NEWS & VIEWS

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Med-Net Concepts, LLC

Providing Person-Centered Care for Residents with Dementia

By:
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Dementia is the term used to describe a progressive, cognitively-impairing condition that is mostly untreatable and ultimately terminal. Dementia profoundly affects a person's memory and emotions and the ability to speak, plan, learn, reason, and eventually, perform everyday tasks.

Historical Thinking About Dementia

Egyptian "psychiatrists" around 2000 BC are believed to have been the first ones to document the concept of dementia. Since that early identification as a debilitating condition, dementia has been characterized in many ways. For example, in ancient Greece and Rome it was considered a normal and inevitable aspect of aging, and no one was immune.

Many well-known historical figures spoke about dementia. Hippocrates, considered to be the "father of medicine," labelled what he described as the deterioration of the mind due to aging as "paranoia." Influential Greek philosophers Plato and Aristotle considered mental and cognitive decline an "unavoidable consequence of age." The Roman philosopher Cicero suggested that an "active mental life" could delay or put off declining cognitive ability. The highly influential Roman physician Galen, whose writings were very influential in the 2nd century A.D., used the term "morosis" to describe dementia. He considered dementia a mental disease and indicated age was one of the contributing factors.

During the Medieval age, almost no science and research occurred because of an intolerance and discouragement of such activities expressed by the Church and other religious sectors. The 17th and 18th centuries opened the field of anatomical pathology due to the growing acceptance of the exploration of the human body through dissection. Scientists were able to observe cerebral atrophy along with other changes due to disease and age.

In 1797, this cerebral atrophy was named "dementia" by the French psychiatrist, Philippe Pinel. The word dementia was derived from a Latin term that means "out of one's mind." Pinel is credited with advocating for more humane treatment of persons suffering from mental disease, including dementia. Until the 19th century, people with mental diseases were placed in asylums and treated very badly.

Some Dementia Characteristics and Classifications

Different forms of dementia have been identified based upon the type of changes or the location in the brain where the impairment occurs, and some forms are associated with different medical conditions, Dementia associated with meningitis, thyroid impairment, nutritional deficiencies, and alcohol abuse, can often be reversed if the cause is identified early enough. Dementia related to Alzheimer's disease, however, and some other dementia forms are considered to be terminal.

Alzheimer's Disease is the most common cause of dementia with an estimated 50-70 percent of dementia diagnoses being attributed to it. Some other types of dementia include:

- Vascular dementia
- Lewy body dementia
- Frontotemporal dementia
- Dementia associated with Parkinson's disease
- Huntington's Disease
- Creutzfeldt-Jakob disease (also known as "mad cow" disease)

Dementia in all of its forms knows no boundaries. These 2018 Alzheimer's Disease Facts and Figures illustrate the growing global impact of dementia in both cost of providing care and the numbers of people with the disease-

- Nearly 10 million new cases of dementia are diagnosed every year-one every 3 seconds.
- 50 million people worldwide are living with dementia-a number expected to triple in 30 years.
- Total estimated cost of dementia worldwide is $1 trillion-expected to rise to $2 trillion by 2030.
- If the cost of providing global dementia care were a country, it would be the 18th largest economy in the world.

The Centers for Disease Control and Prevention (CDC) reports that 47.8 percent of residents living in long-term care facilities have a diagnosis of some type of dementia. Other statisticians indicate that the number may be as high as 60 per cent.

Need for Long-Term Care for Residents with Dementia

The care needs of an individual with dementia, whether it is due to Alzheimer's disease or another cause, depends upon how advanced the cognitive impairment has become, and the symptoms being displayed.

