



CMS 2012 Tri-Regional PACE CONFERENCE

Programs of All-Inclusive Care for the Elderly

Philadelphia | March 2012



TRANSCRIPT

Plan of Care

Suzanne Ribero-Balassone, RN, Vice President of Clinical Services, PACE Organization of RI
Cheryl Dexter, RN, MS, Vice President of Quality & Compliance, PACE Organization of RI

Hi, good afternoon. Thank you. Got a room full of diehards who held out for the last presentation, so thank you guys for being here. I have to get my buttons straight, I'm sorry. I just a in-service on this. You'd think I'd remember.

Just a few learning objectives to go through. We're going to explain ways to incorporate participants' needs and preferences in the care planning process. I'll be going through this this afternoon, and to formulate participant center care plans utilizing the five essential components of the CMS Guidance. And then, later in the presentation Cheryl will describe two methods of measuring compliance with the CMS Guidance.

So I'm going to go backwards. Just a couple of things about the PACE Organization of Rhode Island. We are a statewide organization, which poses a couple of challenges for us and a couple of fun things, too. We do have two sites. One of our sites is located in our capital city of Providence, and that's our largest site. And our second site is about 45 minutes away, closer to Connecticut, so our staff does travel quite a bit in our state, but our staff is used to kind of getting in their car and traveling around. We opened our first site in December of 2005, and we did welcome one participant, and I heard another PACE site say that earlier, so I guess we're not unique in that fact, but our first participant, whose name is Lillian, she is forever endeared in our hearts, but she was very welcoming and loved our – loved our organization. And a little bit spoiled. We had about ten staff members taking care of our one participant. And she used to comment on how wonderful this PACE organization was. We are now up to about 215 participants, and hopefully we give the same wonderful care, but probably not as astute as Lillian would remember.

And we do manage a large multicultural population, as probably most of you do. Our largest population is Caucasian. We do have an almost equally as large Hispanic population, who speaks mostly Spanish, so it is a challenge for our staff. We do have a large Spanish-speaking staff that helps us muddle through each day. We do have a large Cambodian population, also, and a Liberian population, too.

So those were some external characteristics of our organization, and internally, things were growing as well. But not so gracefully. As we added more participants to our organization, we began to look internally and discovery that we were a little bit disorganized. Our team members were ill-prepared and disorganized for our meetings at times. We would go to our team meeting and found some of our IDT

members kind of rustling through their papers. You'd call on them for a team meeting to give some input and they'd kind of give you the deer-in-the headlights look. There was lack of follow up from team meetings. We'd often leave team meetings, you know, with our little yellow notebooks in hand and walk with our marching orders, but there was really no formalized way to come back to team with a follow up that we all walked away with the day before. There was really no documentation of team meeting that we could, if you missed a team meeting, to kind of look at if you were absent for the day, to go back and know what you missed the day before. So there was a lot of missed opportunities for problem solving in our teams. And our team meetings lasted about two, two-and-a-half hours in the morning. We did morning meeting and our care planning meetings together in the morning, so we would meet at 8:00 and not get out until about 10:30. So you all working in a PACE organization know that that ten to two time is really prime, so we would get out of our team meetings and our participants were, you know, kind of waiting in the hallways for us, saying, you know, where were you guys, we're ready. And our team members would just hit the floor running. So it was a pretty chaotic way to start our day.

We had a little bit of an unfocused agenda for our team meetings. We would go into team and we would just start our day by just running our list. We would start with A and go all the way to Z, and take about every one of our participants. And not really in a organized manner. So we would often say things like, you know, well, how is Mrs. Jones doing today? And I would kind of cringe as the facilitator because that conversation can just lead you anywhere. You know, oh, Mrs. Jones' son is back in town again, you know, well how long was he gone for? Well, gee, I don't know. So it would just – conversation would just go on and I'd just go, ohh, you know. So we missed a lot of opportunity for really good concrete problem solving. Our clients tended to stay in acute care longer than we wanted them to because we really didn't get to the heart of the problem.

