry</td>
</tr>
<tr>
<td>Response to behavior</td>
<td>Problem to be managed; medication, restraint</td>
</tr>
<tr>
<td>Behavioral goals</td>
<td>“Normalize” behavior; meet needs of staff &amp; families</td>
</tr>
<tr>
<td>Non-pharmacologic approaches</td>
<td>Focus on discrete interventions</td>
</tr>
<tr>
<td>Overall result</td>
<td>High use of meds, continued suffering, decreased well-being</td>
</tr>
</tbody>
</table>

A. Power, *Dementia Beyond Drugs* (2010)
“Behaviors” vs. “Behavioral Communication”

**Agitation (Self-Referred)**
- Clapping
- Yelling/Screaming
- Slapping thighs

**Message:**
- Something is wrong with me!
- Do something!

**Response:**
- Curiosity
- Identify the need
- Precipitating factor(s)

**Aggression (Other-Referred)**
- Hitting/Kicking
- Pinching
- Biting
- Threatening/Swearing

**Message:**
- Stop! Leave me alone!
- At its core = FEAR

**Response:**
- De-escalate – back off, come back later
- Identify fear triggers
- Foster sense of safety & security

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**Maslow’s Hierarchy of Needs**

- Physiological needs: food, water, warmth, rest
- Safety needs: security, safety
- Belongingness and love needs: intimate relationships, friends
- Esteem needs: prestige and feeling of accomplishment
- Self-actualization: achieving one’s full potential, including creative activities
- Self-fulfillment needs

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3/13/2013
A Person-Centered Approach

- A continuous, relationship-based process...
  - Listening
  - Paying attention
  - Trying things
  - Seeing how they work
  - Changing as needed

Consider – What works for you?

Questions to ask before Rxing

- What did you do to try and figure out why the resident was doing <fill in the blank>?
- What is resident trying to communicate to us about their <fill in blank>?
- What is reason for resident doing <fill in blank>?
  - Unacceptable answer (Dementia or sun-downing)
- What did you try before requesting medications?
Primary Challenge is Changing Beliefs

- Most health care professionals and families believe:
  1. “Dementia behaviors” are abnormal & need to be treated.
  2. Antipsychotics medications are effective.
- Without addressing these underlying beliefs, attempts at practice change are unlikely to succeed due to fear and resistance.

Déjà Vu All Over Again?

- When else have we been successful at changing beliefs, resulting in changed practice?
  - Use of seat belts in cars
  - Use of physical restraints in nursing facilities
  - Others?
- What worked well in changing staff and family beliefs that restraints are helpful? What did not work?
- What have you seen outside of healthcare work to change people’s beliefs or attitudes?
Questions, Reflections

☐ Any questions?
☐ Take a moment to reflect on this segment and make some notes on your worksheet.

Dementia

An overview on diagnosis, prognosis and treatment
DSM IV Criteria for Dementia

- Impairment in memory
- Impairment in 1 other domain of cognitive function (naming, language etc.)
- Cognitive impairment effects function
- Symptoms not due to:
  - delirium, or
  - psychiatric illness

Domains of Cognitive Function

- Naming (Agnosia)
- Language (Aphasia)
- Function (Apraxia)
- Memory
  - Short Term
  - Long Term
- Insight & Judgment
- Calculations
- Visual Spatial orientation
- Attention & concentration
- Executive functioning
  - planning
  - organizing
  - sequencing
  - abstracting
## Example Symptoms of Cognitive Impairment

<table>
<thead>
<tr>
<th>Impaired ability to acquire &amp; remember new info</th>
<th>Impaired reasoning of complex tasks, poor judgment</th>
<th>Impaired visuospatial abilities</th>
<th>Impaired language functions (speaking, reading, writing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>repetitive questions</td>
<td>poor understanding of safety risks,</td>
<td>inability to recognize faces or common objects</td>
<td>difficulty thinking of common words while speaking,</td>
</tr>
<tr>
<td>conversations,</td>
<td>inability to manage finances,</td>
<td>to find objects in direct view despite good acuity,</td>
<td>hesitations;</td>
</tr>
<tr>
<td>misplacing personal belongings,</td>
<td>poor decision-making ability,</td>
<td>inability to operate simple implements,</td>
<td>speech, spelling, and writing errors.</td>
</tr>
<tr>
<td>forgetting events or appointments,</td>
<td>inability to plan complex or sequential activities.</td>
<td>orient clothing to the body</td>
<td></td>
</tr>
<tr>
<td>getting lost on a familiar route.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Changes in personality, behavior, or comportment uncharacteristic mood fluctuations such as | |
| agitation,                                     | |
| impaired motivation, initiative, apathy, loss of drive, | |
| social withdrawal,                             | |
| decreased interest in previous activities,     | |
| loss of empathy,                                | |
| compulsive or obsessive behaviors,             | |
| socially unacceptable behaviors                | |

