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EDITOR’S PREFACE

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Since its initial publication, the PACE Medical Directors Handbook has introduced numerous prospective PACE Medical Directors to the PACE model, guided dozens of new Medical Directors into their new roles, and reminded veteran Medical Directors of the full range of our clinical, administrative, and regulatory responsibilities. By all accounts, the Handbook has filled a void and fulfilled expectations.

When the Handbook was first published in late 2006, there were 37 PACE organizations operating in 25 states serving 15,000 older Americans. As we enter 2011, the number of PACE organizations has more than doubled, PACE is an option in 29 states, and there are now over 23,000 PACE participants across the country. Clearly, the PACE model is thriving.

As PACE grows, the need for the PACE Medical Directors Handbook remains. Organizations looking to sponsor PACE rely on the handbook to educate and recruit qualified medical leaders, and those leaders refer to the handbook as they contemplate their participation in the transformation of care delivery that characterizes PACE. The Handbook serves to document what we do and how far we have come.

Since the first edition of the handbook was released, however, there have been several important clinical and operational developments such as the advent of rural PACE, which has required adaptation of the model to a challenging new setting; an increasing interest in breaking out of the traditional staff model and using community physicians under
federal waivers, and a growing awareness of the ethical issues that we confront on a daily basis.

In recognition of their end-of-life obligations, PACE organizations continue to develop innovative approaches to palliative care, while PACE programs are increasingly enrolling younger participants with chronic mental illness and substance abuse problems who require specialized services and supports.

Over the past four years, the NPA Primary Care Committee, our PACE Medical Director forum, has embarked on the ambitious task of reworking clinical guidelines for preventive health and chronic medical conditions into model practices that apply recommended interventions to the population we serve in a thoughtful manner.

In addition, there have been substantial changes in the regulatory environment. Reporting requirements have changed, the need to capture diagnostic information for risk-adjustment has increased, and there are new responsibilities under Medicare Part D.

We also continue to learn from each other and from our interdisciplinary partners, while we benefit from a growing body of Geriatric health services research and lessons learned from other models of community-based long-term care. As we engage in national health care reform, we also hope that our efforts will inform colleagues outside of PACE and that we can more broadly influence care delivery for older adults and other vulnerable populations.

All of these developments have made a revised PACE Medical Directors Handbook essential. This second edition of the Handbook features seven entirely new chapters that address emerging issues and responsibilities. Many of the remaining chapters have been substantially revised. We have added other features that we hope will enhance the Handbook’s value.

Despite the additions and improvements, the audience for the Handbook remains the same: future and current PACE Medical Directors. As with the first edition, the authors are drawn from the PACE community, and I am grateful for their contributions. Most
important, for those who are new to PACE in particular, we hope that this collective and collaborative effort will reflect and reveal the spirit of open exchange, mutual support, and shared mission that has always characterized PACE.

Adam Burrows, MD

Boston, MA

December 2010
FOREWORD

The Rewarding Experience of PACE Medical Directorship

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What makes being a PACE Medical Director the world’s best job? Although there are many answers, the first and foremost is people. The people for whom we provide care are varied, and each has a life story full of interesting events and human drama. The caregivers of our participants likewise have their individual stories, but the overriding themes of family loyalty, caring, and concern for others help make our efforts worthwhile. The people with whom we work (both PACE staff and contract providers) are dedicated, competent, caring professionals; and working with them on a day-to-day basis is both a privilege and a pleasure. Particularly, the collaborative relationships among physicians and nurse practitioners are part of the reward. Being in PACE is also an entrée to a wider community of caring, with endless opportunities to see the brighter side of human nature, and to give back to the community of which we are a part.

Another aspect of the world’s best job is the range and scope of responsibilities. Caring for individual participants; working in hospitals, nursing homes, assisted living facilities, and home environments; being involved in policy development; having opportunities to mentor and educate young professionals; participating in a wide range of research opportunities; and participating in national initiatives through NPA are all part of this job.

The position of PACE Medical Director is characterized by continuous challenge and change. I can think of no other job that has changed so much in the last fifteen years without losing important aspects of its satisfaction. The challenges are constant, and constantly changing, but continue to be related to supporting the comprehensive care of a very vulnerable group of people, and remain worthwhile challenges to meet. Even with an increasing administrative burden related to becoming a provider type, the ongoing
participant focus makes it rewarding. People who find their job boring after a few years should try this one.

Finally, this is the world’s best job because of its intrinsic spectrum of rewards. It combines the daily rewards of medical practice and personal interactions with the intermediate term rewards of program development and oversight, and with the long-term rewards of research and public policy development. So many careers require surrendering one or more of these aspects, but not this one. Furthermore, it nurtures our idealism and focuses on the needs of each participant, freeing us from the tyranny of reimbursement driven care that characterizes so much of today’s medicine.

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The PACE Medical Director requires the skills of clinician, administrator, standard-bearer and great communicator, all seamlessly melded. Contrary to popular belief, the position does not require an MBA degree in addition to an MD, but if you also have an MBA, all the better.

Medical care in PACE straddles unique universes: the provider universe and the capitated health plan universe. The Medical Director has to operate comfortably in both, gliding (sometimes floating) smoothly between the two.

With PACE as a provider, the Medical Director must recruit, train and retain physicians, nurse practitioners, and physician assistants to provide high quality medical services. These primary care providers (PCPs) must also be effective colleagues on an interdisciplinary team. The PACE interdisciplinary team is as challenging a team as exists in any healthcare system, not just for its size (20-25 members) but also because of its diverse composition. In addition to clinic and home care nurses who share the same
universe as primary care providers, the team also includes social workers, occupational and physical therapists, nutritionists, recreation therapists, transportation drivers, and health aides. Successful integration of PCPs on the team is the secret ingredient of a successful PACE Organization. As chief physician of this provider universe, the Medical Director is part standard-bearer for high quality medical care and part cheerleader for the PCPs to negotiate and communicate rather than direct.

In the health plan universe, the Medical Director must recruit and retain a contract provider network comprised of physician specialists, acute care hospitals, skilled nursing facilities and ancillary service providers. In this universe, the Medical Director is the chief quality officer, a kind but firm enforcer of contract terms, and a great communicator. The PCPs in your PACE provider universe depend on the Medical Director to maintain a quality and accessible network of contractors. As the chief Medical Administrator in the health plan universe, the Medical Director works collaboratively with other administrators to maintain the financial health of the PACE Organization, to manage risk, and to plot strategy for continued growth.

The PACE Medical Director is a challenging position. It demands excellent clinical credentials, creativity, compassion, courage, and common sense.

Mary Gavinski, MD
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The role of the PACE Medical Director is a very challenging and rewarding position. It allows a motivated physician the opportunity to design and implement a geriatric care system that is a model of care for the elderly. The physician can design a practice that truly embodies the tenets of high quality geriatric care while allowing creative and innovative thinking. It can be a combination of clinical care, preventive and population based care, managed care, quality care system design and
teaching for medical students, medical residents and fellows and other health professionals. It blends an administrative role with a hands-on approach to geriatric care.

Willie Orr, MD  
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Before I began my odyssey with PACE, I was a geriatrician in a community outpatient geriatric clinic with a relatively frail outpatient population. We followed an occasional patient in the nursing home but didn’t follow our patients in the hospitals and had a team approach with nurse practitioners and social workers. Even though that practice did a good job with the frail elders, many of our patients still failed to remain in the community because of the healthcare system, not because of the medical care. PACE intrigued me because I hoped that I finally would have the resources available which would allow me, as a geriatrician, to accomplish the goal of preventing nursing home placements.

The reality has been true to the hope. In PACE, you are freed of the restraints and rules that hamper your ability to provide comprehensive, thoughtful care. The PACE team surrounds you with professionals who are equally committed to the same ideal. The team can draw upon all that experience and gradually expand their ideas to truly match needs to services and you find that remarkably frail people are ending their lives in their community and not facing the end in a nursing home.

Finally, as Medical Director, you have the opportunity to help shape and mold this concept and practice to a program which has a real impact on the lives of those you serve and the larger population of frail seniors.
For the geriatrician, or any clinician deeply interested in and dedicated to the care of older adults, it becomes readily apparent early on in his or her PACE experience that there are extraordinary enhancements that PACE brings to acute and chronic care of the frail. I would characterize the most important of these as follows:

PACE creates care environments (the day centers), and the access to those environments for those who would typically be homebound, that permit the frail participant to interface regularly with all traditional geriatric service disciplines under one roof (the interdisciplinary team). This permits interactive, more immediate decision making, and rapidly developed and modified care plans. The intimate co-mingling of the disciplines, often seeing the participant jointly in the same day, facilitates a merging of perspectives that quite often leads to better, patient-centered decisions than might be made in more traditional, physician driven settings.

PACE merges professional services with a powerful social setting. This facet cannot be understated, as this regularity of attendance of the frail elder, and the window it permits to that person’s usual functioning, to the staff members who must react to alteration in function, quite frequently permits the detection of subtle changes due to underlying physical or emotional illness. In a more traditional setting, these likely would progress more often to advanced medical illness requiring hospitalization or further decline.

PACE removes traditional bureaucratic barriers to service provision—complicated regulations, insurance mandated forms to approve care, and arbitrary cutoffs for necessary services that might improve a particular individual’s functional state.
When these barriers are removed, the interdisciplinary teams (groups of caring and skilled individuals) are more beneficial to that specific person’s functionality.

PACE creates the incentives for providers to be intimately involved with the participant in all transitional centers of care—in the community, during hospitalization, or a nursing facility stay. The PACE Organization is uniquely, personally and financially responsible for the participant regardless of setting. Unlike traditional systems, providers are thus aware of the details of illness, functional changes, and personal wishes of the participant throughout transitions. This ensures the strongest possible efforts, regardless of time-frame, to return a participant to community living if desired and feasible.

For the PACE Medical Director, the task is to both embrace these enhancements personally and to strive, to select and to inspire a staff of clinical providers to be central members of well functioning interdisciplinary teams who appreciate the uniqueness and power of the model.

He or she does so in ways that are often specific to the local environment and circumstances of the PACE sponsoring organization, but all PACE Medical Directors share common tasks:

a) To promulgate high standards of contemporary geriatric therapeutics and diagnosis and to foster an environment of continued learning and commitment to excellence.

b) To select a provider staff who will enthusiastically embrace the care of the frail with all of its complexity (and at times frustration) and who will thrive in a team environment—respecting and eliciting the contributions of team colleagues in all aspects of the participant’s care.

c) To develop and nurture a system of associated contract providers (e.g. hospitals, nursing facilities, on-call groups, specialists, and pharmacy providers, among others), and educate them to the PACE mechanism of care and how it can enhance their own care to
the frail. The PACE Medical Director must also be constantly assessing the quality and efficacy of these relationships, educating and providing feedback where necessary but also seeking other options if indicated and available.

d) To promote an environment of continuous performance improvement in all facets of clinical services, analyzing suboptimal processes and outcomes and modifying them accordingly, to achieve better results.

The daily work of carrying out these tasks, while often difficult in a world dominated by much larger systems of health care is nonetheless a highly rewarding endeavor. It provides the Medical Director (and colleagues) with the satisfaction of making enormous individual impact on the lives of persons at considerable risk, but also in one’s own locality while nationally influencing change in how care can best be delivered to this cohort.

There are personal joys to be had as a Medical Director in PACE as well. No other health services setting more fully permits and fosters intimate, interactive, mutual respect and reliance among health disciplines and non-professional health services staff. One quickly grows to admire and enjoy the power of true teamwork in grappling what are at times puzzling dilemmas, with no roadmap to follow except the expertise and caring of a group of colleagues committed to a goal

Additionally, no clinical setting permits such a regular intersection with patients outside the provider-patient encounter, and thus a chance to develop a closer relationship and understanding of the struggles of frail patients and their families. PACE centers are places where one is often left to marvel at the adaptations made to a long life of considerable social unrest and physical disability, and a late life attained with hard work, good cheer, closure, and peace.
Chapter 1

Introduction to the PACE Organization

The History of PACE

The PACE model of care can be traced to the early 1970s, when the Chinatown-North Beach community of San Francisco saw the pressing needs of families whose elders had emigrated from Italy, China and the Philippines for long term care services. For these families, the option of placing their elders in nursing homes was not a culturally acceptable solution. In order to meet this community need, Dr. William L. Gee, a public health dentist, headed the committee that hired Marie-Louise Ansak in 1971 to investigate solutions. They, along with other community leaders, formed a nonprofit corporation, On Lok Senior Health Services (On Lok is Cantonese for "peaceful, happy abode"). In 1973, On Lok created a community based system of care and an innovative way to offer a comprehensive array of medical supervision, physical and occupational therapies, nutrition, transportation, respite care, socialization and other needed services using home care and an adult day setting.

The timeline for the creation of PACE is outlined below.

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<td>1971</td>
<td>William Gee, DDS, and two others execute articles of incorporation for the nonprofit Chinatown-North Beach Health Care Planning and Development Corporation (later renamed On Lok Senior Health Services) and retain Marie-Louise Ansak to study the feasibility of building a nursing home in the community. She finds a nursing home would be both infeasible financially and culturally inappropriate. Instead she obtains funding to train health care workers, in cooperation with University of California San Francisco. She also outlines a comprehensive system of care combining housing and all necessary medical and social services, based on the British day hospital model.</td>
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<td>1973</td>
<td>On Lok opens one of the nation’s first adult day centers in San Francisco.</td>
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<td>1974</td>
<td>On Lok begins receiving Medicaid reimbursement for adult day health services.</td>
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<td>1975</td>
<td>On Lok adds a social day care center and includes in-home care, home-delivered meals and housing assistance in its program.</td>
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<td>1978</td>
<td>On Lok’s model of care expands to include complete medical care and social support of nursing home-eligible older individuals.</td>
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<td>1979</td>
<td>On Lok receives a four-year Department of Health and Human Services grant to develop a consolidated model of delivering care to persons with long term care needs.</td>
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<td>1983</td>
<td>On Lok is allowed to test a new financing system that pays the program a fixed amount each month for each person in the program.</td>
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<td>1986</td>
<td>Federal legislation extends On Lok’s new financing system and allows 10 additional organizations to replicate On Lok’s service delivery and funding model in other parts of the country.</td>
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<td>1987</td>
<td>The Robert Wood Johnson Foundation, the John A. Hartford Foundation and the Retirement Research Foundation provide funding to On Lok and the first replication centers to support their efforts.</td>
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<td>1990</td>
<td>The first Programs of All-inclusive Care for the Elderly (PACE) receive Medicare and Medicaid waivers to operate the program.</td>
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<td>1994</td>
<td>The National PACE Association is formed.</td>
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<td>1997</td>
<td>The Balanced Budget Act of 1997 establishes the PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs.</td>
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<tr>
<td>2000</td>
<td>The Robert Wood Johnson Foundation and the John A. Hartford Foundation fund the PACE Expansion Initiative to assist the National PACE Association in expanding the benefits of the PACE model of care to more families in need.</td>
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<tr>
<td>2001</td>
<td>Alexian Brothers Community Services in St. Louis becomes the first PACE provider to become a full, permanently recognized part of the Medicare and Medicaid programs.</td>
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<td>2006</td>
<td>Final PACE Regulation published by the Centers for Medicare and Medicaid Services in November. Congress awards grants of $500,000 to 15 organizations for rural PACE expansion.</td>
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<td>2007</td>
<td>Forty-two PACE programs are operational in 22 states.</td>
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<td>2010</td>
<td>The Veterans Affairs central office awards funds for a pilot program for seven VAMCs to contract for PACE services with eleven PACE organizations.</td>
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<tr>
<td>2011</td>
<td>Eighty PACE programs are operational in 28 states.</td>
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As outlined, the Robert Wood Johnson Foundation provided funding for six centers in 1986, in addition to On Lok, to develop PACE demonstration programs, made possible by Congressional authorization of additional Medicare and Medicaid waivers. Based on the success of the demonstration programs, PACE was able to make the rare transition from demonstration program to permanent provider type. The Balanced Budget Act of 1997 approved the granting of provider status to PACE Organizations under Medicare and gave state Medicaid agencies the option to include PACE as a Medicaid benefit.

There have also been recent initiatives to expand the availability of PACE to new markets and populations. In April 2006, CMS issued the Rural PACE Provider Grant Program Solicitation Announcement. The grant entitled “Establishing PACE (Program of All-inclusive Care for the Elderly) as a Community Care Option for Rural Elders” was made to the National PACE Association (NPA) to provide support for several activities that were designed to leverage a separate $7.5 million federal grants program administered by
the Centers for Medicare and Medicaid Services (CMS) to 15 rural PACE applicants (of which 14 were awarded full PACE program status by the end of the Hartford Foundation grant). The Grant Program provided 14 grantees with $500,000 each to support the development of a rural PACE program for some of the most vulnerable Medicare, Medicaid and dually eligible beneficiaries within thirteen states across the country. CMS awarded all of the possible funds and the maximum number of grants available to expand patient-based care to a greater number of people with Medicare and Medicaid who live in rural areas.

Another initiative to expand the availability of PACE was forged through a partnership between NPA and the Department of Veterans Affairs to secure VA payment for PACE. In early 2009 this effort focused on implementing a pilot with the Philadelphia VA Medical Center (VAMC) and LIFE U Penn PACE program. In November 2009 the VA Central Office issued an RFP to encourage Patient-Centric Care as an alternative to Institutional Care. PACE, especially in rural areas, was one type of program that was solicited as part of this RFP. In January 2010 the VA Central Office awarded funds for a pilot program for seven VAMCs to contract for PACE services with eleven PACE organizations, which allowed for 80 veterans to be enrolled at any given time across all the participating PACE organizations. The plan moving forward is to advocate that this contract arrangement be expanded to all VAMCs wishing to contract with PACE.

