



# CMS 2012 Tri-Regional PACE CONFERENCE

Programs of All-Inclusive Care for the Elderly

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## TRANSCRIPT

### Interpreting Level Two Events in the Community

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Good afternoon, everybody. So on the break this morning, I called back home to our clinic and I spoke with [Theresa Tyse], one of our nurses; and she said, "How's the conference going today?" And I said, "It's going really well." I said, "I'm a little worried because we're towards the end of the agenda that we might not have much attendance as it lingers towards the end." And she said, "Well, tell them the same applies that it does for parents at a recital, that no parents can leave till the last kid performs." So that's the rule.

Anyway, so Janet and I were in the holding area; so we didn't hear all the discussion. But from what we could tell, a lot of the things that we're going to touch on were also touched on in the presentation that preceded us. So if that's the case, forgive us. We couldn't hear everything that was happening, and you can set us straight." So Janet and I are going to present this primarily from our perspective as providers at a PACE site -- 150 participants, only PACE site in Maryland, and we've been in business for 15 years. So put that into perspective. We can talk later about why we're 150 and been in business for 15 years, but that's another story.

So here's the objectives, pretty much as I stated. The focus of our talk -- and Janet will be giving a really nice overview of the process by which we address these issues -- but the focus will be from the perspective of our model collectively and how these events that fall into the category of Level II events, why they might be -- and I suspect that this was touched on in the session before -- or necessarily be considered different because of the model that we practice and particularly considering two aspects. One is the community or non-institution based care where a lot of care is provided in various sites, much of which is not under our direct control; and the other aspect being the end-of-life care that we typically provide. So that's what we'll do; that's the objective for today.

So like all of you know, we target a population which is distinct; and I'll walk through these, but these are all directly relevant to the position that we're proposing of a different set of standards or a different approach to assessing these Level II events -- not different, but a perspective that would be informed by these characteristics of PACE.

So the physically/cognitively frail -- that goes without saying; a focus on community-based care. Our design, our mission, our intent is to keep people out of places where it's easier to control and manage care. So an institutional setting where it's in a building, and there's 24-hours staff, and the protocols

and procedures are implemented and carried out on a 24-hour of basis is different than a model of care that is in the community, where the people typically live on their own or live with people who aren't our direct staff. And just to reiterate that, most of our participants – although not all – most of our participants spend most of their time out of our direct supervision and therefore direct ability to implement.

It is appropriate that we be responsible for care planning, and Janet will touch on that, in guiding care; but there is a certain limitation of implementing plans that would impact the occurrence of Level II events. Again, our mission is to allow people to stay in those settings for as long as possible – ideally to the very end of life – and that is done in the majority of cases. Unlike other long-term care settings, the PACE model, as you all know, is more successful in allowing people to die at home.

So you put all that together and you say well, you have these reportable events which, you know, interpreted or implicit in that is there's something about the care that needs to be reviewed, evaluated, potentially changed. You say, "Well, you're doing this under these circumstances. That's a bit risky for the program to do that and for the person to receive care under those circumstances." And I think that we all embrace, yeah, there is a certain amount of accepted risk in that; and with that comes the possibility of a certain rate of these events. And we'll talk more about that. But a general rule which we all embrace, I know, is that allowing people to be autonomous generally trumps protecting them from bad things when the protection is at the risk of compromising autonomy.

I won't go into the details of this because of the nature of this audience, and you can certainly access this document online through the CMS website if you don't already have it. And it's basically describing the events, how they came to be or more in the details of what they are. And basically, in the old jargon of sentinel events or things that shouldn't be or we'd prefer not to have happen or at least happen at the lowest rate possible. And the other key thing is that they're at the individual level. They're not at the program level, in distinction from the Level I events which are also things we track but are aggregated – although it sounds like that may be changing a bit from the earlier talk today. So we interpret by these being collected, recorded and analyzed that there's a significance behind that that we should pay close attention to why those are occurring, what they imply about the performance of the program. And lurking in the background is what that means from the standpoint of our ability to provide quality. So what do these mean in the context of these mean in the context of providing quality care to our participants? And I think what you were probably – from what I could hear – were touching on in the last session as well.

So this is a fairly recent phenomenon in the Level II initiated by CMS – the NPA representing all of us in the PACE world, established in collaboration with CMS this external reporting taskforce to revise, refine and then ultimately unveil to the practicing PACE world. I was fortunate enough to participate on that task force. And I know that a lot of scrutiny both back and forth from NPA and CMS was helpful in getting it revised to the final form that it was. The timeline – I think about a couple years in the making; and it was officially, as you all know, at the beginning of 2011, so a little over a year ago.

