SAFELY REDUCING RE-HOSPITALIZATIONS & ANTIPSYCHOTIC DRUG USE

IRENE FLESHNER, RN, MHA, FACHE
PRINCIPAL, RENO, DAVIS & ASSOCIATES

HCANJ

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Outline of today

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- 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

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- 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

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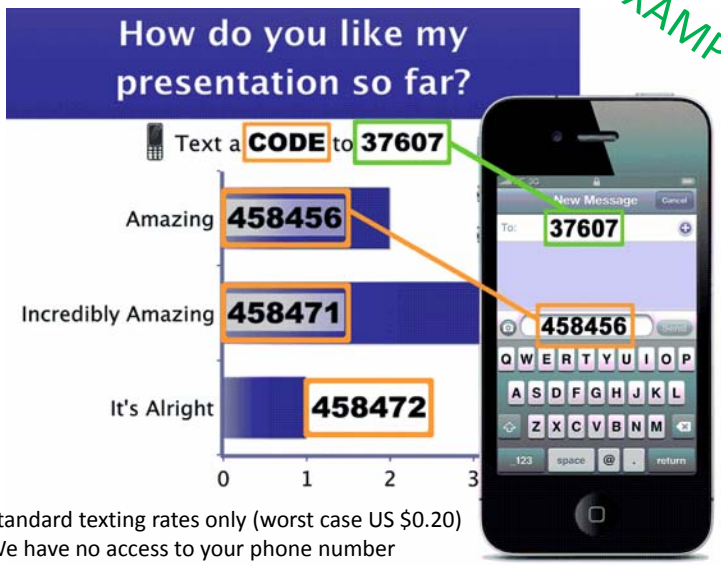
- Throughout the day, we will ask you to answer questions using an online polling technology.
- Respond by sending standard text messages – please have your cell phone handy
  - If you have unlimited text messaging, this will be free
  - If not, it may have a small cost per message
- Your information 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

EXAMPLE



TIPS

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

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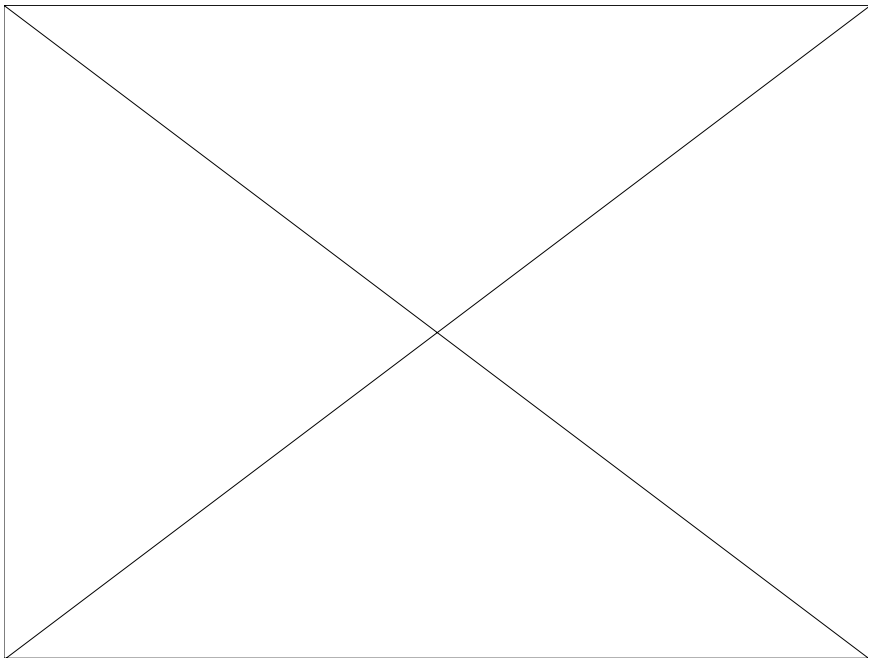
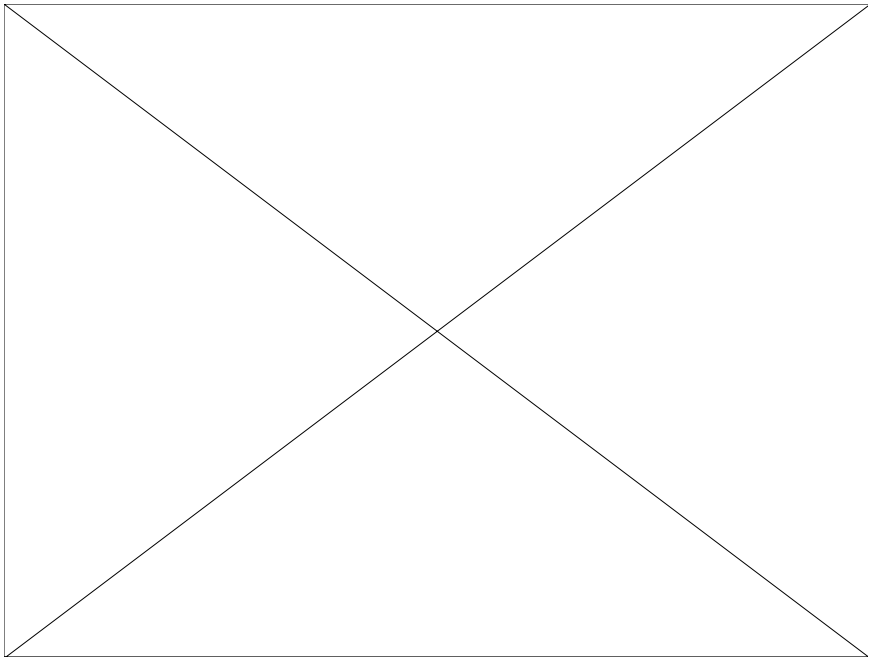


Poll: Who is in the audience?



Poll: What brings you here today?

Technical vs. Adaptive Change

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- 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.