What is PACE?

PACE is an acronym for the Program of All-Inclusive Care for the Elderly. The PACE program was designed to provide a multitude of delivery services to the frail elderly. By delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible.

The care and services included in this program are:

- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing home care when necessary

These programs are innovative because they provide continuous care and services offering individuals eligible for nursing home care the option of continuing to live in the community. Because these health care costs are traditionally paid for through the Medicare and Medicaid programs and out of people’s pockets, access to a comprehensive system of care that encompasses preventive, primary, acute and long-term care is usually not possible. One key to the PACE model is the combining of dollars from different funding streams in order to deliver a comprehensive set of services focused on the health and well-being of the individual.

Because PACE delivers care differently from traditional long-term care providers, it can be difficult to understand how all of the elements of the program work together. For example, the public may be mostly aware of the PACE Organization’s vans which provide transportation to PACE participants. Policy makers may view PACE as a program that integrates Medicare and long-term care funding in a way that saves taxpayer dollars while providing more effective care. PACE participants and their family members might see the PACE center that they attend as the central part of the program. But it is the combination of the different components of the PACE model, including the work of the interdisciplinary teams, that results in care and services tailored to the individual needs of each PACE participant.

The ability to coordinate the care of each participant enrolled in PACE is key to the model. PACE Organizations coordinate and provide all needed preventive, primary,
acute and long term care services so that their participants can continue living in the community. To understand how PACE works, it is important to learn about the components of PACE that enable it to respond to the unique needs of each participant enrolled in the program. The PACE Organization is comprised of interdisciplinary teams, capitated payment arrangements, PACE centers, and transportation.

The interdisciplinary teams are comprised of physicians, nurse practitioners, nurses, social workers, therapists, van drivers, aides and others who meet regularly to exchange information and solve problems as the conditions and needs of PACE participants change. Through interdisciplinary teams, the viewpoints of different disciplines are brought together, and information gained through interaction with the PACE participant over time and in different settings is shared. This approach empowers those involved and allows more information to be available at the critical points when decisions are being made.

PACE Organizations receive a monthly capitated payment (a lump sum from Medicare combined with Medicaid or a participant’s private pay resources that is used to pay for a variety of comprehensive services) and are responsible for the care their participants need. As such, the financial interests of the PACE Organization and the care needs of the persons they serve are aligned in a unique way. Regardless of whether needed services would be reimbursed under traditional fee-for-service Medicare and Medicaid, PACE provides a comprehensive set of preventive, primary, acute and long term care services that are specifically tailored to the needs of each PACE participant to help them avoid hospital or nursing home placement to the greatest extent possible. The program is designed to closely monitor participants for even subtle changes in needs, which if left unattended, could lead to costly acute care episodes.

For example, a Medicare beneficiary shows up at the emergency room every month to be treated for skin infections caused by fleabites. The traditional, fragmented care delivery system would have trouble addressing the root cause of her condition and might just keep treating the patient’s fleabites. For a PACE enrollee, the team, with input from social workers, home health aides and drivers who have been in her home, may decide to
fumigate her home and provide a flea dip for her pet. This flexibility can produce more cost effective solutions and a higher quality of life than prescribing costly medications or continually hospitalizing an individual.

PACE participants can regularly attend the PACE center, on an average of three days a week if desired. This center includes a health clinic with a primary care physician and nurse practitioner, physical and occupational therapy facilities, and at least one common room for social and recreational activities. Unlike fee-for-service Medicare and Medicaid programs, PACE has the flexibility to provide services like occupational and physical therapies even when the goal is to maintain or slow the decline of an ability, not to cause measurable improvement. Because PACE participants have regular contact with primary care professionals who know them well, slight changes in their health status or mood can be immediately addressed.

Transportation for PACE participants is another covered benefit. Transportation is critical to the implementation of the care plan. It is a key way PACE supports families who are providing care for their loved ones. Transportation is not only to and from the day center, but also to other appointments. Providing transportation also places a driver, who has been trained to observe cues, in the home of the PACE participant. Drivers can then report these cues that may signal a change in health status or other changes that should be monitored.

What Does the PACE Population Look Like?

In order to qualify for PACE, a person must be 55 years of age or older, live in a PACE service area, and be certified by the state to need nursing home-level care. Like nursing homes, PACE tends to attract participants who are older and who have very high care needs.

The average PACE participant:

- is 78 years old;
- is female (75 percent of participants are female); and
• has 7.9 medical conditions (many of which are chronic conditions including diabetes, dementia, coronary artery disease, and cerebrovascular disease).

Although extremely frail, most PACE participants live alone in the community; only seven percent live in nursing homes. However, when participants need nursing home care, they do not disenroll from PACE. The PACE Organization pays for nursing home care whenever necessary. The care of the interdisciplinary team follows them through all care settings including hospital stays and nursing home placements. PACE helps arrange supportive housing when appropriate.

PACE has surprisingly good outcomes considering the needs of those it serves. Overall, hospital days per thousand Medicare fee-for-service (FFS) beneficiaries in 2009, was 1,811 days\(^{(1)}\). For the same time period hospital days per thousand for Dual FFS members, not all of whom would have met the Nursing Home eligibility criterion set by PACE, was 3,327 days\(^{2}\). In contrast, the hospital days per thousand, for Institutional FFS members, to which a PACE enrollee comes closest in terms of having need for long term care, was 7,497 days\(^{3}\). During the same period of time, the hospital days per thousand PACE enrollees was 3,500 days\(^{4}\). It is important to note that the data for PACE enrollees has been derived from data submitted for 25 PACE organizations out of 60 and is for nearly 10,000 participants out of a total of around 20,000. Other indicators of the good outcomes of PACE were highlighted on a study conducted by Abt Associates. The study concluded that PACE participants have improved health status and quality of life, lower mortality rates, increased choice in how time is spent, and greater confidence in dealing with life's problems than non-PACE individuals with comparable health needs. Another study conducted by the Secretary of Health and Human Services in 1997, compared PACE enrollees to individuals receiving home and community-based (HCBS) waiver services. The study found higher quality of care and better outcomes among PACE enrollees. According to the study, in comparison to HCBS clients, PACE enrollees reported better preventive care, better self-rated health status, less pain and likelihood of depression and better management of health care.
How Does Housing Fit into the PACE Model?

Housing is not a covered benefit or service under PACE. However, most PACE Organizations find that strong relationships with accessible, affordable housing providers are important. As PACE Organizations mature and their participants continue to age, arranging appropriate housing becomes a key to maintaining participants in the least restrictive and often most cost effective environments.

Does PACE Serve Only People with Low Incomes?

There is no income eligibility requirement for participating in PACE. However, during the PACE demonstration process, many providers and state policy makers were interested in how the PACE model could be used to provide care to hard-to-serve populations. PACE has been a successful model of care because it integrates across the full continuum of care and services possible, regardless of who is paying. In the future, it is likely that payment sources for PACE enrollees will be more mixed as programs seek to serve many different income levels. PACE participants already use a variety of payment sources, including Medicaid, long-term care insurance benefits, and their own out-of-pocket resources.


(4) Adjusted for partial year enrollment.
CHAPTER 2

Medical Decision-Making in the PACE Model

Mike Brett, MD
Melinda Lee, MD
Laura Trice, MD
David Wilner, MD
Roger Zioncheck, MD

Key Points

- Medical decision-making for older persons is best done in the context of an overall goal of care.

- Understanding the life expectancy, values, and preferences of participants can help the PACE team determine overall goals of care.

- The NPA Primary Care Committee suggests stratifying care according to the broad goals of Longevity, Function, and Palliation, and has developed model practices and preventive guidelines based on this approach.

PACE participants are a heterogeneous group, with differing health profiles, prognoses, preferences, and goals of care. Life expectancy and quality of life issues provide an important context for generating individualized plans of care in the PACE model. As providers, we need to remember that our personal goals of care may vary from those of our patients.
There are several well-validated approaches to estimating life expectancy. The best instruments include functional characteristics in addition to age and medical variables to predict mortality. One of these models was developed and validated in a cohort of community-dwelling PACE participants (1). This index uses a risk score to identify PACE participants whose life expectancy is limited.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Age 75-84</td>
<td>2</td>
</tr>
<tr>
<td>Age 85+</td>
<td>3</td>
</tr>
<tr>
<td>Dependence in toileting</td>
<td>1</td>
</tr>
<tr>
<td>Partial dependence in dressing</td>
<td>1</td>
</tr>
<tr>
<td>Complete dependence in dressing</td>
<td>3</td>
</tr>
<tr>
<td>Malignant neoplasm</td>
<td>2</td>
</tr>
<tr>
<td>CHF</td>
<td>3</td>
</tr>
<tr>
<td>COPD</td>
<td>1</td>
</tr>
<tr>
<td>Renal insufficiency or failure</td>
<td>3</td>
</tr>
</tbody>
</table>

The higher the total point score, the worse the prognosis. Participants whose total score is greater than five have a less than 50% likelihood of living three years.

The same investigators had previously developed a prognostic index to predict one-year mortality in patients aged 70 years and older following hospitalization (2). This index also utilized functional characteristics in addition to other risk factors by considering performance of five basic ADLs (bathing, dressing, toileting, transfers bed to chair, eating) at hospital discharge.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Dependence in 1-4 Basic ADLs at discharge</td>
<td>2</td>
</tr>
<tr>
<td>Dependent in ALL Basic ADLs at discharge</td>
<td>5</td>
</tr>
<tr>
<td>Solitary cancer</td>
<td>3</td>
</tr>
<tr>
<td>Metastatic cancer</td>
<td>8</td>
</tr>
<tr>
<td>CHF</td>
<td>2</td>
</tr>
<tr>
<td>Serum creatinine &gt; 3.0 mg/dL on admission</td>
<td>2</td>
</tr>
<tr>
<td>Serum albumin 3.0–3.4 g/dL on admission</td>
<td>1</td>
</tr>
<tr>
<td>Serum albumin &lt; 3.0 g/dL on admission</td>
<td>2</td>
</tr>
</tbody>
</table>

Two-thirds of patients whose total point score was greater than six died within one year; one-third of patients whose score was in the 4-6 range died within a year.

These two prognostic tools, as well as others, together with informed clinical judgment, may be helpful to the PACE team and primary care providers in advising participants and families about prognosis and appropriate goals of care.

Consideration of a participant’s goals of care is particularly important when applying practice guidelines that may have been developed for a population of non-frail adults. This has been the rationale for the development of Model Practice guidelines by the NPA Primary Care Committee (PCC). To date, the PCC has developed Model Practices for Diabetes Mellitus, Chronic Heart Failure, and Chronic Kidney Disease, as well as guidelines for Preventive Care (see appendix).

The PCC recommends that whether a primary care provider follows any of the Model Practice summary recommendations for an individual participant should depend upon factors specific to that participant, including the participant’s preferences, prognosis and life expectancy, co-morbid conditions, functional status, and goals of care. For this
reason, the PCC advises that adherence to the recommendations per se is not an appropriate measure of quality of care.

One can categorize goals of care using a three-trajectory model of patient-centered pathways based on work reported by Schamp and Tenkku (3). In this framework, the PACE primary care provider, often in collaboration with other team members, identifies an overall goal of care with participants and families after assessing a participant’s health conditions, prognosis, treatment options, and life expectancy, and providing education about those issues. Determining an overall goal of care then helps guide which specific interventions to recommend.

The goals in this framework can be categorized broadly as Longevity, Functional and Palliative:

**Longevity:**

The participant desires to live as long as possible, typically wants all medically indicated treatments, is willing to try to comply with diet and activity recommendations and restrictions, and to try to comply with medications and monitoring. The participant usually accepts all surgeries, ICU admissions, ventilator support, dialysis, cardiopulmonary resuscitation (CPR), including advanced cardiac life support (ACLS), intravenous therapies, and artificial nutrition and hydration (ANH). Appropriate screening tests and procedures would generally be welcomed.

**Functional:**

The participant is most interested in preserving function, will pick and choose among invasive and noninvasive interventions, typically restricts procedures such as CPR, dialysis, and mechanical ventilation and often wishes to limit some
otherwise indicated medications. Potential benefits of screening tests are balanced against risks and burdens.

**Palliative:**

The participant desires that comfort be the main concern. Treatment decisions are made based on whether or not they contribute to comfort. Life-sustaining treatments such as CPR, mechanical ventilation, and dialysis are usually not desired. Few lab tests are indicated and medications are aimed at providing comfort or improving quality of life. There would be no role for screening tests.

In summary, the PCC created the Model Practices to be a reference for PACE Medical Directors, primary care providers, and interdisciplinary PACE teams. They were meant to differentiate the care delivered to a more independent Medicare patient from the care that might be more appropriate for the frail, disabled, multiply morbid elderly participants that we serve. In addition, the Model Practices highlight three broad categories of goals that we see commonly within our participant population.

In applying the Model Practices, the goals of care pathway identified for a particular participant is driven by the participant’s goals, not by the opinion of the primary care provider or team about what goal best fits the participant or about which pathway offers the treatment approach that the provider/team thinks is most appropriate. The participant, caregiver, provider, and other IDT members may and should influence the participant’s choice of goals by educating them about their conditions, prognoses, and possible trajectories. Thus, the Model Practices are meant as tools to help decision making regarding when an intervention or therapeutic target may or may not be appropriate. The Model Practices also provide support to the PCP in responding to those who may have a “one size fits all” mentality and who fail to recognize the unique aspects of the people we serve.
While adherence to specific recommendations of a Model Practice is not intended to be used as a quality measure, implementation of a Model Practice itself could serve as a process measure, and outcomes such as change in rate of admissions for CHF after implementing the CHF Model Practice could serve as meaningful quality measures.

References


Hiring and Supervising PACE Primary Care Staff

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Hiring Primary Care Providers (PCPs) is one of the essential components of the PACE Medical Director’s job. Finding highly qualified individuals and helping them develop into sound PACE PCPs ensures the program performs at the highest level of quality and achieves the best clinical and financial outcomes.

Physicians

Key components of a good PACE physician:

- Excellent clinician skills that cross all aspects of medicine. Comfortable with outpatient care and in-patient medicine. Has outstanding skills in assessing information from specialists and able to decide how to integrate the information into the participant’s plan of care.
- Adept at communicating with colleagues, team members, and administration.
- Able to relate to others on the team as peers, combining confidence with humility.
Recruiting and Hiring

PACE centers employ Internists, Family Practitioners, Geriatricians, and Osteopaths. The level of work experience among physicians ranges from post-training to those approaching retirement. A number of methods are used to search and recruit for primary care physicians.

Recruitment usually starts with investigation and advertising in the local area or city. Contacts with Medical Administration at hospitals and academic Medical Centers, along with the local medical society are good places to start. Success has been found communicating via email to these organizations. This includes a request to post the openings within their organization. This request also includes asking colleagues to network and communicate the job opening to others in the field. Advertising the position within academic programs is also a valuable way to recruit. These organizations have residents and fellows who are finishing their training, as well as physicians who are applying to their institution, and are a valuable applicant pool.

Utilizing other PACE centers is also a useful tool for advertising a job opening. Often times, PACE centers that work with training programs may know of upcoming trainees who are finishing their residency and fellowship, as well as colleagues looking to relocate, that may be interested in a PACE position.

If those forums are unsuccessful, a search can be expanded to the entire state and beyond by contacting the same types of organizations as mentioned above.
PACE Organizations have recruited through National Publications such as JAGS and JAMA. These publications are expensive and are less effective than the above methods. National meetings should also be considered for a place to advertise and recruit.

Once a few primary care physician candidates have been identified and screened, a formal interview is scheduled for the final two to three candidates. It is recommended that the Director of Operations, Director of Nursing Services and one member from the team participate in the interview as well. It is also helpful to schedule a lunch with the interviewees and as many of the primary care staff as possible.

PACE Organizations have had success with many types and experience levels of PCP hires, though these differences will affect the type of initial and ongoing support that is needed. While Geriatric training and experience are helpful, they are not essential – the “fit” with the culture and mission of PACE are more important. A physician with Geriatric experience has more knowledge applicable to the PACE Organization. It is more important to recruit someone who fits the complete package desired by the program. A PCP can master Geriatric content through supervision, monthly meetings, CMEs, and conferences.

**Orientation and Training**

It is highly encouraged that physicians are given a complete orientation and strong foundation before completely immersing in their new positions. This combined with ongoing training will help ensure success. Below is a sample approach to orientation and training used by Community Care for the Elderly (CCE) PACE Program.

- Day 1 – The physician meets with Human Resources and receives an orientation to the organization and completes any mandatory in-services.
The PACE Medical Director schedules lunch with the new physician and one or two other primary care or clinical staff.

- Day 2 – The PACE Medical Director reviews primary care policies and procedures, and orients the new physician to the center. It is also recommended that the new physician meet for one half to one hour with key staff people.

- Day 3 – The new physician begins with a morning meeting at the center and reviews the clinic operations and medical records. In addition, the physician meets with the rest of the staff. Depending on the level of training, it may be necessary for the Medical Director to conduct a new participant assessment or periodic reassessment. At CCE, this is used as an opportunity to review clinic policies and procedures.

- Week 1 – The physician should meet with key people in administration including CEO, COO, CFO, Directors, and Clinical Services people. Over the next several days, the new physician should conduct morning meetings and work with physicians at various centers. This provides the new physician an opportunity to interact with different teams and clinics in operation. Afternoons should be spent at the center, working alongside one of the physicians or Nurse Practitioners (NPs).

- Week 2 – The new physician is scheduled for hospital tours and nursing home tours if they have not previously worked in these institutions with which PACE contracts.

