



Program of All-Inclusive Care for the Elderly Level II Reporting Case Studies

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March 7, 2012

- Revising Level II Guidance
 - Incidents and Thresholds
 - Reporting process
 - Content
 - Definitions
- Sorting and analyzing Level II incidents from January 2011-January 2012
- Improving quality of care

Case Study #1

- 89 year old participant with diagnosis of CVA, COPD, and depression
- Participant on palliative care
- Seen in PACE clinic on 9/29/11 for 6-month careplan update
- Medication filled on 10/29/11; called participant to deliver—no answer and left message
- 11/5/11 no contact with family or participant to deliver meds

Case Study #1 (cont'd)

- 11/24/11 family calls to report a “rash” on patients back
- 11/26/11 participant seen in PACE clinic
 - Dx with 5 stage IV pressure ulcers, and 4 stage II pressure ulcers
- 11/27/11 home care provided for wound care
- 12/3/11 participant expired

Discussion

- What could the PACE organization done differently?
- What could the participant/family done differently?
- Were these pressure ulcers preventable?
- How can the PACE organization staff be reeducated?
- How can the we prevent this from occurring with other participants?
- Any lessons learned?

Case Study #2

- 86 year old participant who lives alone fell at home on 10/13/11
- Participant did not attend PACE center on 10/13/11-10/15/11 (Scheduled days to attend PACE center)
- History of diabetes and COPD. No history of falls.
- Participant was found by home health aide on 10/17/11 on the floor behind the front door

Case Study #2 (cont'd)

- Who should be notified at this point?

Case Study #2 (cont'd)

- The participant was taken to the Emergency Department via EMS on 10/17/11
- Participant had fractured right hip and fractured ankle
- Participant reports she tripped over the rug at the front door. She was attempting to go get the newspaper off the front porch
- Participant had hip and ankle surgery and was discharged from hospital on 10/25/11 due to post-operative complications

Case Study #2 (cont'd)

- Is there anything the PACE organization could have done differently at this point?
- What quality improvement initiatives might the Root Cause Analysis reveal?
- Is there a need for further education to the participant, family, or PACE organization?

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