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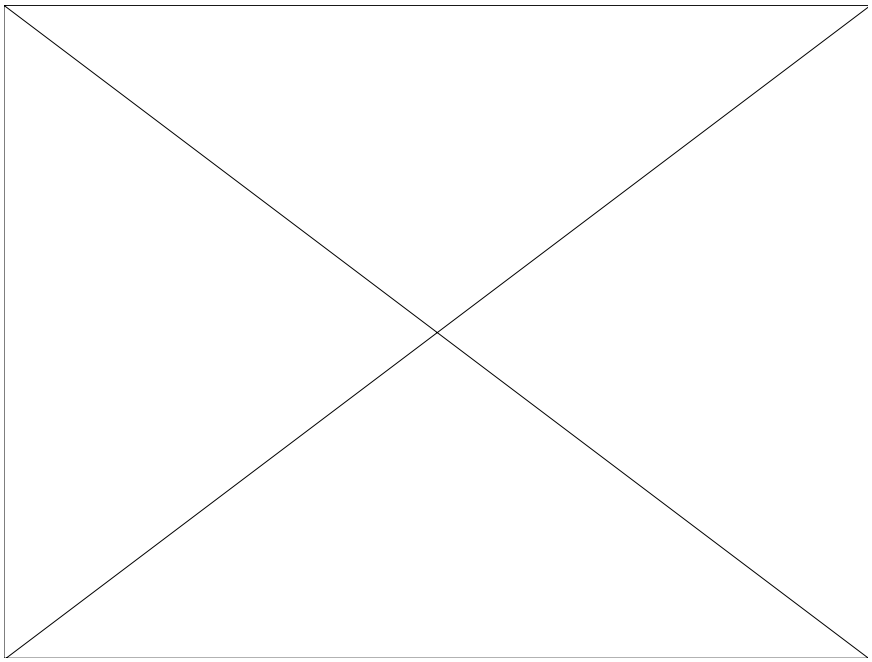
Safely Reducing Avoidable Hospital Readmissions

AHCA quality initiative goal:

Safely reduce hospital readmissions by 15% by March 2, 2015



Poll: In my facility, the top reason that re-h...

Why does this issue matter?

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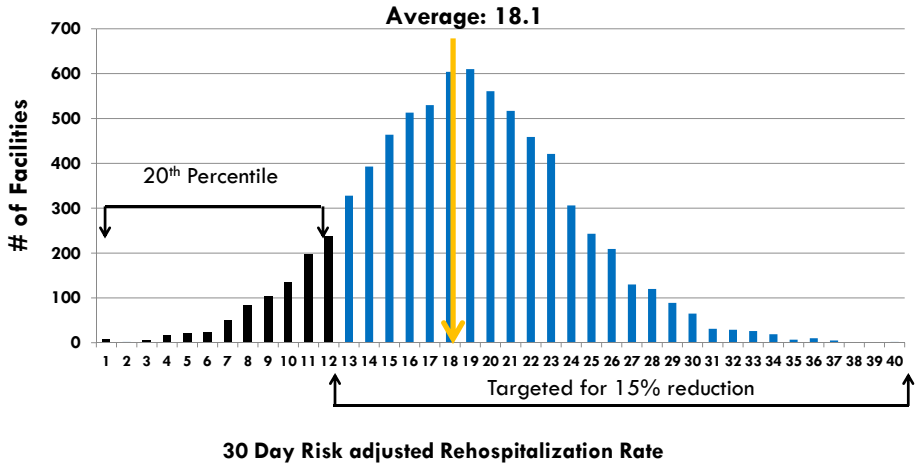
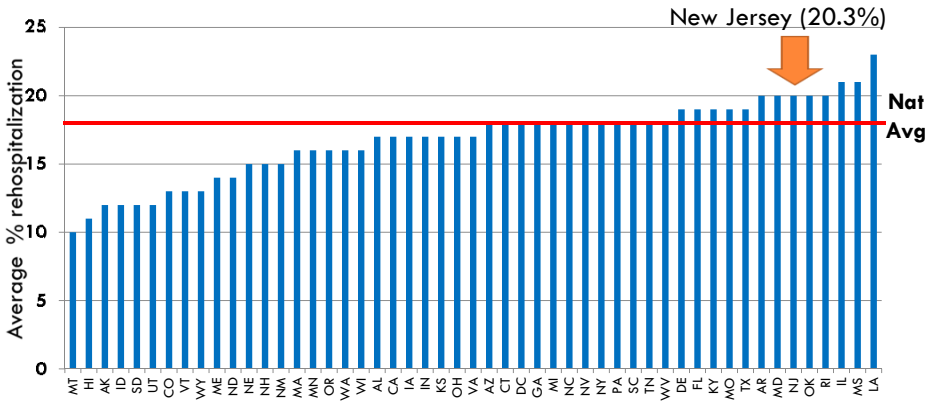
- Triple Aim: Better Care, Better Health, Lower Cost
- Complications, poor health outcomes and decline for older adults
- Many readmissions are avoidable
- 30-day readmissions from SNFs cost Medicare $4.34 billion (Mor, 2010)
- Payment incentives changing from volume to value: ACA, VBP, ACOs, etc…

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

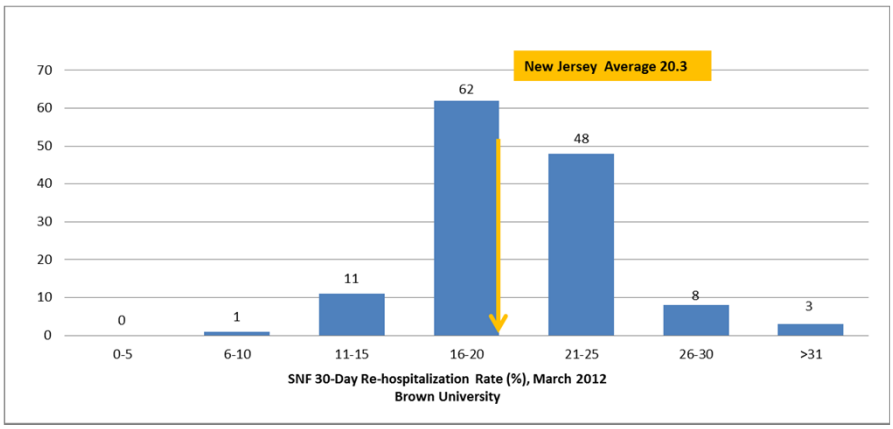


State Rankings 30d Rehospitalizations

State Averages – 1-year, as of March 2012



Distribution of NJ Facilities SNF 30-day Re-hospitalization



What steps do you need to take now?

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

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

INTERACT Goals

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- 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?

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- 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

Why INTERACT?

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- 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

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- 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

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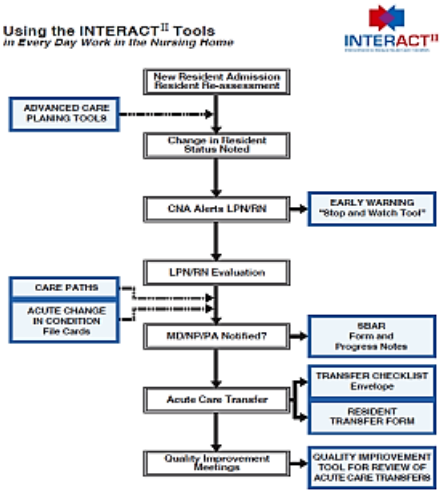

- Critical to work with staff and champions to identify where & how tools fit YOUR processes.
- Goal - do not duplicate! Enhance, complement, replace.

