Reducing antipsychotic medication use: Stories from the field
Caralyn Davis, Staff Writer

At the July 10 MLN Connects National Provider Call on the CMS National Partnership to Improve Dementia Care in Nursing Homes, the Centers for Medicare and Medicaid Services (CMS) pulled together an array of experts from state coalitions, quality improvement organizations (QIOs), providers, and the research community to share experiences in the ongoing effort to improve dementia care and reduce antipsychotic medication use.

There are no quick-fix best practices that automatically result in a large-scale reduction in antipsychotic medications, said Margie Donegan, the administrator at The Glen at Willow Valley, a 205-bed skilled nursing facility in Lancaster, Penn. Rather, reduction depends on “the combination of many practices over time,” she stressed. In 2008, The Glen’s rate of antipsychotic medication use in long-stay residents was 20.6 percent. As of February 2013, that number is down to 13.23 percent, said Donegan.

Based on their experiences, Donegan and the other experts recommended that providers take the following steps:

Don’t target zero
Some providers have mistakenly received the message that the goal is zero percent antipsychotic medication use for dementia patients, pointed out Nancy Fendler, the technical advisor for the Georgia Learning Collaborative at Alliant GMCF, Georgia’s QIO.

The actual goal is reduction, not elimination. “There are some folks who need to be on antipsychotics,” said Fendler. The key is to collaborate with physicians and psychiatrists and to ensure that antipsychotic medications are appropriately care planned, she added.

The partnership “is really about individualized, person-centered approaches to dementia,” agreed Alice Bonner, PhD, RN, CMS’...continued on page 3

Stress: an occupational hazard
Betty Frandsen, RN, NHA, MHA, C-NE

The National Institute for Occupational Safety and Health defines occupational stress as “the harmful physical and emotional responses that occur when the requirements of a job do not match the capabilities, resources, or needs of the worker.” According to the Centers for Disease Control and Prevention, studies of nurses have identified stressors commonly linked with stress reactions. These stressors include:

• Work load
• Time pressure
• Lack of support from supervisors
• Sleep deprivation
• Understaffing
• Career development issues
• Difficult or very ill patients

If it continues unrelieved, stress has the potential to adversely impact the health of workers and may be associated with psychological reactions, such as irritability and job dissatisfaction; behavioral reactions, such as sleep problems and absenteeism; and physical reactions, including headache, upset stomach, and blood pressure changes (CDC, 2008, p. 3).

A combination of organizational change and stress management is frequently needed in order to reduce stress for health care workers. Organizational interventions include the following:

• Team process—This worker-participative method gives employees the opportunity to participate in decisions that impact their jobs. The team approach in health care has demonstrated success in improving job satisfaction and reducing turnover, absenteeism, and job stress. ...continued on page 5
NURSES FACE TECHNOLOGY FRONTIER

Judi Kulus, RN, NHA, MAT, RAC-MT, C-NE

Having a love-hate relationship with information technology is common. When our computer devices work we love them, and when they don’t we want to pull out our hair. Sometimes we want to throw our facility’s hard drives out the window.

The challenge for many nurses in long-term care is that information technology sometimes dictates how we care for our residents and restricts flexibility in assessment and interventions. For example, a software system’s clinical assessment, such as a comprehensive pain assessment, may be outdated and not have all the elements needed for it to be either resident focused or thorough, and yet the nurse is required to complete it. This means increased work for the nurse.

Another challenge for staff nurses, as well as for MDS coders, is how many “clicks” it takes to enter a data element into the software system. It’s vexing when it takes 15 clicks of the mouse to enter a resident’s weight. The frustration is compounded when it takes us away from spending time caring for our residents. Frustration mounts when the computer is slow, freezes, or has a screen with such small print that as you sift through its tabs and windows you can’t find the information about the resident you’re looking for.

When information technology systems, such as electronic medical records, are developed well, they create efficiencies. For example, for nurses starting their shift, a to-do list created from the electronic 24-hour report can help to ensure follow-through on important issues. The to-do list can assist nurses in prioritizing their day, allowing greater focus on residents.

So why is information technology a new frontier? Information technology has been around for a long time, but with the Affordable Care Act’s requirements for health-information exchanges and the developing technical specifications for electronic records that feed into the exchanges, nurses will be impacted like never before.

Can we as LTC nurses shape and impact the use of technology in nursing homes? Yes, we can use our voices to speak up about how current technology is helping or hurting resident care. We can embrace the information technology frontier and shape our own future.

