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TRANSCRIPT

Level II Reporting: Case Analysis

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Hello, everyone. My name is Anitra Johnson. I'm the Nurse Consultant for the PACE Program at Central Office. So most of your issues and concerns – I am that person behind the curtain. I'm new to the PACE Program. It's been a year at the end of this month. So a lot of your issues and concerns, I'm not aware of. So in this presentation, my information is at the end of the slides. Feel free to call or e-mail me with any of your issues or concerns because I'm not aware of a lot of things because they're going to other staff or non-clinicians, and you're not getting the answers that you need.

So today Lieutenant Commander Leboe and myself will talk about PACE updates and just go over two case studies that have come across our desk and just to give an overview of how the root cause analysis should go on. I am currently in the process of revising the Level II Guidance. It has been a year – January '11 through January '12 – and I'm quite aware of most of the issues and concerns that you have regarding the Level II Reporting Process. We're looking at the incidents and the thresholds initially to see how we can add, remove and redefine some of the incidents and thresholds to make this process a little easier and useful to you all, as well as myself and the other clinicians and account managers.

We're also revising the way that we report Level II incidents. And things that we would like reported for training and tracking purposes may not always require root cause analysis. So we're trying to figure out how can we go through the incidences that may not require root cause analysis; for example, that patient that's at end of life. They don't want to turn; they don't want to reposition; they don't want to eat. Stage II, III and IV, the /INAUDIBLE/ are we can't prevent them; but it's nothing you can have done differently to prevent them because the participant is going through the death process. Those things, I don't feel as though we should continue wasting your valuable time and resources to have these phone calls when the Stage III and IVs, we can't prevent them. We've done what we should have done when they were well. And as they go through the death process, we can report them so we can track and trend; but going through the root cause analysis may not be the most effective way to continue with this process.

The content in the Level II Guidance, there's a lot of data in there that is old – e-mail addresses, the content, definitions – we're revising those as well. And it's come to my attention that nothing's tracked and trended by PACE organization, by state, by region or nationally. So I think I'm up to November by entering all of the Level II incidents, and then myself and another clinician will start analyzing all of the

Level II events to provide you all some information on how you sit within your state, your region, across the nation with falls, pressure ulcers, so on and so forth.

And I'm going to hand it over to Michael.

One of the key take-home messages we want to share with everyone this afternoon regarding Level IIs is that we are looking to improve the quality of care and to assist you with doing so. The Level II calls, and I want to stress this, is not to be punitive on any level. I know there's been discussions out there about where this information goes or what we do with it; but it's really all about us trying to help you achieve the best outcomes for your participants and, once again, just having the best quality care possible.

What we're going to be doing next is going over two case studies that have come into some of the regions, and then give you just the background information of what the case was about. And then we really wanted this to be interactive; and we're going to throw questions out there to you and to give you some sort of idea of the way in which that we process the information that's being shared on the conference calls because one of the questions we constantly get is, "Well, what is it that you're exactly looking for?" And what we would like to do today is be able to teach you the way in which we're looking at things and to see if we're making sure we're looking at things on the same page with you. So once again, I'm going to throw questions out there; and I'm hoping that you guys will be able to give some feedback. And once again, there is no right or wrong answer as we go through it.

So the first case study is about an 89-year-old participant with a diagnosis of a CVA, COPD and depression. She is on palliative care. Her last time she was seen in a PACE clinic was on September 29, 2011, for her six-month care plan update. Her medication was filled on October 29, 2011; and the PACE organization called to deliver the meds at home, but there was no answer. So a few days have went by – 11/5 – there's still no contact with the family or the participant to deliver the meds. So here comes 11/24, the family says, "Hey, guess what? My mom has some sort of rash on her back. Can she come in the clinic?" So the PACE organization's like, "Of course, bring her in right away." So she was brought in, and what happened? On 11/29, the PACE Clinic noticed that she had five Stage IV pressure ulcers and also had four Stage II pressure ulcers. So immediately the PACE organization wanted to implement wound care right away, the next day, obviously, because of taking the right care of your patients. But unfortunately, you can see a few days later she expired.

So the first question that just comes out there – and this is for anyone – once again, no right or wrong – is, "What could the PACE organization have done differently?"

/INAUDIBLE/

Exactly, you got it right on. And that was once again, we're looking to help you look at – okay, all right. His answer was that the PACE organization should have followed up with the medications immediately. If you go back and you look at the dates, the medication was due on 10/29 and still on 11/5. So there's your first problem right there. Even, "You went one entire day with no contact; why did you go two days?" So that's how we're trying to help you guys look at the processing of your system.

All right, so the next one is, "What could maybe the participant or the family done different?"

/INAUDIBLE/ ...just said, "What could the PACE organization have done differently?" I just wanted to add if the person is on palliative care and apparently not coming to the Center, then there's a missing

piece in terms of coordinating the care and going out to regularly see the individual, as well as the medication.