What you don't measure won't matter

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Why measure your rehospitalizations?

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- 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

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

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

- Numerous Existing National Measures: AHCA, CMS, MedPAC
- Internal measures – hospitals, managed care companies

Where Can I Get Data on My Rates?

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- AHCA – Long Term Care Trend Tracker
  - Free AHCA member benefit
  - 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

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- 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

Advancing Excellence

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

Tracking hospital transfers

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ACUTE CARE TRANSFER LOG

Facility Name _____ Month/Year _____/_____

Resident Room Number	Date of most recent admission to the facility	Admitted to the facility from* (circle)	Status at time of Transfer* (circle)	Date of Transfer	Time of Transfer (circle a.m. or p.m.)	Outcome of Transfer (check which applies)		Hospital Diagnosis for ED visit or admission
						ED visit only (returned to facility)	Admitted to the hospital	
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			

Analyzing Data & Looking for Opportunities

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- 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?

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- 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

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

BREAK

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What's the real issue here?

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Transfer decisions are complicated

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- 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?

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- 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

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QUALITY IMPROVEMENT TOOL
For Review of Acute Care Transfers
(Updated September, 2009)

INTERACT

Use this tool to review transfers of residents to an emergency department or for direct admission to the hospital. *The goal is to understand the reasons for the transfer and identify potential opportunities to improve identification and management of changes in resident status and reduce avoidable acute care transfers.* PLEASE COMPLETE EACH SECTION

Section 1: BACKGROUND INFORMATION

Resident's Last Name *First Name* *Age* *Unit/Room #*

Date of most recent admission to nursing home: ___/___/_____

Resident hospitalized in the past year? ☐ No ☐ Yes If yes, list dates and reasons below:

Resident status at time of transfer: ☐ Long stay(LTC) ☐ Short stay(SNF)

Payer was: ☐ Medicaid ☐ Private Pay ☐ Medicare Part A ☐ Evercare ☐ Other managed care

Section 2: TRANSFER INFORMATION

Date of transfer: ___/___/_____ Day of week _____ Time of transfer ___:___ AM/PM
Nurse involved in transfer: _____ Sent by 911? ☐ Yes ☐ No
MD/NP authorizing transfer: _____ ☐ Resident's Primary ☐ Covering Provider

What symptoms or signs prompted the transfer?

Was the resident admitted to the hospital? ☐ No Yes☐

If yes – what was the admitting diagnosis: _____

What happened on the day of the transfer?
(Briefly describe the clinical scenario *ON THE DAY of the transfer - use SBAR for reference*)

What was the resident's code status at the time of transfer? ☐Full code ☐ DNR ☐Other

1

The growth process:

"My initial determination was based on the fact that ….if the patient was admitted….I automatically felt is was unavoidable…..but I've had a culture change with my thought process…"

Exercise - What's Mrs. Smith's story?

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- 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

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- 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

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- **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

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

Early Identification of Acute Changes

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Stop & Watch – early warning tool

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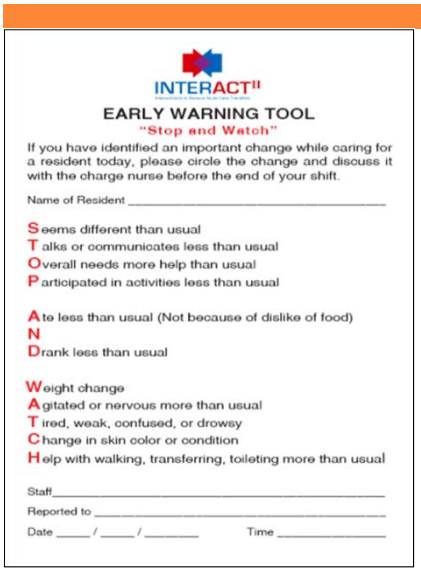

INTERACT II

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.

Name of Resident _____

Seems different than usual
Talks or communicates less than usual
Overall needs more help than usual
Participated in activities less than usual

Ate less than usual (Not because of dislike of food)
N
Drank less than usual

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Staff_____
Reported to _____
Date ____ / ____ / _____ Time _____

- 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

Why is it important?

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- 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

Exercise – Part 1

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- 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 about1-week prior to Mrs. Smith's transfer back to the hospital

Exercise – Part 2

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- 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

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- 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!

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SBAR

Communication and Change in Condition Tool

Exercise: How Do You Handle Change in Condition?

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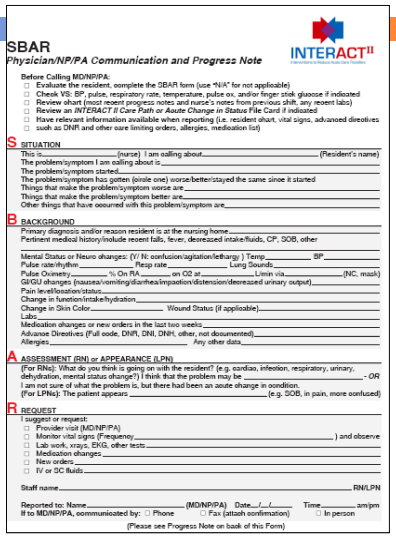
- At your table - discuss your current change of condition process.
- Review your assessment/evaluation, notification and documentation process
- Identify how the SBAR could help
- Identify tools and processes that could be replaced by the SBAR
- Debrief

SBAR: A Change in Condition Tool



SBAR
Physician/NP/PA Communication and Progress Note

INTERACT II

Before Calling MD/NP/PA:
- ☐ Evaluate the resident, complete the SBAR form (use "N/A" for not applicable)
- ☐ Check VS: BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ Review chart (most recent progress notes and nurse's notes from previous shift, any recent labs)
- ☐ Review an *INTERACT II Care Path or Acute Change in Status File* Card if indicated
- ☐ Have relevant information available when reporting (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S SITUATION

This is _____ (nurse) I am calling about _____ (Resident's name)
The problem/symptom I am calling about is _____
The problem/symptom started _____
The problem/symptom has gotten (circle one) worse/better/stayed the same since it started
Things that make the problem/symptom worse are _____
Things that make the problem/symptom better are _____
Other things that have occurred with this problem/symptom are _____

B BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home _____
Pertinent medical history/include recent falls, fever, decreased intake/fluids, CP, SOB, other _____
Mental Status or Neuro changes: (V/ N: confusion/agitation/lethargy) Temp _____ BP _____
Pulse rate/rhythm _____ Resp rate _____ Lung Sounds _____
Pulse Oximetry _____ % On RA _____ on O2 at _____ Liters via _____ (NC, mask)
GI/GU changes (nausea/vomiting/diarrhea/impaction/distension/decreased urinary output) _____
Pain level/location/status _____
Change in function/intake/hydration _____
Change in Skin Color _____ Wound Status (if applicable) _____
Labs _____
Medication changes or new orders in the last two weeks _____
Advance Directives (Full code, DNR, DNI, DNH, other, not documented) _____
Allergies _____ Any other data _____

A ASSESSMENT (RN) or APPEARANCE (LPN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _____ - *OR*
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs): The patient appears _____ (e.g. SOB, in pain, more confused)

R REQUEST

I suggest or request:
- ☐ Provider visit (MD/NP/PA)
- ☐ Monitor vital signs (Frequency _____) and observe
- ☐ Lab work, xrays, EKG, other tests: _____
- ☐ Medication changes _____
- ☐ New orders _____
- ☐ IV or SC fluids _____

Staff name _____ RN/LPN

Reported to: Name _____ (MD/NP/PA) Date ___/___/___ Time _____ am/pm
If to MD/NP/PA, communicated by: ☐ Phone ☐ Fax (attach confirmation) ☐ In person

(Please see Progress Note on back of this Form)

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

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- **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

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

LUNCH

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Safely Reducing the Use Of Antipsychotic Medications

Dementia Re-Examined

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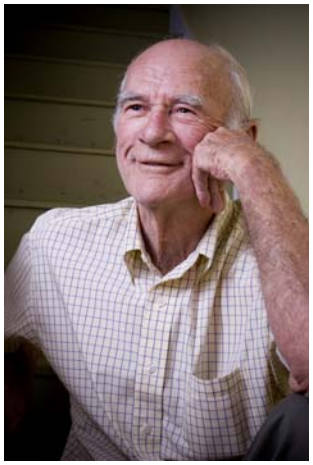
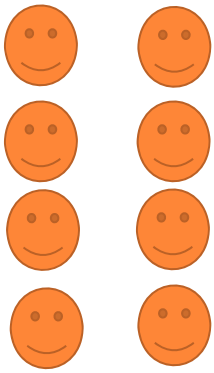


Poll: Which statement best represents your bel...

Exercise – "Speed Dating"

65

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



What would you do if…?

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- Make sense of the situation – what's going on here?
- How do you feel?
- What do you do?

How Do We Understand Behavior?

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- 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?

Biomedical vs. Experiential Model of Dementia

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	Biomedical Model	Experiential Model
View of behavior	Confused, purposeless, driven by disease & neurochemistry	Attempts to cope & problem-solve, communicate needs
Response to behavior	Problem to be managed; medication, restraint	Care environment inadequate; conform environment to person
Behavioral goals	"Normalize" behavior; meet needs of staff & families	Satisfy unmet needs; focus on individual perspective
Non-pharmacologic approaches	Focus on discrete interventions	Focus on transforming the care environment
Overall result	High use of meds, continued suffering, decreased well-being	Rare use of meds, attention to spiritual needs, improved well-being

A. Power, *Dementia Beyond Drugs* (2010)

"Behaviors" vs. "Behavioral Communication"

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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

Maslow's Hierarchy of Needs

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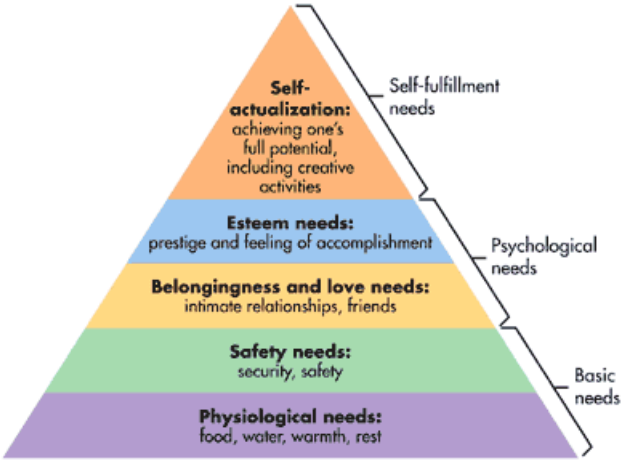

A Person-Centered Approach

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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

72

- 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

73

- 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?

74

- 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

75

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

76

Dementia

An overview on diagnosis, prognosis and treatment

DSM IV Criteria for Dementia

77

- 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

78

- 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

79

Impaired ability to acquire & remember new info

- repetitive questions
- conversations,
- misplacing personal belongings,
- forgetting events or appointments,
- getting lost on a familiar route.

Impaired reasoning of complex tasks, poor judgment

- poor understanding of safety risks,
- inability to manage finances,
- poor decision-making ability,
- inability to plan complex or
- sequential activities.

Impaired visuospatial abilities

- inability to recognize faces or common objects
- to find objects in direct view despite good acuity,
- inability to operate simple implements,
- orient clothing to the body

Impaired language functions (speaking, reading, writing)

- difficulty thinking of common words while speaking,
- hesitations;
- speech, spelling, and writing errors.

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

80

- 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)

81

- 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

82

- **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

83

- 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

84

- 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

85

- 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

86

- 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

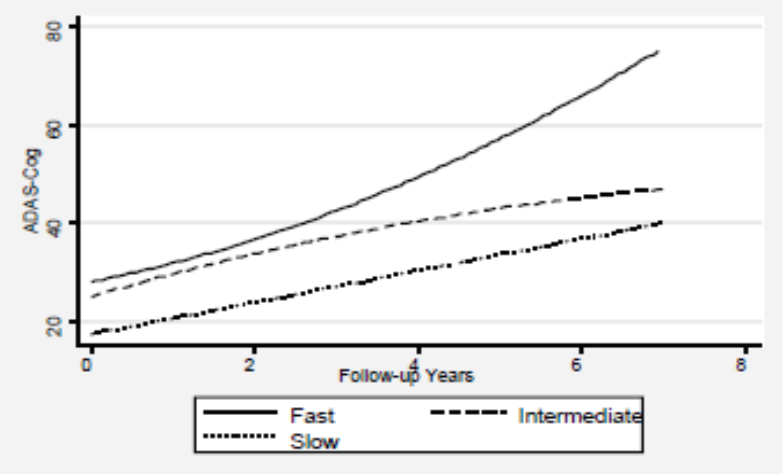
Severe Impairment in Alzheimer's

87

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

Cognitive Decline in Alzheimer's

88



Doody *et al*. Predicting progression of Alzheimer's disease. *Alzheimer's Research & Therapy* 2010, **2**:1-9

