Okay, this is Darlene. I have 2:30 p.m. so I think we will get started and have a few more join us as we go. To start with, let me remind you to press *6 on your phone to mute it so we do not have background noise please. We will have a question and answer period, and so to ask a question or make a comment, you will press #6 to unmute your phone.

In your handouts, there is an evaluation so we ask that you fill that out and complete within the next week. Fax it back to Tami, and her fax number is right there on the back of that form, 785-273-5130.

Okay, today we are going to have Jenna Lehrman speak from Pine Village and after that we will have a question and answer period, and then I will have a few things to run over with you all before we close out the day. Jenna Lehrman RN, is a Behavioral Health Specialist at Pine Village in Moundridge, Kansas. She started her journey at Pine Village in 2011 as the RN neighborhood coordinator for assisted living and memory care. In her current role as the Behavior Health Specialist, she is responsible for overseeing the memory care neighborhood, training staff in dementia care and educating and helping staff with behaviors campus wide.

We found out that they had started using behavior based ergonomics therapy, so we have asked her to share that with you. And so, I will let her take over at this point. Jenna?

Thank you. Good afternoon. Yes, I'm going to go over what BBET is, how BBET works, and the experiences that we have had here at Pine Village since starting this program and where we are headed. First of all, Behavior-Based Ergonomics Therapy or BBET for short is what we call it, was developed by Dr. Bharwani and his daughter Meena at Wright State University in Dayton Ohio. He is an ergonomics professor and also works in the nursing department. There was a facility in Ohio who petitioned him to come up with a program for their dementia care residents to help reduce falls and behaviors. So, they developed this non-medication program designed to reduce and even prevent behaviors associated with dementia.

We know that residents with dementia have difficult changes happening within their brain. With this, they oftentimes lose the ability to verbalize or even effectively communicate what is bothering them or what it is that they need. So as caregivers, we are able to handle stressful situations ourselves and that happens today.

On any given day, we might experience a vacuum running, a phone ringing, somebody telling us important details that we need to know and we are also hungry on top of that. Generally, we can hear what is being said and verbalize what we need to help reduce the stress we are experiencing. The same scenarios for somebody with dementia would likely not be able to verbalize what was...
bothering them, nor be able to problem solve how to fix this. With that, they are raising their stress level, which generally will result in an outward decline of stress, either physical behavior, emotional behavior or something vocal.

Dr. Bharwani, being an ergonomic professor is in the business of reducing stress. So, he developed BBET to help reduce mental stress. By using BBET, we are able to recognize the signs of stress and then we have the tools available to us to reduce this stress. Thus, we enhance the resident’s ability to better understand us and sometimes even better their ability to communicate with us. And when we found this program, that is kind of why we contacted Dr. Bharwani and wanted to bring it here, to help engage our residents and reduce stress.

Pine Village is the first and only community in Kansas that has implemented BBET at this point. Right now, there are facilities all over Ohio and Kentucky.

How BBET works? The purpose is to provide residents access to personalized activities in order to manage their behaviors. Those with dementia do better with personalized interventions for care, identifying clinical versus nonclinical causes for behaviors. There are many reasons why someone with dementia can have behaviors, but staff has to be able to identify whether it is something clinical, like hunger, thirst, fatigue, infection, or non-clinical, which would be boredom, disengaged or dissatisfied with their environment. That would be going back to their room and everybody is moving about, there are vacuums running and they need to go to the bathroom.

With BBET, staff would need to eliminate that clinical cause. They would have to take them to the restroom first, and then address environmental factors causing stress. That is where BBET would come into play. Through BBET, staff becomes trained or dementia experts. They are able to identify telltale signs of a behavior prior to it starting.

They learn to intervene much quicker and even become proactive rather than being reactive to any situation. The wonderful thing about BBET, it is completely customized to each and every one of our residents. So every residents family gives us information about their past and kind of gives us an idea of the tools that we have, what will best suit that person. So it is not a blanket statement or activity for every person. It is just what they like, what they enjoy.

Okay, so why BBET? When we were researching and trying to find activities for our residents and our memory care neighborhood, we wanted to find something that was meaningful to them, but could also help reduce behaviors, even in the medications that we were having to give the residence. We also found that through BBET, this resource center is available 24/7, 365 days a year. No matter what is going on, what day or time it is. These resources are available to our residents 24/7.

