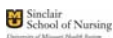


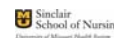
BEHAVIORS AND CARE PLANNING

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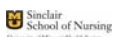
OFFICE OF INSPECTOR GENERAL (OIG)

- Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents - published May 2011
- Six month review of atypical antipsychotic drugs usage in nursing homes



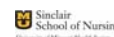
FINDINGS



- 14% of elderly nursing home residents had Medicare claims for atypical antipsychotic drugs
- 83% of Medicare claims for atypical antipsychotic drugs for elderly nursing home residents were associated with off label conditions; 88% were associated with the condition specified in the FDA boxed warning






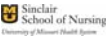
FINDINGS



- 51% of Medicare antipsychotic drug claims for elderly nursing home residents were erroneous, amounting to \$116 million
- 22% of the atypical antipsychotic drugs claimed were not administered in accordance with CMS standards regarding unnecessary drug use in nursing homes



	RECOMMENDATIONS
	<ul style="list-style-type: none"> ■ Facilitate access to information necessary to ensure accurate coverage and reimbursement determinations ■ CMS response: CMS did <i>not</i> concur with this recommendation and expressed several general concerns with the report due to lack of diagnosis information for prescriptions
	

	RECOMMENDATIONS
	<ul style="list-style-type: none"> ■ Assess whether survey and certification processes offer adequate safeguards against unnecessary antipsychotic drug use in nursing homes ■ CMS response: CMS concurred and stated it has already assessed and made improvements in the survey and certification process
	

	RECOMMENDATIONS
	<ul style="list-style-type: none"> ■ Explore alternative methods beyond survey and certification processes to promote compliance with federal standards regarding unnecessary drug use in nursing homes ■ CMS response: CMS concurred and is exploring alternative strategies (contractual agreements among drug manufacturers)
	

	RECOMMENDATIONS
	<ul style="list-style-type: none"> ■ Take appropriate action regarding the claims associated with erroneous payments identified in our sample ■ CMS response: CMS concurred and will consider what appropriate actions need to be taken when the claims data are received from OIG
	

WHAT DRUGS AT WHAT COST?

- Quetiapine (Seroquel)
 - \$86 million
- Risperidone (Risperdal)
 - \$87 million
- Olanzapine (Zyprexa)
 - \$94 million
- Aripiprazole (Abilify)
 - \$29 million



WHAT DRUGS (CONT.)

- Ziprasidone (Geodon)
 - \$10 million
- Clozapine (Clozaril)
 - \$1.5 million
- Olanzapine/Fluoxetine (Symbyax)
 - \$431,000
- Paliperidone (Invega)
 - \$207,000



WHAT ABOUT THE RESIDENTS?

- Side effects: drowsiness/sedation, restless, somnolence, low blood pressure, impaired judgment
- Increase risk of death in the elderly:
 - Abilify, Clozaril, Zyprexa, Symbyax, Invega, Seroquel, Risperdal, and Geodon



NOW WHAT???



SURVEYOR GUIDELINES CHECKLIST

- Used to review the care and services for a resident with dementia
- It is to be used with Interpretive Guidance for F309: Quality of Care: Provide Care/Services for Highest Well-Being



ASSESSMENT AND UNDERLYING CAUSE IDENTIFICATION

- Behavior description: onset, duration, possible precipitating events or environmental triggers and related factors (appearance, alertness, etc.)
- Sudden change or worsening from baseline; was MD notified for medical evaluation?



ASSESSMENT AND UNDERLYING CAUSE IDENTIFICATION

- Medical causes ruled out: attempt to find root causes with a comprehensive assessment
 - Usual and current cognitive patterns, mood and behavior, risk to resident or others
 - Typical communication for basic needs
 - Prior life patterns and preferences



COMPREHENSIVE ASSESSMENT

- Assessment needs to include the physical, mental, and psychosocial needs of the resident, and also identify risks and/or determine underlying causes of the behavior and impact upon the residents function, mood and cognition
- If not, could be cited F272 - Comprehensive Assessment





CARE PLANNING

- Resident and family involvement (to the extent possible)
- Reflects individualized team approach with measureable goals, timetables and specific interventions






CARE PLANNING

- Includes
 - Involvement of resident/representative
 - Description of targeted behaviors and how to prevent them
 - Why behaviors should be prevented or otherwise addressed
 - Monitoring the effectiveness of any/all interventions



DOCUMENTATION BEYOND THE CARE PLAN

- **Documentation** of the meeting and what was discussed
- If resident/family/representative refuse recommendations, was counseling on consequences and alternative approaches discussed?