That's exactly right, thank you.

All right, does anyone have any ideas maybe what the participant or the family could have done differently? I hear someone back there.

/INAUDIBLE/.

Yes, that is true; but obviously, this was a family that was not probably – in my opinion – not coping so well and just struggling with their disease process and the dying process of their mother. So they're not reaching out to the PACE organization. So once again, it goes back to the PACE organization to be constantly looking at those people who are on palliative care, end of life, to make sure that they're getting the contact on a daily basis.

So does anyone think that these pressure ulcers could have been avoidable?

So the story behind – oh, go ahead.

When we've been talking about end-of-life care at this conference -- if the family had been educated – and, "These are things to look for" – then there may have been an additional opportunity for the family to have called in and said, "You know, these are things that are starting to happen with Mom."

Very good, thank you.

Anyone else? Well, of course, these pressure ulcers probably could have been preventable. The long story behind it is basically because the daughter wasn't coping well with watching her mom die, she just kind of got stuck in that place; and not having the emotional support, she left Mom just in the same place for the entire month. And unfortunately, that's why she got the pressure ulcers.

So what does anyone think how the PACE organization should be re-educated? What do you guys feel that, you know, is there a specific department or a discipline, or is it a whole new IDT team that needs to look at the re-education component. I'm curious to know – and once again, there's no right or wrong answers here – but it's looking at the team approach and maybe where they could have been re-educated.

Very strong in a multidisciplinary approach – I would look at therapy. Was there a special mattress on the bed where she was? Did they train in re-positioning? If there were people going into the home, did they look that they were being re-positioned and have regular skin assessments? Did the dietician assess the nutritional status and put everything in place that she could? The home coordinator – ours does a lot of training with the family.

Thank you.

Anyone else have a thought? Tony?

Well, the only thing that I thought about was, “Where was home care?” Was the family on their own? Was there any personal care being delivered at all? Was the daughter solely responsible? And I don't think she should have been.

Mm-hmm. You bring up great points, thank you.

I think when you start to have someone on palliative care, that's kind of a tricky situation I think. If you're not well educated in palliative care, it's sort of that place between acute and hospice; and I'm not sure that a lot of organizations have a lot of really good sense of palliative care. So you might put somebody on palliative care; and just because you check the box doesn't mean you have to move on. You almost have to put them in a category by themselves to say, “This is what might happen. This is what to be prepared for.” So I think it's sort of a red flag for us sometimes with palliative care.

Ms. Thomas?

Yes, I know the case. Another component was the family had a trust issue, and they did not want home care in their home.

So once again, it was more about what the daughter's emotional needs were going through at the same time. And that is a big component of this case that got overlooked.

So going towards – and does anyone think there could have been something different from occurring with other patients – how we could possibly would have helped this family or this participant so this doesn't happen to any other participants in that organization?

The question that I would ask in a situation like this, “Where was the IDT?” Did the IDT come together and discuss the case once the individual's status changed? Was the plan of care amended to reflect what services this individual would receive under palliative care? And who was the discipline that's going to be responsible?

Great, thank you very much.

Anyone else have any thoughts?

Yeah, I just want to go back to basics. I assume that this gets a root cause analysis.

Correct.

There's no doubt in my mind. This is a catastrophic outcome, and all catastrophic outcomes come from multiple human and system failures. That's basic 101 in outcome analysis. So that's how I would approach it in my organization – systems and human failure. And get everybody who was involved -- IDT plus other providers – and try to make two lists – systems/humans – and then try to piece it together and to see where the failures were because it was multiple human failures and it was multiple either latent system errors – systems that we know have problems with them, we'll kind of like take it for granted everything's okay -- or systems that just malfunction.

Yes, thank you.

Anyone else?

I heard someone say that the family didn't want people in their home. And one of the comments I wanted to make was first of all, one of my first thoughts was, "Why -- you know, this lady seemed to be at the end of her life -- why was she considered palliative care rather than offered hospice care? Secondly, I do think that if you have families that are uncooperative in not allowing people in when it may be in the best interest of the participant, that it does become an ethical issue. And I think that program should have an ethical decision-making process or an Ethics Committee process -- some way of dealing with these situations because that woman could be at risk because her family is refusing it, even though it's in her best interests. And I think that should be considered.

Yes, thank you; you're exactly right on.

Anyone else have any thoughts?

So what is the take-home lesson learned from this case study? It is -- we heard a lot of different opinions here -- but once again, it's about the coordination of the care of the individual. And unfortunately, like the gentleman said earlier, it was a catastrophic case. This is not something that happens all the time in terms of that many pressure ulcers. But unfortunately somebody was kind of -- the ball just kind of got dropped; and it's unfortunate.

And I do have one other question over here.