Another thing about BBET, it does not require additional staff and does not require one-on-one care while therapy is being used. We did not need to add anybody to work in our neighborhood, and they don't have to spend one-on-one time when using these activities. Residents are engaged in meaningful activities that are of specific interest to them. As residents are more calm and engaged in these specific activities throughout the day, staff were able to focus on tasks but also
help engage residents in meaningful activities. They don't feel as though they spend their entire shift putting out fires or things that come up throughout the day. This, overall, reduces their stress level too. So as we reduce the stress level of our residents and the stress level of our staff, the atmosphere completely changes and it is a much more calm environment and also a peaceful place to live and work.

This is what our resource center looks like. We had a little activity room in our neighborhood that we transformed to our resource center for BBET. The picture on the left is our memory prop boxes. This is what is the most individualized out of the entire program. Because those bright yellow boxes are when you first walk in and in the front are headphones with each resident’s names on it. But behind that is stuff from the past. Whether it be picture albums, magazines, old letters, or even smells, perfumes from the past. We can put that in there, and that can be offered to a resident as a calming item.

To the right of that on the top shelf, the left is the black boxes. Those are our music therapies. So, we have 30 different CDs that are pertinent to that generation. We have things like Lawrence Welk, Elvis Presley, and we also have some Christmas music and children's music.

On the right is the DVD or video therapies that we have. There is also 30 of those. Some of the things that a lot of our residents have enjoyed, the moon landing is one of those. We have sporting events that we can play, cake decorating, cooking, traveling are all videos to choose from in the library. The memory prop boxes, video and music therapy are all considered comforting therapies. So those are things that we would use to one prevent a behavior or to reduce stress for somebody already starting to show signs of behavior.

Below that are the stimulating items. So, we have about 36 different games and items to use for calming exercises. Some of them are puzzles and games and some of them are more tactile items. Those are used for residents that are lower functioning and unable to use puzzles and games because those are beyond what they are able to use at this point.

Staff is trained to know when to use each of the stimulating or comforting therapies. When families come to visit, they are able to go into this resource center if they choose and they can pick from any of the items in there. We have a listing of all of the music and DVD options and they can go in and choose those items and then we have headphones so that they can share and listen or watch the same thing that their loved one is watching while they are visiting.

What you cannot see in the resource center, is a training station that staff can go to and watch training videos required for this program. There is also a podium that holds our DVD players. We use individualized DVD players for the residents when they want to watch a video.

The next slide shows some of our residents and caregivers enjoying the BBET resource center. On the bottom left, this lady, we had a very hard time getting her to take a bath. Using BBET, we were able to in the morning get her up and help her get breakfast and then we were able to start playing Elvis for her. Elvis was her favorite. She could be crying, upset, walking around the unit, and we would put Elvis on her headphones and she would instantly start smiling and dancing, singing with staff.
They were then able to kind of dance their way into the spa room, take the CD out of the personal CD player and put it into the CD player in the bathing room and she would listen to Elvis while she would take a bath. It would help her calm down and do her bathing.

The top middle is the staff member doing a stimulating game with one of the residents. In this game, they were able to pick out a picture and they duplicated it. What is nice about this is that the residents get to choose. Just because there are rules for the game doesn’t mean they follow them.

Staff encourages them to use items in whatever way they can. The bottom right, two of our residents are able to share a video. They are watching something that one of the residents families brought in that he enjoyed watching before. At this lady thought it was interesting, so staff were able to set them both up to watch the video together.

This video shows some prop boxes being used. On the left, this resident was enjoying sorting mail. Family would bring in the junk mail that they would get and put it in his prop box and he would spend, you know hours sorting through that, reading, making piles and deciding who needed what.

This sweet lady on the right has her baby doll. That was as real to her as any baby would be to one of us. She fed the baby, put the baby to bed, she would ask us to babysit when she needed to rest. She loved that baby. When she would start to get concerned or tearful or wanting to leave, staff were able to bring her the baby and talk to her a little bit and would get her through that. She would end up smiling and talking and singing to that baby. It also helped when families wanted to leave, they could bring her the baby and let her know, we will be back to visit so that they could see the baby again and she was fine with that. It was a much more therapeutic transition when the family was leaving, rather than her being tearful and wanting to go with them.

