

CMS 2010 Regional PACE Conference

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TRANSCRIPT

Care Planning

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The guidance. We were supposed to have a presentation on the guidance during one of our user calls earlier in the fall, and that didn't happen. We will have a detailed discussion of the guidance on an upcoming national user call if all goes well in January. So I'm just striking some of the high points and laying a framework here for what this real life experience to come.

What's critical to the care planning guidance is our interdisciplinary team. It's unique to PACE and it's really what makes the care planning program work. It also is part of, for a physician, for a clinician, this is, the care planning program is, it's just phenomenal for me. Ideally we want to be able to look at the patient holistically, and that's what the care planning guidance allows us to do. Hopefully. These are the pieces that we expect to have assessed, and I think, you know, clinically, we frequently have the medical assessment and the functional status. Those, you know, that goes without saying. But as the clinician, there's a lot more that I'd like to be able to address, and frequently there's no time to get into the social, psychosocial or cognitive needs of the patient. But that's critical, frequently, to what's going on in everything else. So we're fortunate to be able to do this.

Uh oh. We're getting a little carried away here. Let me go back. The few things that I just want to highlight here. The care guidance, the care planning guidance, is really, the third bullet here, it's really to help, again, the PACE organization, your interdisciplinary team, to help assess and reassess and reassess and reassess. That's important for these patients. That's the key to what makes being a PACE patient very special. Unlike in Medicare Vantage World, the special needs plans are struggling to say why are we special, and we're working with them to show that they are special. We don't have to work, we don't have to prove to the world that PACE is special. If you're a patient in this PACE program, it's already clear. You already know that you're special. We already have all these unique tools. Ultimately, again, the goal is to improve the patient's quality of life, the health outcome and quality of care.

My favorite picture. I think all of us know who the members of the interdisciplinary team should be, and this is just to let you know that I know too. But it's also to highlight the fact that the interdisciplinary team is not comprised of only clinicians because for our PACE patients, the van driver, the PACE center director, personal care coordinator, those individuals play a key role as well. They're not necessarily a part of the medical assessments and reassessments, but believe me your van driver can really assess that patient for you. How many of you, we heard about the soccer mom, how many of you are carpoolers? Have driven carpool? No? Okay. Me too. How many times have you been driving that car, a car full of kids, especially the teenagers. That's, that's the one. To them, all of a sudden you're invisible. I can't tell you the kinds of things I have learned from my children and their friends while I'm driving the car. Sometimes I want to just go – and stop right there. Sometimes I've had to intervene in the conversation. But most of the time I just listen and when I get my two boys home we have a

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discussion about that conversation in the car. So it's the same thing. The van driver will hear things or see things because no one's expecting him or her to be paying attention.

But if, if that van driver has been educated to the importance of his or her role on the IDT, then he or she will be paying attention and will be able to provide the clinical team with some very good information. Maybe Ms. Marsha just got on the van this morning and said, and he said good morning Ms. Marsha, how are you? Uh, not too good today. And he just says okay, well hope you're feeling better, and gets her seated. But then when he gets to the PACE center, he lets the staff, the clinical staff know, Ms. Marsha wasn't herself today. And that might be enough, it should be enough, for one of the clinicians to say Ms. Marsha, come, let's have a chat today. I want to talk to you about something and see how you're doing. And she may open up and let you know. You know, it might be something very small. Maybe she didn't get a phone call from, you know, relatives. Or maybe yesterday was her birthday and nobody remembered because she lives alone. Who knows. But whatever it is, clearly it could have an impact on her health. And on her well being. And it may even have a longer impact. Maybe this is the needle in the haystack. Maybe it's the beginning of depression or something else. So that van driver plays a critical role in how we care for our patients. So I don't want us to overlook that, that role in our care planning guidance. It's a team approach. And even though there's only eight members who do the clinical assessments, don't forget the non-clinical members of the team.

These are some of the roles that we have and that are identified in the care planning guidance, but I only want to bring your attention to one bullet. And I've mentioned this already, and you'll probably hear it again from me. It's, it's something I feel passionate about and I don't want us to forget. We are responsible for delivery of care twenty-four hours a day for our patients. That's it. Twenty-four seven. Before going, going back into, sort of CMS, I spent six years in emergency preparedness. And emergency preparedness was twenty-four seven. We cared for the state twenty-four seven. Cared for the federal, the nation, at a federal level twenty-four seven. Well, same thing. Our PACE patients get twenty-four seven care.