- Weeks 3 and 4 – The physician begins assuming care for the participants at the center. The Medical Director and the Primary Care manager, if the program has one, should schedule oversight time with the new PCP and
the Nurse Practitioner at the center (daily to three times a week). The oversight is informal, providing an opportunity to touch base, answer questions, and review any difficult cases or operational issues.

- Month 2 – The Medical Director conducts an assessment of the physician. The Medical Director may decide at this time to work more frequently with the physician and evaluate whether the physician requires additional time with the Medical Director or Nurse Practitioner. A review of the physician’s practices and patterns, along with observations of the new physician’s participation in the morning meeting is used to assess the physician’s practice. The Medical Director also uses discussions with the new physician in addition to input from key administrative and clinical staff at the center.

- Month 2 and beyond – Depending on the physician’s level of experience and overall assessment to date, the Medical Director may administer monthly updates and more frequent oversight if needed. The Medical Director evaluates the new physician through discussion of difficult cases or questions that have arisen. During this period, frequent feedback from other staff at the center is helpful in identifying areas in which the physician might need further support. Often, the physician has strong medical skills, but needs to learn the PACE philosophy and practice. The “team” approach to managed care principles often is less familiar to a new physician and time spent teaching and modeling this approach helps the new physician become successful more quickly.
On-going Training and Education

In addition to one-on-one training, monthly primary care meetings are conducted. These meetings include: educational updates, operations updates, pharmacy and nursing updates and a time to discuss problems as identified by the primary care staff.

Also as part of the physician’s competency evaluations, areas are identified in which the physician needs more training. Physicians are asked to use their CME allowance and time to study those areas.
Nurse Practitioner

Recruiting and Hiring

Many of the same methods included in this chapter used to hire a physician are used to hire a Nurse Practitioner. In addition, many traditional ways of advertising are also used.

Recruitment is often done via the newspaper. Successful recruitment is also done through postcard mailings to the Nurse Practitioner mailing list provided by the local NP society. In addition, NPs who are clinical preceptors for the NP programs can be used to help recruit directly from those programs. This is a successful recruitment practice in that many NPs who have previously trained for the program are able to gauge who would work well in the program. Recruitment from this area decreases orientation time because of the previous experience held by the NP.

It is preferable to hire Nurse Practitioners who have worked as nurses prior to becoming an NP. Experienced NPs are more seasoned and clinically attuned.

At CCE, there are Geriatric NPs, Adult Medicine NPs, and Family Practice NPs. While those who attended Geriatric NP Programs have more geriatric knowledge to start, previous nursing experience and an overall fit with the PACE Organization - that is, being conscientious, a team player, a good clinician, and a good communicator - is more important than area of concentration. The NP can obtain specific Geriatric skills and knowledge, but since the overall NP training is relatively brief, education and prior experience can be helpful.

Orientation and Training

Training for NPs is much the same as the physicians. The Primary Care Manager who oversees all the NPs does most of this training. In addition, because NPs and primary
care physicians practice collaboratively in PACE, the primary care physician is constantly involved in the training as well.

NPs are taught the specifics of geriatrics through attendance at Primary Care meetings. In addition, NPs may attend conferences that concentrate on this area of work.

**On-going Training and Education**

On-going training for new NPs is similar to the physician’s on-going training. In addition, the NPs meet quarterly to discuss issues specific to the work. On-going training is very important for NPs due to the varied level of experience and prior training received. As such, a Primary Care Manager is responsible for hiring, orientation, on-going training, some supervision and coverage for NPs. This person works closely with NPs and the primary care physician to assure NPs have the necessary competencies.

**Collaborative Practice**

Although each PACE Organization structures the practice somewhat differently, PACE physicians and nurse practitioners operate a shared practice. At some PACE centers, the NPs have their own separate caseload that is overseen by the physician. At other PACE centers, it is a fully shared practice.

It is imperative that the Medical Director clearly defines the form of the collaborative practice in the policies and procedures of the PACE Organization. Because NPs deliver primary care alone and have prescriptive authority, they need to have a high level of competency and the limits of their autonomy should be clearly defined. In addition, there needs to be a consistent type of practice across the entire PACE Organization.
Appendix A

Community Care for the Elderly
Physician/Nurse Practitioner
Collaborative Practice Agreement

The undersigned Nurse Practitioner (NP) has advanced skills in the assessment of the physical and psychosocial status of elderly individuals through securing health histories and physical examinations. The NP also has advanced training in primary care diagnosis and treatment of illness in the elderly. The NP is prepared for these skills through advanced education and supervised clinical experiences. The NP is licensed by the State of Wisconsin Nursing Licensure Board, is certified as an advanced practice nurse, and has prescriptive authority through the State of Wisconsin. In the CCE Program, NPs work collaboratively with a primary care physician to manage the participant’s medical care.

1. **Acting without consultation, the NP may perform the following tasks:**

   - **Clinical Monitoring,** such as, but not limited to:
     - Vital Signs, Weight, I and O, Finger stick glucose monitoring, Stools for Occult blood
     - Activity Levels
     - Physical Therapy, Occupational Therapy, Speech Therapy
     - Diet changes
     - Infection Control Techniques
     - Skin/Wound Care
     - Referrals to Podiatry, Optometry and Dental
     - Follow up referrals to Medical Specialists

   **Initial Referrals to Medical Specialists require consultation with the Primary Care Physician.**

   - The NP has been given authority by the Wisconsin Board of Nursing to prescribe medications (Wisconsin Board of Nursing status, Chapter N6.03 (2) subparagraph (a,b,c,d), excluding prescribing controlled substances (per Wisconsin statutes 161.01(4). CCE will accept the NP’s signature as authorization to dispense or administer the medications prescribed.

   - Other duties as outlined in the CCE Primary Care Policy and Procedure Manual and the CCE Partnership Physician Handbook.

   - Diagnostic testing, such as, but not limited to:
     - Chemistry Panel, CBC, U/A, Drug levels, x-rays, EKG
CCE will accept all above orders from the NP without physician co-signature.

2. Telephone and written communication regarding the CCE participant’s health status can be directed to the NP initially. In an urgent care situation, the NP will assess the urgency of the patient care situation. The NP will then initiate diagnostic procedures and/or treatment if within her/his scope of practice and knowledge of the participant, previous discussions with the participant’s physician, and within the scope of this collaborative agreement. If the situation is more complex, the NP will contact the physician for his/her input or to arrange for a physician evaluation.

3. The NP may contribute to the physical examination for admission to the CCE program, as well as periodic re-evaluations.

4. The NP will assess, monitor and manage common, acute and chronic health problems of the elderly based on their educational knowledge, using Geriatric Primary Care References and Protocols.

The CCE NPs use the following guidelines, references and protocol books:

<table>
<thead>
<tr>
<th>CCE Primary Care Policy and Procedure Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Patient Care Guidelines for Nurse Practitioners</em> c. 2003</td>
</tr>
<tr>
<td>By: Axalla J. Hoole, M.D.</td>
</tr>
<tr>
<td>Robert A. Greenberg, M.D.</td>
</tr>
<tr>
<td>C. Glenn Pickard, Jr., M.D.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Guidelines in Adult Health c. 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>By: Constance R. Uphold</td>
</tr>
<tr>
<td>Mary Virginia Graham</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Care Medicine c. 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>By: Allan Goroll, MD</td>
</tr>
<tr>
<td>Lawrence May, MD</td>
</tr>
<tr>
<td>Albert Mulley, Jr. MD.MPP</td>
</tr>
</tbody>
</table>

5. The physician and NP may develop additional protocols to address particular situations. The Medical Director and Professional Advisory Council before adoption will review these.

6. The NP will consult with the physician when encountering patient care situations not covered by protocol or requiring additional consultation/direction. If the primary care physician is not available, they will designate an alternate physician to be available to cover the participant.
7. The NP functions collaboratively with the physician and will work with the physician and their office staff to transfer non-emergent clinical information to the primary care provider in a timely manner. The NP will utilize the Partnership Communication Form to convey this information.

8. This agreement will be reviewed annually by CCE Administration and the Medical Director for quality and compliance. Any additions or changes will be forwarded to the primary care physician for review and signature.
I have read this agreement and understand the Wisconsin Partnership Program protocol entitled “Nurse Practitioner/Primary Care Physician Collaboration” and the Partnership Physician Handbook.

I have discussed my working relationship with the CCE Nurse Practitioner.

I understand the Nurse Practitioner may write orders and authorize services as mentioned in the aforementioned manuals and agreements.

The Nurse Practitioner will, at a minimum, communicate the following to keep me apprised of each member’s health status:

- Initial History and Physical
- Periodic Reevaluations
- Interdisciplinary Plan of Care
- All Acute/Urgent Contacts
- Results of diagnostic tests

Any additional requirements regarding contact by the NP will be listed here along with any additional protocol requests:

I understand that the Nurse Practitioner will maintain ongoing communication with me, including attending some member office visits, so that we may work in collaboration to provide medical care to each member.

CCE Medical Director, NP Quality Coordinator and the CCE Director of Quality Assurance oversee the Quality of the Partnership Nurse Practitioner’s clinical practice.

In signing this I agree to all the terms and conditions mentioned.

__________________________________________  Date
Primary Care Physician (signature)  

__________________________________________
Primary Care Physician (print)  

__________________________________________  Date
NP (signature)  

__________________________________________
NP (print)  

__________________________________________
NP license#  NP Prescriptive Authority #

__________________________________________
NP certification#

Mpg/tk/cb 12/3/02
CHAPTER 4

The PACE Clinic

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Key Points

- The PACE clinic primarily serves the participant’s needs and not the provider’s needs.
- Care in the PACE Clinic includes routine medical care but also interventions in lieu of inpatient care such as IV hydration, antibiotic administration and observation.
- Expect increased visits per participant (compared to traditional models) due to accessibility and the need to detect new issues and exacerbations of chronic problems at an early stage.
- The PACE clinic day is often compressed between 10 & 2 p.m., but provider staff continues clinical activities in other settings earlier and later.

The PACE clinic exists to allow the clinical team to provide medical care for PACE participants. The PACE primary care team of physicians, nurse practitioners (NPs), and physician assistants (PAs) (collectively Providers), with the assistance of nurses and medical assistants (MAs), is responsible for providing primary medical care to PACE participants. This care encompasses initial and semi-annual assessments, chronic care management, and acute and urgent care for new or active conditions. As such, the clinical
area must be able to schedule patients for routine care but also needs much flexibility to handle changes in daily need and volume. Since a PACE center can serve a census that ranges from a few participants at start-up to 300 participants at full capacity, and some programs have used one clinical area for two centers, one size does not fit all. So, as with many things in PACE, adaptability and flexibility are the keys to success.

**Scope of Activities**

Despite the low ratio of participants to providers, several factors can contribute to a high volume of encounters when compared to traditional care delivery settings. These factors include the intensive scrutiny given to participants, the presence of most participants at the PACE center on a regular basis and the expanded role of the PACE primary care team in managing the full range of chronic medical conditions. In a traditional doctor-patient relationship, early symptoms are often not reported, thus the physician is not aware, and the patient may eventually present with acute symptoms to the Emergency Department (ED). A major goal of care in PACE is to avert preventable ED visits and hospitalizations so as to limit clinical and functional decline.

A typical PACE participant has multiple chronic conditions, is functionally impaired, and is at risk of having an acute problem on any day. Therefore, the PACE provider needs to see the participant to assess early symptoms and initiate early interventions. Participants come to attention in a variety of ways and the clinic triage staff and medical team should be receptive and adaptable to all of these: self-reporting; reports from field staff (including nurses, drivers, aides); reports from day room staff; and calls from family members and other caregivers. The PACE Clinic staff anticipates these problem-based visits and fits them in with the scheduled routine visits.

There are unique transportation and scheduling issues to consider in planning the PACE clinic day. Often, the time of arrival of the participant at the clinic cannot be scheduled precisely because of the variability in transportation pick-ups and the coordination with a morning visit by the in home service staff. Then, after lunch, many of the participants are
anxious to leave and get home. The clinic day for face to face visits tends to be compressed between 10 AM and 2 PM. These same four hours include time for participants to eat lunch, receive personal care, attend therapy and social work appointments, and take part in recreational activities. Because of these features, providers engage in an ongoing process of triage, attending to participants based on the urgency of the condition or visit, frequency of attendance, and scheduled time of arrival and departure. Given a participant’s regular attendance at the center, it is possible to postpone a non-urgent visit to later in the week. A priority list might be, from highest to lowest: acute care, new enrollee evaluations, follow-up to recent acute care visits, annual or semi-annual re-evaluations, and then chronic care (such as a blood pressure recheck or pain medication review).

Traditional barriers to provider encounters are eliminated in the PACE environment. There is no billing or cost to the participant for the visit, and the physician is salaried to provide and manage the medical care of the PACE enrollee. The average PACE participant attends the center 2-3 times per week so in-center exams can easily be arranged. There is time for the provider to make home visits if indicated. Transportation between home to center is readily available. Thus, participants with acute problems such as COPD exacerbations, pneumonia, or cellulitis can be rechecked daily, receive IV therapies and avoid inpatient stays.

In making decisions about which provider sees a given participant, the PACE Medical Director must consider PACE regulations and must take into account the skill set, level of experience, and additional responsibilities of each doctor, NP, and PA. PACE regulations require each participant to have a primary care physician who is involved in -initial and semi-annual assessments, and who provides the overall direction of care. The physician is required by regulation to participate in interdisciplinary care planning. Commentary from CMS in 2006 suggests that the NP and PA assist and collaborate with the physician. Some provider organizations have the NPs and PAs perform comprehensive evaluations with the physician’s close and documented input. Others have the NPs and PAs concentrate on acute care, end of life care, dementia care, or other specific aspects of
care. Your state licensing boards and your organization’s NP and PA job descriptions and collaborative agreements may also influence which provider performs the various visits.

**Physical Space**

The physical set-up of the PACE clinic combines characteristics of a traditional medical office, an urgent care center and an inpatient nursing facility. There should be hospital style beds available for participants who cannot safely lie on a standard exam table and for those who need prolonged observation and/or treatments such as IV or SC hydration therapy. Some centers have a multi-bed observation area where participants receiving such therapy can be observed. Most exam room needs to be able to accommodate a wheelchair as many participants come in their chairs and can be examined in that position. Other exam rooms may have an exam table, but it should be able to be raised and lowered. One should plan on two exam rooms each for the number of providers who will see participants at the same time. But since medical visits to participants also occur at home, in the Skilled Nursing Facility (SNF) when patients are acute or subacute, and in the hospital, not all providers will be scheduled in the clinic every day. There also needs to be a room or private area for the nurse to do evaluations and treatments. While the majority of rooms will have beds, at least one room should have an exam table as it is physically more taxing on the provider to examine a participant in bed, and some exams, such as pelvic exams, are more successfully performed on an exam table. With fewer exam rooms and beds, one or two ill participants needing ongoing care can halt the clinic flow.

**Scheduling and Staffing**

The provider has to understand their team role in the clinic, just as he or she does on the PACE Interdisciplinary Team (IDT). A standard outpatient practice is set up to primarily serve the needs of the providers. The provider generates most of the revenue and therefore must be at the center of the clinic operation, assuring maximum productivity.
PACE, the participant is the focus. As such, services are arranged around the needs of the participant. Thus, there are competing priorities for the participant’s limited time at the PACE Center. For example, timely arrival at the center is predicated on a home health aide getting to the house to get the participant ready in the morning, and timed so that the worker finishes before the arrival of transportation. The participant may have a more urgent need to see a therapist, social worker, or nurse. A particularly favored activity may be scheduled and the participant reluctant to leave it for their medical visit. Team meetings and family meetings need to be accommodated. Certainly, given these constraints, the clinic attempts to maximize the professional staff’s productivity, but the clinic must understand that its needs do not always receive priority. Time allocation is a negotiation between all departments and IDT members.

Staffing patterns vary significantly among PACE centers. Some centers use a primary nursing model of care so that each participant is assigned a primary RN, and each RN has a panel of participants. Other centers have used RNs as managers and leaders of the clinical team, but staff the clinical areas primarily with LPNs. LPNs and RNs also staff the day rooms, doing skilled assessments and giving scheduled medicines and treatments. Medical office assistants (MAs) can staff the clinic to bring participants to and from the exam room, prepare the participant for the required exam including obtaining vital signs, and perform technical tasks such as obtaining EKGs and performing phlebotomy. A nurse is usually needed to provide skilled services such as intravenous hydration or medication administration as the provider is moving on to the evaluation of the next participant. PACE regulations indicate than a RN must perform a participant’s initial and periodic assessments (460.104(c)). Other ancillary staff will depend on the size of the center and may include clerks, phlebotomists, and pharmacists.

**Equipment**

Usual physician office equipment is necessary in the PACE clinic including sphygmomanometers, pulse oximeters, scales, thermometers, reflex hammers, tuning forks, otoscopes, ophthalmoscopes, monofilament testers, and bed and table linens.
Because urgent care is given at the clinic, additional supplies, equipment, and medicines must be available. These supplies should allow the clinic to provide at least IV and SC hydration, oxygen therapy, nebulizer treatments, wound management including I and Ds, minor laceration repair, and sharp debridement, splinting, joint and soft tissue injections, and cerumen removal. Medicines should be available, complying with state and federal laws, to initiate treatment for acute infections (antibiotics may be needed IV, IM and/or PO), acute or exacerbated pain, COPD and CHF exacerbations, angina, and other acute conditions that the provider and organization feels can be treated in this outpatient setting. An emergency supply of psychotropic medicines may be needed for acute or exacerbated behavior issues that put the participant or others at risk.