Here at Pine Village, since starting BBET in our memory care neighborhood, we have consistently over the past year and almost a half now have reduced our PRN medications by 47 percent. Staff have the resources and tools to use to find an item or find something meaningful for the resident that they are able to not have to give that medication and they are able to work through a behavior that is happening. But, they have also become experts in determining what a stressful situation is for a particular person and intervening with the BBET therapy prior to that particular situation.

Staff, also if you ask them, they know that they're going to try something from the resource center before they go to that medication. It is kind of a last resort at this point to use medication. They have lots of options and tools if they really want to make BBET work rather than the medication, if they need to.

One of the biggest impacts we have been able to do is that BBET is opening up new possibilities for us. Prior to BBET, staff were uncomfortable with venturing out, especially taking the whole neighborhood. Just this last summer, we were able to take all of our 14 residents to Tanganyika,
which is a wildlife park near Derby. With this, all of our staff members were able to go but we were able to get families to go with us and they were able to share that. Our residents were with their children, great-grandchildren, and even great-great-grandchildren. As staff have learned to use BBET and make the atmosphere more calm, they are gaining confidence and they feel empowered to start venturing out on things that are not in the neighborhood.

And with that, we have been fortunate enough to share that, like I said, with the families. Also, with BBET, the interactions between staff and residents are much more positive. Before, staff were always trying to put out fires, trying to prevent things. Every time someone was at risk for falling and they were getting up, staff were running across the room saying, wait, or no no. So they started associating that with negativity. And as soon as staff were offering them things that they enjoy, like music, babies, games, the interactions and relationships between staff and residents were more positive and that has also helped him going on these trips and outings.

We have a picture of one of our residents with a lemur crawling on him. And to the right we have our residents with families. And we were able to get a couple of our residents to go on a camel ride. And also, a picture of one of the great-great grandsons that was able to enjoy some time with his grandma on this trip.

Families have really enjoyed the BBET program. One of our family members said, “since starting the program, my mother is much more happier and it has resulted in more meaningful visits”. Like I said, it’s sometimes difficult for loved ones to come in, especially when loved ones are unable to communicate and so the visits seem awkward and uncomfortable and are difficult for families. Since BBET, we have a whole resource center that they can go to and maybe they are not trying to talk to each other but they are able to enjoy something together. Whether it be country music or watching a cake decorating video, or even families will bring in DVDs and movies that they can sit and watch together and just enjoy time being together and not feel that pressure to be saying something or doing something all the time.

One of our other resident family members summed it up. Although the initials are hard to remember, the activities are part of the therapy and specific to that person’s need. Specific behavior makes all of the difference between agitation and calm, between fear and security. Her husband could be very anxious, but when staff was able to give him music on his CD player, he relaxes. The scowl on his face becomes a smile. BBET has allowed me, as a loved one, to relax and smile as well.

Some of our caregivers are able to facilitate family visits that have meaningful outcomes. The BBET therapies allow families to be involved in the activity with their loved one. So, kind of like what we talked about. When families come in to visit, CNAs or nurses are able to go to the resource center and show them the available options so that they can share that with their loved one during the visit.

One of our nurses also said that prior to BBET we only had redirection, distraction or medication to prevent or manage behaviors. And now they have specific activities for each individual to get them involved. Since BBET, the residents are much more calm. It has also reduced a lot of medications for residents and they are able to sleep better at night because their days are more
for fulfilling with BBET. And we have seen that a lot.

For some of our residents, they are unable to sleep at night. They sleep during the day and we have resources to use with them thru the night and once they are calm and able to sit and the music or DVDs are playing for them, they are able to fall asleep. Generally, they sleep through most of the night.

That is the end of the presentation. So, I can open it up for questions now.

Okay, thank you, Jenna. This is really interesting information. If anybody has a question or comment, you can press #6 to unmute your phone. I have a couple of questions. I was wondering if you could give us an idea of the cost of implementing this program.

With that, I am not terribly familiar. I can't tell you an exact cost because I don't know. But from talking to management team and administration, it was much more affordable than anybody had anticipated or what they thought when we first heard the presentation presented to us here at Pine Village.