Just a comment, we are going to face cases like that where the family, for whatever reason, they neglect the loved one. And I think, you know, it has to come to a point when you have to report that case -- either to Adult Protective Services -- to get some sort of support. Because if we have done all -- whatever it takes, assuming that the IDT did whatever was supposed to be done, still we don't get any answer -- no answer at home, not from anybody in charge of the participant, then Adult Protective Services should be considered.

Thank you.

Any other questions or any other comments?

Well, I want to thank you for participating in this. Once again, this was just an opportunity to share with you guys how we are processing these Level II calls in terms of looking at questions and trying to help everyone think a little bit outside the box. And I'm going to turn it over to Commander Johnson, and she is going to present case number two. Thank you.

Okay, case study number two: An 86-year-old participant who lives alone fell at home on 10/13/11. The participant did not attend the PACE Center on 10/13/11 through 10/15/11, and those were their scheduled dates to attend the PACE Center. The participant has a history of diabetes and COPD, with no history of falls. The participant was found by the home health aide on 10/17 on the floor behind the front door. Who should be notified at this point? What would we expect the home health aide to do once he or she arrived at the participant's home?

I hear, "Call 911," "Call the PACE Center." Call the PACE Center. The participant was taken to the emergency department via EMS on 10/17/11. The participant had a fractured hip and fractured ankle.

The participant reported she tripped over the rug at the front door when she was attempting to go get the newspaper off the front porch. The participant had hip and ankle surgery and was discharged from the hospital on 10/25/11 due to post-operative complications. This is a big issue with a lot of Level II calls when the participants have stays over five days, whether they're related to the initial incident or not. This incident was related to the fall; so this was beyond the five days, and it did need to be reported as a Level II.

Is there anything that the PACE organization could have done differently at this point? Is there anyone that we need to re-educate or something different that the home health aide could have done?

The beauty of PACE is that if an individual is a regular attendant of a PACE program and that individual is not seen for several days, you would think that that would trigger something from the staff to do some type of follow-up call. That's my comment on that.

Yes, ma'am. And that's what was discussed on the Level II call -- that no one went out in between this timeframe to check on the participant to see why they weren't there for three days.

The next question, "What quality improvement initiatives might the root cause analysis reveal?"

/INAUDIBLE/ ...and causes the fall. You have to do an assessment and do like a root cause analysis to find out specifically the underlying conditions that brought her to that condition. And then not only before if preventing all the time, but now, what are we going to do after the surgery? Because in adults at that stage, a hip fracture is very significant.

Exactly.

It changes the whole life of that particular participant.

Thank you.

One of the first things that crossed my mind is whether home safety assessment had been done initially and whether they recommended removing the rug in front of the door as a trip hazard.

And the rug wasn't documented as a home safety hazard until they discussed it on the root cause analysis. So that throw rug that she loved probably could have been maybe placed somewhere else, or we may have just had to inform her we couldn't have this here because it was a safety hazard. And this is the result of having that rug there. This definitely could have been prevented.

Is there a need for further education to the participant, the family or the PACE organization after looking at this Level II incident?

Here we go, right here.

Hi. The first thought that comes to my mind is, "Why wasn't this participant followed up on the first day that she wasn't there in the PACE Center when she was supposed to be there?" And also after the organization looked at what had happened, I would say they needed a change in processes to follow up immediately. And she could have had a lifeline as well.

Exactly, and that was the suggestion – the Medical Alert system and was there a process in place? Is there a certain amount of days, certain amount of hours, when the participant doesn't respond or doesn't show up at the PACE Center, when does your staff make that call and when do they make a visit to the participant? So those items were implemented in that PACE organization.

Another question that I would ask is whether the van driver checked on the lady. If she was on the manifest to be picked up, you know, why did the van driver did not communicate with her through the door somehow?

Exactly.

And that would have prevented a lot of suffering.

And once the van driver – no one answered the door – they just went to the next stop. There wasn't any interventions, any phone calls, or awareness to the PACE Center besides the participant not showing up.

Anyone else?

We have eight minutes left. I don't know if anyone has any just general Level II PACE questions that myself or Mike might be able to answer? I will let you know once the Level II Guidance is revised, my next step is to start on the care planning guidance to get a work group together to go through the care planning guide and issues that you all may have expressed – account managers have expressed, clinicians have expressed – that need to be considered as we go through revising these guidances.

Yes, sir? Sure.

/INAUDIBLE/ ... brought up earlier about somebody goes to the hospital for one reason – complications – end up staying longer than five days; and always the question comes to me, you know, "Is this a Level II or not?" Any guidance on how to decide those issues that – you know, let's say somebody went in for a hip fracture, got pneumonia, things like that.

Right.

In my opinion that's Level II, right? They wouldn't have been in the hospital unless they fell.