The other thing that's critical here is, especially in areas of rural PACE centers or other areas that might not be rural but may not attract or have to utilize contract staff, that contract staff needs to be held to the same standard that you would hold any other member of the team. Rural PACE uses a lot of community-based physicians and providers. I'm sorry folks. Those providers have to meet the same standard that I would have to meet if I worked in the PACE center. What's important about that? It's because do you want to be seen as delivering different tiered response and healthcare? No. You want to be able to say the quality of healthcare is the same whether it's being delivered by one of our contracting physicians or it's being delivered by a PACE provider who is on staff. You don't want to have a two-tiered system. You don't want patients to feel like if I get seen by Dr. Davenport, she's not going to spend any time with me, she's only here two hours and she's not interested in me. We don't want to hear that. You know. We want to hear oh, Dr. Davenport may only be here for two hours but I know that she's going to evaluate me and the patient and the patient's family will be happy with the care that I give the two hours that I'm there.

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The care plan covers the spectrum. It covers the patient whether or not the patient's at the center or, remember, twenty-four seven, in the hospital, in the nursing facility. Wherever the patient goes, that care planning process continues. So if you have a patient who's been admitted to the hospital, then that care plan starts to evolve and change as part of what's happening to that patient in the hospital. There should be some communication with the IDT and the hospital staff. We shouldn't have issues of transition of care like we have sometimes in Medicare Vantage. And part of it's because we have difficulty in Medicare Vantage, although we're working on it, connecting, when a patient goes into the hospital, connecting with the hospital list and making sure when that patient's discharged that the nurse case manager in the SNIP or the MA plan is able to connect the dots there. That doesn't always happen because of the way the system is designed. But PACE should not have that problem. That's our job. When the patient goes in the hospital, just like my patients went into, unfortunately, went into the surgical intensive care unit, I had to follow them and make sure. We have to do that. We can't lose that transition period to make sure that on discharge that our patient gets everything that he or she needs.

Okay. The health assessments. We have kind of four standard types and then we have the home assessment. And I'm going to go through these quickly. We should be familiar with them but I know that it gets, it gets tricky with them. So most important thing is that as soon as we know a patient's being enrolled in PACE we should get them in for that assessment. I can't tell you how many nights I wouldn't be able to sleep if I had a new patient come into my PACE center and I don't know this patient. I don't know what his or her clinical needs are. Here I have Ms. Marsha again, and I don't know what her health status is. What am I going to do? What happens if she has, you know, a diabetic event and I didn't even know she was diabetic? That she should have been on this medicine. Or, you know, she has heart disease. Or maybe something, I won't say small, but just, you know, she has high blood pressure and it's been undiagnosed to this point. So the key is we, as part of our care planning, we need to get to those patients as quickly as we can and make sure that we understand what's going on with their health and health status. Ideally, if we could, you'll see in the next slide, if we could get to the patient on pre-enrollment, we know the patient's coming and we get to conduct the assessment, that would be great. And I hate to say, you know we're calling these assessments, again, it's the clinical model. So basically I'm talking about histories and physical exams. Right. That's what we're talking about in these assessments. But the thing for us that allows us to have a little more latitude is that under the PACE model it's not just the history and physical exam, it's a detailed history, it's a detailed physical exam, it's a detailed discussion about your psychosocial and cognitive and personal needs. We also need to do it, once a person's in there, within a month. That's, as far as I'm concerned, way too long. But that's the guidance. Just keep that in mind. It's way too long.

These have to be done in person. You might, as you do the history and physical, as you do the assessment, you might decide that we need to have a specialist. Maybe, you know, again, Ms. Marsha has respiratory disease but maybe she really needs to be referred to a pulmonologist and get this asthma or COPD or whatever's going on under control, so that's fine. We can do it. We need to do whatever we need for her. But we also need to do that in person. That's not just calling up, you know, Dr. Davenport, I have this patient here, looks like, you



know. No. Dr. Davenport, we need to make an appointment for you to see our patient. Okay. That has to be done in person.

I mentioned the pre-enrollment. Ideal if we can do it. The other thing that's important is if you have any, any change in health status, um, a patient comes to us from another program. A new PACE patient. We need to make sure that there hasn't been any change. It's not so much, again, just taking the word for the previous healthcare provider, it's assessing this patient in person.

Periodic assessments. You know, in the guidance we say semiannual at a minimum. But, again, and you'll see where we have the unscheduled assessment in the guidance. Whenever you need to assess the patient, that's the time to do it. These, the care planning guidance is just that. It's guidance. You have to look at the patient and determine what is appropriate for that patient.