## Cognitive Screening Tests

- Mini-Mental State Examination (MMSE)
- Mental Status Questionnaire (MSQ)
- Short Portable Mental Status Questionnaire (SPMSQ)
- Blessed Information-Memory-Concentration Test (BIMC)
- Short Test of Mental Status (STMS)
- Blessed Orientation-Memory-Concentration Test (BOMC)

- **Brief Interview for Mental Status (BIMS)**
  - Used in MDS 3.0
Mini-Mental Status Exam (MMSE)

- Screening instrument for dementia (not Alzheimer’s)
- Performs poorly in very mild/early dementia
- Score 0 to 30
  - cut-off <21 suggests dementia
- Scores vary with
  - education level (literacy level)
  - ethnicity

MMSE

- Orientation
  - What is the day, date, month, year, season
  - What is the city, state, county, building, floor
- 2. Registration
  - Name 3 objects. Then ask patient to repeat all 3 objects.
- 3. Attention and calculation
  - Ask the patient to count backward by 7s from 100 or Spell “WORLD” backward
- 4. Recall
  - After 2 minutes, ask for the 3 objects’ named above.
- 5. Language & Visual-spatial
  - Point to a pencil and a watch. Ask the patient to name each
  - Ask the patient to repeat “No if’s, and’s, or but’s”
  - Ask the patient to perform a three-stage command: “Take this piece of paper in your left hand, fold it in half, and lay it on the table.”
  - Ask the patient to read and follow the written command: CLOSE YOUR EYES.
  - Ask the patient to write a sentence.
  - Ask the patient to draw 2 interlocking pentagons.
DSM-IV Criteria for Alzheimer’s

- DSM-IV criteria for dementia
- Gradual onset with continuing cognitive decline.
- Cognitive deficits are not due to:
  - Other central nervous system conditions that cause progressive deficits in memory and cognition
  - Systemic conditions known to cause dementia

Accuracy of Criteria for Alzheimer's

- 80-90% clinical AD have AD at autopsy
- Misdiagnosed causes
  - Lewy Body Dementia
  - Multiple Sclerosis
  - Vascular dementia
  - Picks disease
  - Frontal lobe dementia
  - PSP
  - Parkinson’s disease
  - Cancer
Mild Impairment in Alzheimer’s

- Disorientation for date
- Naming difficulties
- Recent recall problems
- Mild difficulty copying figures
- Decreased insight
- Social withdrawal
- Irritability
- Mood change
- Problems managing finances

Moderate Impairment in Alzheimer’s

- Disorientation for date and place
- Comprehension difficulties
- Impaired new learning, calculating skills
- Getting lost in familiar areas, wandering
- Not cooking, shopping, banking
- Delusions, hallucinations
- Agitation, restlessness, anxiety, aggression
- Depression
- Problems with dressing and grooming
- Aphasia and apraxia
Severe Impairment in Alzheimer's

- Nearly unintelligible verbal output
- Remote memory gone
- Unable to copy or write
- No longer grooming or dressing
- Incontinent

Cognitive Decline in Alzheimer's

Treatments for Alzheimer’s Disease

- N-methyl D-aspartate (NMDA) antagonist
  - Namenda® (memantine)
- Cholinesterase inhibitor
  - Razadyne® (galantamine)
  - Exelon® (rivastigmine)
  - Aricept® (donepezil)
- Estrogen
- Vitamin E
- Ginko-Biloba

Cholinesterase effect on ADAS-Cog

![Graph showing the effect of Cholinesterase inhibitors on ADAS-Cog scores over 24 weeks of therapy. The graph compares Tacrine, Donepezil, Rivastigmine, Metrifronate, and Placebo.](attachment:image.png)
What is the Evidence on Effectiveness of Antipsychotics in Persons with Dementia?