Dementia can affect different areas of the brain and the symptoms that are displayed depends on the areas affected by the disease. For a person to be diagnosed with "dementia" it usually requires significant impairment in two or more of the following areas:

- Difficulty communicating and using language
- Difficulty concentrating and paying attention
- Difficulty with judgment and reasoning
- Difficulty with visual perception
- Memory problems

Persons with Alzheimer's disease and some other forms of dementia may also exhibit difficulty performing routine tasks, changes in behavior, and behaviors like these:

- Disinterest in things they previously enjoyed
- Mood changes that include increased aggression and irritability
- Social withdrawal
- Difficulty sleeping or a change in sleep patterns
- Delusions and/or hallucinations
- Depression
- Difficulty finding their way and increased wandering

Most people in the earlier stages of dementia are able to function and remain in their home-especially if there is a caregiver living with them. Unfortunately, tasks such as running errands, buying groceries, paying bills, and housekeeping can soon become difficult to perform because they require more memory function and planning.

Living in an assisted living or a memory care facility may allow some individuals with early to middle stages of memory loss some independence due to those facilities having 24-hour staffing.

The ever-increasing cognitive impairment tends to raise the amount of help a person needs with the activities of daily living (ADL)-eating, bathing, dressing, mobilizing, and toileting. Also, the tendency for a person with dementia to forget to eat and drink may cause them to become malnourished and dehydrated. Decreased appetite is also common with dementia.

The memory loss and impaired judgment involved with dementia makes it essential that a person have a caregiver administer his or her medications and make sure that the individual actually takes their medications and does not pocket them or place them somewhere else.

Some behavioral changes in individuals with dementia are very distressing and difficult for families or a caregiver to manage. They are often the reason a family or spouse will decide to place that person in a long-term care facility. They often include the following:

- Development of delusions-believing something is true that is not or that an event happened when it did not
- Hearing, seeing, or feeling sensations that are not real
- Frequent wandering
- Emotional outbursts including crying
- Personality changes like anxiety, depression, and/or irritability
- Increased agitation
- Repetitive behaviors such as rummaging, tearing tissue or paper, looking out a window, yelling, or shouting
- Disturbed sleep

Long-Term Care Facility Requirements for Providing Person-Centered Care of Residents with Dementia and Alzheimer's Disease

The Centers for Medicare & Medicaid Services (CMS) has moved person-centered care from just being a best practice to a matter of policy position. To that end, CMS issued these statements regarding changes in regulations:

"...Facility staff members must implement person-centered care approaches designed to meet the individual needs of each resident."

"...Competency involves staff's ability to communicate and interact with residents in a way that promotes psychosocial and emotional well-being, as well as meaningful engagements."

"...These reasonable accommodations may be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preferences."
(§483.35 Nursing Services: F725, F726, F727, F728, and F729; §483.21 Comprehensive Resident Centered Care Plans: F656, F657, F658, and F659; §483.24 Quality of Life: F675, F676, F677, and F679)

Restrictive Pharmacological Interventions

CMS regulations no longer allow the use of pharmacological interventions in place of a person-centered care plan. CMS issues these statements regarding this directive:

"...The intent of this requirement is that the facility implements gradual dose reductions and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication."

"...'Behavior interventions' are individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical, or psychosocial wellbeing."

"... 'Expressions or indications of distress' refers to a person's attempt to communicate unmet needs, discomfort, or thoughts that he or she may not be able to articulate. The expressions may present as crying, apathy, withdrawal, or as verbal or physical actions such as: pacing, cursing, hitting, kicking, pushing, scratching, tearing things, or grabbing others."
(§483.45 Pharmacy Services: F755, F756, F757, and F758)

Effective Interdisciplinary Care Approach

Effective person-centered care requires staff, residents, and family members to participate together in an interdisciplinary care approach. CMS describes this way:

"...Providing behavioral healthcare and services is an integral part of the person-centered environment. This involves and interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities."
(§483.40Behavioral Health Services: F740, F741, F742, F743, F744, and F745 and §483.24 Quality of Life: F675, F676, F677, and F679)

An example of a facility's non-compliance regarding the lack of interdisciplinary care approach involved a scenario provided by CMS about a resident who had incidents of repeated elopement. While the elopement attempts were documented, there was no documentation regarding the resident's underlying anxiety that motivated his elopement attempts nor was there any effort to treat it. Consequently, the resident's behavior increased until he sustained an injury as a result of an elopement attempt. The resident's physician noted that even though the facility had an "interdisciplinary care team" in place, effective collaboration did not occur causing a failure to intervene and prevent the resident's injury. Just having a care team is not sufficient. CMS is requiring care teams to be assessed and evaluated regarding how successful the teamwork is among care partners.