And, as I said before, topics discussed in morning meeting weren't really put into structured minutes, so it was hard for us to go back and track that again at a later time.

And we had lack of compliance with requests for service tracking. About two years ago, in our prior CMS meeting, we had a finding for that, finding that our team was taking a little bit too long to make decisions around requests for service. And a cli – clients would come in and ask for things, you know, I want more home health aide hours, and our team would kind of mull it over and say, well, let's send out, you know, the home care coordinator to look at that. Then it would come back to team and we'd mull it over a little bit more, and really just couldn't decide on that. So it would take us longer than that 72-hour time frame. And we were finding that we couldn't really have a good way to track that, so we just didn't know how long it was taking. Just a little bit disorganized.

And timelines in our care plan were always Q6 months. You know, we'll reevaluate this in six months. We'll take a look at this in six months. We'll get back to that in six months. We just really had trouble setting short term goals for our participants. Has anyone been there? Okay.

So, first of all – whoops, did I skip a slide? No. I'm sorry.

So the CMS Guidance was released in September of 2010. And when we really read through that, it set the criteria on how to formulate care plans and assessments, and it offered structured guidelines on how to formulate our processes. So, I think we just put it in the slide, you know, thank you CMS for that because we were just really struggling with, you know, how to get those processes in place. So our senior management group met and just thought that this was a real opportunity for process

improvement for us. And we put together a care planning IDT to kind of really just mull through that, the care planning guidance, and just go through that from start to finish and put together a process that we could present to our IDT and say we just need to grow up a little bit and get into our adolescence.

So some new tools were born out of this initiative, and I'm going to talk about those a little bit in some upcoming slides, but we formulated a COS tool and a RAD tool, which I'll speak about in a little bit. And we developed some new roles in our IDT, and that was a scribe and an EMR documenter, and I'll talk about those in a bit, too.

So we had to begin with our team behavior. Our team set their own rules on how they would like to behave in our team meetings, and we called this the rules of engagement, almost like going to battle, you know, our team just really set – set their own behavioral rules. And some of the – the things that they set, you know, they just agreed to be on time and ready to start. So when our team meeting started at 8:00, they were in there a few minutes before, in their seats and ready to go. No more rustling papers, no more shifting around. They were just ready to go at 8:00. And to prepare for that meeting ahead of time.

To be aware of the time and avoid too much information. No more talking about Mrs. Jones' son and how long he's been gone on vacation, you know, if that wasn't really relevant and needed to be problem solved in that meeting. Keep conversations short and direct, you know, to the point. Some of our disciplines, and I won't – you know – they'll remain unnamed – but like to go on and on and they're great storytellers, but a half-an-hour team meeting in the morning isn't the time to be telling your stories. It's just time to get right to the facts.

And to set time limits for each care plan and to stick to it. We set 20 minutes time limits for each of our care plans, and we really try hard not to go over that. Not that we never do, but we try really hard not to.

And to cover your own absences. We really feel the gap in morning meetings and care planning meetings when a discipline is missing. Care plan meetings can't happen when a discipline's missing unless the absence is covered. But also in morning meeting, if you're talking about a client hospital and your physician isn't there, it's really hard to know what's going on with that client.

And attendance is mandatory. You know, that goes back to the point I just made.

And then we also decided to separate our morning meeting and our IDT meeting. No more two-and-a-half hours in team meetings in the morning. That was brutal. So we separated our morning meeting. We have that in the morning, and our IDT care planning meetings are in the afternoons.

Some of the tools we instituted was the scribe tool, you heard me mention that a few minutes ago. Our scribe tool is really a tool that we project in the morning, and it – it's more a rolling agenda that allows our facilitator to go through different, various items in our team meeting. That keeps our team on track. And it keeps team notes and also documents follow up from our team meeting. It provides a script, almost, for the facilitator to follow. So we go through the same items every morning in team, so the team members know what to expect in morning meeting.