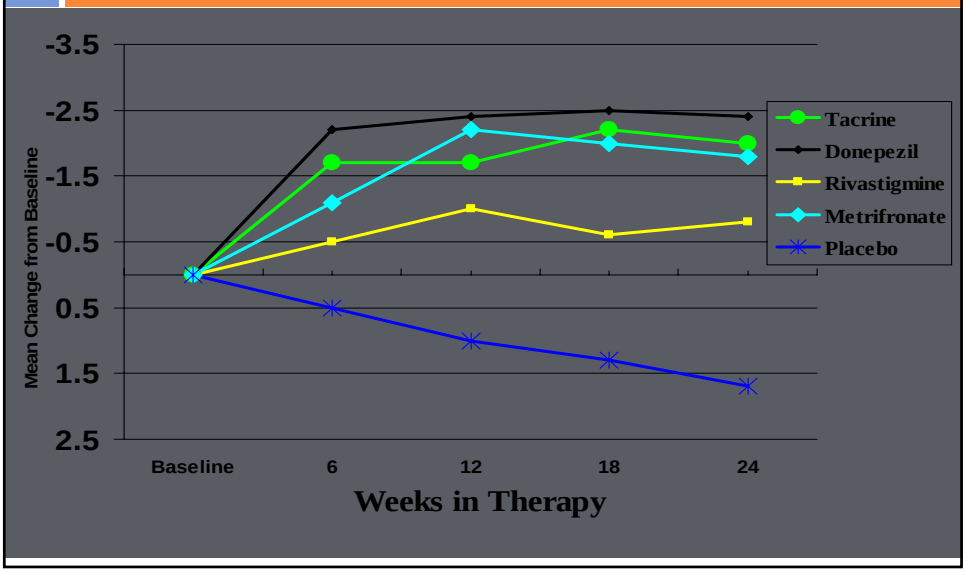
Treatments for Alzheimer's Disease

89

- 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

90

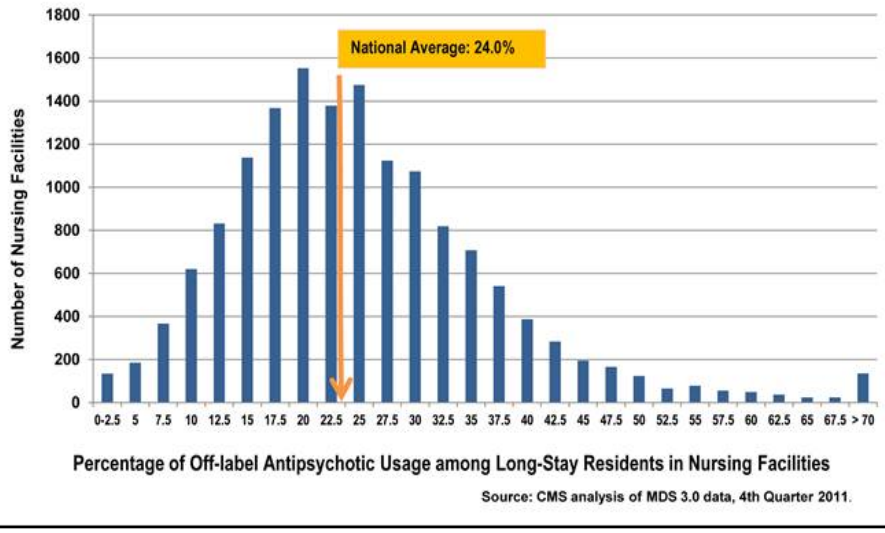


What is the Evidence on Effectiveness of Antipsychotics in Persons with Dementia?