National Use of Antipsychotic Meds

National Average: 24.0%

Percentage of Off-label Antipsychotic Usage among Long-Stay Residents in Nursing Facilities

Source: CMS analysis of MOS 3.0 data, 4th Quarter 2011.
State Distribution: Long-Stay Measure

Off-Label Use of Antipsychotics
Q3, 2012

New Jersey – 18%

National average rate is 23%

Distribution of NJ Facilities
Off-Label Antipsychotic Use, Long-Stay

Distribution of NJ Facilities Antipsychotic Medication Use

Percentage of Antipsychotic Usage among Long-Stay Residents in Nursing Facilities, NJ

Source: AMCA Analysis of CMS Nursing Home Compare data, 3rd Quarter 2012
Antipsychotic Medications

- **Conventional**
  - Compazine
  - Haldol
  - Loxitane
  - Mellaril
  - Moban
  - Navane
  - Orap
  - Prolixin
  - Stelazine
  - Thorazine
  - Trilafon

- **Atypical**
  - Aripiprazole (Abilify)
  - Asenapine
  - Clozapine
  - Iloperidone
  - Olanzapine (Zyprexa)
  - Paliperidone
  - Quetiapine (Seroquel)
  - Risperidone (Risperdal)
  - Ziprasidone

Poll: What is the drug you most commonly use i...
Effectiveness of Commonly used APMs

- Zyprexa, Risperdal and Abilify - small but statistically significant effect compared to placebo
- Seroquel – no statistically significant effect

The Use of Depakote for Treatment of Agitation in Dementia Patients

- Current evidence does not support use of Depakote to control agitation in people with dementia.
- No evidence of efficacy of valproate preparations for treatment of agitation in people with dementia among treated patients compared with those not receiving treatment. (RCT)
- Demonstrated higher rate of harmful effects, such as falls, infections and gastrointestinal disorders (diarrhea, nausea) among those receiving valproate preparations.
FDA-Approved Diagnoses

- Schizophrenia
- Bi-polar Disorder
- Irritability associated with Autistic Disorder (Abilify & Risperdal)
- Treatment Resistant Depression (Zyprexa)
- Major Depressive Disorder (Seroquel)
- Tourettes (Zyprexa)

When prescribed for a patient without an FDA approved diagnosis; the prescription is considered as an “off-label use”, which is allowed by the FDA and Medical Boards.

FDA Black Box Warning

- Issued in 2005

- Warning: Increased Mortality in Elderly Patients with Dementia-Related Psychosis

  Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. [Name of Antipsychotic] is not approved for the treatment of patients with dementia-related psychosis.

  **WARNING**
  Increased Mortality in Elderly Patients with Dementia-Related Psychosis — Elderly patients with dementia-related psychosis treated with typical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (median duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 1.5%, compared to a rate of about 0.9% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infections (e.g., pneumonia) in nature. [This drug] is not approved for the treatment of patients with dementia-related psychosis.
Common Off-Label Uses

- Dementia with “behaviors”
  - Agitation
  - Aggression
  - Walking about
- Acute Delirium
- Obsessive-compulsive disorder
- Psychotic symptoms (e.g. hallucinations, delusions) with neurological diseases
  - Parkinson’s disease
  - Stroke

Poll: APMs are effective as a PRN (as needed)
Effectiveness in Dementia

- **Antipsychotic effect takes 3-7 days to start working** – acute response is due to sedating side effect
- Randomized controlled trial (RCTs) - gold standard method to determine effectiveness of medication
  - Persons randomized to receive a drug or a placebo
  - Clinicians also blinded to who gets the meds when rating outcomes
- **Meta-analysis is method that combines the results from multiple RCTs**

Scales to assess Behavior in Dementia

- **NeuroPsychiatric Inventory (NPI)**
  - Assesses 12 behaviors on a 4-point scale: delusions, hallucinations, agitation/aggression, depression, anxiety, euphoria, apathy, disinhibition, irritability, aberrant motor behavior, sleep, eating disorders
  - Higher score = worse symptoms
- **Cohen-Mansfield Agitation Inventory (CMAI) scale**
- **Behavior Pathology in Alzheimer’s Disease Rating Scale (BEHAVE-AD)**
- **Clinical Global Impression of Change (CGI-C)**
Effectiveness in Dementia is Weak
Meta-Analysis (JAMA 2011)