Items discussed in the meeting. We start off with intakes, enrollments and disenrollments. Those are the first items we talk about. Then we go to hospitalizations. Is there anyone currently in the hospital

we need to problem solve and get working on to get them out. Also, skilled nursing stays. Anyone on hospice care or having a respite stay at the moment. Any on call issues that might have happened overnight. Falls. We talk about our falls here. If there's any team problem solving that needs to happen around falls. And any old business that has happened the day before or the week prior that needs to be followed up on that – that is still outstanding.

And then we get to our new business agenda. The agenda is really just a computerized white board for us. It's just a word document that's stored on our shared server. So all of our staff members have access to it during the week. They can just go in, they can put agenda items on there, and it's just projected again during our team meeting so that the team has foresight about what is going to be talked about in team meeting so that they can come in prepared. And we just project that during team meeting. And again, things like falls, a client having new symptoms, if there's been a change in status, if a client's been hospitalized, all of that just goes right on our agenda. And this is also used by the facilitator to kind of just run through and keep team organized.

So once we decided on team behavior and how we would conduct our team, then we needed to decide on whose care plan is this anyway. We really tried to move our care plan from being IDT focused to participant focused. When we took a look at our care plans prior to this initiative, what we found was that most of our care plans really reflected what I – what our IDT wanted.

Our assessment tools were duplicative from discipline to discipline. A lot of the times, we asked the same questions. And our participants would tell us that. You know, the nurse would ask questions and they'd say, I just answered this from the doctor. Or the intake coordinator just, you know, I just told her all of this. What they didn't realize is we were coming at it from different disciplines so we felt we were coming at it from a different angle, we were asking different questions. But the questions sounded the same to the participants and they felt like they were telling us the same information over and over again.

So we wanted to focus – when we redid our assessments, this team really took it on, our care planning IDT, and we formed assessment groups to look at our assessments. And we really wanted to focus on evidence-based criteria. So we researched all different healthcare venues. We looked at nursing facilities and what assessment tools they looked at. We looked at your organizations, we asked PACE care organizations to let us look at their assessment tools. And you let us, so thank you. And we reformulated all of our assessment tools for all of our eight disciplines to make them markedly different. Some questions we did keep the same and we did ask across disciplines questions we thought were important to duplicate. But we also included the question on every one of our disciplines, you know, what do you want from this program? And what do you want my discipline to focus on, you know, for you? And then we incorporated that into the care plan. For example, our care plans used to say for diabetes, you know, the client's hemoglobin A1c will be seven or less. And our participants used to look at it and go, what's a hemoglobin A1c? But that was very important for our clinicians to have that there, and it's a very important, you know, benchmark, for – for diabetes, and I can understand why it would want to be there, but our participants, it wasn't very important to them. What they would rather see on there was that they could have chocolate cake, maybe, for their birthday. So we would try to incorporate that into their care plan and make that more participant centered.

SMART objectives. This is really going to be discussed in the next slide, but we incorporated this as an acronym when formulating our objectives to make sure that our objectives were meaningful and also reachable for our participants.

And the COS tool, which stands for Change of Status tool, this tool helped identify – helped our IDT identify when clients were having a change in status. Prior to this tool we often, you know, would wonder if our participants needed a care plan update. You know, we would look at them and go, you know, she – Mrs. Jones looks a little bit different in the center. She – she looks a little functionally different. I wonder if she's having a change in status. Unless it was obvious, unless they were being discharged from a hospital, you know, or nursing home, or had, you know, a change in institutional setting, we knew that was a change in status and we would update their care plan at that time, or get them a new care plan at that time. But if it wasn't so obvious, or if they had an improvement in status, it wasn't always being done. And we had, really, no formal mechanism to make this happen, until we formulated this COS tool. And the COS tool is really just a series of questions that we answer in team that allows us to add a numerical score. And it tells us if the client is having a change in status. And at the end, depending on what the score is, it will tell us if it's a care plan update or if the client needs a whole new care plan because they're dramatically different than what our care plan currently tells us. This can be done – be requested by any team member or non-team member. If the bus driver comes in and says, you know, I think Mrs. Jones is different, had a hard time with her at home, she didn't want to get out of bed, I couldn't get her on the bus as usual, I had to use the lift to get her on, you know, that might be – warrant a COS tool.

