

CMS 2010 Regional PACE Conference

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TRANSCRIPT

Level II Reporting

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Good morning. I bring greetings from central office in Baltimore. Thank you. Jill, thank you for the fun facts and that introduction. When she asked me for fun facts, I thought "What do I really want to share?" Not too much. Anyway, I'm very, very excited to be here today, and I just want to thank the regional offices for convening this conference and for inviting me to be part of it. We have a lot of accomplish in this short window, so I'm going to get started.

What I'd like to do is give you an overview of what I'm going the to try to talk about in this timeframe and then go into each specific item on this list in as much detail as we can. There will be -- I'm a little -- I'm sorry, I'm trying not to speak too loudly. If you can't hear me, let me know, but that was just too loud for me. I'll give you a little bit of background. We'll talk about the reporting process for Level II, some of the incidents and thresholds. I think you have the slides. We'll go over them a little bit. I didn't put everything that's in the guidance in the slides but we will be having some training coming up, and we will go into the thresholds in more detail with that training later in December.

There's one case example that I want to go through, and hopefully that will illustrate how we'd like to implement the Level II reporting. And, of course, I can't talk about any of these aspects of our guidance whether it be Level II, care planning, or any other aspect of the PACE program without relating it to our quality assessment and performance improvement. Then a little bit on some of the future direction and a little summary of the overview.

One of the things I think that's very important about the Level II guidance is that there haven't been anything updated in a quite a white. 2004 is a long time, and there are have been a lot of changes in the PACE program, a lot of changes in the thinking at CMS since then, and a lot of changes in the staff overseeing both the PACE programs and our programs at regional office and central office.

So I think that having the workgroup develop this guidance was really timely. It started, obviously, well before the Affordable Care Act, but I think it was timely in terms of being ready to institute something new and something that will help make us more accountable in our care for our PACE participants. We also hope that this guidance provides more clarity, and within the guidance we do have examples. I think that's important as we noted already.

I would like to take the opportunity to emphasize that the Level II reporting opens a door for us to discuss some of these situations with your account managers. Please, by all means, utilize the account managers in the regional offices as a resource and then

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utilize at central office as a resource as well. This Level II reporting also opens the door for an additional type of reporting that we're still trying to work out a little bit, and that is how we determine when a patient has ongoing loss of function that's related to an incident. We haven't decided how we're going to close that loop, but we do know that we're not going to allow that sequelae from incident to be an ongoing result of the incident. So it may be something that we work on closing at three month or six months to be able to say that the loss of functional status or the injury that resulted really is only related up to this time to that particular incident.

The workgroup and some of the other clinicians, both in the PACE organizations and at CMS will be talking about this and looking at how we will fill that loop, but this gives us the opportunity to start reporting on those type kinds of incidents. We released the guidance in October, but I think all of you know that we are going to implement this guidance come January 4th.

One of the things that we heard was that we did not want to implement this right away, that we needed time for all of us, at central office, regional office, and within the PACE organization to digest the guidance to get a chance to prepare questions, and then to also have training. So we have allowed this window so that we could go ahead and do that, and as I said, we will be conducting training in December.

I think what's most important here is that the level II guidance really is an opportunity for us to identify strengths and weaknesses in our program. We need to do that and then use that information as part of our ongoing quality improvement, quality assessment program. Ultimately the reason we're all here is to improve health outcomes for our patients.

By the way, I guess I should stop right here and just say you'll hear me -- I'm a physician. You'll here me talk about PACE participants as patients. When I've spoken at the MA Medicare Advantage conference or at the Snip form leadership conference a couple weeks ago, I really emphasize that for me it's importance to relate to our beneficiaries, our enrollees, our participants as patients, and I think one of the things that we've forgotten about is that the PACE model is a medical model. And I think if we keep that in perspective we may have less concerns with our IDT, our Interdisciplinary Team, because that's the model that they're trained on, that's the model that they're accustomed to practicing under. And to a physician, to a nurse, a participant doesn't quite mean the same thing as a patient. So you have to forgive me up front. I will continually go between patient, participant, but for me all of our Medicare beneficiaries, all of the enrollees, all of the PACE participants are my patients.