AANAC is a member of the Long-Term and Post-Acute Care Collaborative (LTPAC). The LTPAC is a group of organizations working together to advance the use of technology for resident care. Each year the LTPAC hosts a technology summit in Baltimore. This summer AANAC representatives participated in the planning and attended informational sessions on an array of topics related to how technology is shaping health care.

The summit included these important topics:

• **The Electronic Health Record Based Solutions That LTPAC Providers Need Today:** New information technologies require patient-centered virtual care teams, reducing friction between systems and caregivers through integrating technology into care processes, using electronic health record platforms that support extensibility, workflow, decision support, and integration of emerging technologies.

• **New Payment Models Requiring Care Coordination and Integration:** The demonstration projects that include Bundled Care and Accountable Care Organizations are focused on creating new payment systems that enhance care coordination and integration. Care coordination includes the use of information technology to create seamless care among hospitals, nursing homes, and home settings.

• **E-Decision Making:** Clinical decision support, apps, and analytics are being developed to advance the use of e-decision making that will transform our health care system.

• **Use of Enabling Technologies:** Even the most advanced EHR is not the end-all-be-all. To improve quality of care, LTPAC organizations need to expand their vision to include telehealth, remote monitoring, medication management, and safety technologies to support innovative care delivery and payment models.

• **Person-Centric Longitudinal and Transitional E-Quality Measures:** As we move into person-centric longitudinal care, the need for harmonized e-Quality Measures is ever apparent. LTPAC organizations are faced with the need to collect an increasing number of e-Quality Measures for an increasing number of different groups. CMS is working to identify, select, and prioritize e-Quality Measures that are being advanced through the National Quality Forum and Five-Star ratings.

Quality Assurance and Performance Improvement (QAPI) will necessitate the use of technology for data management and tracking of quality-improvement plans.

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deputy associate regional administrator in the Northeast Division Survey & Certification Group. “It is not about getting the rate of antipsychotics or any other drugs down to zero. That would be chasing a number, and that is not what our residents need. What they need is for us to be individualizing so that people who should be on these medications based on a thorough evaluation and a comprehensive team approach are going to remain on them—and people who are going to benefit from nonpharmacologic approaches have that as part of their care planning process.”

Learn about each individual resident

“We assess for cognitive function, activities of daily living, and involvement in daily group recreational activities or therapeutic engagement,” said Donegan. This assessment helps The Glen ensure the appropriate placement of residents.

“We also utilize a comprehensive assessment tool called our resident profile,” she pointed out. The resident profile, which when possible is completed by a family member prior to admission, provides the care team with vital information about the resident, including preferences, medical history, daily routines, and behaviors.

“The family members are important as part of the process,” added Donegan. “Their insight into the resident’s behavior is invaluable. Getting to know your residents—what they are and what their past has been—will enable the care team to better understand the resident’s needs and how best to meet those needs.”

Laura Gitlin, PhD, director of the Center for Innovative Care in Aging at Johns Hopkins University in Baltimore, also stressed the importance of comprehensive assessment. Gitlin is conducting ongoing clinical research on a three-phase program designed to prevent and reduce behavioral symptoms, primarily agitation, in people with dementia using an individualized, person-centered, nonpharmacologic approach.

“The program, referred to as a tailored activity program, involves identifying the preserved capabilities of the person with dementia, their previous and current interests, hobbies, and occupations, and their functional capacity, from which activities are designed that match their capacity and interests,” Gitlin explained. “Then caregivers are trained to set up, monitor, and use the activities on a daily basis.”

The first phase of the program is a comprehensive assessment “in which the occupational therapist takes a very careful history and interviews the family, as well as the person with dementia, to identify interests and previous occupations that may help inform the type of activity that is introduced,” said Gitlin.

The therapist also conducts a set of performance-based assessments “that enable the OT to identify the best functional capacity of that person and the very specific types of cueing that that person may need in order to engage in the intervention,” she added. “The assessment also includes an understanding and an observation of the physical environment and the capacity of caregivers—what they will need to know and learn in order to be successful using the activities.”

Educate staff

Interdisciplinary team members must be well-educated in three key areas: behavioral management, individual therapeutic engagement, and the facility’s practice-of-care standards, stressed Donegan.

The RN clinical manager on The Glen’s skilled dementia unit is a certified dementia specialist, she noted. This manager teaches mandatory dementia training for all team members who work on the dementia unit.