- Zyprexa, Risperdal and Abilify - small but statistically significant effect (12 – 20%) compared to placebo
- Seroquel – no statistically significant effect
- Antipsychotics led to an average change/difference on the NeuroPsychiatric Inventory (NPI) of
  - 35% from a patient’s baseline
  - 3.41 point difference from placebo group
  (note: a 30% change and 4.0 difference is the minimum threshold needed for a clinically meaningful result)
- No conclusive evidence was found regarding the comparative effectiveness of different antipsychotics

Source: JAMA 306:1359-69 2011; Meta-analysis 38 RCTs in dementia
Dose for Antipsychotics Used in Dementia

<table>
<thead>
<tr>
<th>Medication</th>
<th>Low Dose</th>
<th>Normal Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole (Abilify)</td>
<td>&lt;2 mg/d</td>
<td>2-15 mg/d</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa)</td>
<td>&lt;5 mg/d</td>
<td>5-10 mg/d</td>
</tr>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>&lt;50 mg/d</td>
<td>50-100 mg/d</td>
</tr>
<tr>
<td>Risperidone (Risperdal)</td>
<td>&lt;1 mg/d</td>
<td>1-2 mg/d</td>
</tr>
</tbody>
</table>

Effectiveness with Low Dose

- Low dose Risperdal (<1 mg/d) - small positive effective but also increased risk of adverse events
- Low dose Zyprexa (5 mg/d) - no positive effect but does have increased risk of adverse events
- Low dose Abilify and Seroquel effectiveness unknown, but Seroquel at normal dose is ineffective

Source: Cochrane Review 2012; Meta-analysis 16 RCTs in dementia
Associated with adverse outcomes

- Off-label use of antipsychotics in nursing facility residents are associated with an increase in:
  - Death
  - Hospitalization
  - Falls & fractures
  - Venothrombolic events
- Conventional antipsychotics are worse than atypical antipsychotics

Odds of having an adverse event after receiving an Risperidone 1 mg/d compared to placebo

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Odd Ratio</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>1.25</td>
<td>0.73 to 2.16</td>
</tr>
<tr>
<td>Somnolence</td>
<td>2.40</td>
<td>1.70 to 3.20</td>
</tr>
<tr>
<td>Falls</td>
<td>0.84</td>
<td>0.63 to 1.14</td>
</tr>
<tr>
<td>Extrapyramidal disorder</td>
<td>1.78</td>
<td>1.00 to 3.17</td>
</tr>
<tr>
<td>UTI</td>
<td>1.40</td>
<td>0.92 to 2.13</td>
</tr>
<tr>
<td>Edema</td>
<td>2.75</td>
<td>1.51 to 5.03</td>
</tr>
<tr>
<td>Abnormal Gait</td>
<td>5.31</td>
<td>2.24 to 12.62</td>
</tr>
<tr>
<td>Urinary Incontinence</td>
<td>13.6</td>
<td>1.81 to 101</td>
</tr>
<tr>
<td>CVA</td>
<td>3.64</td>
<td>1.72 to 7.69</td>
</tr>
<tr>
<td>Drop out (had to stop meds)</td>
<td>1.43</td>
<td>1.01 to 2.03</td>
</tr>
</tbody>
</table>

Source: Cochrane Review 2012; Meta-analysis 4 RCTs in dementia
Evidence Base for Discontinuing Meds at Lose Dose

- RCTs comparing withdrawal of medication to continuing antipsychotics show:
  - No difference in outcomes between placebo group and continued medication group
  - About 75% remain off the drug after the trial
    - Less than 25% need to be restarted on antipsychotic
  - Placebo group (drug withdrawal) have fewer adverse events
RCT to withdraw antipsychotics\textsuperscript{2}