I'll spend a little bit of time on some of the definitions. I don't want to spend too much time on Level I reporting, but I want to just run through a couple of slides on that as part of the framework and then move into the Level II reporting. I think everyone knows about the elements that are part of the Level I reporting. Key aspects here are on the next couple of slides.

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One of the things that will be important to note is that deaths unfortunately are reported under both systems. It gets a little tricky, but it's there for both of the system. Also, I think what's important to note is that Level I reporting has a different mechanism than Level II reporting. Level I reporting is done through our HPMS system, and we're actually really concerned about how we use the data on Level I reporting. As Karen Milgate [PH] mentioned earlier, and you're going to hear this again in the quality presentation tomorrow, but the use of data really become important for us in the PACE program. No one knows really what the good work that has been done under the PACE program. No one really knows how the extent of the impact that we are doing with the PACE program, and part of it is because we have not traditionally really looked at the data. We have not had a huge evaluation since PACE was a demonstration, and that was a long time ago.

This is my second tour with CMS, and I was with CMS in the mid to early '90s, and PACE was still early in its infancy, and it was still a demonstration. So when I came back last year, I was very excited to learn that PACE is really a teenager right now, and you know how things are with teenager, it's time to evaluate the situation and see what's going on so we can move PACE into adulthood. So we will need data, and we'll be talking about how we can do what needs to be done for the PACE program.

Let's talk a little bit now about the Level II reporting. The key for us is that Level II alerts CMS to an incident that really could be used to maybe demonstrate where we could have quality improvement, where we might have been able to intervene to prevent this incident, and where we need to do more in the PACE organization. It's not designed to penalize the organization. It's not designed to hurt anyone in this process. It's really designed as a learning process and one where we can go on and take the opportunity to have interventions that will improve the care and the programs.

The difference in reporting for Level II is that rather than using the HPMS system, level two reporting is done much like the Sentinel reporting now, through an e-mail mailbox to CMS. What is important for us is that we have staff who actually man and review these e-mails on a regular basis, and we are working with our clinical staff to do that really more frequently.

How is Level II reporting different in terms of the thresholds and some of the examples of the incidents that are required for reporting under this system? Well first of all, we have about 17 incidents that have been identified in the guidance, and I hope that each and every one of you has the copy, if not with you has that in your office at your center and that all the staff have copy. But there are 17 incidents that we use for thresholds.

What is critical here, and I think this will come out more as part of our training, but I want to make sure because it's not clearly -- I went back to the guidance to see how it was worded. It's there but it may not be worded quite like this. What we're asking for is that when your IDT team, interdisciplinary team, has been made aware of or has decided that a particular incident is a Level II reporting that, then, within 48 hours, you report to us at CMS and at regional office and with your state administering agency.

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So it's not that as soon as the event happened that we're 48 hours to report. That would be nice but that's unrealistic, because the event or the incident could happen almost anywhere. But once your IDT -- your IDT team has to come together and figure out, yes, we think this is a Level II reporting situation for our PACE members. Then within 48 hours after that, we would like to be notified. So I hope that helps in terms of the implementation, and it's something, again, we will repeat over and over to make sure that's clear.

The other thing that I think is important is that most of these incidents where you look at the 17 incidents, they're pretty serious incidents, and most of them are going to require a root cause analysis, but not all. And as a PACE Center, as an organization you have the right to think about it and to say to your regional office account manager, "We don't think that this particular incident requires a root cause analysis and why." If you feel that way, then once you've identified that, you should contact by phone the regional office immediately and discuss that.

Now that doesn't mean that we won't say, "Well we think it is," but at least it's something that can be discussed. So I think that's also it's in the guidance but it may not be as clear as one would like, so I just want to make sure that we're clear on that. Okay. Most will require but not all. Bless you.