And both on the CMS side – which we know, we've heard a lot about – and on the PACE provider side, there was preparation and trying to not only come to an agreement about what those Level II events should be and how they should be explicitly defined and be the most appropriate – but then also what the impact might be in using them. So the PACE providers naturally, when there's a new monitoring/reporting process, there's a bit of anxiety with that; and I'm sure many of you shared that as well. And not knowing exactly if it captured what we do and what we do well, or if it maybe didn't

exactly reflect what we did do well -- and we'll talk more about that with regard to our mission and how that was addressed with information from the NPA office to the provider organizations; little cluster -- huddles about what to do and how to anticipate; and then to begin the actual data collection anticipating; and then of course Janet will talk more about what we have done as a site, with her leadership, to actually do this.

So this is important to point out. This is our NPA survey; this is not a CMS survey that I'm sharing this data with. This was provided to me from Maureen [Ennis] from the MP Office, and this is data they collected over a four-month period last year -- so at the beginning. 61 of the 75 sites participated at that time. The majority -- well over half of the participants' lives -- were included in that survey. In that window, there were 194 Level II events. And you can see there that about 75% or 77% -- three-fourths -- were in the top two. So when you're talking about the bulk of what's being reported, it's pressure ulcers -- and I could hear from the discussion that's what you all were talking about -- and falls with injury. And the data does support that.

So there's additional data provided to me from the National PACE Association was that this in addition a national database for falls -- not falls with injury, Level II. So from the HPMS data, that is also being collected and put together to establish a baseline. And we'll come back to this idea of what's the right baseline and what baseline of these rates is reflective of PACE in general, what's reflective of what we think is quality care within a PACE organization. And as I said, these rates are unknown. I mean, we are the organizations that are doing it; and we just started, so we are establishing the baseline of these events, and we're all very interested to not only know what those numbers are but kind of why we're doing this talk is to help inform the interpretation of that data, given the mission and the nature of our program. And would the impact on interpretation -- can the preparation and understanding impact that?

So at our own site -- our 150-participant site in Baltimore -- Janet, who organizes this, collected this, and not exactly the same. Of course we have a smaller number, so we have the ability to -- and this is since the beginning. So I'll show you from the beginning of 2011 to now, there were 18. So these are 72% of 18 and 17% of 18. So our rate over an extended period -- about a year -- was similar, although we didn't have enough events to have a broader distribution as you saw in the NPA survey.

But what I wanted to point out in highlighting these top two -- and I know that it was discussed in the last session -- is when you reflect on our mission and you think about what we're trying to do and the lack of direct involvement that we have on the 24-hour care -- although we implement care plans and we guide care and we try to do all these things to get positive outcomes -- these two events, particularly in our own experience, were occurring at a high rate. People in the community, people who were end-of-life -- 13 of the 18 Level II events were people who died within six months of the Level II event being reported. And only one of those was directly related to the Level II event reported. So you can see that the prognosis and the care plan and the goals of care are almost certainly different in that population, which probably we almost certainly believe affects the risk for having at least the top two, possibly not the third.

So that's my part. I want to hand it over to Janet and let her speak about how we approached it at the site.

Thank s, Matt. Boy, I am as short as I thought I was.

Good afternoon, everybody. So not to be redundant, but I wanted to give you a little bit of background about how we got started at Hopkins ElderPlus. And as many of you had a little angst when this first started, we went from sentinel event report to Level II. And that occurred in January 2011. We started off by doing a lot of education with our staff on the written guidance. We spent a lot of time in morning meeting talking about it. And one thing that really helped us is we developed a tool – several tools, a checklist and an investigative worksheet -- which has really helped us stay organized with this process.

So as I stated, right off the top we made a conscious decision that we were going to have this reported at morning meetings. So this happens to be a standing agenda item every morning. I usually facilitate morning meetings. And this gives us an opportunity to talk as a group about the particular event we might be discussing. And anybody can bring up anything. And so we kind of look at it as a team and see if there's opportunities here – if this is in fact a Level II if it's going to meet the criteria.

Once we've had that discussion, I'll go back and review a little further about what happened with the event. And if in fact it is reportable, I'll go ahead and do that via e-mail. And one of the things that I do is assign the appropriate team member or members to investigate the situation. And in our experience, we've had a variety of people be that investigator. We've had a social worker most recently do it. We've had our nurse practitioners do it. Our wound care nurse – we have a nurse that works closely with the nursing home. So it kind of just depends what the situation is who's going to be the person assigned. And then really my role is to assist them with that. So I kind of coordinate the whole process.