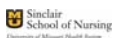
CARE PLANNING

- Develop plan of care with measureable goals and interventions to address the care and treatment for a resident with dementia related to behavioral and/or mental/psychosocial symptoms in accordance with assessment, resident's wishes and current standards of practice
- If not, may cite F279 - Development of a Comprehensive Care Plan

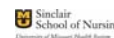
IMPLEMENTATION OF THE CARE PLAN

- **Identify, document, and communicate** specific targeted behaviors and expressions of distress as well as desired outcomes
 - Person-centered interventions
 - Communication between staff and consistency with care
 - Investigate potential causes of any sudden changes in behavior
 - Sufficient numbers of trained staff



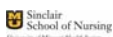
IMPLEMENTATION OF THE CARE PLAN

- Facility provided or arranged provision of services by qualified persons in accordance with the resident's written plan of care? If not, can cite F282 - Services by Qualified Persons



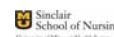
CARE PLAN REVISION AND MONITORING

- Adjust interventions based on impact
- Care plan modified as necessary
- If above not done, could be cited F280 Right to Participate in Planning Care – Revise Care Plan



CARE PLAN REVISION/MONITORING

- Ensure that the physician responds in a timely fashion and if not, the **medical director** should be contacted for assistance



CARE PLAN REVISION/MONITORING

- Facility provided necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental and psychosocial well being in accordance with the assessment and care plan
- If not, cite F 309 - Provide Care/ Services for Highest Well-Being



QUALITY ASSESSMENT AND ASSURANCE

- Resident care policies and procedures outline a systematic process of care for residents with dementia
- Monitoring of consistent implementation
- Correct any identified quality deficiencies
- Provide monitoring and oversight for the care



NOW WHAT

- Rules vs Reality
- How would you like to be treated????
- Does Dementia take away our feelings?
- Does Dementia mean that we no longer care how we are treated?



LOOK IN THE MIRROR

- What would you like people to know about you???
- What will make or break your day??



WHAT DOES THE PERSON WITH DEMENTIA NEED?

- Attachment:
 - Without the reassurance that attachment provides, it's difficult for **any** person to function well
- Inclusion:
 - It's possible for people to be together but profoundly alone; care plans sometimes overlook this



WHAT DOES THE PERSON WITH DEMENTIA NEED?

- Occupation:
 - To be involved in the process of life in a way that is personally significant and uses one's abilities
- Identity:
 - To some extent, identity is conferred by others with subtle messages about his or her being



WHAT DOES THE PERSON WITH DEMENTIA NEED?

- Comfort:
 - Feelings of closeness and security
- AND**
- Love:
 - A blending of all of the above that enhances self-worth and well-being



PHYSICAL NEEDS OF THE PERSON WITH DEMENTIA



- Physical Comfort:
- Could pain, illness, or discomfort be an issue?
 - Has the person been assessed for new or worsening of other progressive disease, besides dementia, that may cause pain or discomfort?



PHYSICAL NEEDS OF THE PERSON WITH DEMENTIA

Nutrition/Hydration:



- Is the person hungry or thirsty?
 - Why?
 - Is this a regular pattern?
 - **Medication issue?**

PHYSICAL NEEDS OF THE PERSON WITH DEMENTIA

Sleep/rest:



- Is the person sleepy in the day time?
 - Possible reasons?
- Is the person not sleeping at night?
 - Possible reasons?
- Is the person getting needed rest during the day?
- Is this a life pattern?
- **Medication issue?**

PHYSICAL NEEDS OF THE PERSON WITH DEMENTIA

Elimination:



- Does this person have a regular toileting or cueing schedule?
- Has there been a change in elimination patterns, either urinary or bowel?
- Is the person accepting of toileting or cueing?
- Could approach for toileting be an issue?
- **Medication issue?**

PHYSICAL NEEDS OF THE PERSON WITH DEMENTIA

Exercise:

- Is this person getting appropriate exercise to maintain their highest level of independence?
- If not, what are some possible reasons?
- **Medication issue?**

PHYSICAL NEEDS OF THE PERSON WITH DEMENTIA

Physical Hygiene:

- Are the person's hygiene needs being met (bathing, oral care, etc.)?
- If not, why?
- Is there a mismatch of assistance to ability?
- Could approach be an issue?
- Could environment be an issue?
 - Water/air temp too hot or too cold, lighting, institutional bathroom



RESIDENT'S PERSPECTIVE

- **All behaviors have meaning and are a form of communication**
- Focus on **assessment** and not the reaction
- What is the resident trying to tell us?