Okay. So did you just have to get the training from the people who started this? And then you provided your own supplies and stuff, I am assuming?

Actually, no, part of the set up that they do or implementing this program, they provide a lot of support. They come in and order everything and set everything up. They do initial training with staff and give us the dementia care videos to become those dementia experts and they provide one-on-one training with staff initially to get them trained in the program. And from there, like I am the coordinator here at Pine Village, I can go and train future staff on the program.

That's great. So, how long did it really take you to get implemented to where you felt like you had it going?

Really, it was immediate. They visited in July, and by March of the next year, they had the resource center set up and we started going and since then, we have consistently been using it. Staff were excited and ready. We did a lot of gearing up and getting excited about it. So once it was actually implemented and they have been using it consistently since day one.

Great. Does anybody else have any questions or anything for Jenna?

No? Okay. Jenna, can you pass me the ball?

I have a question, Darlene. I was wondering how they got a hold of the company to get the program started?

Originally, it took some work. There was not a whole lot of information out there so I had to use a bunch of resources. I e-mailed Dr. Bharwani and Meena to get their preferred contact information. So I can get that to Darlene if anybody wants that information, as soon as I have it I will send it to her.
Okay, thank you.

Great. Anybody else?

I have a question. Do you have boxes individualized for each patient? How do you get that information on what to put into those boxes?

Families will fill out a personality profile for those memory prop boxes. With that, they bring stuff from home. As far as CDs and DVDs and stimulating items that we use, from the information family gives us we pick out of the library what would be most appropriate or pertinent to that person and then we have an action plan that is very easy to use. It is just coded, we walk into their rooms and if they love country music, all we have to do is look at their action plan, it will say M4, staff will grab that CD and takes it to the resident.

Okay, thank you. One more thing. Did the company give you that personality profile, the form for the family to fill out?

Yes. They are very thorough and anything you need, they have and probably have already thought of.

Okay, thank you again.

Anybody else have any questions? Okay, if not, we will go on with the rest of the things I need to bring up and if Jenna is still on the line we can ask questions if we need them later. I just need to run over a few things about some upcoming things and some progress on the quality care collaborative. I can't even think here today. You would think it was Friday.

One thing, since we were talking about BBET, I ran across something called SAIDO, which stands for Smart Aging Intervention, Do Learning. I don't know a whole lot about this. The definition is there on your screen. And I know that it involves research. They are doing research about using this type of learning which originated in Japan, I believe. But, it is trying to use this type of learning to enhance dementia residents and their ability to maintain their communication ability and their personal independence.

The reason I bring it up now is simply because I saw that LeadingAge is having their leadership conference and it is in November at the Meridian Center in Newton, and they're having a session on SAIDO if anybody is interested. I don't know how many of you are LeadingAge members, but they do allow nonmembers to attend sessions as well. So you can go on their website and get information about that. I just thought I would bring that up to you as another possible resource for another way to increase the quality of life for our dementia residents.

The other thing I wanted to talk a little bit about today is the AP, antipsychotic measure. We have been talking about antipsychotics forever, it feels like, I am sure. And I'm sure that some of you are getting sick of hearing about it. But, we still have some work to do in that area. The original goal of CMS was 15% relative improvement. And so, that has not been reached even
though that was the goal for December of 2012. They are currently at about 9 percent relative improvement. Kansas however is only at about 7.6. So my concern is what does Kansas need in order to make more improvement in this area? I have visited with many of you on the phone and as we are doing the dementia care training and I visit with those people at that point as well. And some of you have done wonderfully and made great progress. Some of you have not and seem a little stuck. So I just thought I would present some data and talk a little bit about what is going on and see if we can figure out if there is anything else you need for you to be successful.

This particular slide, I looked at the data that we have. And I compared the entire state with those of you that are participating in our quality care collaborative, and then the rest of the nursing homes in the state that are not participating. And so you can see that those of you that are participating are doing better by a fair amount than those that are not. The entire state average is about 24 percent or so. And then the non QCC homes are higher, at about 24.6 percent or so, and those in the collaborative are down to 22 percent. So that is marvelous and you might say what am I worried about? I am wondering why we can’t be even better.