Now I'd like to spend a few minutes going over some of the examples of the incidents and the thresholds. One of the things, although they're a nice table in the guidance, sometimes it's a little hard to pull them out. So part of the training that we'll be doing will include preparing more slides like this one where it's really pulled out and it's not kind of in the background, what the incident is and what we think the thresholds are that would trigger a Level II report.

Clearly here we're focusing on suicides, homicides, unexpected outcomes, and if we have a situation where a coroner is involved. For fall, this is a little tricky because in this situation, again, death is there, and one of the pieces we're training will be to summarize in our training module all the other incidents where death could be part of the threshold and pull that together too. So if there's a fall, if there's a motor vehicle crash, if there's a burn, there are a lot of places where, unfortunately, death is the outcome that's listed. But I think it will help in training to put that all together. I kind of like to think of all this as one package so if I have to think about it, it's a result of any of the following indicators or incidents, so we'll include that type of slide in the training packet.

The thing that's tricky here is that the fall, if it results in one-day hospitalization or two days, then that will not trigger a Level II report. But if the patient has been hospitalized four or five day or more then it does. And then after on the fifth day -- after the fifth day as we move into the sixth and seventh day or onward, then within 48 hours of knowing this, then CMS would like to be notified. We also would like to be notified within 48 hours of the decision that we feel that the patient is going to have permanent loss of function. So, again, that's a little tricky with the fall, but we'll work with it and we'll help you to work with it also.

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There are additional reporting requirements; for example, if we have a patient who has an adverse event, then the FDA, especially as the result of some equipment failure or certain medications, then the FDA would like to be notified as well. So that's where some of this additional reporting comes in. How many of you are you familiar with the FDA adverse reporting system? Not enough. Okay. So I think that's something -- no, it's probably a good thing that we haven't had the report, but I think it's important to know how to use the tool. Sorry. You're raising your hand.

Can you hear me? Oh, sorry. Reporting that it may possibly be a Level II, see what I'm saying?

If you're not sure if it's a Level II?

Yes.

If you're not sure, please contact your account manager and discuss it with him or her, and then if we have to we can have a three-way call to talk about it.

Thank you. Because before they would say, "This may become a Sentinel event," but then it did not, but it's still better to report.

It's better to report than not.

Thank you.

Okay. Thanks. Okay. With the FDA reporting system I think that, as I said before, it's a good thing that many of you haven't had to use the system, but because it's one of the requirements and it's a tool that, I think, we need to maybe have some training on. So I'll make a note of that, and we can work with that in a separate training. The other type of reporting is for food borne illnesses or outbreaks that could be reported to the state or, it depends on where you are, how your state public health system is organized. It might be -- for some parts of the country it might be local Health Department first and then state. Some places it may be state. So depending on how you ordinarily would report outbreaks to your public health system then you would follow the same process for reporting a food borne illness or a potential outbreak.

Now you're asking me, "Why would that be important in my PACE Center?" And, you know, you may have a food borne outbreak, hopefully you won't at the center. But think about an unfortunate incident where one of the patients has been admitted to a nursing home facility or long-term care facility. As we move into this time of year, many of the long-term care facilities have respiratory outbreaks. Unfortunately they have a lot of norovirus outbreak.

Once a patient leaves your care at the center and is admitted to a hospital, a long-term care facility, rehab any center, we are responsible for that patient. So that patient doesn't become a non-PACE patient just because they're not physically at the center



today. That patient is our patient 24/7. So we need to follow that patient wherever that patient going.

And it's sort of reminds me of my experience as a resident. I started out in surgery and then I saw the better ways and moved on to primary care. However when I was a surgical resident, just because my patient got admitted to the surgical intensive care unit didn't mean that I could say, "Okay, I'm done." No. If anything, even more so, I had to round on that patient in the surgical intensive care unit to make sure that everything that needed to be done for that patient was done.