In fact, developing nonpharmacologic approaches “requires an entirely new way of thinking and new competencies,” suggested Gitlin. Those new competencies include how to be a member of an interprofessional team; how to engage in teamwork; how to problem solve to find the best nonpharmacologic approach; and knowing the roles of the occupational therapist, recreation therapist, CNA, nurse, physician, psychiatrist/psychologist, and possibly social work vis-à-vis the use of nonpharmacologic approaches.

“Competencies also include knowledge about behaviors, how to read facial messaging about possible signs of underlying pain or infection, and how to read pre-clinical signs before behaviors such as agitation escalate to the point that staff are relying on clinical solutions vs. nonpharmacologic,” said Gitlin.

Implement a strong behavior management program

“Our behavior management program is instrumental in our success,” said Donegan. “When a behavior is identified, our team will review the behavior at the next standup meeting. The team attempts to determine the root cause analysis of the resident’s behavior: Is this a new behavior, or is it related to a possible change in condition, for example, a fever?”

If the team identifies that a behavior is new, “the behavior is monitored for five to seven days to identify the triggers and what interventions are most successful in defusing the behavior,” she said.

The behavior management team, which includes social services, recreational therapy, and nursing, develops a care plan. “For residents with more challenging behaviors, we utilize the expertise of our consulting psychologist and psychiatrist to assist with behavior management,” said Donegan. The resulting care plan

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is then communicated to the entire interdisciplinary team on all shifts.
In the Johns Hopkins tailored activity program, caregivers receive an “activity prescription” for each resident, noted Gitlin. This prescription is included in the medical chart so that all team members can see “exactly what the activity is and how to set it up and use it,” she explained. “The activity prescription also includes what the person’s capacities are, what their strengths are, how long they can attend to an activity, whether they have fine or gross motor capacity, and so forth.”

**Pay attention to PRN meds**

For all PRN psychotrophic medications, “we request a physician’s order for a 10-day stop date,” said Donegan. That requires the interdisciplinary team to reassess the medication’s effectiveness. “Additionally, we do weekly audits to ensure the nurses are following the procedures to make certain PRN medications are not administered unless nonpharmacologic interventions have been attempted.”

**Assess your program’s effectiveness**

At The Glen, an antipsychotic drug committee meets on a monthly basis. This committee includes the consulting pharmacist, social worker, clinical managers, and recreational therapy. “The committee reviews all residents on psychotropic meds, any new admissions, and ... dose reductions,” said Donegan. “Additionally, the committee reviews the residents’ behavior management records, which document our PRN medications, interventions prior to the administration of medications, medication effectiveness, and any side effects.”

**Involve front-line staff**

Donegan offered this example of how the involvement of front-line staff can drive medication reductions. One resident was having “a lot of behaviors” on the 11 to 7 shift. The CNA consulted with the resident and indicated that the resident would wake up every night very cold. Providing this resident with a warm blanket from the blanket warmer when she woke up in the night “was instrumental in defusing the behavior,” she explained.

During the Q&A, Kenneth Brubaker, MD, medical director at The Glen, also noted that one of the first things he does when making rounds in the unit is to spend time with the CNAs discussing the residents. “I feel that they probably know more about the residents than the LPNs or the RNs in many cases,” he said. “Often we minimize the valuable information that we can get from the CNAs.”

**Give the medical director a leadership role**

At The Glen, Brubaker takes an active role in physician education on the appropriate use and correct diagnosis for antipsychotic medications. “Under his direction, one of our geriatric-trained attending physicians has successfully used medications such as Neurontin [gabapentin] for mood and pain management,” said Donegan. “This physician practice has made a significant impact on reducing our antipsychotic medication usage.”

When considering a change from an antipsychotic to a mood stabilizer such as Neurontin, it’s important to avoid simply switching from one psychotropic drug to another, suggested CMS’ Bonner. A “very important take-home” is that The Glen team only switched to mood stabilizers in particular instances where nonpharmacologic measures and approaches had been attempted and failed, she stated.

**Ask for input from OT**

While research on the use of tailored activity programs in institutional settings is limited at this point, one key observation is that this intervention “is implemented primarily by occupational therapists,” said Johns Hopkins’ Gitlin. Often behavioral management teams fail to include OTs. However, “they possess a very specific skill set and training that makes them ideal for being part of the team using a nonpharmacologic approach,” she stressed.