A PACE clinic (and center) will have to decide about crash carts and Automated External Defibrillators (AEDs) for participants with acute life threatening cardiac or pulmonary events. Most PACE organizations require that medical, nursing, and other clinical staff be Basic Life Support (BLS) certified. State licensing requirements for your adult day health center vary, but may require such certification. Since AED use is taught as part of BLS, is simple to use, and can easily be checked for proper functioning, many centers will consider obtaining and maintaining an AED. Many PACE centers do not have “crash carts” as providing Advanced Cardiac Life Support (ACLS) is not required in the PACE regulations. Those centers would access the Emergency Medical System (911) for participants or staff which need ACLS care.

**Summary**

In summary, the PACE clinic offers many advantages for the care of frail, functionally impaired older adults. The length and intensity of a primary care visit does not need to conform to any payment system. The relatively small patient panel size allows each provider to know participants in depth so that a visit can focus on both the participants’ current needs as well as their chronic care needs. Visits and notes focus on what was done, not on what is needed for billing purposes. Other members of the interdisciplinary team, such as therapists, social workers, and nurses, are a few steps or phone call away,
so that they can be readily recruited to help with management. Primary care providers are able to utilize the staff of the entire PACE Center. The center becomes a valuable observation and care environment where providers can call upon other staff members to monitor how participants are faring and how they are responding to different interventions. Thus, even though the PACE clinic may not be organized around primary care, its unique structure greatly enhances the ability of primary care staff to care for frail, disabled, and complex older patients.
One of the PACE Medical Director’s primary responsibilities is assembling and maintaining a network of contracted medical providers. The network includes consultants and inpatient facilities, as well as the system for off-hours coverage. The network must be reliable and responsive to the needs of frail and disabled elderly participants, as well as to those of the PACE Organization. In addition, the Medical Director must work with administrative leaders in the PACE Organization to ensure that the contracts with network providers are fair, clinically appropriate, and financially prudent.

**Consultants**

In assembling a panel of consultants, there are several key regulatory, clinical, and administrative principles to consider:

1. **Composition of Panel**

The PACE Provider Regulations explicitly require the PACE network to include a comprehensive range of medical specialties in its panel of contracted consultants [Section 460.92 (k)]. The PACE Organization must provide participants with the names of the contracted consultants for each specialty upon enrollment and when there is a change in the panel [Section 460.112 (b)(1)].
2. Locus of Control

A key clinical principle guiding the use of consultants in the PACE model is that the PACE Primary Care Providers (PCPs) and PACE Interdisciplinary Team retain responsibility for managing chronic medical and geriatric conditions. Thus, consultants advise the PACE providers, rather than assuming responsibility for ongoing management. This principle has important implications for the design and maintenance of the consultant panel.

A. PACE Clinical Competencies

The clinical and financial success of the PACE model assumes that the PACE team will develop a close relationship with each participant and will have a thorough understanding of the participant’s medical, functional, and social background. This detailed and interdisciplinary understanding enables the PACE team to exert far greater control over chronic conditions than providers are generally able to achieve in traditional medical models. PACE Primary Care Providers are uniquely positioned to determine whether a test, intervention, or technology will promote the functional goals and serve the health preferences of PACE participants.

The unique features and advantages of the PACE model shape the nature of the PCP and consultant relationship. The consultant answers the questions posed by the PACE PCP, who then places any recommendations within the holistic context of the participant’s cognitive, functional, and social situation. For some consultants, this may represent a transformation in their usual approach. It also places certain obligations on the PACE PCP. Because the PACE PCP manages chronic conditions, the PACE PCP must establish competency and credibility in the care of conditions commonly encountered in the PACE population. These include chronic medical conditions such as heart failure and diabetes; as well as
disabling neurologic conditions, such as Parkinson’s disease and related disorders; geriatric syndromes, such as falls and incontinence; and late life psychiatric conditions, such as depression and the behavioral complications of dementia. Establishing core competencies in these areas will provide necessary credibility for the PACE physician in relationships with consultants, as well as with participants, caregivers, and other members of the PACE team.

**B. Role of Consultant**

Because the locus of control for the care of chronic conditions resides with the PACE Primary Care and interdisciplinary teams, it is important to utilize consultants in a manner consistent with that approach. Thus, in PACE, a cardiologist is not asked to manage chronic heart failure or a neurologist to manage Parkinson’s disease. Instead, a cardiologist is posed a specific question, such as whether a patient with a dilated cardiomyopathy and atrial fibrillation would benefit from cardioversion, or to a neurologist about whether a patient with Parkinson’s disease and motor fluctuation would benefit from a COMT inhibitor.

Locus of control is maintained through a number of other features of the PACE model. The PACE Primary Care team orders medications, thus allowing the PACE PCP to determine the appropriateness of a given medication in the context of a patient’s co-morbid conditions, overall health status, and other medications. Similarly, the PACE team authorizes tests and procedures, thus giving the PACE PCP an opportunity to determine the necessity and value of a given recommendation and to consider what other measures might be required for its implementation, such as a discussion with caregivers, an escort, or a short-term stay at a nursing facility. Finally, the PCP determines the need and frequency of any follow-up visits.

One common exception to these principles is Ophthalmology, where, because of its specialized nature, the PACE PCP usually cedes control of ongoing
management. However, recommendations for procedures, such as cataract surgery, should still be weighed by the PACE team in the context of the patient’s overall function and well-being.

3. Features of the PACE and Consultant Relationship

The PACE Medical Director must establish the tone and procedural features of the relationship with the consultant, and must select consultants who can operate within those parameters. The tone should be mutually respectful, with the PCP and consultant each recognizing the core competencies of the other. Consultants should be interested in the care of frail elders and sensitive to their needs. Given the nature of PACE, consultants must be committed to collaborative care, and must be able to recognize the contributions of the PACE PCP and team. Last, the consultants must be accessible for telephone and electronic communication, as well as for timely patient visits.

The PACE Medical Director must also create a system to facilitate the flow of information. The system must assure that the consultant has access to necessary information when seeing the patient, including medical background, current medications, family contacts, and health wishes. The consultant must also know exactly what question or problem is to be addressed. The system must also ensure that the patient and caregivers are aware of the referral and that appropriate escort and linguistic supports are made available, if needed. On the other end, the system must allow the consultant to communicate recommendations, and requested follow-up in a prompt manner. Last, for the benefit of the PACE Organization’s claims department, the system must provide for authorization of a requested visit or intervention as well as for confirmation that the service was provided.

At the Upham’s Elder Service Plan, a consult requisition form is used to communicate information to the consultant and serves as a service authorization mechanism. The form is faxed to the consultant and also accompanies the participant. Along with the consult form, a copy is sent of a face sheet, which includes demographic and medical
information. The receipt of a completed consult form by the PCP confirms that the service has been provided and signals to administrative staff that the claim, when it arrives, should be paid. If a completed consult form or some equivalent document is not received, the claim is not paid.

Ideally, the consultants who see PACE participants in outpatient settings will also see them when they are hospitalized. However, this may not always be possible, especially at academic medical centers where consultants rotate ward responsibilities. Nonetheless, as a courtesy and to promote optimal continuity of care and communication of clinical information, it is always a good idea to inform outpatient consultants when one of their patients is admitted. Similarly, inpatient consultants should be informed about the prior involvement of colleagues in the outpatient setting.

Two consultant fields deserve special mention: surgery and psychiatry. It is particularly important to establish good working relationships with surgical consultants. Key surgical disciplines for PACE include general surgery, vascular surgery, urology, and orthopedics. The principles of accessibility, communication, collaboration, and mutual respect apply here especially. To support these principles, the PACE physician should adopt the role of medical consultant for patients undergoing surgery: completing the pre-op evaluation, assisting with the informed consent process, following the patient post-operatively in the hospital, and facilitating discharge plans.

PACE Organizations adopt different strategies to address mental health needs. Approaches range from contracting with community-based providers to developing an in-house mental health team devoted exclusively to PACE, or some combination thereof. An in-house team may be composed of a clinical psychologist, clinical social worker and/or nurse clinical specialist, with support from a consulting psychiatrist. Whatever approach is utilized, basic PACE principles apply. Because the PACE team is in the most frequent and intimate contact with the participant and caregivers, it must be enabled and empowered to manage day-to-day psychosocial issues.
When PACE Organizations enroll patients with chronic mental illness - an increasingly common phenomenon - these patients often come with long-standing mental health providers. Because of the particular vulnerability of this population, PACE Organizations should not terminate successful mental health relationships upon enrollment and should make every effort to contract with outside providers and incorporate them into the PACE care plan and team framework.

4. Contracting

The PACE Medical Director plays an integral role in assisting the PACE administrator responsible for contracts, and is an active participant in contract negotiations. A general approach is for the PACE Organization to pay the rate that the consultant would receive if the patient was not enrolled in PACE. Essentially, this means that the PACE Organization would pay Medicare rates. As an incentive for consultants to participate in the program, PACE Organizations can promise prompt payment of claims, assuming that the consultant complies with the consult report mechanism.

When PACE Organizations contract with consultants at an academic medical center, typically through a contract with a faculty practice group that includes all affiliated physicians, the PACE Organization must also contract with the medical center for the associated facility fee. These fees are expensive, often eclipsing the professional fee charged by the consultant. Also, unlike the professional fee, the facility fee is not subject to any defined Medicare rate. This can be a difficult area to navigate during contract negotiations, and PACE Organizations may need to bargain hard to get a reasonable rate.
Hospital

The hospital is a key provider in the PACE network. PACE provider regulations require the PACE Organization to contract with a hospital that participates in Medicare or Medicaid (Section 460.70 (b)(1)(i)) and is located either within or near the PACE service area (Section 460.70 (b)(2)). The PACE Organization must provide the full range of inpatient services (Section 460.92 (o)).

Because one of the fundamental PACE principles is continuity of providers across clinical centers, the PACE physician(s) should serve as the attending physician when a participant is hospitalized for medical diagnoses or as the medical consultant if the participant is on a non-medical service. Beyond maintaining continuity of care, this practice serves several other purposes:

- Establishes the credibility of the PACE Physician(s) with participants and families by managing care and communication when the participant is most ill and vulnerable
- Optimizes transfer of clinical information from the community setting to the hospital and back to the community
- Facilitates prompt and safe discharge planning

1. Choosing a Hospital

Pre-existing relationships and obligations of the PACE sponsoring organization may determine the choice of contract hospital. If, however, the PACE Organization is free to select among different hospitals, the PACE Medical Director must consider a number of factors. Obviously, geographic proximity, quality of care, and reputation in the target community served by PACE are key determining factors. The willingness of hospitals to contract with PACE also plays a role.
There are several other important questions that the PACE Medical Director should consider in selecting a hospital. PACE Organizations tend to be mission-driven community-based organizations, and their provider network relationships work best if their contract partners are like-minded agencies and institutions. Thus, the PACE Medical Director should ask: Does the hospital share the PACE mission of serving the poor and vulnerable? Is the hospital respectful of community-based providers? Does the hospital demonstrate sensitivity to the needs of frail elders?

The PACE Medical Director must also decide whether to contract with a teaching hospital or a community hospital. Early in the PACE experience, On Lok and others recommended contracting with community hospitals. This recommendation was based on the principle that community hospitals afforded the greatest control over utilization and discharge planning, as well as offering more favorable rates. However, there are good reasons to consider contracting with a teaching hospital. A teaching hospital offers the continuous presence of house officers who can address new problems and issues as they arise. It also offers the full range of consult services, and, given the teaching environment, it is an ideal setting for PACE physicians to learn new skills as they care for their patients. Furthermore, PACE physicians have an educational obligation to engage hospital-based trainees and expose them to the geriatric principles that make PACE a unique and successful model of community-based long-term care. Of course, the teaching hospital must be a willing partner, and the PACE Organization must be able to contract at affordable rates and establish a well-functioning collaborative relationship.

2. Contracting with a Hospital

There are two basic approaches to paying for inpatient services: per diem and per hospitalization. All-inclusive per diem contracting is generally preferable, if the hospital is willing and if the negotiated daily rates for different levels of care (Medical-Surgical, ICU/CCU, Psychiatric) are acceptable. Since its inception and across all centers, PACE has been able to control hospital length-of-stay, maintaining an average of four days per admission. This is shorter than average lengths of stay for comparable populations. Thus,
per diem costs will generally be lower than Medicare Diagnostic Resource Group (DRG) rates and will provide cost savings to the PACE Organization over time.

Several factors account for shorter lengths of stay in PACE. Because PACE is familiar with a participant’s chronic medical, functional, and social issues, the hospitalization can address acute issues without the diversion of attention toward chronic problems that can prolong lengths of stay. Because the PACE Organization manages discharge planning, has ready access to community-based and institutional discharge options, and can easily augment existing care plans with additional services, PACE physicians are able to discharge a patient at the earliest safe opportunity to a community setting or, if necessary, to a contract nursing facility for a short-term transitional stay. Because PACE Organizations establish a long-standing relationship with participants and caregivers and demonstrate trustworthiness in fulfilling care plans and meeting needs, discharge recommendations are generally well-accepted. Last, because PACE is familiar with a participant’s health wishes and goals of care, there is less need to extend hospital stays while the staff and family struggle to understand the patient’s health wishes.

The alternative to per diem contracting is paying an all-inclusive rate for the entire hospitalization. The all-inclusive rate can be the Medicare DRG rate or a fixed rate that is not adjusted for diagnosis. The advantage of per hospitalization rates is that they limit the exposure of the PACE Organization and protect against the potentially high costs of catastrophic cases requiring prolonged ICU care. For new PACE Organizations that are anxious about their ability to manage hospital length-of-stay or are concerned about the risk of catastrophic costs, per hospitalization contracting can offer peace-of-mind while the PACE team gains experience and confidence.

Another approach to limiting exposure to catastrophic costs is to purchase reinsurance. These policies typically activate at a threshold of inpatient costs, above which the insurance covers a certain percentage. These policies can be expensive and have not been widely adopted by PACE Organizations. Instead, as PACE Organizations grow, they set aside excess revenue as a risk reserve, thus essentially self-insuring against future
high costs. However, for a new program, reinsurance may be an option until the program develops experience and a risk reserve.

In addition to contracting for inpatient care, the PACE Organization must also contract for outpatient services, such as outpatient clinics, imaging, and diagnostic and therapeutic procedures. Contracts for outpatient services can be more complex than for inpatient care because Medicare reimburses hospitals for outpatient services at cost-based rates, rather than at defined Medicare rates. At the Upham’s Elder Service Plan, outpatient services are paid at a negotiated percentage of charges.

3. Out-of-Network Hospitals

While PACE Organizations make efforts to direct patients to contract hospitals, participants may end up at non-contract hospitals under emergency conditions. For continuity and control of care, the PACE Medical Director may want to facilitate transfer to the PACE contract hospital, if that option is safe and acceptable to the transferring facility. Often, however, the PACE team may not learn of the situation until after the participant has been admitted or the out-of-network hospital may feel the patient is too unstable for transfer. If transfer is not possible, the PACE Medical Director or PCP should establish contact with the treating physicians and nurses, provide background information, maintain daily communication, and facilitate discharge planning. The PCP should also communicate regularly with the participant’s family. When possible, the PCP should also make a hospital visit and meet with the treating team. When PACE participants utilize out-of-network hospitals under emergency conditions, the PACE Organization is responsible for paying no more than what Medicare or Medicaid would have paid.

4. Emergency Department

PACE participants have the right to access emergency services without prior authorization (Section 460.112 (d)). PACE provider regulations define an emergency as...
a condition manifested by acute symptoms of sufficient severity such that a prudent layperson could expect the absence of immediate medical attention to result in serious jeopardy, impairment, or dysfunction (Section 460.100 (c)).

The major problem confronting PACE Organizations in their relationship with emergency departments is that there is a profound misalignment of orientation and priorities. PACE Organizations are comfortable and skilled in managing the risks associated with community-based care of frail older patients and rely less on technological approaches. Emergency physicians tend to have less knowledge and experience with systems of care in the community and often lack confidence in the adequacy of social supports and reliability of follow-up. Emergency physicians tend to be risk averse and fearful of litigation, resulting in approaches that rely heavily on technology and institutional resources. Thus, if a typical frail, disabled, medically complex, socially challenged PACE participant ends up in a hospital Emergency Department (ED), there is a high likelihood that the emergency physician will want to order tests and admit the patient. The PACE PCP may feel otherwise, thus setting up the potential for conflict.

The PACE Medical Director can help mitigate this potential conflict. The Medical Director should create systems to ensure that PACE is notified when a patient arrives in the ED, so that the PACE staff can provide background information that might preempt admitting decisions. The Medical Director can also meet proactively with ED staff to educate them about PACE and the resources it is able to deploy and, in doing so, lay the foundation for a mutually respectful relationship. Most importantly, the PACE Medical Director must establish the mechanisms to prevent unnecessary ED utilization, by creating responsive, reliable, and capable systems of off-hours coverage and educating PACE participants and families about the availability of PACE to respond to acute issues.

Ultimately, however, the PACE Medical Director must recognize that the ED is a unique setting that operates under its own set of rules and limitations. If a participant ends up in the ED, PACE accepts that clinical problems routinely handled by the PACE team in the
PACE center, such as falls, infections, confusional states, and exacerbations of chronic medical conditions, will generate very different responses in the ED. Thus, a patient with recurrent falls may be admitted for “rule-out MI” and a syncope work-up, a patient with chronic constipation may get a contrast-enhanced abdominal CT scan, and a patient with dementia may get a head CT and admitted for “delta MS” and nursing home placement.