Kansas has always been one of the better states as far as improving quality measures, so I would like to see us continue that. This is another way to look at it and this is just comparing the QCC homes to the other Kansas homes. And this is the last three months of data that we have. So, it is May, June and July of 2013. And as you can see, the green on the left hand side is the latest data, July 2013. And that actually is down to 21.47. So we are continuing, in fact last month we made a nice little jump downward, which is great. The rest of the state is improving but at a much slower rate and obviously much higher rates to begin with.

One of the things, when I talk to different homes particularly when we are doing the dementia capable care training, I ask who is on your team and what kind of process do you have in place? My concern and this is my biggest concern as far as this whole process is concerned, is that the process really is not there. You have steps that you are doing and you may be making progress. But, one of the things that we need to focus on is the QAPI issue, which of course has not become a rule yet. But when it does, one of our goals is that you are ready for that. You won't have to stress about it when it becomes a rule. Many times, what I see is that the pharmacist makes a recommendation to reduce the dosage of a drug or to discontinue it and either the doctor agrees to it or says no. And that is the total process.

And what I would like to see is that you establish a team and throughout this whole collaborative, we have encouraged getting staff on your QA/PIP team. It should not just be the administrative type staff. Part of QAPI pulls in all of your staff, not everybody, obviously, but it pulls in all different levels of staff to work on different pieces of your quality program.

So for the AP situation, I would encourage you to use a floor staff nurse whether it is a charge nurse or even a medication aide, to be part of this group. And obviously the pharmacist is a part of that group as well. Explain to your physician what you are doing, meet and basically what you are going to do is look at each resident. You're going to determine what that resident is on and why.

And there is a page, and I have forgotten where it is. But, there are several resources that you can
use. But, this next slide shows you an algorithm, and we have this in your handouts. But, we have also printed this and had it laminated. We will be mailing this out to you along with other resources that I will talk to you about in a minute.

The thing that you need to think about is what is the process that you go through in order to make improvement? And right now, we are talking about AP meds, but we could be talking about falls or anything else. Before I go further, let me explain the algorithm for treating BPSD, and if you have forgotten what that means, that stands for behavior and psychological symptoms of dementia.

So in all of the training that everybody has been doing over the past several months, and probably a year now, we have talked about behavior and what that means. And basically, you should understand by now that behaviors of any kind are a way of communicating an unmet need. Because many dementia residents cannot verbalize what they need at the moment, that comes out in different kinds of behavior.

So, the first thing that you would do is to review each resident individually that is on a medication and determine what was the behavior that caused them to be put on the medication? Then you would look at what might be the source of that behavior and when does that behavior occur, how often? Try to determine what that trigger might be. Also on the MDS, you have to use the BINS score. So if you use that, you have to look at what that score is. There are other assessments that you might use instead or in addition to. Find out as much as you can about that resident. Kind of like Jenna was talking about as far as, you know, what kind of memories they have, what kind of work they did. What are their likes and dislikes as far as food and colors and activities? So that you get the best knowledge that you can about that particular resident.

Once you have determined that information, and there are a couple of assessment sheets on our website, review that type of information for each resident. Once you have done that, you would look at this algorithm and there are three steps involved. Step one is simply saying, you're going to try to identify contributing factors. So, there are four areas that you look at whether it is physical, psychological, environmental or psychiatric. And determine what kind of behavior or what the behavior is trying to tell you. And of course sometimes, this is kind of like being a detective or a sleuth. You have to figure out and sort of investigate trial and error kinds of things to figure out what the source of the issue might be. Generally we encourage you to start with physical things, like pain, hunger, thirst and that sort of thing. Those are the easiest to satisfy and the quickest to respond to.

Step two would be selecting and applying nondrug interventions. Based on the type of the problem, the person and what they're doing, you begin to look at what you might be able to do instead of giving them a pill. So you want to meet their needs without giving them drugs, basically what you have heard us say for many months now. There are basically two areas to look at with that. You can adjust your caregiver approach. And that means how I am responding as a caregiver, how I am responding to that individual when they have a particular behavior.

If I get a little anxious or hurried, does that definitely affect how they respond to me? And we know that it will. Another area is the change in the environment. And we have talked about this
many times as well. We know that alarms and overhead paging and all of that can be very disruptive to a dementia resident. It confuses them, they can’t figure out what it is. It makes them anxious and uptight generally. So we encourage them to get rid of that sort of thing.