And changes to the care plan are scheduled within five days if somebody, you know, if their COS tool score warrants a new case plan, that's scheduled in five days. So the team has five days to go out and do the assessments. And every care plan change is reviewed with the participant or family or caregiver. And that's usually done by our social work staff, either by phone or in person, depending on the preference of the participant or caregiver.

So SMART elements – and this is right from the CMS Guidance – when formulating your objectives, we use our – the SMART tool. So objectives in the care plan should be specific. And in order to accomplish the goals of care, objectives shouldn't be vague. You just need really to define the objectives in order to have a clear path in order to achieve them.

Need to be measurable, because if they're measurable, then you know when they've been achieved. Achievable. Is this doable, and can both of you believe that you can reach this goal?

Realistic. This allows a participant to believe that they can accomplish this goal of care and strive for the accomplishment.

And time sensitive. To set timelines for both short and long term goals, not just every six months. This allows movement in the care plan and the goals to be met in a short period of time as well as over the entire care planning cycle.

And then we also designate responsible disciplines and clearly outline those in our care plan. So you know who's responsible for accomplishing the objective in the care plan.

So when attending to participants' needs and building a participant centered care plan, it's really important to define what do they really want. As you heard me say before, there were slow decisions or no decisions being made in our team meetings due to lack of information or hesitance to deny a service. And what we were finding is that participants would come in and ask for very specific things from us. You know, I want two hours of my CNA on Friday because I want them to make me a meal. And what we were finding was that if we would do an assessment and found out that we could provide them with

a meal in a different way, we could give them a take-home meal or the CNA service only really needed to be a half an hour, is this really calculated into a denial of service for the participant because this isn't – they didn't ask for a meal, they asked for two hours of a CNA service on a Friday. So if this was the request that came to our team, it calculated into a denial of service. So what we did was we really trained our team to ask, you know, what are you really asking for? And to ask the question why? Why, why, why, why, over and over again, to really drill down – because sometimes the participants don't really know what they're asking for, they just try to make your job easier and solve your problem.

So we came – actually Altitude Edge Consultants came out to our organization and helped us with a tool that we renamed the Request and Decision tool, we actually formulated it to be more user friendly for our organization. But we use this Request and Decision tool for every participant request that comes across our IDT. And what it does is it just really drills down to what the participant really wants. That's actually question number one, is what does the participant really want. And it asks you to ask why a few times, so you can really get to the heart of what they're asking for. And it just really streamlines a request to one narrow process. What we were finding was the participant requests were coming at our IDT from all different areas. They may come in from the bus driver who went to pick up the participant. The bus – you know, the bus driver – or the participant may say to the bus driver, you know, I really need a CNA to help me out with meals on Friday while the bus driver's picking them up. Or it may come from the social worker. It may come from the janitor. It may come from the receptionist answering the phone. So our IDT was inundated with all of these different requests and we really couldn't keep track of where they were coming from. But now they all come through a RAD tool for our team, so it organizes it to one process for us. And it also allows for cost-effective, smart decisions based on medical necessity. Because it makes you go through a series of questions. And two of those questions, or two options are, if this doesn't work, what are two other options for this participant? Can you think of anything else that might work for them? So it makes you think of other creative solutions. And it also allows for CMS timeline adherence and tracking because we put that – the CMS timeline – right on top of the RAD tool. So the date of the participant request is right on the top. The date the team, you know, heard the request. The date the team acted on the request. And was it approved or denied. Did the client appeal the request. That whole timeline is right on the top of our RAD tool, so it allows you to track the timelines. And when CMS came out to do our survey this time, we did not get a finding in this area, so we were all very happy about that.