STAFF'S PERSPECTIVE

- What can I do to take care of this person?
- How can I care for him without feeling threatened, or punched or kicked?
- Is there help when I need it?



ASSESSMENT AND CAUSE IDENTIFICATION

- Documentation of the behavior in relationship to:
 - Onset, duration, intensity, possible precipitating events, or environmental triggers
- Related factors:
 - Appearance, alertness, etc.



ASSESSMENT AND CAUSE IDENTIFICATION

- Medical causes ruled out:
 - Review the Behavioral Symptoms CAA (#9)
 - An excellent baseline for the identification of potential cause or causes
- Don't forget, **pain** could be the issue (or at least a contributing factor)



ASSESSMENT AND CAUSE IDENTIFICATION

- Complete the Medical/Physical Assessment
- Talk to everyone and anyone who knows the person now and also prior to admission (neighbors, spouse, family, etc.)
- You can't help the **now** if you don't know the **before!!**



CARE PLANNING SET THE STAGE

- How are your care plans set up?
- Can you tell who the resident is simply by the care plan?
- Can you "see" the PERSON who is the resident?



CARE PLANNING SET THE STAGE

- A picture of the resident
- A story of who they are:
 - What they want to be called: nick names, formal name, etc.
 - Occupation
 - Family names
 - Favorite things to do
 - What brings them joy



CARE PLANNING

- What behaviors are we talking about for this individual?
- What triggers the behaviors?
- What calms the resident?

Be specific and give examples



BEHAVIOR EXAMPLES

- Joe becomes anxious (wringing hands, pacing) when a room gets too crowded
- Charlotte “searches” for her clothes in other rooms and does not like to be told that she is doing anything wrong



BEHAVIOR EXAMPLES

- Sam is very suspicious and food containers need to be opened in his presence
- Julie becomes physically aggressive (kicking, hitting, etc.) if she does not understand what you are doing (i.e. being toileted, time for a meal)



MEASURABLE GOALS


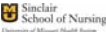
Think about the coding of the MDS:

- Physically aggressive: Carol will have less than 4-6 days a week of kicking and hitting staff
- Verbal: John will have verbal outbursts (shouting and cussing) less than daily




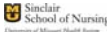
MEASURABLE GOALS

- **Problem:** Daily crying
 - Progressive goals:
 - Episodes will decrease from daily to 4-6 days per week
 - Episodes will decrease to 1 to 3 days per week
 - No further episodes


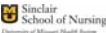
INTERVENTIONS

- Start with what the person has shown is important to them
 - Enjoys watching police shows such as CSI and NCIS
 - Takes a nap every afternoon
 - Eats slowly (so try to have Joan in the dining room promptly)
 - Enjoys a cup of coffee or dish of ice cream


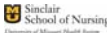
INTERVENTIONS

- Then move to potential triggers
 - Don't sit Susan next to John in the dining room, as it upsets his wife
 - George does not like when the dining room is very noisy, move him to the assist dining area
 - June will only shower on Saturday evening so she is ready for "church" on Sunday

INTERVENTIONS

- Then what to do if the individual does start having behavioral expressions
 - If Joe starts cursing/yelling ensure his safety and leave the room; come back 5-10 minutes later, he will apologize, accept it and move on
 - Susan will start wringing her hands if she is getting upset; take her back to her room and put on the TV and give her some quiet time

DOCUMENTATION

- Paint a picture of what happened
- What happened **before, during, and after**
- Even if it happens everyday we need to note it **everyday** (if we don't why are having problems)
- Interventions **MUST** be tried **each and every time**
- If PRN medications are given, document on why it was used and what interventions were tried



RESOURCES

- *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home residents* (OEI-07-08-00150), issued May 2011. Available online at: <http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf>



RESOURCES

- Dementia Care Mapping class: August 24 through August 27, 2015 and will be at the Primaris; more information will be available later this spring
- Dementia Care Mapping will also be the topic at the MidMO MC5 meeting on 2/11/15



RESOURCES

- QIPMO Educators and Leadership Coaches – Contact Jessica Mueller at (573) 882-2041 or muellerjes@missouri.edu
- QIPMO website: www.nursinghomehelp.org