Well it's the same thing for PACE for our PACE patients. Wherever that patient goes so do we, and we have to follow that patient and interact with the family and to make sure that that patient has everything he or she needs while that patient is in a long-term care facility, the hospital, or wherever. Our job doesn't stop. It's 24/7. Okay.

The process of reporting: It's not easy and I'll admit that the guidance is not simple. But I think once we work through it and understand it, and more importantly, understand why we're doing this, then I think it may make sense. It may be hard and it may be a little bit burdensome at times, and I'll be the first to admit it. But I think that we're trying to do this for the right reasons.

First of all, we talked about this a little bit already, the incident occurs and you have to determine whether or not the incident does meet the Level II threshold. IDT notified, convened. Now, 48 hours later, hopefully sooner, but you have that window, please notify us. Begin your root cause analysis within 24 hours of notifying us at CMS. If a root cause analysis is needed and it's not going to be a smaller version of an investigation, then you need to start it with 24 hours. And then there's a month to complete it.

And please don't feel like you have to do this by yourself. We are here to support your and to help you and guide you, so we need to work as a team. If there are questions, if you need assistance with what you're doing on the root cause analysis then talk to us. Communication is going to be critical throughout this process.

Finally, we come down to where we have a conference call, and the PACE organization will summarize the situation for us on that call. And this usually happens after you have completed your report, so you have your documentation and you can refer to that and hopefully, if you needed to, we've talked before.

These are the elements of the Central Office. I'm sorry. Central Office and then RO is Regional Office, and PO is PACE Organization. These are the elements of the case summary that, when we have the discussion and when you complete the report, would be part of our discussion. Similarly, these item as well. I think what's most important on this slide relates to -- again, this is not trying to blame anyone, so that's why I want to identify that -- the precipitating or contributing factors and then the patient's involvement. Let me talk a little bit about that for a minute.

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The contributing factors: The reason that this is important is because it will help us to understand what happened and how we could have prevented or changed things in the future. Obviously we can't change what happened to this patient right now, but we can, especially if it's something that other patients could benefit, it's something that we could intervene and change so we don't have a situation like this arising again.

The participant's actions or involvement or the patient's role in this -- again, we're not blaming the victim here. That's not what that's amount. It's about understanding. It's about looking at the patient and trying to figure out why did this happen to Mrs. D, why did this happen to Miss Marcia, and making sure that we have the tools, like no other program in health care. PACE has the tools to address anything that's going on with this patient.

So if Miss Marcia had a fall because her medication was a little bit off or she didn't eat when she needed to eat before medication, we can intervene. We can understand her diet. We have a dietitian on the team. Maybe she didn't like what she's supposed to eat, or maybe as a diabetic it wasn't clear to her because there may be some cognitive impairment that before she takes her insulin she does need to eat or she doesn't or whatever she needs to do.

So I think we need to -- I'll give you an example. My father is diabetic. He's not insulin dependent. Frequently he'll take his oral hypoglycemic and wait the half hour, but next thing I know, he's waited two or three hours. That's not appropriate. The half hour is fine, but once he starts to wait longer, his blood glucose is going to start dropping, so that's a small intervention to remind him, you know, don't let that half hour go into a two or three-hour period. You need to eat.

So it's not blaming the victim. It's helping, it's educating, and it's trying understand what the factors are that will make the patient improve and also to prevent any additional sequelae.

This is another piece of the reporting summary, and I think what I wanted to emphasize here are the last three bullets, the compliance with your PACE organization's policies, identification of risk points, and proposed area for quality improvement. All three of these bullets really tie into that last bullet, quality improvement, and that's what this is about. If we have an incident, how do we make it better? How do we develop an intervention that will improve quality for our PACE patients?

Okay. Now this is a schematic of what we just talked about in term of the reporting process. So we start here and over here, and we'll go through -- I'm not going to keep going back and forth, although it's tempting because I'm a parent and I don't want to favor one side or the other or one, you know, area or the other but I won't do that. But now that I've oriented you, we'll follow the arrows. We talked about this reporting process. And this is just a schematic. I like pictures, and it just helps me to be able to articulate where we're going and what's expected.