100 w/Dementia on antipsychotics

\begin{itemize}
  \item 54 Continue med
  \item 46 Stopped med
\end{itemize}

Outcomes assessed over 3 months

\begin{itemize}
  \item 54 Continue med
    \begin{itemize}
      \item Outcomes
        \begin{itemize}
          \item 76\% no change in behaviors
          \item NPI total worse
          \item Agitation worse
          \item QOL worse
          \item 9\% stopped due to behaviors
        \end{itemize}
      \item Statistical Difference
        \begin{itemize}
          \item None
          \item None
          \item None
          \item None
          \item None
        \end{itemize}
    \end{itemize}
  \item 46 Stopped med
    \begin{itemize}
      \item Outcomes
        \begin{itemize}
          \item 67\% no change behaviors
          \item NPI total worse
          \item Agitation worse
          \item QOL better
          \item 13\% stopped due to behaviors
        \end{itemize}
      \item Statistical Difference
        \begin{itemize}
          \item None
          \item None
          \item None
          \item None
          \item None
        \end{itemize}
    \end{itemize}
\end{itemize}


RCT to withdraw antipsychotics\textsuperscript{3}

165 w/Dementia on antipsychotics

\begin{itemize}
  \item 83 Continue med
  \item 82 Stopped med
\end{itemize}

Outcomes assessed @ 6 months

\begin{itemize}
  \item 83 Continue med
    \begin{itemize}
      \item Outcomes (N=51)
        \begin{itemize}
          \item Cognitive Fxn worse
          \item NPI total worse
          \item \textbf{Verbal fluency worse}
          \item ADLs worse
          \item Agitation 32\%
        \end{itemize}
      \item Statistical Difference
        \begin{itemize}
          \item None
          \item None
          \item Yes
          \item None
          \item None
        \end{itemize}
    \end{itemize}
  \item 82 Stopped med
    \begin{itemize}
      \item Outcomes (N=51)
        \begin{itemize}
          \item Cognitive Fxn worse
          \item NPI total worse
          \item \textbf{Verbal Fluency better}
          \item ADLs worse
          \item Agitation 34\%
        \end{itemize}
      \item Statistical Difference
        \begin{itemize}
          \item None
          \item None
          \item Yes
          \item None
          \item None
        \end{itemize}
    \end{itemize}
\end{itemize}

\textsuperscript{3}Ballard C et al Plos Medicine 2008; 5:e76: 587-599
Net effectiveness

“For every 100 patients with dementia treated with an antipsychotic medication, only 9 to 25 will benefit and 1 will die”

Drs Avorn, Choudhry & Fishcher
Harvard Medical School
Dr Scheurer
Medical University of South Carolina


CMS measures

- % Started during 100 days\(^1\) = 3%
- % Receiving medication long stay\(^1\) = 24%
- % Receiving medication on admission\(^2\) = 12%

\(^1\)Source: CMS Nursing home compare reported July 2012 using data from 4th Quarter 2011
\(^2\)Source: MDS 2.0 data 2010 analysis of admission assessments excluding schizophrenia and bipolar disorder
CMS quality measures

% started on medication following admission
- % of individuals in a facility for ≤100 days who were not admitted on the medication but who have it started during their 100 day stay excluding individuals with schizophrenia, Tourette’s and Huntington’s disease

% long stay residents who receive the medication
- % of individuals in a facility for > 100 days who are receiving the medication excluding individuals with schizophrenia, Tourette’s and Huntington’s disease

Surveyor CASPER measure (to be phased out)
- % of individuals in a facility who are receiving the medication excluding individuals with schizophrenia, Tourette’s and Huntington’s disease, Psychotic Disorder, Manic Depression, Hallucinations, or Delusions

CMS Antipsychotic use (Short Stay)

Denominator:
- All short-stay residents

Exclusions:
- Any resident with
  - Schizophrenia (I6000 = 1), or
  - Tourette’s Syndrome (I5350 = 1), or
  - Huntington’s disease (I5250 = 1)
- Any resident with initial assessment indicated antipsychotic use
  - N0400A = [1], OR NO410A = [1, 2, 3, 4, 5, 6, or 7]
- Missing data for Numerator variables N0400A OR N0410A = missing

Numerator:
- Any resident with at least one assessment indicating antipsychotic use
  - N0400A = [1], OR NO410A = [1, 2, 3, 4, 5, 6, or 7]

( ) specifies the MDS 3.0 coding used to calculate the quality measure.
CMS Antipsychotic use (Long Stay)

**Denominator**
- Long-stay nursing home residents except those with exclusions.

**Exclusions**
- Any resident with
  - Schizophrenia (I6000 = 1), or
  - Tourette’s Syndrome (I5350 = 1), or
  - Huntington’s disease (I5250 = 1)
- Missing data for Numerator variables N0400A OR N0410A = missing

**Numerator**
- Any resident with at least one assessment indicating antipsychotic use
  - N0400A = [1], OR N0410A = [1, 2, 3, 4, 5, 6, or 7]

( ) specifies the MDS 3.0 coding used to calculate the quality measure.