If the PACE Medical Director or Primary Care Physician is unable to propose an alternative course of action or discharge plan that assuages the concerns of the ED physician, the PACE Physician may offer to see the patient in the ED and assume responsibility for the patient’s care. The ED typically requires the PACE physician to write a thorough note and to obtain the consent of the patient and family for the plan. This approach may not be feasible at off-hours, in which case it becomes necessary to accept the ED plan, see the patient, if admitted, at the earliest possible convenience, and determine an appropriate course of action going forward.

In that PACE is often unable to exert control over what happens in the ED, it is helpful to structure the hospital contract in a manner that protects PACE from costly utilization. Per diem contracting is particularly helpful in this regard. If the ED insists on admitting a patient against the advice of the PACE PCP, the PACE PCP can evaluate the patient the following morning and, if appropriate, discharge to home or to the PACE Center. Under per diem contracting, the PACE Organization pays for one hospital day, inclusive of the ED charges. Another helpful contracting approach is negotiating all-inclusive ED rates. Under this approach, if the ED insists on ordering expensive imaging tests before discharging a patient back to PACE and the community, the costs to the PACE Organization are capped. At the Upham’s Elder Service Plan, a two-tier all-inclusive ED rate was negotiated with the contract hospital, with the tier determined by the total of the charges generated.
Nursing Home

PACE utilizes nursing homes (NHs) for three activities: skilled care (post-acute and sub-acute), respite, and long-term placement. The PACE Medical Director plays a key role in selecting nursing homes and in establishing and maintaining relationships with contract facilities. The Medical Director must also maintain compliance with the regulatory principle that the PACE Organization maintains clinical responsibility for participants even when they are admitted to NHs and that participants are clearly identified and recognized by NH staff as PACE enrollees. The PACE Medical Director also has responsibility for making sure that PACE PCPs and NPs are properly credentialed and oriented.

1. Skilled Care

Skilled nursing facility (SNF) care encompasses post-acute (following hospital discharge) and sub-acute (direct from the community) admissions. PACE Organizations contract directly with NHs and are not subject to the Medicare provision requiring a three-day hospitalization prior to accessing SNF-level care (Section 460.94 (b) (4). SNF care is an essential resource in PACE. As a discharge option, it limits lengths-of-stay, and as a sub-acute option, it permits a higher level of observation, monitoring, and treatment than is possible in the community, while limiting reliance on hospital-based care. Contracts for skilled care can be based on per diem all-inclusive rates or on base rates with additional charges for pharmacy and therapy services.

The PACE Medical Director must select NHs that have the ability to provide skilled nursing and rehabilitative services for a frail, complex population and are comfortable with higher levels of acuity and a collaborative care model. The NHs must have the bed capacity and flexibility to respond promptly to referrals from the PACE team and must be willing to accept admissions at off-hours. A typical scenario is a participant evaluated and treated in the PACE center for an acute problem who remains too unstable to return home at the end of the day but is not sick enough to warrant hospitalization. Because of
limited bed availability at some preferred NHs, the PACE Organization may need to contract with multiple facilities to meet its needs.

The PACE Medical Director must act reciprocally to establish mechanisms to respond promptly to NH staff. PACE primary care staff should speak directly with NH staff at the time of admission and should see patients within 48 hours. There should be ongoing communication between NH staff and PACE Primary Care staff at all hours. PACE Primary Care staff must also have the availability and flexibility to make timely visits when patients in NHs require urgent attention. Maintaining and supporting good communication and responsiveness will mitigate potential conflict and will help sustain the crucial PACE-NH relationship over time.

2. Respite

PACE Organizations make generous use of institutional respite. Periodic respite beyond day health helps to sustain caregivers who are struggling to keep difficult patients at home. At the Upham’s Elder Service Plan, two weeks of NH-based respite are offered annually, though in situations of high caregiver stress, up to two weeks quarterly is provided. In the long run, NH-based respite can forestall permanent NH placement and save money.

3. Long-Term Placement

Inevitably, some PACE participants will require long-term NH placement, either because of functional decline, unmanageable behavioral complications, or the inability of family members to continue their caregiving roles. As with short-term admissions, PACE staff must be available to respond to urgent issues, so that acute problems can be addressed at the NH, when appropriate, without emergency transport to the hospital. The PACE Medical Director must also be respectful of the NH regulatory environment and must ensure that PACE Primary Care staff sign orders, complete paperwork, and make periodic and annual visits.
Off-Hours Coverage

The PACE Organization is responsible for care in all settings 24 hours a day, every day of the year (Section 460.98 (a)). Thus, the Medical Director must construct a system to address problems and events that occur when the PACE Center is closed. The system must be reliable and responsive, such that participants and caregivers can be confident that it will function promptly and effectively. A reliable system of off-hours coverage will permit early recognition and treatment of acute issues and will reduce unnecessary emergency room and inpatient utilization. As with any PACE service, reliability and quality will be enhanced if off-hours providers are members of the PACE team.

It is important to remember that participants and caregivers have the right to access emergency care without prior authorization (Section 460.112 (d)). CMS defines an emergency as “a condition manifested by acute symptoms of sufficient severity such that a prudent layperson could expect the absence of immediate medical attention to result in serious jeopardy, impairment, or dysfunction” (Section 460.100 (c)). PACE Organizations must inform enrollees of this beneficiary immediately.

There are two components of the off-hours coverage plan that the Medical Director must address: telephone response and inpatient management.

1. On-Call Telephone Response

The key elements of an off-hours telephone response system are the following:

- Answering Service
- Initial Responder
- Medical Responder
- Access to Information
• Access to Resources
• Documentation

It is helpful to establish a single, unique phone number for the PACE Organization. Participants and caregivers can be instructed to call the PACE number at any time for all non-emergent problems, thus allowing them to become familiar with a single number. During normal operating hours, the call would arrive at the PACE Center(s), but after hours, the calls should be forwarded to the answering service. The answering service should respond with the name of the PACE Organization, inform the caller that the PACE Center is closed, and offer to call the on-call responder. For programs that serve multilingual communities, it is helpful if the answering service has non-English linguistic capacity.

Ideally, the initial responder will be a member of the PACE clinical team, but the initial responder need not be a medical provider, as many off-hours calls will not be medically related. Most off-hours calls concern issues related to personal care services, meals, supplies, medications, and transportation. At the Upham’s Elder Service Plan, our nurses (center-based and home-based) and our nurse practitioners rotate taking calls and receive a nominal hourly supplement for the responsibility.

The answering service will page the initial responder and provide contact information. The initial responder will then call the participant or caregiver, determine the nature of the problem, and initiate a response. If the initial responder determines that the problem might constitute a life-threatening emergency, the responder should advise the caller to call 911 and request that the participant be transported, if safe and appropriate, to the PACE network hospital. If the problem is a non-emergent medical issue, the initial responder should contact the medical responder and stand by to help implement any plan of care. All off-hours calls from nursing facilities should be considered medically related.
The next line of response is ideally a PACE physician or nurse practitioner. If the PACE Organization utilizes non-PACE medical responders, it is the responsibility of the Medical Director to educate and support the responders about PACE philosophy, resources, and network providers.

The response of the medical responder will be determined by the nature of the problem and by the range of off-hours PACE resources available for deployment.

Potential responses include the following:

- Call to 911
- Expedited transport to a health facility
- Scheduling of an urgent skilled nursing visit
- Ordering and delivery of medications
- Scheduling a next-day visit to the PACE Center
- Education and reassurance

The initial and medical responders must be able to access essential information about a participant when responding to an off-hours call. Availability of information is facilitated by an electronic health record (EHR) to which the responder has remote access, but, in the absence of an EHR with remote access, the PACE Organization must utilize paper resources.

At a minimum, off-hours responders must have access to the following information:

- Demographic information
- Contact information, including health care proxy
- Medical problem list
- Current medications
- Allergies and adverse drug reactions
• Health wishes
• Hospital record number

At the Upham’s Elder Service Plan, we have created a one-page fact sheet that is updated regularly and kept in a loose-leaf binder included in the on-call bag, along with a beeper, cell phone, phone directory, and manual of off-hours policies and procedures.

Given the range of potential off-hours responses, the PACE Organization must establish access to a number of key off-hours resources. The availability of resources will be influenced by local factors and by the size and maturity of the PACE Organization. For example, larger PACE Organizations may keep one or more PACE Centers open on weekends, holidays, and for extended weekday hours. Under these circumstances, an on-call provider may transfer a patient to a PACE Center for evaluation and potential treatment. Larger PACE Organizations may also be able to hire nurses to work evening, weekend, and holiday shifts, thus permitting unscheduled skilled nursing visits at off-hours. Ideally, the contract pharmacy will be able to deliver medications at off-hours, but in some service areas, this may not be feasible.

If the on-call medical provider determines that a participant does not face a life-threatening emergency demanding a 911 call, but nonetheless requires expedited transport to a health facility, such as a hospital emergency room or an urgent care center, either the initial responder or the medical responder should facilitate transportation and communication of essential information. The PACE responder should contact the contract ambulance service, provide background information, and direct the ambulance to the PACE network hospital or other destination. The responder should also call the ED or other center and communicate directly with the responsible physician, providing relevant information, including current issues, past medical history, medications, and health wishes.
All off-hours events require documentation and incorporation into the medical record, consistent with the regulatory requirement for a comprehensive, integrated, interdisciplinary PACE medical record (Section 460.210). Furthermore, thorough documentation supports communication to other members of the PACE team at morning meeting and permits review for quality improvement purposes.

2. Inpatient Coverage

The PACE Medical Director must establish systems for care of hospitalized patients on weekends and holidays, and for those times when the PACE physician(s) is on vacation or at conferences. Most PACE Organizations adhere to the principle that the PACE physician serves as the attending physician for hospitalized medical patients and as the medical consultant for participants on non-medical services. When possible, off-hours hospital coverage should follow the same principle. In larger PACE Organizations, the Medical Director can draw upon a team of PACE physicians in creating hospital coverage schedules. Newly established and smaller PACE Organizations need to rely upon outside physicians for coverage. The nature of this coverage will be determined by various local factors, such as the identity of the sponsoring organization and the presence of existing coverage relationships. If the PACE Organization relies upon outside physicians, the Medical Director must select the physicians carefully, establish contractual relationships, either by barter and payment, and provide initial and ongoing education and support to ensure that covering physicians apply PACE principles of communication and care.

Summary

With time and experience, PACE Organizations become skilled at applying the resources of the PACE Team and the PACE Center in caring for participants, and participants and caregivers consistently express high levels of satisfaction with these key features of the PACE model. Nonetheless, events occur at unexpected times and PACE Organizations must also rely upon outside providers and institutions in assembling all-inclusive systems.
of care. The PACE Medical Director plays an essential role in ensuring that the medical components of this all-inclusive system are responsive to the needs and expectations of the participants and the program.
The Role of the PACE Medical Director in Intake and Enrollment

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The PACE Medical Director plays a critical role in facilitating the intake and enrollment of new PACE participants. The Medical Director’s role begins with the marketing of the program and then continues through three key points in the intake and enrollment of individual patients. These three points are (1) initial referral, (2) PACE Center visit, and (3) development of a provisional care plan. The Medical Director also has responsibility for implementing the PACE regulatory provision that requires PACE Organizations to enroll any eligible patient who can be maintained safely in the community with PACE services at the time of enrollment (Section 460.150).

Marketing

PACE Organizations receive referrals from a variety of sources. The relative contributions of different referral sources may vary across different services areas, but will generally include Primary Care Physicians, Area Agencies on Aging, Home Health Agencies, Senior Housing sites, and Nursing Homes. The PACE Medical Director plays a critical role in educating the medical and aging communities about the role of PACE in the long-term care continuum. Importantly, the PACE Medical Director must reassure medical providers and aging agencies that PACE does not pose a competitive threat to existing providers and systems of care. The Medical Director must convey that PACE does not seek to enroll patients for whom current care plans are working and where integration of services is succeeding.
The Medical Director must effectively communicate that the PACE mission is to enroll patients who are “falling through the cracks” or who are at risk for “falling through the cracks.” These are the patients for whom care and services remain fragmented despite the best efforts of providers – the patients whose care plans are failing. Typically, these are patients who are losing contact with their primary care physicians because of increasing disability, communication and transportation difficulties, and high utilization of institutional settings. These are patients for whom the constraints and pressures of office-based practice create insurmountable barriers to the orchestration of complex care.

In marketing the PACE Organization, the Medical Director must consistently affirm the PACE mission, namely, to care for frail, disabled, and complex older patients who are at high risk of nursing home placement and to enable them to remain living in community settings through an integrated program of interdisciplinary care. The Medical Director might point out that PACE may enable patients to access services that might otherwise be unavailable or limited in duration, scope, and frequency; such as home health services, adult day health, rehabilitation, and transportation, as well as coordination of care and the full array of interdisciplinary team services. In short, the PACE Medical Director must help to establish PACE in the local market without alienating existing providers who may serve as the program’s best referral sources.

**Intake and Enrollment**

As prospective enrollees move through the intake process, the PACE Medical Director acts as – to borrow an image from auto racing - the “flag man” for the Intake and Enrollment team. As the PACE team and the prospective enrollee learn about each other, the Medical Director waves yellow, green, red, or checkered flags, depending on the status of the referral and the enrollment process. A key governing principle is that the PACE Medical Director is involved in the entire process, from initial referral through the participant’s start date. Intake and Enrollment must be a team process, analogous to care provided by the PACE Interdisciplinary Team, rather than an activity delegated exclusively to the Intake and Enrollment staff. Another principle is that as soon as
enrollment starts, the Interdisciplinary Team must be prepared to “hit the ground running”- to deliver care on day one without encountering any unexpected surprises.

**Referral**

After fielding a new referral and making a preliminary judgment that the patient is an appropriate candidate for PACE, the Intake and Enrollment Coordinator should inform the Medical Director. The Medical Director should then inform the patient’s Primary Care Physician about the referral, detailing the source of the referral and the reason. If the patient’s Primary Care Physician is unfamiliar with PACE, the Medical Director should describe the PACE Model of Care and explain that if the referral results in enrollment, the PACE Primary Care Physician would be assuming responsibility for care. The Medical Director should then ask if the Primary Care Physician agrees with the referral.

Typically, the physician will acknowledge difficulty in caring for the patient, citing complex care requirements and unmet needs, as well as concerns about unnecessary hospital utilization and premature nursing home placement. Often this provides valuable clinical information and sets up a relationship in which the physician may become a source of future referrals. The Medical Director should then give the Intake and Enrollment Coordinator a “Green Flag” to proceed with the intake and enrollment process. The Intake and Enrollment Coordinator should then send a letter to the physician, along with marketing material, and should provide regular updates on the status of the enrollment.

On rare occasions, a physician may take exception to a referral. The Medical Director should encourage the physician to speak with the patient, the family, and the referral source. This would enable the physician to clarify the issues that motivated the referral and identify potentially unmet needs. It would also ensure that existing providers continue to provide care. The Medical Director has an obligation to affirm the principle of patient choice, that is, the patient and family are entitled to decide whether to enroll in
PACE, but the Medical Director should agree to wave a “yellow flag” – to advise Intake and Enrollment staff to hold off on moving forward with the referral until the physician has had an opportunity to speak with the patient, the family, and the referral source. The Medical Director should let the physician know how to contact PACE if s/he determines that the patient would indeed benefit from referral to PACE or if there are ever other patients who might be appropriate referrals. The Intake and Enrollment Coordinator should then send out a letter and marketing material.

Typically, the physician will express appreciation for the courtesy of the call and, after consulting with the patient, the family, and the referral source, will reconsider and decide that PACE would indeed best serve the patient’s interests. The physician may even identify other patients to refer. Although this process of soliciting the approval of the patient’s physician may take time and energy, it is a worthwhile effort, especially early in a program’s experience, in that it mitigates the risk of PACE being perceived as a threat, and maintains and strengthens collegial relationships between PACE and the primary care community. Additionally, it provides another opportunity to market the program.

**PACE Center Visit**

The pre-enrollment visit to the PACE Center by the prospective participant, often accompanied by family, is a critical moment in the enrollment process. For the prospective enrollee and caregivers, this may be the first opportunity to give substance and form to what has been an abstract concept. For the PACE team, it offers an opportunity to meet with a prospective enrollee and the family, to make a favorable first impression, explain the PACE model, collect information, and begin to establish a working, collaborative relationship.

During the start-up phase of a PACE Organization, it is helpful for the Medical Director to be the medical provider that meets with the prospective participant and family. As a program matures, and as it adds additional PACE Centers and staff, this responsibility can be delegated to other primary care providers. Patients and families may be anxious...
about the prospect of changing primary care physicians and systems of care, and the PACE Medical Director or other PACE Primary Care Physician can often relieve much of this anxiety during the pre-enrollment visit.

In addition to presenting a human face and voice to the PACE concept, the physician should try to achieve two other major objectives during this initial encounter:

- Collection of basic medical information to generate an initial provisional care plan and, if required, support the determination of PACE clinical eligibility, and
- Communication of basic PACE operating principles

Some PACE Organizations use the pre-enrollment visit to conduct a complete initial medical evaluation, with history, physical examination, and laboratory assessment. This is not the practice at the Upham’s Elder Service Plan for several reasons: (1) the patient has not yet established a clinical relationship with the PACE Organization and its primary care providers, (2) the patient may not ultimately enroll in PACE, and (3) the emphasis at the pre-enrollment visit should be on establishing communication and sharing information; performing a complete history and physical might be counterproductive in achieving these objectives.

Nonetheless, the PACE Physician should use the pre-enrollment opportunity to gather key information from the patient and caregivers about current care. One should attempt to identify the following for each pre-enrollee:

- Primary Care Physician
- Specialists
- Hospital
- Major Medical Problems
- Current Medications
• Active Issues
• Pending Tests or Procedures

Gathering these data will facilitate the development of a provisional care plan and will prevent loss of continuity of care. The PACE physician or enrollment coordinator should also obtain a signed medical release at this time, if not earlier, so that medical records can be obtained promptly.