Sometimes different particular pictures or something may just be disturbing to some particular resident. So, it is a mystery that you have to solve, in a sense. And then on the right-hand side of this, it shows you evidence-based interventions. And, some of them are things that Jenna talked about before. Like the kind of music that they like, the kind of TV shows they like, activities that will interest them and so forth. The third step is to simply monitor that and see if the intervention that you chose is actually working.

Another thing that you have heard us say repeatedly during this quality collaborative is that you should do PDSA cycles; plan, do, study, act. What I just described is exactly that. You figure out what the problem is, figure out the best plan to intervene in that particular problem and then you carry that out. Then you look to see if it worked or if it did not work.

If it became better but not as good as you would like, then you can adjust the intervention, alter it somewhat, and start over. And you plan the next step by changing what you have done. Carry that out and once again, look at that and analyze it and see if it works. Now, we generally do this all the time, in a sense. You know, we try something that does not work, so we try something else. The difference is that we are going to actually document in some fashion the PDSA cycles that you have gone through. One of the reasons we do that is so that you do not start repeating yourself. And so that you can look back and see the progress you have made or if someone new comes along that they don't try something that you have already tried and determine that it didn’t work.

So, you simply move your process along faster. Let's see, here. As I mentioned, we will be mailing a laminated copy of this out to you in the next week or so. Another thing that we have developed and have laminated for you are what we call our dementia care cards. Some of you have received a sample of these already, if I have been out to your facility to do the dementia care training. But, we will mail everybody else a couple of sets of these. There are six laminated cards on a ring, and they have a step-by-step approach for dealing with behaviors. And so they talk about things like the difference between dementia and delirium and how you determined that and make that assessment. They also talk about the different types of behavior problems and how you can address that. They talk about the different drugs and which drugs can cause delirium or problem behaviors and so forth. So, that will be coming to you as well.

Another thing that is in your packet is simply a three-page tool that talks about different things to do besides drugs for the behaviors that you may see. This particular one divides interventions into different categories, based on the type of behavior. For example, I think the first one on the page is if they are resisting care. So, something that you can look at in the environment, there is actually two columns under each side. One side is the environment and one side is more clinically related. So you can look at these and determine, figure out which ones would work best for your particular patient.

Once again, you may have to do several PDSA cycles to figure out what is going to be best. It
lists a variety of interventions that you can try instead of medication.

I might mention at this point, one of the other things I am still hearing from some facilities is, oh we have a diagnosis for everybody that is on a medication. Well, that is not good anymore. I know we used to do that, but simply adding a diagnosis of psychosis with behaviors is not going to fly anymore. If they have dementia, the only thing these drugs do for that dementia resident is make them drowsy. So, they may not be acting out anymore, but they are probably not doing a lot of other things either. And they can also be detrimental as far as the physical aspect of the individual. So, I think the average is one in 25 will die from use of an antipsychotic. That can be because many times they have developed pneumonia and got an infection or something. But it also decreases their mobility rate and cognitive ability simply from the drug. This particular tool is also in your handout. On the top on the right hand side, you see a list of medications and on the left-hand side is a list of the major side effects, from these drugs. Then the yellow and red areas, the boxes tell you whether it is a high risk for that medication, a low or medium risk. So, if you have anybody on those meds that are listed, you can simply look at that and say, these are the things I should be watching for for this particular resident. Ideally, you should be figuring out a way to back them off of the medication. But certainly, in the meantime, you should be looking at making sure they're not developing any of those side effects. In doing this work, we have also heard of lots of fabulous incidents where residents basically woke up after the meds were stopped and they have had some time to come back to their selves and they began talking or walking or feeding themselves or things that they have not done for some time. In the end, basically if we are trying to do resident centered care, or person centered care or culture change or whatever you want to call it now, you can't do it if you don't have the best quality for that resident. And taking them off of these antipsychotic meds is going to be a step in that direction.