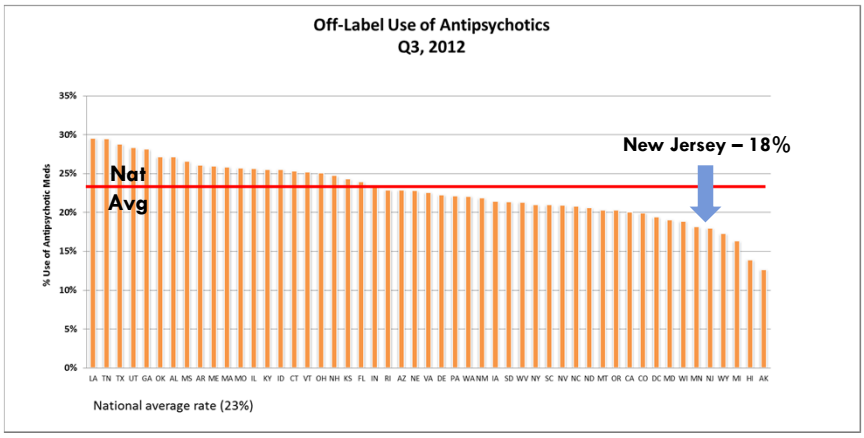
91

National Use of Antipsychotic Meds

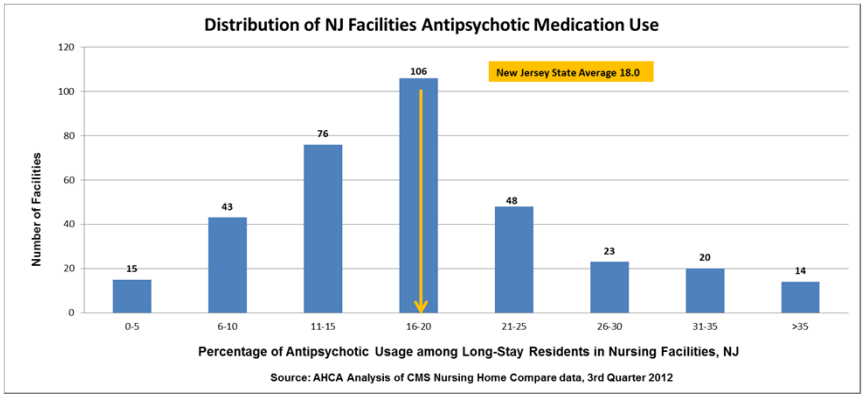
92



State Distribution: Long-Stay Measure



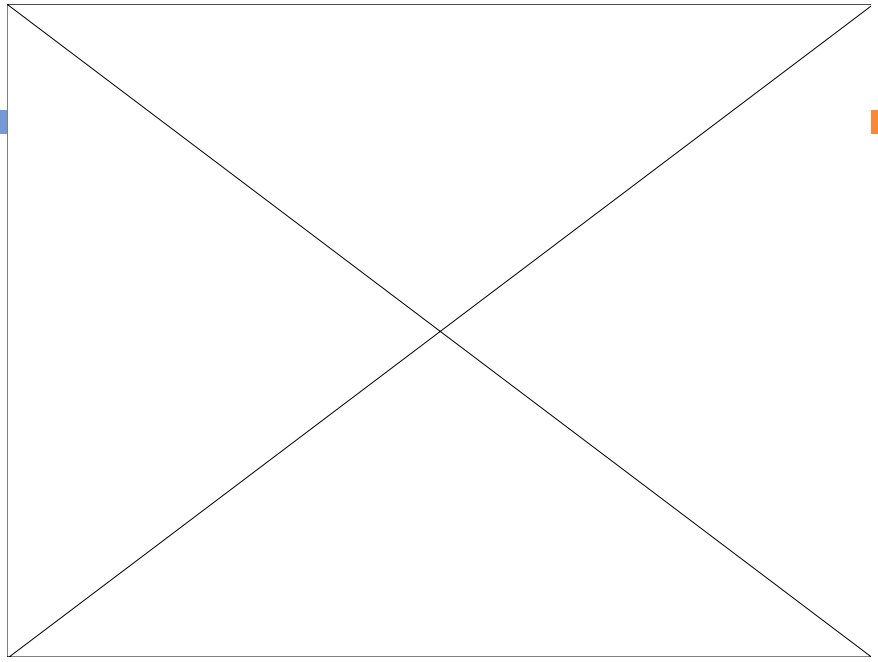
Distribution of NJ Facilities Off-Label Antipsychotic Use, Long-Stay



Antipsychotic Medications

95

- Conventional
  - Compazine
  - Haldol
  - Loxitane
  - Mellaril
  - Moban
  - Navane
  - Orap
  - Prolixin
  - Stelazine
  - Thorazine
  - Trilafon
- Atypical
  - Aripiprazole (Abilify)
  - Asenapine
  - Clozapine
  - Iloperidon
  - Olanzapine (Zyprexa)
  - Paliperidone
  - Quetiapine (Seroquel)
  - Risperidone (Risperdal)
  - Ziprasidone



Poll: What is the drug you most commonly use i...

Effectiveness of Commonly used APMs

97

- 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

98

- 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

99

- 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

100

- 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.

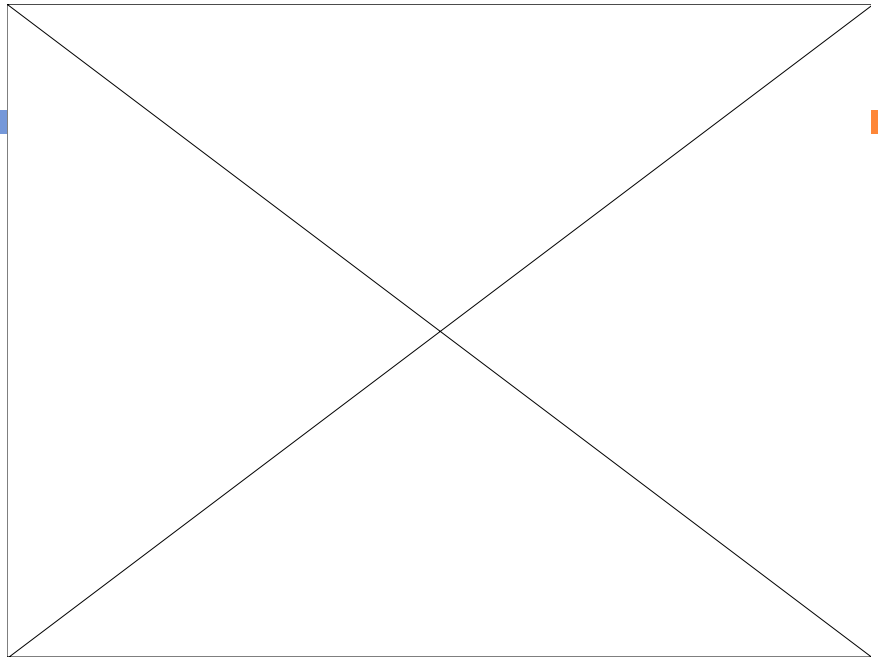
WARNING

Increased Mortality in Elderly Patients with Dementia-Related Psychosis — Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal 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 4.5%, compared to a rate of about 2.6% 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 infectious (e.g., pneumonia) in nature. [this drug] is not approved for the treatment of patients with dementia-related psychosis.

Common Off-Label Uses

101

- 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

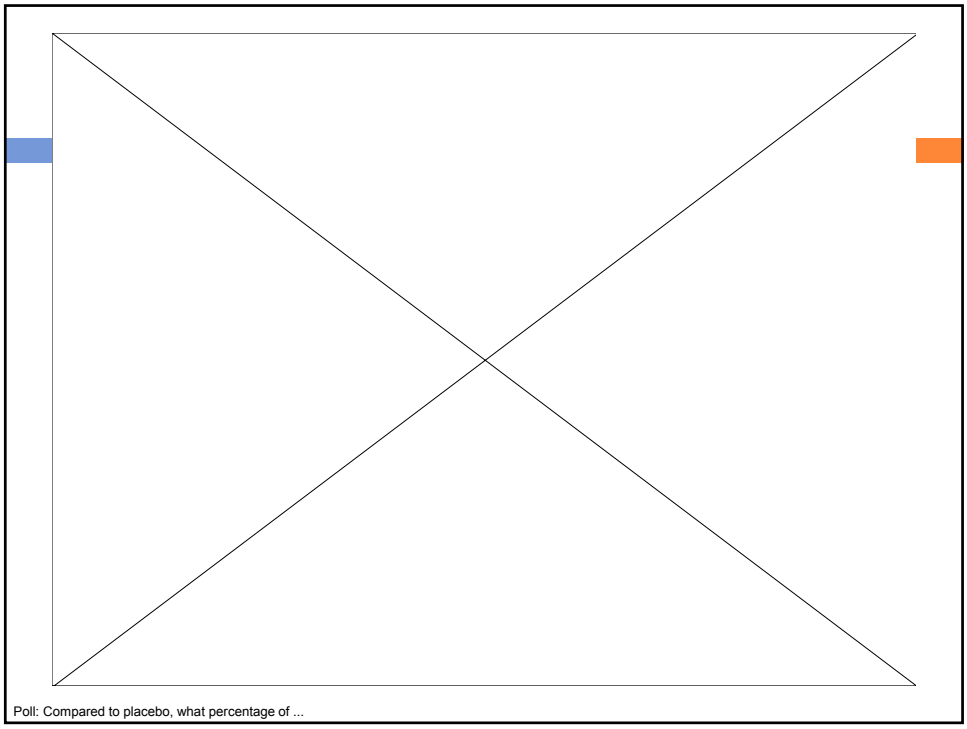
103

- **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

104

- **NeuroPsychitatric Inventory (NPI)**
  - Assesses12 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)**



Poll: Compared to placebo, what percentage of ...