The PACE physician also uses the pre-enrollment visit to explain key PACE principles, especially those that may differ from what the patient and family have experienced in other care settings. This information will enable the patient and family to make a fully informed decision about enrollment in PACE. It also helps orient the patient and family to the operating principles that make the PACE model succeed and reduces the likelihood of misunderstandings occurring after enrollment.

Key principles to describe include the following:

• The need to change primary care physicians upon enrollment
• The need to utilize the PACE network of providers exclusively, including the network hospital and specialists
• The collaborative practice approach of the PACE physician and nurse practitioner
• The role of the PACE primary care team in managing chronic medical conditions and acute medical problems, in contrast to a specialist-dominated approach
• The interdisciplinary approach of the PACE Team
• Continuity of care and providers across clinical centers, including the PACE Center, home, hospital, and nursing facility
• Availability of the PACE Organization 24 hours a day, seven days a week
The PACE physician should also emphasize the critical importance of communication in the PACE model. The physician should explain that the patient should notify the PACE team about any change in health status, even if a change occurs during off-hours, and should describe the system for accessing care at off-hours. Consistent with Medicare requirements and PACE beneficiary rights, the PACE physician should remind patients to call 911 for life-threatening emergencies. However, the physician should assure the prospective enrollee and family that the PACE Organization is available to respond to all other problems at any time. It is often helpful to describe the variety of responses that PACE can deploy, including delivery of medications or supplies, home visits from a nurse or physician, transportation to the PACE Center for evaluation and treatment, or, if necessary, transportation to the emergency department.

The pre-enrollment encounter can provide information that leads the PACE Medical Director to wave a “red flag” informing the PACE enrollment team that it must halt the enrollment process. Reasons for halting the enrollment process are limited to the following:

- Unwillingness of the prospective enrollee to change primary care or accept the PACE provider network,
- Pending nursing home placement, or
- Information that would lead the PACE Medical Director to conclude that the patient could not be maintained safely in the community with PACE services.

Enrollment cannot be denied for any other reason, assuming that the patient meets PACE eligibility criteria. Burden of illness or high care needs are not grounds for denying enrollment.

The PACE Medical Director might wave a “yellow flag” at this point, indicating the need for further consideration or communication, if the patient is scheduled for imminent
surgery, is about to undergo a major change in care, such as beginning dialysis, or is in the midst of a diagnostic evaluation that might influence the enrollment decision. In these cases, it is unwise to interrupt pending plans and safer to delay PACE enrollment until a major transition is completed. Another reason for a “yellow flag” is that a provider or facility needs to be added to the PACE network. An example might be a mental health provider or a linguistically unique agency.

**Enrollment and Care Plan**

If, however, there are no reasons to delay or suspend enrollment, the PACE Medical Director waves a “green flag” to proceed. The Medical Director contributes to the development of a provisional care plan by indicating how frequently the enrollee will need to attend the PACE Center for medical management purposes. The Medical Director also sets up any medical referrals that are pending or that might be needed more urgently.

Hopefully, by gathering information from the patient, family, and medical providers, as well as from review of medical records, the PACE team will be able to begin work as soon as the “checkered flag” waves at the moment of enrollment. The PACE physician should enter initial orders for medications and other treatments a few days prior to the enrollment date so that nurses and other team members will have adequate time to prepare. The physician should conduct the initial complete medical evaluation as soon as possible after enrollment - within the first week for medically complex patients, but no later than the one month after enrollment for all others. The physician also should be prepared to share information with other members of the PACE team at the new participant’s first interdisciplinary care planning meeting.

**Summary**
The PACE Medical Director plays a crucial role in marketing, intake, and enrollment. If the Medical Director is appropriately and sufficiently involved in these functions, the PACE Organization is more likely to enjoy a mutually respectful relationship with the local medical and long-term care communities and to experience referral patterns that support healthy census growth. The PACE team will also be better prepared to provide care for its complex patients from the point of enrollment and will be less likely to encounter misunderstandings and unexpected clinical problems.
CHAPTER 7

PACE Medical Directors and Quality Programs

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Key Points

- Understand the regulations related to QAPI and PACE and the medical director’s role.
- Proactively develop collaborative working relationship with the Quality Coordinator of your organization.
- Contribute to the development of your QAPI plan, or at least know what you are responsible for.

PACE Medical Directors are guided by regulations for their responsibilities in the domain of QAPI (Quality Assessment and Performance Improvement). Where applicable, the regulatory reference is noted below.

Overall Medical Director Role in QAPI

PACE Regulation 42 CFR Part 460 states: “The organization must employ, or contract with, in accordance with §460.70, a medical director, who is responsible for the delivery of participant care, clinical outcomes, and the implementation, as well as oversight, of the quality assessment and performance improvement program.” The regulatory
interpretation of this includes: “Thus, the medical director is responsible for achieving the best clinical outcomes possible for all participants. Under this requirement, we would expect the medical director to use data comparing the program with other PACE organizations, where data are available, and to use the organization’s data to demonstrate internal improvements in outcomes over time.” So, it behooves the PACE Medical Director to be familiar with the regulatory and practical aspects of the QAPI program requirements. (Where applicable, the regulatory reference is noted.)

Regulatory Requirements

The regulatory requirements for QAPI programs are mostly found in Subpart H – QAPI §460:130-140, which describes six topics: General rules, Committees with community input, QAPI plan, Minimum requirements of QAPI program, Additional QI Activities and Internal QAPI Activities.

1. General Rules

The General Rules (§460.130) indicate the PO (PACE Organization) must develop, implement, maintain and evaluate their QAPI program, must assure the program is effective and data-driven, reflecting the full range of services furnished and will show improvements in all types of care. The expectation is that POs will operate a continuous QAPI program that does not limit activity to only selected kinds of services or types of patients, using as much flexibility as is necessary in order to fully meet obligations to its participants’ care. CMS does not require the use of a common quality assessment tool or a set of specific outcome measures beyond the data elements for monitoring as established in the program agreement (though some states will expect other specific elements, such as DataPACE 2). Thus, POs have the flexibility to develop the program that best meets their needs. The desired outcome of the QAPI requirement is that data-driven quality assessment serves as the engine that drives and prioritizes continuous improvements for all the PO’s services.
To support the data-driven QAPI process, POs must maintain a health information system (§460.202) that collects, analyzes, integrates, and reports data necessary to measure their performance and to develop their QAPI. This system is not required to be electronic, but it must have the capability to measure your PO’s performance, including outcomes of care.

The PO’s Governing body (§460.132) has final authority and responsibility for the QAPI program, as directed by the Medical Director and a Quality Coordinator (§460.136). Though the Medical Director may also serve as Quality Coordinator, most PACE organizations have a staff person with designated responsibilities for QI, often on a part-time basis.

Recommendations: Medical Director should proactively develop a solid working relationship with your Quality Coordinator, with regular meetings to review the QAPI program, to monitor progress on projects, to assist with developing the system for data collection and analysis, and to provide direction for further quality activities or corrective actions. The Medical Director will often chair or co-chair the Quality Committee and may present reports to the governing body. The mission of your sponsoring organization may filter down to the PACE administration and Quality program with variable intensity and commitment. By identifying unifying themes or priorities, the leaders of the administration and QAPI program set the focus for QI efforts. Building upon momentum and values that are already driving the staff and processes will ease the disruptions that sometimes are associated with QI.

2. Committees with Community Input

Your organization must develop and maintain one or more committees with community input (§460.134) to (1) evaluate data collected pertaining to quality outcome measures, (2) address the implementation of and results from the QAPI plan, and (3) provide input related to ethical decision-making, including end-of-life issues.
and implementation of the Patient Self-Determination Act. This committee(s) would be expected to provide guidance to your PO regarding its QAPI program and the ethical issues faced by POs. Some PO’s accomplish this through their Ethics Committee, but may also solicit input from a Participant Advisory Committee (PAC). The intent of the PAC, which is comprised of participants and participant representatives, is to provide a Participant Representative with issues as recorded in minutes of their meeting to present to the PO governing body.

**Recommendations:** Medical Director should actively promote a healthy Ethics Committee with appropriate community representation. Besides having regular meetings to review specific ethics issues and cases, this committee should be supplied with meaningful quality data (e.g., copies of the Quality Committee minutes and reports) for review and comment. The input from this committee should be forwarded to the Quality Committee for inclusion in the agenda and minutes of their next meeting. Some Medical Directors serve as chair of the Ethics Committee, but this is neither necessary nor even desirable in most cases. The Medical Director should be on the distribution list for minutes of the Participant Advisory Committee to be aware of issues that impact quality of care or may require advocacy or action in the Quality Committee.

### 3. QAPI Plan

PACE Organizations submit a QAPI plan as part of their PACE application, which must meet certain requirements (§460.132). CMS and the State will have already approved a QAPI plan prior to its inclusion in the program agreement and auditors will review the plan during monitoring visits. It must be written and be reviewed annually by the PO’s governing body as well as have a formal evaluation annually, which guides the required annual plan revision. The QAPI plan must specify how your PO will identify areas in which to improve or maintain the delivery of services and patient care; develop and implement plans of action to improve or maintain quality of care; and document and disseminate the results of the QAPI activities to the PACE staff and contractors. Most auditors also expect that QAPI activities by communicated to participants and caregivers.
Recommendations: Organizational philosophies toward QI are highly variable – most will embrace QI precepts on paper, but resource allocation may not match the words. Thus, the Medical Director plays a key role in obtaining operational buy-in to the QAPI Plan. QAPI Plans as originally developed for the PACE Application tend to be somewhat generic. In collaboration with the Quality Coordinator and the Program Director and governing body, make efforts to adapt the plan to be particular to your organization and circumstances. Be sure that it is a real plan, with enough specificity that you can use it as guide during the year. You will be held accountable to the QAPI Plan, so be careful to be neither overly general nor prescriptive to a degree that you cannot keep your promises. Be enthusiastic, but recognize that others may not share that enthusiasm. The Medical Director is an important champion for quality and must be an advocate for the QI staff and support QI efforts in all departments.

4. Minimum Requirements of the QAPI Program

Your QAPI program must include the use of objective measures to demonstrate improved performance (§460.134) with regard to five domains detailed below. An essential component of an effective quality improvement program is risk assessment and management. Risk management entails identifying and systematically reducing potential risks to the safety of PACE participants. Risk assessment ideally is conducted prospectively to prevent occurrences that result in adverse health outcomes to participants or staff (or harm to the organization’s physical plant/equipment or fiscal status). In reality, risk assessment is most often conducted retrospectively, in response to an event that results in medical, psychosocial, cognitive, or functional harm to a participant or staff.

Service utilization - the purpose of including utilization data (e.g., hospitalization use, Emergency Care or specialty care) in the QAPI program is to help ensure that participants receive the appropriate level of care through their PACE center. Analyzing utilization of and reasons for emergency care and hospital and nursing home admissions can likely
identify areas for improvement.

Caregiver and participant satisfaction - caregiver and participant satisfaction with services is an important aspect of a QAPI program. A PO must survey, on an ongoing basis, participants and their caregivers to determine satisfaction with the services furnished and the outcomes achieved. The QI Committee can use survey results to identify opportunities to improve services and caregiver and participant satisfaction. Your PO may choose its own survey tool, but will be expected to demonstrate how it is used as part of the QAPI Program.

Outcome measures derived from participant assessment data - these measures can be used to determine if individual and organization-level measurable outcomes are achieved compared to a specified previous time period. These measures should represent the various areas needed to monitor care for PACE participants, including physiologic, functional, cognitive, mental health, social/behavioral, and quality of life outcomes. For example, POs might focus QI activities on outcomes such as stabilization or improvement of specific ADLs from a baseline period to each follow-up period; improvement in dyspnea or blood sugar control since admission into PACE; and improvement in caregiver stress.

Effectiveness and safety of staff-provided and contracted services – this includes the competency of clinical staff, promptness of service delivery, and achievement of treatment goals and measurable outcomes. PACE staff must demonstrate skills and competencies necessary to facilitate desired outcomes for participants. Outcome measures should be derived from current clinical and professional standards as applicable to PACE participants. The PO is expected to include criterion-referenced performance measures of staff skills and to utilize these data to ensure that staff members maintain skills. The PO should provide training as new techniques and technologies are introduced and for new staff. Each PO must demonstrate a system of appropriate complexity for tracking the competencies of staff and for identifying and addressing staff training needs effectively. These data should be an integral part of the QAPI program to
provide routine feedback on staff performance.

Non-clinical areas - the types of outcomes in this area include outcomes related to participants’ grievances, transportation services, environmental issues, life safety and meals. For example, if a PO finds a high rate of unresolved grievances, the QAPI program might target activities to improve the grievance process. Performance must meet or exceed minimum levels on standardized quality measures; for example, to achieve at least 80 percent flu immunization rate for PACE participants. If your QI Committee determines that tracking a non-required outcome measure will benefit participants and improve the level or delivery of service, the QI Committee should identify and collect information to monitor that measure. You can expect regulators will establish additional minimum performance standards based on analysis of available data sets that are applicable to PACE participants. The data must be verifiable in terms of accuracy, timely collection, and completeness.

**Recommendations:** The Medical Director sometimes has a better understanding of data management and statistics than others in the PO. Be ready to assist the Quality Coordinator in choosing reasonable data elements and defining their calculations. The Medical Director has an important role in providing guidance for additional standards of clinical practice within the organization; for example, using NPA Model Practice guidelines, or physiological outcome measures. You may also be an important resource in developing or adapting the health information system (such as an EMR or paper record forms or disease registry) to facilitate tracking of quality indicators.

### 5. Additional QI Activities

CMS or the State Administrative Agency (SAA) may require POs to participate in periodic, external quality improvement reporting requirements. Examples of participation in an activity include the reporting of data items for outcome measurement
purposes, participation in the survey process, and participation in a CMS-directed national quality improvement project. The Level Two reporting requirements (see Appendix 1) are an example from CMS. Some SAAs require POs to participate in DataPACE2 reporting and to also report those indicators to the SAA. DataPACE2 indicators are developed through the NPA and will likely evolve to include more clinical measures. The current DP2 indicators are listed in Appendix 2.

Recommendations: Medical Directors may need to work with IT and/or Medical Records staff to identify proper data sources for reporting.

6. Internal QAPI Activities

The QAPI plan and processes are continuous and require sustained attention and management. The PO must use its set of outcome measures to identify areas of good or problematic performance and take demonstrable actions targeted at reinforcing or improving care based on these outcome measures. Quality projects that result in performance improvement must be become incorporated into your standards of practice for the delivery of care, and then periodically tracked to assure that any improvements are sustained over time.

Since an organization cannot improve everything at once, you must set priorities for performance improvement, considering the prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes. (However, any identified problems that threaten the health and safety of participants must be corrected immediately.)

Together with the Quality Coordinator, the Medical Director ensures that all team members, PACE staff, contract providers, PACE participants and caregivers are involved in the development and implementation of the QAPI activities and are aware of the results of these activities. The IDT is in a unique position to provide PACE management with structured feedback on the performance of the PACE program and suggest ways in
which performance can be improved.

QAPI Work Plan

The effective QAPI Plan will be married to an annual Work Plan. The goal of a QAPI Work Plan (QWP) is to identify clearly what quality indicators will be tracked in the next year along with priorities for QAPI projects. The QWP is developed from the annual evaluation of the QAPI plan from the previous year, plus additional suggestions through the Quality Committee. A suggested approach is to start developing the QWP in October by preliminary evaluation of previous year’s quality data. The Quality Committee may consider this draft in November with staff assigned to each indicator. These staff will develop the method to track and report the data and submit their recommendations to the Quality Committee, which will make final decisions on what to focus on for the coming year. (This process does not preclude ad hoc QAPI projects throughout the year.)

Areas to analyze for possible QAPI indicators or projects can come from many sources. The QAPI team should examine the following for potential new quality indicators:

- Quality Committee minutes
- Financial trends
- Risk Assessment trends
- Grievance/Appeal/Incident trends
- Significant event trends & action plans
- Disenrollment trends
- Infection/Infestation trends
- Governing Board - strategic direction
- Contractors - satisfaction surveys, outcomes
- Safety/Hazards trends
- Feedback, audit findings
- HPMS data reporting trends (Level One or Level Two)
- Operational initiatives
- Cultural trends in community
• Previous quality projects that need revisiting

The Quality Committee needs to adopt a clear method that reflects appropriate priorities in how you choose elements that will populate the coming year’s QWP. Recall the PACE regulations state that quality initiatives must have objective measures, so the proposed indicators must be measurable. Then they might be triaged by identifying which are high cost, high risk, high profile, high security or high volume issues. Some will have high urgency factors to consider. Others may be prioritized by virtue of being least managed presently. And don’t forget that CMS considers that clinical outcomes are always high priority issues. A sample QWP is presented in Appendix 3.

Once the QWP is finalized, the implementation begins. A good QWP will have established time frames for collection and reporting of each indicator data, with clear assignments of who does that. The Quality Coordinator will be responsible for holding staff or contractors accountable for these reports. Each indicator needs a brief rationale that describes what the purpose is and a measurable outcome target. Ideally, the reporting will include a graphic display. See Appendix 4 for example.

If the indicator is part of a new quality initiative or project, a methodology should be adopted that supports the initiative, such as the Plan-Do-Study-Act cycle. See Appendix 5.

QAPI Program Evaluation

An annual evaluation of the QAPI program is required and will be reviewed by State and Federal regulators at routine audits. This evaluation should be detailed and result in a written report. A sample report outline is provided in Appendix 6.