*Editor’s note: Additional resources like the complete slide presentation and a link to CMS audio and written transcripts of the call can be found on AANAC.org in the digital version of this article.*

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- **Hospital Readmissions:** Quality patient care involves avoiding unnecessary hospitalization. Hospitals, nursing homes, and home health agencies are using technology and working together to reduce hospital readmissions and improve care planning for their patients in successful and increasingly innovative ways. This important initiative is one of the advancing, first steps toward longitudinal care.

Technology is our new frontier. As nursing leaders participate in CMS demonstration projects, don’t let information technology challenges intimidate you and silence your voice. Let’s get involved in shaping the emerging technologically advanced health care system. Our future work lives and our residents depend on our contributing to the use of technology in nursing home care.
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- **Multidisciplinary health care teams**—Teams comprising staff from a range of departments or a variety of levels within a department can accomplish more because they exchange ideas and integrate information in ways that individuals cannot. Working together also saves time for those who share responsibility for outcomes.

- **Multicomponent interventions**—Interventions that are broad based draw from risk assessment, intervention techniques, and targeted education and combine these to improve conditions and strengthen processes. (CDC, 2008, p. 5)

Staff at the Mayo Clinic recommend stress-management interventions they call the “Four A’s.” The four As are “avoid, alter, accept, and adapt.” A brief explanation of each follows:

- **Avoid**—Where possible, take control of the environment in order to avoid stress. Stress can be reduced by planning ahead. Don’t take on more responsibility than you can reasonably manage. Organize your day by listing tasks in order of importance. Complete the most pressing responsibilities first, and save the others for later or ask for assistance from a co-worker.

- **Alter**—During times of stress, attempt to make changes that impact your stress level for the better. Communicate by using “I” statements when asking others to change their behavior—for example, “I feel frustrated by this heavy workload. Can you help me balance this?” To manage time better, group phone calls, computer tasks, and other responsibilities as possible. If an individual tends to take up a lot of your time, politely say, “I only have five minutes to cover this, so tell me what I can do for you.”

- **Accept**—There are times when the only response is to accept things as they are. Talk about the stressors with a person you trust in order to relieve the pressure. If experiencing anger at someone, free yourself from it by forgiving the individual and moving on. Avoid negative self-talk and focus on the positive. Learn from past mistakes and accept them as “teachable moments.”

- **Adapt**—Redefine the need to achieve perfection in order to function with less frustration. Stop gloomy thoughts when they occur. Try to reframe the situation by looking at it through another person’s eyes. Adopt a saying to use in tough situations, such as “I can handle this” or “This will pass.” Look at the big picture to put things in perspective. Ask, “Will this matter in a year? In five years?” Viewing stressors from this angle can make situations feel less overwhelming.

Identify the triggers that create stress and take time to develop strategies for dealing with them and reducing the irritation they cause. If unable to successfully implement stress-avoidance factors on your own, seek help from a trusted friend or counselor. Improving time-management skills will reduce the feeling of being overwhelmed. Set realistic time goals and adjust as necessary. Protect your time by scheduling periods dedicated to working on the most important tasks.

Relaxation techniques are an essential part of stress reduction. A typical overachiever will put relaxation low on the list of priorities, so move it up and be good to yourself. Relaxation has a positive impact on physical and mental health and can repair damage previously done by stress. Since relaxation means different things to different people, it should be individualized to make it enjoyable. Practices range from the inactivity of meditation up to the activity of sports participation. The important point is that whatever an individual selects should be a technique that works for him or her, and it should be practiced regularly.

The pace of modern life makes stress management a skill that is needed by almost everyone. Juggling the responsibilities of work, home, and relationships necessitates identifying causes of stress and implementing solutions. Stress won’t disappear, but with practice you can manage stress and reduce the frustration it causes. Sharing tips learned with team and family members is an effective way to improve conditions in the workplace and at home. Their implementation of the tips you have shared is an additional way to reduce your stress!

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**RESOURCES**


Q + A

Is it OK that the physician won’t date the Medicare certs and re-certs?

We have an MD who will only sign and date any document including certifications/re-certs, orders (verbal and written), etc. with month and day only. He never puts the year. I see this as a potential problem if audited. Am I correct in my thinking?

Yes, this certainly could be a concern, if these files were pulled for a Medicare post-payment review. Often post-payment reviews are years later. The month and day of the physician’s signature alone would not show the reviewers that these certification statements were signed in a timely manner.