The big circle is the area we just ended up with, completing your summary. But the points I talked about earlier, as we walk through where the PACE organization identifies

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the incident, we determine that the threshold meets the criteria, and then we notified the IDT and notified CMS, conduct the root cause analysis. Okay. Where am I? Do you know where I am? I'm right here. Okay. And then we're going up. And then once you've done the root cause analysis, we'll have the conference call, and finally, we'll end up at our big circle with the summary. Okay?

Okay. This is the fun part. How can we make these examples work? Okay. Well in medical school we do a lot of case studies, and so the way we have designed the training that we're going to have in December, we've designed it as a train the trainer approach, with lots of case studies from the 17 examples. We won't have time in the training to do all the case studies, but the training is scheduled for about an hour, so we'll try to go through, we have about eight that we're going to do.

We will have -- in the slide deck we will have all of the 17 examples developed as case study. But in the training we'll only have time to do eight, and I've tried to pick out sort of the six to eight that are sort of the most difficult to grasp. And then we'll go through that as part of the training. So this is a little highlight from the training that we'll be conducting.

We'll start with the central office staff, we'll work with the regional office staff, and then we'll have two user calls in December. The user calls will be duplicative, so you only have to sign on for one. We also will have the slide deck, and we'll have the audio -- the calls will be taped, so there will be an audio version. So what will be hard for me is I will have to read from a script so that all the training is the same. I'd much rather just talk because so much is in my head, but I will -- I promise to write the script to be consistent. Believe me, that is very, very hard.

Anyway, so here's one example. And, as you know, we have the guidance, you know, they're coming right out the guidance. I'm using those same examples in the training and today, so just to help operationalize the guidance a little bit better, I think. So we have Mrs. D who is this 80-year-old female. She lives at home. She lives by herself, and somehow she fell and was unable to get up. This happened on Monday night. Well unfortunately it was Wednesday morning before she was found. How many have heard stories like this before? Yeah. I think we all have.

The good thing is that she was found, because living alone, there are many people that might not have been found until it was too late. So fortunately, Mrs. D is a PACE patient. She was found because it was -- you know, the home health aid was coming that day. Now some questions to think about. What -- I'm used to having a lavalier. What could happen, what are some of the things we should think about where Mrs. D could have prevented this situation or what could have been some of the things that should have been going on in her life? That's one thing. And then what kind of notification is this; right? Okay.

Well I didn't prepare a laundry list, but these are some of the things. We needed to think about for Mrs. D, you know, is she on medication? She didn't have a history of falls in the past, so something must have changed, but what happened? Does she need to

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have more social support. Why was it Wednesday? Does Mrs. D only come to the PACE Center, you know, twice a week, or is this something we might consider -- and this is not uncommon. There are patients that don't come every day. And if she's relatively healthy and maybe she had some other social networking, so maybe she didn't need to come every day, but that's something to consider.

Maybe we need to change her care plan and think about having her come every day, but finding out what happened, what has changed for this patient. And then, yes, this is a situation that we want to notify the IDT. Irrespective of the type of reporting, the IDT should be notified anyway. They're Mrs. D's medical team, so they need to know anything that happens to her, whether or not it's going to be reported to CMS. But as part of their care for Mrs. D, they need to know. Okay.

So Mrs. D was transported. She had femoral neck fracture. As I said, she had no history of falls, and we couldn't find any reason for her fall. You know, there was, you know, no scatter rugs, she wasn't wearing high heels or something like that. You know, she didn't trip. Her medication was fine. But, you know, there was no precipitating factor. But to find that out, we had to ask questions. We had to investigate to see what was going on and what had changed.

So she had the surgery, and unfortunately Mrs. D developed post-op complications. So now her stay was extended, and instead of five days, now we're in the eight-day window. So what does that mean for us? Now we have to report Level II. So in the beginning this might not have been a level two reporting, but because of the post-op complications and the extended hospital stay, we need to report this to CMS. Okay?