Home health assessments. Or home assessments. It's a wonderful attribute to this program. If we had Mrs. D. in the previous example, maybe when you, we went to her home after the fall, you know, we didn't find anything specific. Maybe if we looked a little harder we would have found out that Mrs. D. likes to sit at her kitchen table while she's eating and watching television with dinner. Well, sometimes she just sits there so long she just dozes off and falls off the chair. So maybe we need to make sure that the chairs in her kitchen have armrests on them so that she doesn't just fall out of the chair. Now making, I'm giving this example as a hypothetical but I can tell you my dad is ninety-nine years old, lives alone, very healthy, he has his chronic diseases, is a physician's dream because he is very compliant. But my dad sits in the kitchen after dinner and watches television and will fall asleep. And he has fallen out of the chair and hit his head. So these things happen. So if his provider could go to his home and see that he has no armrests on his kitchen chair, now obviously I tell, I've told him dad, why don't you go sit in the recliner in, in your living room and watch TV. But, you know, in addition I said why don't we get some new kitchen chairs and we did that. But something as, as small as that can make a difference and prevent the potential of a subdural hematoma. Fortunately that didn't happen. So home assessments are critical to our care for the PACE patient.

How do we design the care plan? Well, you know there are five pieces that need to be in this care plan and I think that, you know, there can be additional pieces but you really want to, to make sure that we have some key elements in the care plan. And we'll talk about those maybe a little bit more as we go along. But the plan will be used primarily to show that there are any risk factors or potential problems for the patient and how they've been resolved and where we are going to go with our next steps. It's very important that all the members of the IDT participate in this care planning process and in the assessments. Again these assessments can, you think of them as kind of a continuous quality improvement process where you have the patient's initial care plan and as we, again, even a minor assessment. Take the van driver. We might need to reassess at that point and look at the care plan and modify the care plan for that patient based on the comments that she made getting into the van that day. So what are the factors that we assess and need to reassess? Well one, we should really look at whatever problem the patient may have on that day.

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What is the chief complaint or the statement of the problem? What are the interventions that we might want to, to do for that patient as we reevaluate the patient's status? What are the timelines that we want to put this care plan on? It might be short term, or it might be something that's longer term. We want to have measurable outcomes. Whenever we have an intervention, we always want to be able to measure what that outcome is. And finally, we want to make sure, you know we have the whole IDT participating, but we want to make sure that we've identified one or two IDT members who really are going to be responsible for implementing this particular piece of the care plan. And if there are multiple pieces, then the roles that the rest of the team may play. It may be something as simple as the dietician going, having been on the home assessment, determined that Mrs. D. didn't have the appropriate nutritional elements in her cupboards or in her refrigerator that she should have based on the education and training that she's supposedly has gotten as a diabetic. You know, she had other things and not the health, food healthy pieces that she needed to have there. Or, you know, with, you know, high blood pressure being part of her co-morbidity, she has a lot of canned soup with sodium elements about, you know, nine hundred milligrams and above. So those kinds of things might seem minor, but if you're trying to control blood pressure for a patient, especially with other co-morbidities, eating canned soup is not the ideal thing on a regular basis. And if this is a main staple for her, then the dietician's role is critical in helping to educate the patient, but also to develop a care plan of how she can substitute maybe some low, lower sodium solutions for her.

Okay, this diagram you will see again and again. It's, it's built from Dr. Burwick's work early in the, or late in the 1990s. And we have it, we don't have it quite like this in our care guidance but basically we have plan, do, and our care guidance, number three, where we have study, is check. But at CMS we're using study. And then the fourth is act. And you will see this again tomorrow when I talk about quality improvement. But it's the continual cycle. It's, you know, looking at what is the care plan for our patient? Implementing that care plan. Do. Studying it or checking it. Is it working? Do we need to revise it? And four, acting. Where we revise and intervene and change, and then we continue the cycle. And it's just ongoing. And continuous.

So leaving time for Karen to get up here and give her spiel, I just want to summarize a few things, and really here I think keep in mind the goals for the care planning. And it, it may sound like a vicious cycle but it's not because a vicious cycle we would just be doing the same thing over and over and over, but here we are reassessing even though we will make a cycle and complete that circle, we're reassessing each step along the way. And the whole goal is to make sure that our patient's getting the benefits from this care planning.

So I'd like to say thank you and I will take questions I think after Karen presents.