Effectiveness in Dementia is Weak Meta-Analysis (JAMA 2011)

106

- 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

107

Medication	Low Dose	Normal Dose
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

Effectiveness with Low Dose

108

- 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

109

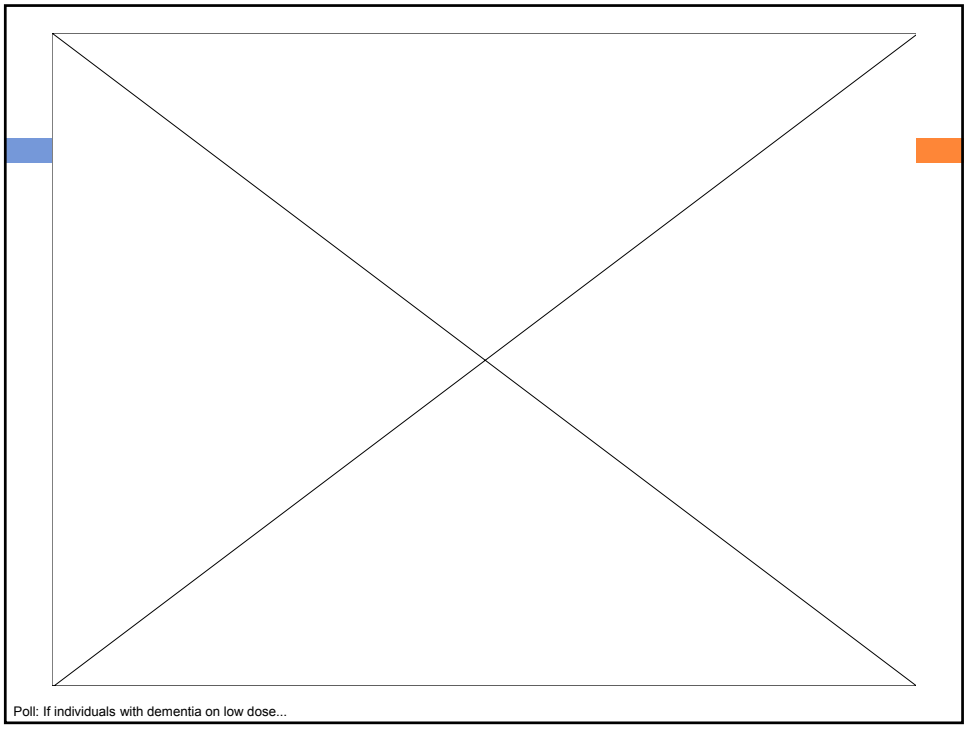
- Off-label use of antipsychotics in nursing facility residents are associated with an increase in:
  - Death
  - Hospitalization
  - Falls & fractures
  - Venothrombolic events
- Conventional antipsychotics are worse than atypical antipsychotics

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

110

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

Source: Cochrane Review 2012; Meta-analysis 4 RCTs in dementia



Poll: If individuals with dementia on low dose...

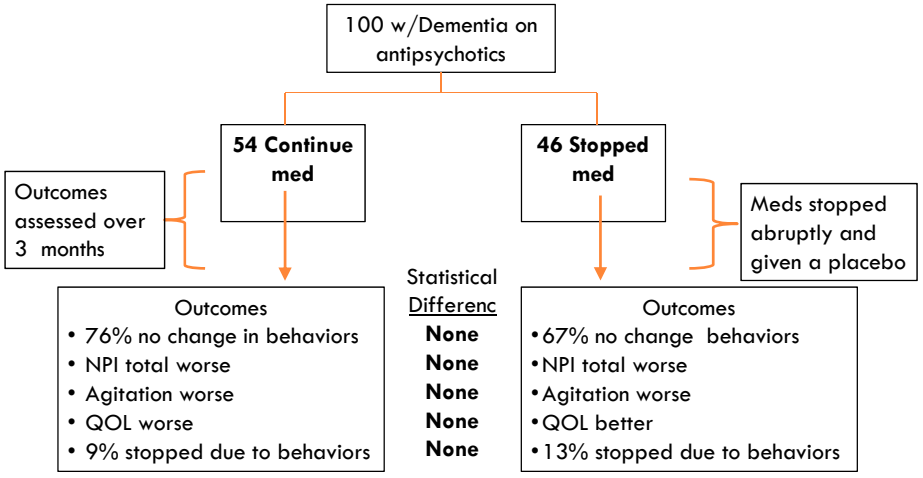
Evidence Base for Discontinuing Meds at Lose Dose

112

- 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[2]

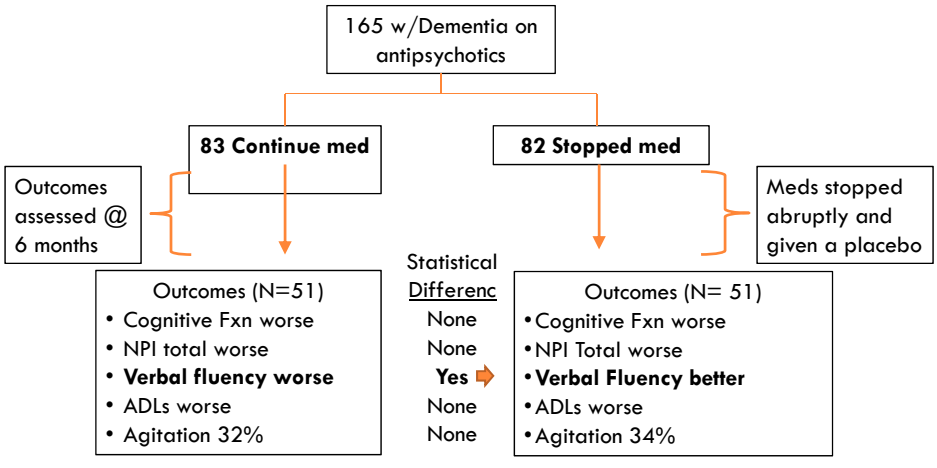
113



[2]*Ballard C et al J Clin Psychiatry 2004: 65:114-119*

RCT to withdraw antipsychotics[3]