So the way to do this is as soon as we know, 48 hours after we've passed that five day, we expect to be notified in that 48-hour window. Okay. The nice thing is to know that Mrs. D made a full recovery. So this is the way the training will be structured, so I hope it will be helpful. It's fun to put it together like this, and hopefully it will trigger you to think about other examples and how we could implement the training, and really, what are the points where, irrespective of whether you're reporting Level II or not, where are the trigger points that we could intervene to help Mrs. D or other patients like Mrs. D. Okay.

So we still have to move on and do the root cause analysis in my depth, do the report, and as I noted, the last bullet there, related to quality assessment and program improvement, performance improvement. So that leads me to a nice segue into my specialty, which we'll hear about tomorrow. But you'll come to learn very quickly whenever you talk to me, all roads don't lead to roam, all roads lead to quality. Okay? So just a little tidbit on quality.

This diagram, this schematic will be one that you will see over and over and over again. The MA world has seen it. The Snip world has seen it, and now the PACE world is seeing it. This is Dr. Davenport's view of the world of quality. Basically I'd like to describe it as, you know, we have our patient in the center. For PACE the IDT serves as protecting the patient, and then the PACE program oversees all of the patient's needs, and the goal is to have improved health, good outcomes, and high quality of care, and



then quality encompasses everything. So if you heard this before, I'm sorry, but you're going to hear it again. For me, quality, in this diagram, is a nice big hug around all of the program. It encompasses the entire program, and that's what we're here for.

So when we talk about quality, we're talking about Level I reporting, Level II reporting, our care plan, our protocols, our disaster plan. Everything we do in the PACE program links to quality. As I said, all roads lead to quality. It's important to take this Level II reporting to look at Mrs. D's situation as an opportunity for how we can improve and that's how we're going to look at it at CMS.

And I don't know how many times you'll hear me say this, but if I have to say it a hundred times, that's fine with me. The whole process of Level II reporting, the whole process of even Level I reporting, it's not to say, "You're a bad PACE organization. You didn't do that." That's not what it's about, because that's not going to change anything. That's going to make everybody defensive and put their hands up.

The whole point of this reporting is to identify where we can make change, where can we intervene, where can we make things better so we don't have this happen again for any patient, and at the same time, we know we're going to make some mistakes. You know, but the thing is we don't make it repeatedly and we move on and learn from it. We grow. And our patients are going to be better for it. So that's really what this is about. And I'm very excited about quality if you haven't been able to tell. I'm calm today, but usually I'm a little more animated. So I apologize for being calm. But I have three talks to give so I have to save a little energy, you know, PACE myself. At least from athletics that's what I've learned, you know, to PACE myself.

Okay. Well where do we want to go? Well these are just a few things, but when you think about it, and I think Karen Milgate did -- gosh Milman school of public health -- Karen Milgate put out a lot of ideas out there for us to think about. But where do we want to go maybe in the short term? That's kind of what I'm talking about right now. But future directions can be beyond that as well, and we need to think about where we want to take the PACE program. But in the short run, what are some of the things we can do right now around the Level II guidance, around the care planning guidance, and around our quality improvement program.

Well in the short run we're all implementers of this program, so we all have to be trained. We all have to understand what we're doing, how we want to do, and do it. So that's the short run. But we also need -- we heard the importance of data. We also need to continue to assess and evaluate not only the reporting requirements but also what's going on in our PACE Center. So at some point we probably will have an evaluation, a larger evaluation.

But in the meantime, the data that you collect day to day on your patient should help drive the changes you make at your local sites. So you shouldn't wait for me to say, "Oh, you know, this is a quality improvement area that you need to address." Every PACE organization is supposed to have a quality coordinator. Your medical director is supposed to be leading the quality improvement effort. Well, again, all roads lead to



quality, so anything that's going on at your PACE Center should be looked at and assessed and reviewed, and where we can, make changes.