---

CMS Surveyor: Psychoactive Medication Use in the Absence of Psychotic or Related Conditions (Long Stay)

**Denominator:**
- All long-stay residents

**Exclusions:**
- Any resident with
  - Missing data for Antipsychotic Medication (N0400A = -, or after 4/1/12 (N0410A = -)
- Any of the following present on target assessment
  - Schizophrenia (I6000=1)
  - Psychotic Disorder (I5950=1)
  - Manic Depression (I5900=1)
  - Tourette’s Syndrome on current or prior assessment if available (I5350=1)
  - Huntington’s Disease (I5250=1)
  - Hallucinations (E0100A=1)
  - Delusions (E0100B=1)

**Numerator**
- Any resident with antipsychotic medication received ([N0400A = 1, or after 4/1/12 (N0410A = 1, 2, 3, 4, 5, 6,7)]

( ) specifies the MDS 3.0 coding used to calculate the quality measure.
BREAK

Exercise: Trial Withdrawal
Poll: Residents who are started on an APM in L...

“Trial Withdrawal” Based on the Evidence

- No role for PRN: antipsychotic effect takes 3-7 days
- Low dose - limited effectiveness, no difference when meds withdrawn:
  - Risperidone [Risperdal] (<1 mg/d)
    - small positive effect, but increased risk of adverse events
    - No difference when meds withdrawn and given a placebo;
  - Olanzapine [Zyprexa] (<5 mg/d)
    - no positive effect, increased risk of adverse events
  - Quetiapine [Seroquel] (<50 mg/d) or Aripiprazole [Abilify] (<2 mg/d)
    - effectiveness at low dose never tested but at normal dose RCTs do not show meds to be effective
Initial steps to reduce

- No role for **PRN** only antipsychotic medications
- Look at discontinue or gradual dose reduction for residents on medications **for greater than 12 weeks** (3 months)
- Evaluate need for antipsychotics **started** on residents during the **evening/night shift or over the weekend**
- Evaluate the need for continuing antipsychotics **started** while in the **hospital**

Exercise – Step 1

- Call your facility and identify a nurse to speak with who can tell you about a case that meets “low-dose or PRN” criteria
  - someone with an off-label use of antipsychotic med
  - PRN-only order
  - **low dose of common antipsychotic medications**
    - Aripiprazole (Abilify) <2 mg/d 2-15 mg/d
    - Olanzapine (Zyprexa) <5 mg/d 5-10 mg/d
    - Quetiapine (Seroquel) <50 mg/d 50-100 mg/d
    - Risperidone (Risperdal)<1 mg/d 1-2 mg/d
Exercise – Step 2

- Gather the information needed to complete your worksheet:
  - How long has the person been on the drug?
    - If > 6 months you do not need exact length, note >6 months
  - Why were they put on the drug?
  - What has their behavior been like recently (past 1-2 weeks)?
  - Has a gradual dose reduction (GDR) been tried in past 6 months? If so, what were the results?

Exercise – Step 3

- With the group at your table, select a case to discuss from among those you have gathered
- As a group, respond to the following questions about this case:
  - What do you think it would take to discontinue the antipsychotic?
  - What additional information do you need?
  - What are the potential challenges?
  - What strategies could you use to address those challenges?
What Are Your Next Steps?

Return to your worksheet individually and complete the questions as they relate to the case from your facility:

- What do you think it would take to discontinue this drug?
- What additional information do you need?
- What are the potential challenges?
- What strategies could you use to address those challenges?

The Challenge of Practice Change

“I did then what I knew how to do. Now that I know better, I do better.”

— Maya Angelou
Questions, Reflections

☐ Any questions?
☐ Take a moment to reflect on this segment and make some notes on your worksheet.

Strategies for Responding to Behavioral Communication
Exercise – What Would it Take?