Essential elements of the care plan, and this comes right out of the Guidance also. But CMS tells us that there's five components of the care plan that needs to be in place. Problem statement. Measurable objectives, which we talked about. Interventions to resolve or mitigate the problem. Anticipated timelines into which to achieve your objectives. Identifying the staff responsible for providing the interventions. And monitoring the outcome.

We did pretty well with identifying the problem statement at our organization. I think we defined that to a T. We were really good at that.

Objectives. Using the SMART tool, we got better at that.

Interventions. We didn't always clearly identify the discipline responsible for performing the interventions. They were sometimes left open and carried over from care plan to care plan without addressing whether the intervention was actually happening.

And our timelines, as I had mentioned before, were always Q six months, so we were working on setting shorter timelines. We now include short and long-term timelines in our care plan.

So, just to recap, a well-defined problem statement will help you define and drill down to your objective. Your objectives, just make it SMART.

Your interventions, just make these agreeable to your participants, and be sure you can achieve them as not to frustrate your participants and your staff.

Your timelines. Set both short and long-term goals, and tracking is the key to accomplishing these goals. And responsible staff. Really outline who will do this and document the outcomes. Clearly define the responsibility within your care plan.

And now I'm going to turn it over to Cheryl, who will talk about some outcomes of our care planning initiative.

A friend of mine has four children, and while they were growing up they would – she and her husband would go through an exercise with them called my personal nightmare. And as an example, one of their sons, Christopher, had this ferocious appetite, and his personal nightmare was that he would get to the dinner table late and there wouldn't be any food left for him. Well, this afternoon I'm living my personal nightmare, which is being the last speaker of the last presentation of the last day of a conference. So, thank you all for hanging in there, and I hope that it won't be your personal nightmare.

Anecdotally we knew at the PACE Organization of Rhode Island, based upon the Guidance that we received from CMS regarding care planning we had that our care plans were not participant centered, they were IDT centered. That our interventions were not discipline specific. They looked really good on our care plans. We had some wonderful interventions documents, but, hmm, six months later the intervention would still not have been accomplished because we didn't say who was supposed to accomplish it, and, of course, the timeline was six months. So a year ago, after Suzanne's diligent work with the interdisciplinary team that she put together, a year ago, in March, we implemented all the changes to our care planning process.

There are a number of ways that we could, at this point, measure our impact of implementing these new processes. Quantitatively and qualitatively. First, we could have looked – we could look at the presence of all five elements that are mandated by CMS that be in the care plan. The problem, objective, interventions, time bound, and the staff that would be carrying out the intervention. We could also look at the SMART objective, are we – are we developing our objectives, specific, measurable, achievable, realistic and time bound? And then qualitatively, we need to look at what the outcomes are. We can have a beautiful care plan, but if our – if we're not looking at what the outcomes of the interventions are, then we haven't completed the quality cycle on this particular initiative.

So what we chose at the PACE Organization of Rhode Island initially was just to look and see if we were following through and developing our initiative – our objectives using the SMART tool.

Of course it's always best to have a baseline, and we did not. We did not look at our objectives prior to implementing the changes to the care plan. Fortunately all of our care plans are archived, so we were able to go backwards and do a retrospective audit on the SMART – on the objectives and see if they adhered to the SMART tool. The audit that we just conducted, we looked at the same participants, the

same problems that were carried over from one care plan period to another, and we looked at their objectives, both pre the care planning changes and post the care planning changes.

This is just an example of the audit tool that I used when I went into the care plans, so I looked at care plans prior to the changes and post changes. I also looked at whether the problem was defined, and looked at the objectives to see if they were specific, measurable, and so forth. The scoring mechanism that I used was that a zero was no compliance at all with that particular element of the SMART tool. A one was partial compliance, so perhaps there were two objectives that needed to be met and one was measurable and another was not, so that would have been partial compliance. And then full compliance speaks for itself.