Exactly. That has been something that myself and the work group has looked at. Participant goes in with a fall and because their sugar was 1,200, they had to stay. As clinicians – and the clinicians need to help the account managers determine – would this have happened if this participant did or didn't fall? And we're trying to figure out a good and clear, concise way to put this in the Level II guidance so everyone understands it. But also know you call or e-mail me at any time when there's a question or concern or you just need some clarification on a Level II.

I have a quick question on the case about what happens if the actual protocol is followed and the participant calls out and proactive calls are made; the participant is fine; and on the day of the fall her scheduled home care aide finds her, she actually is wearing her ERS, but she didn't use it appropriately; but everything really was in place. The home safety evaluation was up-to-date, but she didn't want to remove that rug. So a part of your root cause analysis is always to find where the gap is, and what

happens if you don't really find a gap? And how do you go forward with addressing the rest of the root cause analysis in the Level II?

So we're trying to find out what we would have done if the participant did not want to remove the rug? Is that what your question is?

I guess all the question is, "What did someone not do right?" But what happens in situations where actual policy and protocol was followed, and you just had a bad outcome without anybody to blame for not following protocol and following home safety?

And that has been the case in several Level II calls, because my responsibility is to be on all the Level II calls. The root cause analysis is beneficial for central office, regional office, and hopefully as well, the PACE organization; but all the time we don't have something that we could have changed or done differently or improvise or revise the process because it was something that we could not have prevented. In reference to the participant who recently was at the bus stop and was struck by a bus and expired -- the PACE organization, the clinicians, the account manager -- there was nothing we could have done differently because that patient was competent enough to get on the bus. And they went to the bus stop, stood in the correct place; but negligence on the part of the driver caused an adverse ending. So there isn't always something that we can change, but I think there is always good reasons to have discussions regarding the Level II events. I hope that helps.

Another one here.

I have a situation that arose when we submitted routinely our quarterly reports to HCMS. And in one of our incidents, it was listed that there was an allegation abuse made. There was an allegation. We were then called by CMS and told that this should have reported as a Level II event. So our question is, "Allegations of abuse not proven are now to be reported as Level II events?"

In the current Level II Guidance, there's nothing to say about elder abuse or allegations or actual abuse. That is something that the clinicians and the account managers are considering in the new guidance. What should we do in situations that it's suspected that it has actually occurred -- whether it's physical, financial, whatever kind of abuse could have occurred to this participant -- what is our responsibility to this participant? But right now, as the guidance is written, it's really not clear to say that you should report an incident such as that. So the regional clinician may have made that decision from maybe information that he or she received that that should have been reported as a Level II.

I think it says report to your State agency, which is what we did.

Okay. And then with some of the abuse issues that have occurred, the states, when they have the Adult Protective Services perform an evaluation, they're not required to give us that information; so we're still at a loss. They have performed their investigation; and obviously we're assuming that they found nothing because they didn't come back to us to say, "Remove this participant from this situation." So it seems like we're just kind of stuck. What should we do? Where the money was stolen, again, it was sexual, physical -- that's one of the other incidents that we're struggling with. How should we define it, and should we define this to be a Level II event?

Excuse me, I have one more question over here. I know you've had about a year now with the Level II reporting and listening to all of our stories as we go through the root cause analysis; is there any plans to

put out best practices? I mean, you don't have to say where it came from; but just in listening to everybody talk, I think there's a lot of lessons learned that all of the PACE programs can – you know, maybe that hasn't happened in our program; but if some other program had had it and done a root cause analysis and implemented something, it may help us in the future. So maybe just a suggestion.

And on some Level II calls, I do ask the PACE organization to forward me a policy/procedure/best practice that may have worked. The bedbugs was a big one. Some of the Midwest states had a clear policy on what to do in the incidence of bedbugs. So they sent it to me, and it was available; but on my end, I need to clear it before I can send it out to MPA, to the PACE organizations to use, and to start that whole best practices – standards of practice – for us to utilize. So that is in the workings, but it's just a process to go through – whether it's pressure ulcers, whether it's falls. There were several presentations of charts – spreadsheets – that current PACE organizations are utilizing. Those would be very effective in other organizations, whether small or large or mid-size, to use or at least to have a framework to adjust to fit your needs. But yes, that is something that I have expressed to Central Office and to leadership, that we need to do this. But some of the non-clinicians, it's very challenging to have them understand what we know as best practices as standards of practice as clinicians. So that's another variable that I have because everything we don't have documented. And like you said, "How do we use something that either we don't have the source or it's not a source – it's just as we function as clinicians?"

Thank you.

Thank you.

I have twenty seconds. Oh, so I've passed it. Now they're counting up; they tell me I've gone past my time. But please, feel free. There's reason why you can't call me, you can't e-mail me if you have any questions or concerns. I'm available – as long as I don't have a Level II call. Thank you.