Meanwhile, quarterly updates are useful in keeping stakeholders aware of quality initiatives and progress. The distribution of updates should include front line staff, all organizational leaders, the IDT, Participant Advisory Committee, contracted providers,
the Governing Board and possibly broader distribution via a newsletter or website. Part of the focus for these updates is the sustainability of gains made by quality efforts.
Appendix 1
Required Data Reporting

Level One Reporting Requirements refer to those data elements for monitoring that are regularly reported by PACE organizations via the Health Plan Management System (HPMS) PACE monitoring module. These monitoring elements are detailed in the HPMS PACE User’s Guide, Fall 2005

The data submitted must come exclusively from the PACE organization, not the parent organization. If the PACE organization has more than one site of care/treatment, each site must be identified separately.

Data reported in response to the Level One Reporting Requirement are used by PACE organizations to identify opportunities for quality improvement. For example, based on their review of Level One data reported to HPMS, a PO may:

- Conduct a Quality Assurance Performance Improvement (QAPI) activity using a standardized methodology (e.g., Plan, Do, Check, Act known as PDCA) if a policy or system problem is identified
- Institute QAPI-driven change in policies, procedures, systems, or training as appropriate
- Evaluate the effectiveness of the intervention
- Track and trend for sustainable improvement
- Reevaluate until improvement is sustained
- Document for review during CMS/SAA audit as evidence of a performance improvement activity
- Report findings at least annually to oversight committees including the PACE organization’s governing board.
1) **Routine Immunizations**

**Definition:** PACE participants who received routine immunizations during the reporting year.

**What data will be reported:**
- Number of participants who received the flu immunization this year
- Number of participants who have received the pneumococcal immunization in the last ten years
- Total number of participants at the PACE organization
  - Number of participants not immunized for flu
  - Number of participants not immunized for pneumococcal
- Reason for not immunizing

**Frequency:** During the inoculation time period (e.g. Sept. to Jan.)

**How to use the measure:** Compare the number of PACE participants who were enrolled during the reporting year to the number of participants who received routine immunizations (flu and pneumococcal) during the reporting year.

**Minimum levels of Performance:** The organization will achieve an immunization rate for both influenza and pneumococcal vaccinations of 80% for the participant population that is appropriate. (Rate will exclude those participants who have had prior immunization or the vaccine is medically contraindicated).

2) **Grievances and Appeals**

**Definition:** Grievances are defined as either a written or oral complaints that expresses dissatisfaction with service delivery or the quality of care provided. Appeals are defined as a written complaint for the noncoverage or nonpayment of a service or item.

**What data will be reported:**
- Total number of participants during the quarter
- Total number of grievances filed during the quarter
- Total number of appeals filed during the quarter
- Source of each grievance or appeal (participant, family, caregiver, etc.)
• Date of initiation of each grievance or appeal
• Date of resolution of each grievance or appeal

**Frequency**: Quarterly

**How to use the measure**: Monitor trends and patterns. The actual number of grievances and appeals alone should not be viewed as an indicator of a problem. The high number of grievances could mean that participants are encouraged to speak up for themselves and voice their concerns.

3) **Enrollments**

**Definition**: Individuals enrolled in the PACE program by month.

**What data will be reported**: Number of individuals who enrolled in the program.

**Frequency**: Quarterly

**How to use the measure**: Monitor trends and patterns to determine if there are any accessibility issues and to determine if the PACE organization has sufficient financial resources to conduct appropriate marketing activities. This information can also be used to evaluate the PACE organization’s ability to maintain an appropriate census.

4) **Disenrollments**

**Definition**: Participants who disenrolled from the program for reasons other than death.

**What data will be reported**:

- Total number of participants
- Number of voluntary disenrollments
- Number of involuntary disenrollments
- Reason for each disenrollment: leaving the service area, failure to pay premium, disruptive or threatening behavior, no longer meets States level of care, program agreement with CMS terminates or not renewed, organization is unable to offer services due to loss of State license, keep personal physician, wishes to access out of network or other
**Frequency:** Quarterly

**How to use the measure:** Utilize this information to determine if there are any problems with site operations, such as accessibility, provision of services, etc. that are causing voluntary disenrollments. In addition, this information can be used to review the organization’s policies on involuntary disenrollments.

5) **Prospective Enrollees**

**Definition:** Potential participants who were interviewed, met eligibility requirements but did not enroll in the PACE program.

**What data will be reported:**

- Number of potential participants who were interviewed but did not enroll in the PACE program by aggregate reason
- Indicate the category that explains the reason each potential participant did not enroll, e.g. not safe to remain in the community, mental health concerns, lack of support network, requiring 24-hour care, preference for own physician, preference for other health care provider or institution, financial reason to avoid share of cost, unwilling to comply with treatment plan, or other with explanation

**Frequency:** Quarterly

**How to use the measure:** This information can be utilized to determine if the PACE organization is following the appropriate eligibility criteria and to determine if the organization is conducting appropriate marketing activities.

6) **Readmissions**

**Definition:** PACE participants re-admitted to an acute care hospital (excluding hospitalizations for diagnostic tests) in the last 30 days.

**What data will be reported:**

- Total number of participants
- Total number of participants admitted to the hospital in the last 30 Days
- Specific reason, including diagnosis, for participant’s admission
**Frequency:** Quarterly

**How to use the measure:** Review those with high usage to determine if intervention by the PACE organization could have prevented some of the hospitalizations. Readmission for the same reason in a 30-day period could indicate that the length of stay is too short or there is inadequate follow-up care by the PACE organization. Conduct quarterly comparisons to get a total picture of the care provided by the organization.

7) **Emergent (unscheduled) Care**

**Definition:** PACE participants seen in the hospital emergency room (including care from a PACE physician in a hospital emergency department) or an outpatient department/clinic emergency, Surgicenter.

**What data will be reported:**
- Total number of participants
- Total number of participants by (aggregate) same diagnosis
- Specific reason including diagnosis

**Frequency:** Quarterly

**How to use the measure:** Review those with high usage to determine if intervention by the PACE organization could have prevented some of the visits to the ER.

8) **Unusual Incidents for Participants and the PACE site (to include staff if participant was involved)**

**Definition:** Unanticipated circumstances, occurrences or situations which have the potential for serious consequences for the participants. Unusual incidents that result in no harm or a relatively low acuity of injury are appropriate for Level One Reporting. These incidents are reviewed locally to determine whether a QAPI activity is warranted.

**Examples include, but are not limited to:** falls at home or the adult day health center; falls while getting into the van; van accidents other than falls; participant
suicide or attempted suicide; staff criminal records; infectious or communicable disease outbreaks; food poisoning; fire or other disasters; participant injury that required follow-up medical treatment; participant injury on equipment; lawsuits; medication errors and any type of restraint use. This is not an inclusive list, so we would expect PACE sites to submit quarterly information on any unanticipated situations that occur.

**What data will be reported:** Number of unusual incidents aggregated by reason

**Frequency:** Quarterly

**How to use the measure:** Analyze categories focusing on whether these incidents were preventable, what steps were taken to resolve the problem, and what changes are being made to improve prevention. Is there a pattern that indicates a need for follow-up to investigate health and safety issues and procedures? Is this a program problem (e.g. negligence by staff) or a participant problem (e.g. verbal outbursts by participant with mental illness or severe dementia)?

9) **Deaths**

**Definition:** Death of participants during the given reporting period.

**What data will be reported:**

- Number of participants (can be aggregated by reason and setting, if same)
- Number of deaths
- Setting of the participant's death
- Cause of the participant’s death

**Frequency:** Quarterly

**How to use the measure:** Analysis to determine if there is a pattern indicating inappropriate setting for the participant or problems with accessibility to 24 hour care. Because of the link between the number of deaths and enrollment, this information may also indicate if the PACE organization is maintaining an appropriate census to remain fiscally viable.
**Level Two Reporting Requirements** apply specifically to unusual incidents that result in serious adverse participant outcomes, or negative national or regional notoriety related to the PACE program. Level Two reporting replaces the Sentinel Events Reporting Policy issued by CMS in 2004 by specifying in greater detail the types of incidents that must be reported to CMS and by identifying the circumstances in which reporting is required.

When unusual incidents meet specified reporting thresholds, PACE organizations are required to report them expeditiously as Level Two Reporting Incidents to the dedicated PACE mailbox (pace@cms.hhs.gov) at CMS Central Office (CO) with copies to the Regional Office (RO) and the State Administering Agency (SAA). Table 1 identifies these incidents and related reporting thresholds. Level Two incidents require internal investigation and analysis of the occurrence by the organization with the goal of identifying systems failures and improvement opportunities. Most Level Two reports require the organization to conduct a root cause analysis.

<table>
<thead>
<tr>
<th>Incident</th>
<th>Level Two Reporting Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths</td>
<td>Unexpected outcome related to any unusual incident listed in this table</td>
</tr>
<tr>
<td></td>
<td>Suicide (known or suspected)</td>
</tr>
<tr>
<td></td>
<td>Homicide (known or suspected)</td>
</tr>
<tr>
<td></td>
<td>Unexpected and having coroner involvement</td>
</tr>
<tr>
<td>Falls</td>
<td>Resulted in death</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury requiring hospitalization of 5 days or more</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury for which the determination is made within 48 hours of</td>
</tr>
<tr>
<td></td>
<td>the fall that permanent loss of function is expected</td>
</tr>
<tr>
<td>Infectious Disease Outbreak: An outbreak is 3 or more cases unless State law/regulation applies a more stringent standard.</td>
<td>All incidents of infectious disease outbreaks that meet the threshold of three or more cases (or the respective State standard if more stringent) linked to the same infectious agent within the same time frame (incubation, sub-acute, and acute manifestation) and are reportable to the respective State public health authority. Some situations may require additional reporting to the Centers for Disease Control and Prevention.</td>
</tr>
<tr>
<td>Pressure Ulcer: Acquired while enrolled in PACE.</td>
<td>Unstageable Pressure ulcer</td>
</tr>
<tr>
<td></td>
<td>Stage IV – Pressure ulcer with necrosis of soft tissue through to underlying muscle, tendon or bone</td>
</tr>
<tr>
<td></td>
<td>Stage III – Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue</td>
</tr>
<tr>
<td>Traumatic Injuries and/or other wounds that are not fall-related: Excludes pressure ulcers.</td>
<td>Resulted in death</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury requiring hospitalization of 5 days or more</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury for which the determination is made within 48 hours of</td>
</tr>
<tr>
<td></td>
<td>the injury that permanent loss of function is expected</td>
</tr>
<tr>
<td>Burns</td>
<td>Resulted in death</td>
</tr>
<tr>
<td></td>
<td>Resulted in hospitalization (any length of stay)</td>
</tr>
<tr>
<td></td>
<td>3rd degree burn covering more than 10% of the body without hospitalization</td>
</tr>
<tr>
<td>Medication-related Occurrences</td>
<td>Resulted in death</td>
</tr>
<tr>
<td></td>
<td>Resulted in hospitalization of 5 days or more</td>
</tr>
<tr>
<td></td>
<td>Resulted in determination within 48 hours of the occurrence that permanent loss of function is expected</td>
</tr>
<tr>
<td></td>
<td>Resulted in a near-death event, e.g., anaphylaxis, cardiac arrest</td>
</tr>
<tr>
<td>Adverse Drug Reactions</td>
<td>Any adverse drug reaction that meets the Food and Drug Administration (FDA) guideline for reporting under the FDA’s MedWatch program requires Level Two Reporting to CMS. More information regarding MedWatch reporting and the definition of a serious adverse drug reaction can be found on the FDA’s website at <a href="http://www.fda.gov/Safety/MedWatch/HowToReport/default.htm">http://www.fda.gov/Safety/MedWatch/HowToReport/default.htm</a></td>
</tr>
<tr>
<td>Adverse Outcomes: Serious, undesirable, and unexpected outcome of participant’s care or treatment that is not otherwise defined in this table.</td>
<td>Resulted in death</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury requiring hospitalization of 5 days or more</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury for which the determination is made within 48 hours of</td>
</tr>
<tr>
<td></td>
<td>injury that permanent loss of function is expected</td>
</tr>
<tr>
<td>Restraint Use</td>
<td>Resulted in death</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury requiring hospitalization (any length of stay)</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury for which the determination is made within 48 hours of</td>
</tr>
<tr>
<td></td>
<td>injury that permanent loss of function is expected</td>
</tr>
<tr>
<td></td>
<td>Resulted in injury requiring Emergency Department intervention without hospitalization, such as evaluation, suturing, splinting, or other treatment</td>
</tr>
<tr>
<td>Event Type</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Elopement: Unexpected absence from a PACE-sponsored program setting. Applies to participants with documented cognitive deficit. See glossary.</td>
<td>All elopements in which a participant with a documented cognitive deficit is missing for 24 hours or more; or an elopement that: Resulted in death Resulted in injury requiring hospitalization of 5 days or more Resulted in injury for which the determination is made within 48 hours of injury that permanent loss of function is expected.</td>
</tr>
<tr>
<td>Program-Related Motor Vehicle Accidents: Applies to MVAs in which PACE participants were transported in a vehicle owned, contracted, or operated by PACE personnel.</td>
<td>Resulted in death Resulted in injury requiring hospitalization (any length of stay) Resulted in injury for which the determination is made within 48 hours of event that permanent loss of function is expected Resulted in injury requiring Emergency Department intervention without hospitalization, such as evaluation, suturing, splinting, or other treatment</td>
</tr>
<tr>
<td>Suicide Attempts</td>
<td>All suicide attempts</td>
</tr>
<tr>
<td>Food-borne infection outbreak: 3 or more cases of the same illness resulting from the intake of a similar food source.</td>
<td>All food-borne infection outbreaks that meet the threshold of 3 or more cases of the same illness resulting from intake of a similar food source and are reportable to the State public health authority.</td>
</tr>
<tr>
<td>Fires/Other Disasters</td>
<td>All fires or other types of disasters that meet the threshold of reporting listed in the definition for fire in the Glossary: Environmental event at a PACE-sponsored setting which requires evacuation or closure, or results in a loss of safe housing for a PACE participant.</td>
</tr>
<tr>
<td>Equipment-Related Occurrences</td>
<td>Resulted in death Resulted in injury requiring hospitalization (any length of stay) Resulted in injury for which the determination is made within 48 hours of event that permanent loss of function is expected An equipment related occurrence that meets the FDA guideline for reporting under the FDA’s MedWatch program requires Level Two Reporting to CMS. More information regarding MedWatch reporting can be found on the FDA’s website: <a href="http://www.fda.gov/Safety/MedWatch/HowToReport/default.htm">http://www.fda.gov/Safety/MedWatch/HowToReport/default.htm</a></td>
</tr>
<tr>
<td>Cases of Elder Abuse: Includes abandonment</td>
<td>PACE organizations must follow their states’ statutes and requirements for reporting cases of suspected abuse, neglect or exploitation to the appropriate State agency. All cases substantiated by the responsible State agency meet Level Two reporting requirements.</td>
</tr>
<tr>
<td>Media-related Event</td>
<td>Any report of which the organization is aware through local, state, regional, or national media outlets (print, broadcast, web-based, radio, etc.) that presents a potential or actual harmful characterization of a PACE organization or the national PACE program (e.g., a local newspaper article on an investigation of reported elder abuse by a PACE staff).</td>
</tr>
</tbody>
</table>
**Appendix 2**

**DataPACE 2 Reporting Elements (2009 version)**

<table>
<thead>
<tr>
<th>Participants Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Measurement Category Has Five Dimensions: Age and Gender, Race/Ethnicity, Acuity and Frailty, Health Profile and Payer Sources</td>
</tr>
</tbody>
</table>

### Dimension: Age and Gender

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition (Numerator)</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>244</td>
<td>Percent of Service Population that is Male</td>
<td>Male gender</td>
<td>all participants</td>
<td>point in time</td>
<td>Total participants at a given point in time</td>
<td>quarterly</td>
<td>Participant Records</td>
</tr>
<tr>
<td>245</td>
<td>Percent of Service Population that is Female</td>
<td>Female gender</td>
<td>all participants</td>
<td>point in time</td>
<td>Total participants at a given point in time</td>
<td>quarterly</td>
<td>Participant Records</td>
</tr>
<tr>
<td>234</td>
<td>Years in Program for Current Participants</td>
<td>Number of years of enrollment for currently enrolled participants</td>
<td>all participants</td>
<td>point in time</td>
<td>Total participants at a given point in time</td>
<td>quarterly</td>
<td>Participant Records</td>
</tr>
<tr>
<td>280</td>
<td>Percent of Participants Age 55-64</td>
<td>Date of Birth</td>
<td>all participants</td>
<td>point in time</td>
<td>Total participants at a given point in time</td>
<td>quarterly</td>
<td>Participant Records</td>
</tr>
<tr>
<td>281</td>
<td>Percent of Participants Age 65+</td>
<td>Date of Birth</td>
<td>all participants</td>
<td>point in time</td>
<td>Total participants at a given point in time</td>
<td>quarterly</td>
<td>Participant Records</td>
</tr>
<tr>
<td>233</td>
<td>Average Age of Participants</td>
<td>Date of Birth</td>
<td>all participants</td>
<td>point in time</td>
<td>Total participants at a given point in time</td>
<td>quarterly</td>
<td>Participant Records</td>
</tr>
</tbody>
</table>