And I think you got a handout – hopefully; and if you didn't you can refer to your binder. This is the first part of what we call our "Investigative Packet." And we'll be keeping this altogether for when we actually do our CMS phone call, as well as later down the road if we want to look at this event for some educational purposes or some quality purposes. So if you want to take a look at the checklist, I won't go into great detail about it; but it just is a guide for the person who's acting as the investigator, has a little bit of the description of the incident, any e-mails that might have gone back and forth about the incident, any statements, a little bit in the medical record documentation, if we have to communicate with Risk Management about anything that might have happened surrounding the event.

And then, how do we look at the Level II review? I kind of look at it from two levels. First, I look at it from the participant level. So, was the risk identified prior to the event? In our situation, as Matt alluded to, a lot of them were pressure ulcers. So was this a bed-bound patient? Were they at the end of life? Had they stopped eating and drinking? And in a lot of cases, the answer is, "Yes." Also very important -- was a care plan in place? So had we started comfort care measures with this person? Had we worked with the family, if they're at home, about turning and positioning? And then most importantly, was that care plan implemented? So did we go back and continue to review it?

And then the second level we look at is the program level, which is the higher level. So is there a related Hopkins ElderPlus policy we can refer to, or do we need to change that policy? And then again, also very important, was that policy followed?

This is the second tool that we developed, and this is crucial to when we get to the phone call. And we like to look at these phone calls as a collegial time; it's a learning time. Of course there's a little anxiety before we get ready for the phone call. But this is the worksheet that we use when we're actually getting ready for the phone call so we stay organized. And as you can kind of see from the worksheet, there were some CMS suggestions of things they wanted on the conference call, including the basic demographics, the information on the patient's current status: are they still alive? are they still in the

current situation, or has something changed? a summary of the event – so what happened? what were the contributing factors to the event? and then of course our root cause analysis, and for us, a real important component is, what did we learn from all this and are there some quality-improvement measures we can implement that's going to help us down the road?

So you might ask, "What lessons learned?" And we actually have learned some lessons. We've tightened up some processes, and we've grown through this process actually. So we've identified some trends, and mainly the event that probably I think stands out for all of you is the end of life and a lot of the development of the pressure ulcers. Have we identified risk areas? Yeah, we have; and we've actually reworked and revised a number of different policies and approaches. And all the time, we're identifying new and revised policies as we go along.

And in closing, I just wanted to share a quick case study. I know you probably were inundated with some case studies, but this is a real-life case study of ours. This was a particular individual who'd been on a program for a long time. As Matt indicated, we've been around 15 years; and she'd been in the program for quite some time. She'd been mainly living at home maintained with a sister, although she had a ton of comorbidities and the sister was a little bit of a challenge. And she was a pretty brittle diabetic. She ended up in the nursing home, although that was because she pretty much took a bad fall and her ambulation was poor and she couldn't get in and out of the house. She was at end of life. And we did a pretty thorough investigation when she developed a Stage 3 wound. We have a nurse that functions – kind of a liaison's role with our nursing home. And we had developed a care plan, and we had implemented measures in the care plan. But we did find some improvements we needed to work on. One is, we do have a very good relationship with a nursing home we use frequently, but we still could do better. So we had a lot of conversations with that administrator, and we had some requests and they had some requests. And one of them was to get a weekly skin sheet from them. That was on and off a little bit of a difficulty, which we are getting now which we use weekly at our skin round sessions. And we're making more rounds at the nursing home and developing that relationship.

Matt, I'll turn it back over to you.

So this is our conclusion slide, and we'd love to take questions. I think we have a few minutes left in our time. And so what we drew from this from our assessment and the process we've addressed from Janet's leadership is that the mission of PACE, what we do, increases the likelihood of events that will be classified as Level II. At what level? I think that's yet to be determined, and it will also depend on the population particularly served by a PACE site and the availability or the desires of the population they serve, which may be variable. But certainly underlying it all that the PACE mission does, we believe, increase the likelihood of those.

And the interpretation of the events and significance of them should therefore be interpreted within that context. And we, like many of you who are PACE providers I'm sure, are very interested in continuing our collaboration with CMS who have been great as Janet pointed out. Our conference calls are very informative, very collaborative; and I look forward to them. I don't find them – and I know Janet's always very well prepared, so that helps -- but so far it seems it's for the right reasons and going in the right direction in that regard.