- Imagine that you are upset, frustrated, anxious, scared, lonely, or just having a really bad day...
- Jot down 2-3 things you might do to help improve your sense of well-being
- Discuss with the person next to you
  - If you could not make these things happen yourself, what would someone need to know about you to tailor these “interventions” to make them most successful?
  - If you couldn’t speak for yourself, who could tell others this important information about you?
- Report out
Understanding Potential Factors that can Trigger Behavioral Responses

- **Internal:**
  - Pain
  - Fear
  - Other unmet needs – physical or emotional

- **External:**
  - Environmental factors
  - Caregiver interactions

---

Does the person have a balance of sensory stimulating and sensory calming activities?

- Are there periods of sustained “up” or “down” activity in the person’s day?
- Most people don’t tolerate > 1.5 hours sustained “up” or “down” time.

Kovach, C., Managing Challenging Behaviors: Non-Pharmacological Interventions
July 11, 2012
Does the person have regular, meaningful human interaction?

- Everyone needs meaningful human interaction – it provides feelings of comfort and safety.
- If necessary, order 10 minutes of 1:1 time two times/day as a nursing order.

How stressful is the person’s environment?

- When environmental stressors exceed the person’s stress threshold, the result is stress. This may ↑ agitation.

Kovach, C., Managing Challenging Behaviors: Non-Pharmacological Interventions
July 11, 2012
What are environmental stressors?

**Noise**
- TV on all day
- Pounding pill crushers
- Background conversations
- Phones turned too loud
- Echoes in bathrooms or other tiled areas
- Public address systems

Kovach, C., Managing Challenging Behaviors: Non-Pharmacological Interventions
July 11, 2012

What are environmental stressors?

**Tactile**
- Itchy skin conditions
- Rough handling
- Room temperature too cold or too warm
- Vinyl furniture
- Hard, unpadded chairs
- Wrinkled bed linens or clothing
- Poorly fitted shoes or clothing

Kovach, C., Managing Challenging Behaviors: Non-Pharmacological Interventions
July 11, 2012
What are environmental stressors?

Visual
- Glare from lights
- Shiny floors
- Clutter
- Spaces that are too big or too small
- Unfamiliar environments or people

Are there any other psychosocial factors that may be affecting a person’s behavior?
Remember -- Maslow’s Hierarchy
Think Beyond the Basic Levels...

What clues can research give us:
When does aggression occur?

Study of 124 cognitively impaired residents:
- 86.3% had some form of aggressive behavior in 7-day period.
- 72.3% of events involved response to touch or “invasion of personal space” during caregiving.
- Movement, dressing and toileting accounted for almost 50% of incidents.

M. Ryden, et. al, Aggressive Behavior in Cognitively Impaired Nursing Home Residents, Research in Nursing & Health, April 1991
What clues can research give us: Why is she screaming??

Ethnographic study of seven triads in a nursing home - older person with dementia, primary family caregiver, and 1-2 formal caregivers. Findings:

- Screaming is related to vulnerability, suffering, and loss of meaning.
- Meanings influenced by organizational factors and reciprocal effects between persons who scream and others in the nursing home environment.
- Each person’s screams constitute a unique language that can be learned.
- Influencing factors:
  - respect for the person’s wishes, needs, and personality
  - shifts in power relations
  - feelings of powerlessness and guilt in family and formal caregivers.


Keeping in mind the goal

Stopping the behavior?

OR

Helping the person achieve the best possible well-being?
A Non-Drug Approach Requires...

- Knowing the person – hinges on consistency of staff assignments
- Seeking to understand root cause(s)
- Finding ways to identify and address unmet needs

Strategies to Consider - Domains

- Activities
- Caregiver education
- Communication
- Simplify Environment
- Simplify Tasks

Source: Gitlin, L., et. al., Nonpharmacologic Management of Behavioral Symptoms in Dementia, JAMA, November 2012
Activities

- Tap into preserved abilities and prior interests
- Introduce activities involving repetitive motions
- Set up activity and help initiate participation to extent needed based on person’s abilities

Caregiver Education

- Understanding that behavior is not intentional
- Relaxing “rules” – recognizing that there is no right or wrong in performing activities or tasks
- Understanding disease progression & changing needs/difficulties with initiation, sequencing, organizing and completing tasks
- Avoid arguing with point of view of person with dementia or trying to reason
- Positive physical and caregiving approaches
Communication