One other thing that we want to mention is what CMS is now calling a composite QM score. While you have it in your packet, it will also be coming out with your information as well. CMS decided to look at whether this collaborative is a successful way to make improvements. And what they have done is adding your denominators and numerators for the different measures, and coming up with a composite scores based on that. The second half of this sheet basically tells you how they calculated it. So, they have looked at this and it is not replacing the Five Star system or anything else. In fact, probably only the people in this collaborative will hear about this at least to start with, unless they move forward with it beyond that. But, they have looked beyond this and determined that a score of six would be good.

What we have is I have a list of all of the homes, and I have a list of your composite score, and I'll be sending that out to you as well. This graph shows the composite scores for Kansas versus the nation. And this six here is the goal of CMS. That is what they would like to see people or homes get down to. The blue is Kansas and the red is a nation. As you can see, Kansas has pretty much stayed basically where they are. Each of these dates is six months’ worth of data ending in that month. So, I don't have the national data for the month of July, yet. But basically the scores for Kansas range from 9.43 - 9.54. And the score for the nation are 9.42, but have gone down to 8.97. So the nation as a whole is making progress. I feel like the people in the homes in quality care collaborative are making progress as well. I just wanted you to be aware of this and have the opportunity. Basically what it boils down to is that the better your QM scores are, the better your composite score will be, obviously. So, we will be sending some more information out on that.
Another resource that I wanted to mention is called the Neuropsychiatric Symptoms of Dementia, a Visual Guide to Response Considerations. This book, this is what it looks like. And it is spiral-bound at the top, and it will fold out of the bottom and expand out for you. It was written by Michelle Niedens, and she is a director of education at the Alzheimer's Association and you can order this book from them for $20, plus shipping and handling. This is really a great deal. I know that some facilities have this already, and the Alzheimer's Association does do some education in facilities and sometimes they give those out at that point in time. But, I will put the phone number and the contact information there on your slide, if you're interested in taking a look at this.

And basically, this just looks at the different kinds of behaviors and, how you can address those. This is another resource as far as dementia and nursing home resident. One last thing I want to mention is in the process of the quality care collaborative, there are a couple of things that we have asked you for as participants. If your name is on this particular slide, it means that I do not have any confirmation from you as far as what topics you are really focusing on. Now, everybody is supposed to be working on antipsychotic meds. Some of you have done work with have already and have proved. But, we also ask that you look at one other thing besides that. So if your name is on here, would you please give us a call or else just send me an e-mail telling me what you are working on? And what you have done. That would help us tremendously.

We have deliverables; they are called deliverables that we have to turn into Medicare CMS every so often. And we have one coming out the end of October and we have to tell what topics you have chosen, what you have accomplished, you know, what processes you have in place. If we don't have that information from you, we simply report it as not having done anything, which isn't necessarily true, as far as you are concerned but we have nothing else to base it on. So that is why I'm pleading with you to give me some information here.

One other form that we have to have you complete is what we call a QAPI self-assessment form. Many of you have done this but these people on this slide have not. I am asking that you can complete that. It can be found on our website; it can be found in the QAPI booklet that we sent to you called QAPI at a Glance. It is in there. For a while, we had it on survey monkey, so you could complete it easily that way. It is no longer there at this point in time. But, you can fax the paper copy to us. We would like you to complete it as soon as possible. We would like to report at the end of October that we have everybody's in that point in time, if at all possible. If you have questions or concerns, please call the office. Brenda or I are usually available. Dana can answer some questions as well. So, she is always here as well. So we need to make sure that we are moving ahead in giving you credit for, the work that I know you're out there doing.

Do you have any questions for Jenna or myself? You can unmute your phones by pressing pound six.

[ Pause ]

Any questions? Comments? We have talked at different times about a falls webinar or workshop anything, and we are in the works of planning that and that should be happening very near in the
future. As I mentioned, we really need to know if we are not giving you what you need to improve this. So, please let us know if there's something that you need help with. We try to call periodically touch base with you. Some of your hard to get a hold of than others and I understand that. So if we don't reach you, please give us a call.

Also, I want to remind you to please complete the evaluation that I mentioned earlier and fax back to Tami within the next week or so if at all possible. Anybody have any other questions before we sign off?

I want to thank Jenna again for giving us the information and sharing her journey through BBET. It sounds like a wonderful intervention you've accomplished.

Thank you.

Thank you all for joining today.

[Event concluded]