Carol Maher, RN-BC, RAC-MT
(cmaher0121@earthlink.net)

Is this expensive drug excluded from consolidated billing?

We have a resident with an order for Sandostatin LAR. J2353 is the code I believe. I could not find that it was excluded from consolidated billing, but perhaps I did not look far enough. Question from administration—if the resident goes to outpatient oncology department to receive this drug can they bill separately or are we responsible for charges? If resident goes to physician office to receive med can they bill separately or are we still responsible for charges? I am thinking we are responsible but hoping I am wrong! Can someone point me to the information I need to prove my point? Or set me straight if I’m wrong!

You are absolutely correct! Chapter 8 Section 30.2 of the Medicare benefit policy spells this all out quite clearly! Skilled Rehab is 5 days a week and Skilled nursing must be happening 7 days a week.

Jennifer LaBay, RN, RAC-MT, RAC-MS
(jlabay@hcltdri.com)

Can I delay the SCSA ARD four days because the resident is starting Hospice?

I’m new to all of this so I’m glad I can ask all of you. There was a resident due for a quarterly MDS and she was put on hospice four days after the quarterly was due. So my coworker changed the MDS to a sig change and the ARD was moved from the 92nd day from her last assessment, to the 96th day which made it late. When I asked about it she said well we have a logical reason for it to be late since she went on hospice a few days later. Ummm…. I don’t remember reading that in the manual! Is this true? If so where is that in the manual? Thanks :)

There is no allowance for assessment ARDs going beyond 92 days. The correct course of action when a resident requires a SCSA that can’t be done in compliance with the timing of a quarterly is to finish the quarterly followed by the SCSA.

Judi Kulus, NHA, RN, MAT, RAC-MT, C-NE
(jkulus@aanac.org)

The state accepted my RUG do I still get Medicare default?

Good Morning all. I have 2 situations that I really need help with:

1st situation: I did not do a 30-Dday MDS for a lady because I had to do a COT that covered days 29 – 35, then another COT that covered days 36 – 60. We use AHT and they said I should have done the 30-Day anyway. This is giving us a default code for days 36 – 60. We use AHT and they said I should have done the 30-Day anyway. This is giving us a default code for days

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31 – 60. When I submitted these assessments to the state it accepted the Rug scores that I sent which were rehab scores.

2nd situation: I did a COT on day 6 instead of day 7. It is giving us a default code for day 35 only. The rest of the month we have the appropriate rug score. Again, when I submitted this MDS to the state it accepted the rehab score that I sent.

My question is, how do I fix this to send to Medicare. We feel that since the rehab RUG scores that were sent to the state is different from the default codes that we have to send in to Medicare how is this fixable?

Thanks to anyone that can help with this situation!

AHT is correct. The scheduled assessments are required. You cannot substitute an unscheduled assessment for a scheduled assessment. If that resident is still on Medicare set the ARD today for your late 30-day assessment. If you do not do this late 30-day, those days will be provider liable, not default! AHT is also correct billing one day of default for the early COT. You were one day out of compliance. The fact that the assessments were accepted when transmitted does not mean that there are no payment implications. Read chapter 2 of the RAI Manual for information about the timing of assessments and how to bill late or missed assessments.

Carol Maher, RN-BC, RAC-CT (cmaher0121@earthlink.net)

It is highly recommended that the care planning conducted with and for a resident is personalized. There is no specific regulation regarding addressing the PHQ-9 in part or in whole for care planning.

Can I care plan the PHQ-9 total score or do I have to detail specific mood issues?

I am a SW at a geriatric facility learning the MDS 3.0 manual. My focus is on sections A, C, D, and Q. As a SW who has done many PHQ-9 reports in the past, I generally looked at the overall score first and based on that, made a determination on if a particular question/answer required monitoring or an immediate response taking the overall score into account. Is that the same principle when doing the MDS PHQ-9 or are you required to care plan every trigger regardless of the overall score.

It is highly recommended that the care planning conducted with and for a resident is personalized. There is no specific regulation regarding addressing the PHQ-9 in part or in whole for care planning. That being said, if there are particular items of note in the details of the PHQ-9 that need to be addressed specifically to successfully meet the resident’s needs, then they should be addressed. Use your clinical judgment to specifically, individualize the care plan according to the resident needs and goals.

Judi Kulus, NHA, RN, MAT, RAC-CT (jkulus@aanac.org)

All the articles in this LTC Leader can also be found on the AANAC.org website.