- Allow sufficient time for responses
- Provide simple, 1-2 step, verbal instructions
- Use calm, reassuring tone
- Offer simple choices – no more than 1-2 at a time
- Avoid negative words or tone
- Use light touch to reassure, calm or redirect
- Identify self & others if person does not remember names
- Help person find words as needed for self-expression

Simplify Tasks

- Break each task into simple steps
- Use verbal or tactile prompts for each step
- Provide structured, predictable daily routines
Simplify Environment

- Remove clutter and unnecessary objects
- Use labeling or other visual cues
- Reduce or eliminate noise and distractions
- Use simple visual reminders

Other Potential Strategies to Explore

- Familiar or comfort foods or beverages
- Essential oils/aromatherapy – lavender, rose, rosemary
- Favorite scents – cologne, aftershave, lotions
- Lighting – outside sunlight; ensure lighting is not causing unpleasant visual disturbances
- Interaction with children and/or pets
- Exercise
- Massage
- Music
There is no “one size fits all” – individualized approach is critical

Finding strategies that work for each person is a continuous, relationship-based process...
- Listen – to the person and those who know him/her best
- Pay attention – to what supports well-being & what triggers negative reactions
- Try things – take your best guess
- See how they work – notice what helps and what doesn’t
- Change as needed – and try again!
- Put communication systems in place so that others in your home know what works for whom

Questions, Reflections

- Any questions?
- Take a moment to reflect on this segment and make some notes on your worksheet.
Implementing Practice Change:  
The Key Ingredient = Staff Engagement

Exercise

- Each table will work as a team to complete a task.
- 4 pieces of paper – distribute, face down, at random to 4 people at the table.
- One person is now identified as the manager of your team and 3 team members have specific instructions.
- Manager – open the deck of cards on your table and deal them out evenly to your team members.
Exercise – The Rules

- At “A” tables:
  - The manager may NOT share the goal with team members.
  - The manager must instruct team members, step by step, in what he or she would like them to do to complete the task.
  - Team members may do only exactly what they are asked to do by the manager.

- At “B” tables:
  - The manager should share the goal with all team members.
  - All team members may participate in developing the team’s approach and in completing the task.

Exercise Debrief

- What was the experience like for:
  - Managers – A tables vs. B tables
  - Team members – A tables vs. B tables
  - Observers – what did you notice about the process?

- What can you take away from this experience that relates to implementing any kind of change or new practice in your facility?
“Top-Down” Change

- Think back to a time when you experienced being the “recipient” of a directive from a leader within your organization to make a change in practice or process that you had no part in creating.
  - How did you feel?
  - What barriers or obstacles did you encounter?
  - Did the person who made the decision about what you were asked to do anticipate these barriers?
  - What might have made the change process more effective?

Rolling Out Tools to Change Practice

- [http://qualityinitiative.ahcancal.org](http://qualityinitiative.ahcancal.org)
- Tools to facilitate GDR/discontinuation
  - Nursing Process
  - SBAR
- University of Iowa/Iowa Geriatric Education Center resources:
  - Videos
  - Pocket guides to evidence-based practices
  - Decision algorithms
  - Fact sheets for professionals & families
Facilitating “Bottom-Up” Change

- Facilitating staff-led implementation of change strategies
  - Leaders set expectations & parameters, then step back
  - Remain available to coach and help address barriers
- Identifying and utilizing champions
  - Who is enthusiastic and shares the core beliefs?
  - Who understands the processes you are trying to change and/or those that will be impacted by the change?
  - Who are the informal leaders in your organization?

Implementing Practice Change: The Role of Leadership

- Identify rationale, set expectations
- Champion the change; get staff excited & engaged
- Identify key staff who will support change and lead from within
  - Volunteers, informal leaders
- Provide staff with support to implement change
- Help remove barriers
Questions, Reflections

- Any questions?
- Take a moment to reflect on this segment and make some notes on your worksheet.

Now What? Next Steps...
Summary: Concepts Addressed

- Measurement, tracking, benchmarking
- Root cause analysis
- Pilot testing, rapid cycle improvement
- Changing beliefs as a foundation for changing practice
- Staff-led, bottom-up process improvement

Taking it Home

- Reflecting on the day’s learnings
- Identifying actionable next steps, take-homes, to-dos:
  - What concepts do you want to focus on first?
  - What are some key steps you can take to get started?
  - Whose help do you need?
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