Adequate Staffing

CMS describes the importance that adequate staffing plays in providing person-centered care with this statement:

"...The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population."(F725 Sufficient Nursing Staff)

Training Requirements

Within the training requirements for staff under §483.95 a facility "must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e)."

These topics must include the following areas:

- Mandatory communications training for direct care staff
- Rights of residents and a facility's responsibility to provide proper care of residents.
- Freedom from abuse, neglect, and exploitation that includes:
    - What activities constitute abuse, neglect, exploitation, and misappropriation of resident property.
    - Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.
    - Dementia management and resident abuse prevention.
    - Behavioral health training that is consistent with the requirements at §483.40 and as determined by the facility assessment as required in §483.70 (e).

Additional information that may be useful: Med-Net Academy Module-Dementia Management: Dealing with Challenging Behaviors.

Resources:

1910 Naming the Disease Alzheimer's disease;
https://worldhistoryproject.org/1910/emil-kraepelin-proposes-naming-new-disease-alzheimers-disease

2017-06-15 Dementia Care Presentation;
https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-06-15-Dementia-Care

Alzheimer's Facts and Figures 2019;
https://www.alz.org/media/Documents/alzheimers-facts-and-figures-2019-r.pdf

CMS Training Requirements for Long-Term Care (LTC) Facilities;
https://www.mylearningnurse.org/pluginfile.php/23/mod_forum/attachment/2/Nursing

Dementia Care in Aging Services;
https://www.ecri.org/components/CCRM/Pages/ResCare17.aspx

Do your care staff have the training they need to fulfill these CMS requirements?;
https://www.crisisprevention.com/Blog/July-2018/Fulfill-CMS-Requirements-With-Training

Encouraging Comfort Care;
https://www.sralab.org/lifecenter/resources/download-encouraging-comfort-care-guide-families-people-dementia-living-care

History of Dementia: When did it start?;
http://dementiatalk.net/history-of-dementia-when-did-it-all-start/

Improve Quality of Life by Embracing Non-Pharmacological Behavior Interventions for Dementia Care;
https://www.crisisprevention.com/Blog/July-2018/Improve-Quality-of-Life-by-Embracing-Non-Pharmacol

Long-term Care for Alzheimer's and Dementia;
www.familyassets.com/alzheimers-dementia

Medicare & Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency;
https://www.cms.gov/newsroom/fact-sheets/medicare-medicaid-programs-requirements-long-term-care-facilities-regulatory-provisions-promote

Federal Requirements & Regulatory Provisions Relevant to Dementia Care & The Use Of Antipsychotic Drugs;
https://theconsumervoice.org/uploads/files/issues/ltccc-antipsychotic-drugs-oversight-ftags-2.pdf

National Partnership Dementia Care Resources;
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-Dementia-Care-Resources

When Person-Centered Care Becomes Policy;
https://www.crisisprevention.com/Blog/April-2018/When-Person-Centered-Care-Becomes-Policy

"Med-Net Compliance's Fraud Avoidance Courses Are a Good First Line of Defense"

Jo Ann Halberstadter, Esq

ADMINISTRATORS TAKE NOTE

Med-Net Compliance, LLC now offers two series of fraud modules with NAB/NCERS CEs on our website. Modules 1-8 offers 3 NAB CEs and modules 9-16 offer 3.75 CEs. All modules provide education on fraud, waste and abuse prevention and offer a combined total of 6.75 CEs for successful completion.

To review the NAB Approved courses visit our website:
https://www.mednetcompliance.com/med-net-academy/nab-approved-courses/

All 16 courses on fraud, waste and abuse were developed by Betty Frandsen,
our Vice President of Professional Development and her staff.

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