So what we found was that we improved in all areas of developing our objectives. Our problem definitions, as Suzanne stated earlier, we did a pretty good job on those anyway, and as you can see, we did improve but we didn't have a whole way to go to begin with. I think the area that's interesting that we had the most improvement noted in, was the achievable or agreed upon goals of the care plan. And I think this goes back to where we began to really ask our participants, what is it that you want? Well, yes, we may want your hemoglobin A1c to be this, but you want to be able to eat chocolate cake on your birthday, so how do we combine those? So we really began to look at what was achievable and agreed upon with the participant.

We're still struggling with time bound. The time bound element of the audit. We still had a lot that were six months, we had a lot that weren't clearly defined, so obviously we know what direction we need to go in as we continue to develop our care plans.

Next we'll be looking at our outcomes. This is the – this will be the qualitative piece of our analysis. Right now we document outcomes real time during morning meeting. We have a facilitator that is able to document directly into the care plan where we are in achieving the outcomes that we've set for that particular participant.

Did we implement the interventions that we said we would? If we didn't, did we document why we weren't able to implement the interventions. And did we document the outcomes of the interventions? The electronic medical record that we currently use, we're also able to put in that objectives were partially, fully, or not met at all.

In summary the PACE Organization of Rhode Island identified the following as best practices that moved us toward compliance with the CMS care planning Guidance.

First, we organized. We removed the chaos. We developed rules for team behavior. We developed an agenda. And we document during morning meeting now.

Second, we chose to focus on the participant. Instead of focusing on the goals of the IDT, we removed that. We developed new intake and assessment tools that really focus on the participant. We look at achievable, agreeable, realistic and reachable goals, and what is the participant really asking for.

Third area of best practice for us was the use of the following tools, which helped to remove the subjectivity. Again, our assessment tools have been revised to focus on the participant, our COS tool gives us the – removes the subjectivity of whether or not someone actually has a change of status that

warrants additional assessment or a new care plan, and the RAD tool, which helps us determine whether or not – which is all about our service requests.

In conclusion, the result is that the participant, the caregiver, and the interdisciplinary team are working with a realistic, participant focused care plan. Thank you. Any questions? Is there a question over - ? PACE care.

This is a great presentation. Thank you very much. In terms of removing the goals of the IDT, and I know it can be very difficult when you're in that setting as the discussion gets going to kind of slip back into old behaviors, what did you do to put into place some checks and balances if you did notice the discussion kind of going down a different path as opposed to keeping the focus on the participant? I'll let Suzanne address that.

That's a great question. We just keep getting the – the IDT to focus back on the participant. For example, if the diabetes thing keeps coming up, I keep saying, well, why is that important? What does that mean to the participant? You know, why is that a factor? The participant has diabetes, so why is that important to the participant? And just as a reminder. And the team really buys into this, so they'll go all right, okay, why is that important to them. And it's not that we removed the goals of the IDT. We still incorporate those, because it's important for the team, too, to feel like they're providing care and that they're still working toward their own goals, but the participant also has to buy into that, too, and the participant says, you know, I don't care what my hemoglobin A1c is, you know, and if they're really pushing back on that, then we do, you know, compromise and remove that from the care plan because it's not important to the participant at all. But, you know, but we still work on that clinically as a goal. Does that answer your question?

I was glad to hear eventually you did use the word goal, because when you went over the five elements I was looking for actually somewhere in the presentation where I would hear a goal, because the overall goal is what you want to accomplish, but you state what the problem is and then there is the measurable objective to meet the goal, and sometimes in care planning, what we have found in Virginia when our teams were first getting started, that they would confuse a goal and an objective, and they are actually two different things. And having a goal is very important, just as well as it is to have the objective. So I just wanted to make that comment.

Thank you. Good point. Anyone else? Thank you very much.