One of the things I think that is important for the level two, kind of in closing and summarizing reporting is that it makes us all accountable. It makes me at CMS accountable and headquarters, it makes our regional account managers accountable, and it makes our PACE organization and you as representatives of those organizations accountable. To whom are we accountable? Well in the long run it's not me. In the long run, on a day-to-day basis, it's to that patient who comes to your PACE organization and center every single day. That's the person that we're accountable to.

As I close, I just want to acknowledge that the level two reporting guidance is not something that I put together. I wasn't here yet in my second tour as it was being developed, so I really want to acknowledge publicly the contributions of the PACE organization, all of you who participated in helping to develop this guidance, who saw the need to say, "Well, you know the Sentinel reporting system doesn't quite work. We need something different. We need something that's a little more standardized."

I want to thank the members of the regional office and central office staff and the National PACE Association, as well as others who participated in the workgroup who worked to develop the Level II guidance. As I said earlier, it's not an easy tool, but we'll work together to implement and make it work. Thank you.

We have time for a couple of questions, and we're going to wait until the microphones get to our people for questions. This is being recorded and so we want the people who touch back and go to the website, we want them to hear the full question and the answer. So raise your hand, please. Oh, we have a question over here. Dr. Davenport, Are you ready. Oh, we're over here first. Thank you. Sorry, can't see. Remember, I said flail those arms.

Hi, I'm Angela Talb [PH], and I'm from CMS central office, and I just wanted to make one additional comment. There's been some question about what should and should not be submitted in the Level II report that comes into the mailbox. I just wanted to clarify that we do not want any personally-identifiable information sent in that report. For example, you could put a female participated, age 83, and then a brief paragraph describing the incident. Because there's no personally-identifiable information in there, we also do not want it sent via encrypted e-mail. Please send through a non-encrypted e-mail system. And finally, when you complete your root cause analysis and you send us notification that you're ready for a conference call, please do not include a copy of the documentation of the root cause analysis with that. We do not want any of that in writing. That will be entirely verbal during our conference call.

Question? Go ahead. Are you live?

She may have already answered my question. I was going to ask if the root cause analysis was discoverable?

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I'm not sure. But that leads to another piece. The root cause analysis, Level II reporting, as Miss Talb said, should not have identifiers on it. This is quality assurance information and should not be part of the patient's chart either. Okay? And I think those of you -- do we have any quality coordinators here? Okay. So it's important that -- I think most you know this -- we keep the quality assurance documents separate from the patient care documents.

And one last question over here.

I just had a question about the training that's going to be held in December. Are you going to go over exactly what should be included in the report and the mechanics of what will occur during the phone conference call so that we have some guidelines on what you're looking for? We all have different methodologies of conducting an RCA, but are you going to hit some standard templates or, you know, I know some of the slides went over some of the questions that we should be looking at, and I think that's very standard for a root cause. But is there some type of template that you're going to go over during the training so that we're not redoing the RCA two and three and six times before we get it right for your purposes?

No. I don't want to see the RCA necessarily. I mean I'm not grading you on the RCA. What's more important in the call -- I understand where templates could be helpful. Be if you were really sending this in -- and, Angela, if you want to chime in, that's fine. But I'm more concerned that we hit the high points in the discussion and that we talk about intervention and how to improve. The root cause analysis is really for you, as opposed to for me. And so if you have a template -- and I don't have a problem if you want to share a template among yourselves, but I really don't care what it looks like, as long as it has those elements. I think Angela wants to weigh in.

Right. Well a template, we're not going to see it physically, so whatever is useful to you is fine. And that touches back to the other gentleman's question about whether it's discoverable. If you send us that information, is it is subject to the Freedom of Information Act and could be, so that's why we do not want to see any of that sent via e-mail. We don't want to see it. We want to hear about it. We want to discuss it with you. But we do not, for your protection, want it sent to us, because then it would be subject to FOIA.