So with that, I guess, Janet and I – if we have time – would be happy to take questions.

Early on – Matt, how are you? Here -- It's Fred.

Hey, Fred, how are you?

Early on we actually, by the state, sent our written reports to CMS. And so they said we should never do this again. But upon reflection -- I mean, these are so complicated; and to listen over the phone to a case presentation and not have it in front of you in writing seems to really put the listener, in my opinion, in a disadvantaged position because these analyses are so complicated -- and what you've done and what we've done is, you know, complex. So I just wondered from a CMS point of view why they don't ask for it in writing.

Yeah, I can certainly ask somebody from CMS. I'll go even further. Janet and I have noted that, as you said, they're conversations -- we don't even -- there's a specific, as you all know that participate, to not even mention the name. So they're very anonymous, and they're not written or submitted in writing; so I can see your point, but we'll let CMS remark as well. But it does sort of lend itself to thinking just about quality improvement concepts sort of -- what about this? But as far as getting the precise situation conveyed, I think you make a good point. And if you want to add anything else?

I was going to say, I think /INAUDIBLE/ contact too because there's a lot that goes into the investigative piece of it, so to speak. And we've been cautioned to just go ahead and do it on the phone.

Hi. Thank you for the presentation; it was wonderful. I think from the perspective of Level II, having been on in with Dr. McNabney from a three-year project actually the task force was -- the perspective of not documenting it is because for the very essence that it is a quality initiative. And if there were those situations, then that would be taken up as part of the auditing process or whatever would be appropriate. So it is a quality initiative that is for improvements and from that perspective.

And I wanted to point out -- I know this case. And I think one of the things at Hopkins ElderPlus that I have been a part of, and we definitely have discussions and dialog and really try to come up with quality and stimulate conversation, is one notable thing with this case that they provided is some of the cutting edge pieces that they have instituted for coordination of care -- having a nursing home liaison nurse, having skin rounds. And some of these things and the coordination of it has evolved -- but work and definitely lend to comprehensive care. And I thank you because that is a very difficult issue -- being 24/7 responsible for a participant and the nursing home and the education and training and that dialog that needs to occur is very, very helpful. Thank you.

Matt, I thought it was very interesting your comment about the high mortality rate of people who had Level II reports. And I just wonder if maybe all of the medical directors should pool their data and start to look at that -- whether or not Level II reports are a marker or perhaps a cause of limited life expectancy. And I know Roger Zioncheck is always looking for ways to do better prognostication -- maybe Level II reports may lend us to that point.

I think certainly pooling the information is definitely -- now, it would obviously be a component -- many more people died that didn't have Level II's. But you're absolutely right that it could be informative for sure.

We have one more.

Hi, I'm Cindy from CMS and just to piggyback a little bit on what MJ had said as far as the anonymity of why you don't want anything on paper. And really, it is back to trying to protect you as an organization because in the event of a really negative, adverse outcome and if lawyers would be asking us for information, anything that you sent to us formally would be discoverable. And we wouldn't want something that you're documenting to say, "We could have done something differently" to look negatively on you as an organization. So that was the primary reason why we try to keep it all as a verbal conversation.

We have one more.

Thank you very much. I did want to ditto that. I think that the number one trend that we've seen is that our pressure ulcers are clearly in the very end stage end-of-life; and it's not the pressure ulcer that caused the death, it was the dying process that caused the pressure ulcer. But I do think it would be good to have that data across the board.

My question is on skin assessments, and it's really an issue that we've been talking about over the past year and trying to get that skin integrity check and who's accountable for that. And we seem to really do a good job if we can get them to fully disrobe at a reassessment. But we've had a lot of pushback from some of the participants – up to 50% really do not want to be undressed for those exams. And in reality, even if that was every six months you were doing a full skin, you're really not checking in between. So trying to figure out, How do we manage that gap? And you know, it's finding the pressure ulcer. It's not getting the weekly wound assessment note done; it's really finding it to begin with. And I'm not sure what suggestions are out there on how to better improve our processes.

So getting assessments at the reassessment time, but more even ideally in between you're saying? I know Janet has led out wound care, and I know that we have the formal rounds. And I know that for one thing the Braden score is done with every re-eval; so every six months we have that, which definitely is not the same as a skin assessment, but it's at least allowing us to care plan for high-risk people, which is a real step forward. But I think it's a challenge to get those assessments done and to get them done adequately. But maybe this at least is an explanation to participants why – you want to help them, but it's even mandated or something to that effect.