114



[3]*Ballard C et al Plos Medicine 2008; 5:e76: 587-599*

Net effectiveness

115

"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

Source: Independent Drug Information Service (IDIS) Restrained Use of antipsychotic medications: rational management of irrationality. 2012

CMS measures

116

- % 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

117

- **% 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)

118

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)

119

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 NO410A = [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)

120

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)

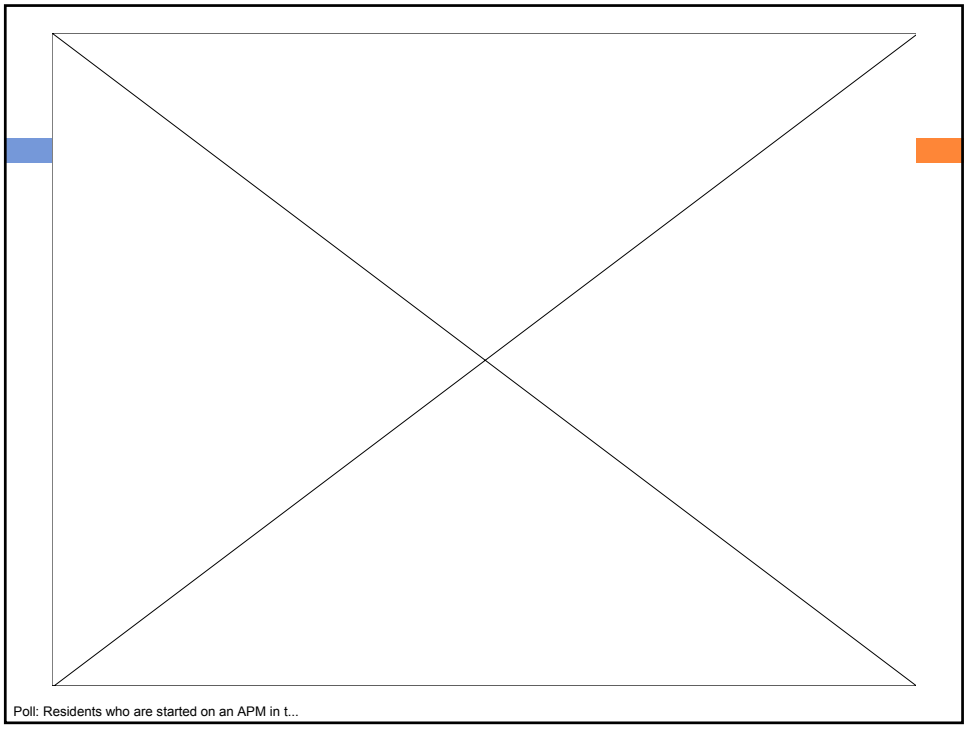
( ) specifies the MDS 3.0 coding used to calculate the quality measure.

BREAK

121

Exercise: Trial Withdrawal

122



"Trial Withdrawal" Based on the Evidence

124

- 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

125

- 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

126

- 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

127

- 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

128

- 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 it 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?

129

- Return to your worksheet individually and complete the questions as they relate to the case from your facility:
  - What do you think it would it 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

130

"I did then what I knew how to do. Now that I know better, I do better."
— Maya Angelou

Questions, Reflections

131

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

Strategies for Responding to Behavioral Communication

132

133 All Behavior Has Meaning

Exercise – What Would it Take?

134

- 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

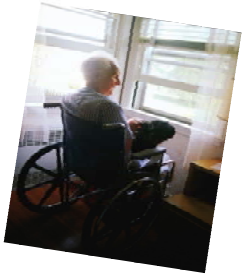
135

- 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?

136

- 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?

137

- 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.

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

How stressful is the person's environment?

138

- 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?

139

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?

140

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?

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Visual

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

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

Are there any other psychosocial factors that may be affecting a person's behavior?

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

Remember -- Maslow's Hierarchy Think Beyond the Basic Levels…

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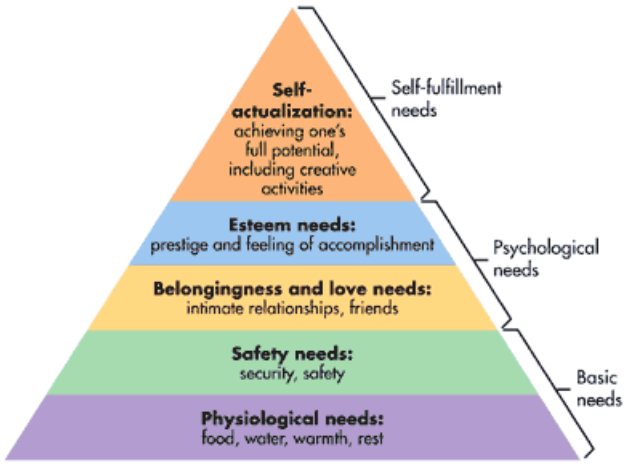

What clues can research give us: When does aggression occur?

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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??

145

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.

Bourbonnais, A. & Ducharme, F., *The Meanings of Screams in Older People Living with Dementia in a Nursing Home*, International Psychogeriatrics, November 2010.

Keeping in mind the goal

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Stopping the behavior?

OR

Helping the person achieve the best possible well-being?

A Non-Drug Approach Requires…

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- 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

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

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

Activities

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- 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

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- 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

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- 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

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

Simplify Environment

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- 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

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- 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

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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

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- 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

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Exercise

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- 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

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- **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

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- 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

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- 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

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- 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

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- 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

165

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

Now What? Next Steps…

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Summary: Concepts Addressed

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- 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

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- 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?

Contact Information

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American Health Care Association
1201 L St. NW
Washington DC 20005
www.ahcancal.org

David Gifford, MD, MPH,
SR VP for Quality & Regulatory Affairs
Dgifford@ahca.org
202-898-3161

Ruta Kadonoff, MA, MHS,
VP for Quality & Regulatory Affairs
rkadonoff@ahca.org
202-454-1282

Reno, Davis & Associates, Inc.
1688 Floyd St
Sarasota, FL 34239

Irene Fleshner, RN,MHA, FACHE
Principal
Irene@renodavis.com
941-365 -1627

AHCA Quality Initiative
Web: qualityinitiative.ahcancal.org
E-mail: qualityinitiative@ahca.org

ahca American Health Care Association

ncal National Center for Assisted Living