### Dimension: Race/Ethnicity

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>250</td>
<td>Percent of Service Population that is White (not of Hispanic origin)</td>
<td>white participants, not of Hispanic origin, enrolled in the program.</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment at a given point in time</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>251</td>
<td>Percent of Service Population that is Black (not of Hispanic origin)</td>
<td>black participants, not of Hispanic origin, enrolled in the program.</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment at a given point in time</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>252</td>
<td>Percent of Service Population that is Hispanic</td>
<td>Hispanic participants enrolled in the program, including participants who are black and of Hispanic origin (applicable to those from Latin America, the Caribbean, etc.)</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment at a given point in time</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>253</td>
<td>Percent of Service Population that is Asian or Pacific</td>
<td>Asian or Pacific Islander participants enrolled in the program.</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment at a given point in time</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>Mst. ID</td>
<td>Measure</td>
<td>Measured Characteristic, Event or Condition</td>
<td>Measured Population</td>
<td>Measurement Period</td>
<td>Denominator</td>
<td>Measurement Frequency</td>
<td>Potential Data Sources</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>---------------------------------------------</td>
<td>---------------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>27</td>
<td>HCC Risk Adjustor</td>
<td>CMS-HCC Risk Adjustor Score reflecting diagnoses, demographic factors, services and other factors used to adjust Medicare payments</td>
<td>Medicare participants</td>
<td>one year</td>
<td>Average Medicare enrollment over a one year period</td>
<td>annual?</td>
<td>RAPS</td>
</tr>
<tr>
<td>241</td>
<td>Average # of Diagnoses</td>
<td>Average number of unique diagnoses that are active within a one-year period per participant</td>
<td>Medicare participants</td>
<td>one year</td>
<td>Average Medicare enrollment over a one year period</td>
<td>annual?</td>
<td>RAPS</td>
</tr>
<tr>
<td>271</td>
<td>Average Number of Medicare and Medicaid (duals) ADL Dependencies</td>
<td>self-reported dependencies in Activities of Daily Living as measured by the Health of Seniors survey</td>
<td>Medicare participants</td>
<td>point in time</td>
<td>Medicare participants who are also Medicaid-eligible responding to the survey’s ADL questions</td>
<td>annual</td>
<td>HOS</td>
</tr>
<tr>
<td>272</td>
<td>Average Number of Medicare-Only ADL Dependencies</td>
<td>self-reported dependencies in Activities of Daily Living as measured by the Health of Seniors survey</td>
<td>Medicare participants</td>
<td>point in time</td>
<td>Medicare participants who are not also Medicaid-eligible responding to the survey’s ADL questions</td>
<td>annual</td>
<td>HOS</td>
</tr>
<tr>
<td>243</td>
<td>Average Number of ADL Dependencies</td>
<td>self-reported dependencies in Activities of Daily Living as measured by the Health of Seniors survey</td>
<td>Medicare participants</td>
<td>point in time</td>
<td>Medicare participants responding to the survey’s ADL questions</td>
<td>annual</td>
<td>HOS</td>
</tr>
</tbody>
</table>

**Dimension: Health Profile**
<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>224</td>
<td>Prevalence of Cognitive Impairment</td>
<td>Diagnosis of cognitive impairment</td>
<td>Medicare participants</td>
<td>point in time</td>
<td>Total Medicare enrollment</td>
<td>quarterly</td>
<td>RAPS</td>
</tr>
<tr>
<td>238</td>
<td>Prevalence of Participants with a Diagnosis of Diabetes</td>
<td>Diagnosis of diabetes</td>
<td>Medicare participants</td>
<td>point in time</td>
<td>Total Medicare enrollment</td>
<td>quarterly</td>
<td>RAPS</td>
</tr>
<tr>
<td>242</td>
<td>Prevalence of Participants with a Diagnosis of indicating Depression</td>
<td>Diagnosis of depression</td>
<td>Medicare participants</td>
<td>point in time</td>
<td>Total Medicare enrollment</td>
<td>quarterly</td>
<td>RAPS</td>
</tr>
<tr>
<td>77</td>
<td>Average Number of Prescription Drugs</td>
<td>Unique prescribed drugs for active prescriptions; not refills</td>
<td>Medicare participants</td>
<td>30 day look back from end of the quarter</td>
<td>Total Medicare enrollment</td>
<td>quarterly</td>
<td>PDE</td>
</tr>
</tbody>
</table>

**Dimension: Payer Sources**

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>246</td>
<td>Percent of Service Population Eligible for Medicaid</td>
<td>Medicaid as a payer for a participant</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>266</td>
<td>Percent of Service Population Eligible for Medicare</td>
<td>Medicare as a payer for a participant</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>248</td>
<td>Percent of Service Population Eligible for Medicare and Medicaid (Duals)</td>
<td>Medicaid and Medicaid as payers for a participant</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>247</td>
<td>Percent of Service Population Eligible for Medicare Only</td>
<td>Medicare as the only public payer for a participant (i.e. Medicaid is not a payer)</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>255</td>
<td>Percent of Service Population Eligible for Medicaid Only</td>
<td>Medicaid as the only public payer for a participant (i.e. Medicare is not a payer)</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>249</td>
<td>Percent of Service Population that is Private Pay Only</td>
<td>Private pay as the only source of payment for a participant (i.e. neither Medicare nor Medicaid are payers)</td>
<td>all participants</td>
<td>point in time</td>
<td>Total enrollment</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
</tbody>
</table>

**Quality**

This Measurement Category Has Three Dimensions: Consumer Satisfaction, Safe and Effective Care, and Supporting Quality of Life

**Dimension: Consumer Satisfaction**

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition (Numerator)</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>274</td>
<td>Consumer Satisfaction Rating</td>
<td>Overall, would you rate the care provided by (PACE organization/day center name) as: Excellent,</td>
<td>all participants</td>
<td>year-most recent result as of March 31</td>
<td>all participants</td>
<td>quarterly</td>
<td>Internal PACE org. survey</td>
</tr>
<tr>
<td>Measurement</td>
<td>Measure Characteristic, Event or Condition</td>
<td>Measured Population</td>
<td>Measurement Period</td>
<td>Denominator</td>
<td>Measurement Frequency</td>
<td>Potential Data Sources</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>275 Consumer Satisfaction - Recommend</td>
<td>Would you recommend (PACE organization/day center name) to close friends or relatives in need of this kind of care? Yes/No/Sometimes-Maybe</td>
<td>all participants</td>
<td>year- most recent result as of March 31</td>
<td>all participants</td>
<td>quarterly</td>
<td>Internal PACE org. survey</td>
<td></td>
</tr>
<tr>
<td>208 Quarterly Voluntary Disenrollment Rate</td>
<td>Disenrollment, all reasons</td>
<td>all participants</td>
<td>quarter</td>
<td>Average total enrollment over a period of time - one quarter</td>
<td>quarterly</td>
<td>Electronic Medical Records; HPMS</td>
<td></td>
</tr>
</tbody>
</table>

**Dimension: Safe and Effective Care**

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>231</td>
<td>Percent of Participants immunized for flu</td>
<td>flu immunization within the prior 12 months</td>
<td>all participants</td>
<td>point in time</td>
<td>all participants</td>
<td>annually</td>
<td>HPMS</td>
</tr>
<tr>
<td>276</td>
<td>Percent of Participants immunized for flu-contraindicated</td>
<td>Participants for whom a flu vaccination was contraindicated within the prior 12 months</td>
<td>all participants</td>
<td>point in time</td>
<td>all participants</td>
<td>annually</td>
<td>HPMS</td>
</tr>
<tr>
<td>232</td>
<td>Percent of Participants immunized for pneumococcal vaccination i.e. a vaccination that occurred no more than 10 years prior to the measurement date</td>
<td>all participants</td>
<td>point in time</td>
<td>all participants</td>
<td>quarterly</td>
<td>HPMS</td>
<td></td>
</tr>
<tr>
<td>277</td>
<td>Percent of Participants immunized for pneumococcal-contraindicated</td>
<td>Participants for whom a pneumococcal vaccination was contraindicated no more than 10 years prior to the measurement date</td>
<td>all participants</td>
<td>point in time</td>
<td>all participants</td>
<td>quarterly</td>
<td>HPMS</td>
</tr>
<tr>
<td>269</td>
<td>Percent of Medicare Participants with Diabetes Receiving a Hemoglobin A1C test in a year</td>
<td>Administration of a hemoglobin A1c test within the prior 12 months for participants with a diagnosis of diabetes; each test should be counted as one test, even if given to the same Medicare participant</td>
<td>Medicare participants under the age of 75 with an active enrollment on March 31 who have a current diagnosis of diabetes and received a Hemoglobin A1C test in the prior 12 months (i.e. April 1-March 31)</td>
<td>point in time-March 31</td>
<td>Medicare participants under the age of 75 with a current diagnosis of diabetes as of March 31</td>
<td>quarterly</td>
<td>Electronic Medical Records, RAPS- for diagnosis</td>
</tr>
<tr>
<td>235</td>
<td>Number of falls per 100 Participants per month</td>
<td>falls, in all locations</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months for the quarter / 3 months / 100 participants</td>
<td>quarterly</td>
<td>HPMS</td>
</tr>
</tbody>
</table>
### Dimension: Supporting Quality of Life

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>236</td>
<td>Percent of Medicare Participants able to Engage in activities that contribute to their quality of life</td>
<td>number of days of life during which participants report being able to engage in activities that contribute to their quality of life</td>
<td>Medicare participants</td>
<td>one year</td>
<td>Medicare participants responding to the Medicare Health of Seniors survey</td>
<td>annual</td>
<td>HOS</td>
</tr>
<tr>
<td>225</td>
<td>% of Participants living at home</td>
<td>living at home defined as a private residence in a single or congregate setting</td>
<td>all participants</td>
<td>point in time</td>
<td>all participants</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
</tbody>
</table>

### Utilization of Services

This Measurement Category Has Six Dimensions: Primary, Rehabilitative, and Specialist Care; Nursing Facility; Home Care; Aging and Social Services and Medications

### Dimension: Primary, Rehabilitative and Specialist Care

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>217</td>
<td>Primary Care Encounters per member per month</td>
<td>Primary care encounters, including encounters with physicians, physician assistants and nurse practitioners</td>
<td>all participants</td>
<td>quarter</td>
<td>member months</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>229</td>
<td>Number of Therapy Encounters per member per month</td>
<td>OT, PT and Speech therapy encounters, including therapy provided by licensed therapists and therapy assistants under supervision of a licensed therapist</td>
<td>all participants</td>
<td>quarter</td>
<td>member months</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>256</td>
<td>Number of Specialist Visits per member per month</td>
<td>Specialist encounters, including all specialist services provided regardless of setting. Specialists includes: audiologist, dentist, optometrist, podiatrist, psychiatrist, medical outpatient specialist</td>
<td>all participants</td>
<td>quarter</td>
<td>member months</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
</tbody>
</table>

### Dimension: Acute Care
<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>210</td>
<td>Acute Hospital Admissions per member per year</td>
<td>Acute hospital admissions</td>
<td>all participants</td>
<td>year</td>
<td>all participants</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>211</td>
<td>Acute Hospital Days/1000 participants per year</td>
<td>Acute hospital admissions</td>
<td>all participants</td>
<td>quarter</td>
<td>all participants / 1000</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>268</td>
<td>Psychiatric Hospital Admissions Per Member Per Year</td>
<td>Psychiatric hospital admissions</td>
<td>all participants</td>
<td>year</td>
<td>total member months in one year / 12 months</td>
<td>annual</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>237</td>
<td>Psychiatric Hospital Days Per 1000 Participants Per Year</td>
<td>Psychiatric hospital admissions</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months in one year / 12 months / 1000</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
</tbody>
</table>

**Dimension: Nursing Facility**

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>213</td>
<td>Percent of participants in long term NF at a given point in time</td>
<td>participants in a long term nursing facility placement, defined as a placement that has lasted 90 days or more</td>
<td>all participants</td>
<td>point in time</td>
<td>all participants</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>212</td>
<td>Short term NF days PMPM</td>
<td>days spent by participants in a short term nursing facility placement, defined as a placement that has lasted 89 days or less</td>
<td>all participants</td>
<td>point in time</td>
<td>total member months</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>214</td>
<td>Long term NF days PMPM</td>
<td>days spent by participants in a long term nursing facility placement, defined as a placement that has lasted 90 days or more</td>
<td>all participants</td>
<td>point in time</td>
<td>total member months</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>215</td>
<td>Long term NF days/1000 participants/year</td>
<td>days spent by participants in a long term nursing facility placement, defined as a placement that has lasted 90 days or more</td>
<td>all participants</td>
<td>year</td>
<td>total member months / 12 / 1000</td>
<td>annual</td>
<td>EMR, Claims</td>
</tr>
</tbody>
</table>

**Dimension: Home Care**

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>226</td>
<td>Number of skilled home care visits per member per month</td>
<td>skilled home care visits, defined as visits to a participant’s home during which skilled health care services were provided</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
</tbody>
</table>
### Dimension: Aging and Social Services

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>227</td>
<td>Personal Care Hours per member per month</td>
<td>personal care hours, defined as hours spent in a participant's home providing personal care assistance</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
<tr>
<td>270</td>
<td>Number of personal care visits per member per month</td>
<td>personal care visits, defined as visits to a participant's home during which personal care assistance services were provided</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months</td>
<td>quarterly</td>
<td>EMR, Claims</td>
</tr>
</tbody>
</table>

#### Dimension: Medications

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>218</td>
<td>Days attending the PACE Center per member per month</td>
<td>days of attendance at the PACE Center</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>257</td>
<td>Number of Social Work encounters per member per month</td>
<td>Social work encounters, including encounters in all settings of care</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>228</td>
<td>Number of transportation trips per participant per month</td>
<td>transportation trips, including trips to transport participants to any destination or to transport supplies or services to participants</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
<tr>
<td>230</td>
<td>Number of meals per member per month</td>
<td>meals provided to participants, in all settings, by the PACE organization</td>
<td>all participants</td>
<td>quarter</td>
<td>total member months</td>
<td>quarterly</td>
<td>Electronic Medical Records</td>
</tr>
</tbody>
</table>

### Growth

This Measurement Category Has Five Dimensions: Total Census, Dual Census, Medicaid-only Census, Medicare Only Census, and Private Pay only Census

### Dimension: Total Census

<table>
<thead>
<tr>
<th>Mst. ID</th>
<th>Measure</th>
<th>Measured Characteristic, Event or Condition (Numerator)</th>
<th>Measured Population</th>
<th>Measurement Period</th>
<th>Denominator</th>
<th>Measurement Frequency</th>
<th>Potential Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>216</td>
<td>Average # of prescriptions filled per member per month</td>
<td>prescribed medications, that require a prescription and that are active during the measurement period, defined as those that have at least one dispensing event during the measurement period; includes refills</td>
<td>Medicare participants</td>
<td>quarter</td>
<td>Medicare member months</td>
<td>annualized</td>
<td>PDE</td>
</tr>
<tr>
<td>Mst. ID</td>
<td>Measure</td>
<td>Measured Characteristic, Event or Condition</td>
<td>Measured Population</td>
<td>Measurement Period</td>
<td>Denominator</td>
<td>Measurement Frequency</td>
<td>Potential Data Sources</td>
</tr>
<tr>
<td>--------</td>
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<td>------------------------</td>
</tr>
<tr>
<td>23</td>
<td>Dual Census</td>
<td>the number of enrolled participants in the program, with Medicare and Medicaid as payer sources</td>
<td>participants with Medicare and Medicaid as payer sources</td>
<td>point in time</td>
<td>n/a</td>
<td>quarterly</td>
<td>EMR</td>
</tr>
<tr>
<td>259</td>
<td>Quarterly Percent Change in Dual Census</td>
<td>change in the number of enrolled participants, with Medicare and Medicaid as payer sources, in the program over a defined period of time</td>
<td>participants with Medicare and Medicaid as payer sources</td>
<td>year</td>
<td>enrolled participants with Medicare and Medicaid as payer sources at the beginning of the measurement period</td>
<td>quarterly</td>
<td>EMR</td>
</tr>
<tr>
<td>24</td>
<td>Medicaid-only Census</td>
<td>the number of enrolled participants in the program, with Medicaid as the only payer source</td>
<td>participants with Medicaid as the only payer source</td>
<td>point in time</td>
<td>n/a</td>
<td>quarterly</td>
<td>EMR</td>
</tr>
<tr>
<td>260</td>
<td>Quarterly Percent Change in Medicaid-only Census</td>
<td>change in the number of enrolled participants, with Medicaid as the only payer source, in the program over a defined period of time</td>
<td>participants with Medicaid as the only payer source</td>
<td>year</td>
<td>enrolled participants with Medicaid as the only payer source at the beginning of the measurement period</td>
<td>quarterly</td>
<td>EMR</td>
</tr>
<tr>
<td>Mst. ID</td>
<td>Measure</td>
<td>Measured Characteristic, Event or Condition</td>
<td>Measured Population</td>
<td>Measurement Period</td>
<td>Denominator</td>
<td>Measurement Frequency</td>
<td>Potential Data Sources</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>25</td>
<td>Medicare-only Census</td>
<td>the number of enrolled participants in the program, with Medicare as the only public payer source</td>
<td>participants with Medicare as the only public payer source</td>
<td>point in time</td>
<td>n/a</td>
<td>quarterly</td>
<td>EMR</td>
</tr>
<tr>
<td>26</td>
<td>Private Pay-only Census (includes private insurance)</td>
<td>the number of enrolled participants in the program, with only a private payer source</td>
<td>participants with only a private payer source</td>
<td>point in time</td>
<td>n/a</td>
<td>quarterly</td>
<td>EMR</td>
</tr>
<tr>
<td>261</td>
<td>Quarterly Percent Change in Medicare-only Census</td>
<td>change in the number of enrolled participants, with Medicare as the only public payer source, in the program over a defined period of time</td>
<td>participants with Medicare as the only public payer source</td>
<td>year</td>
<td>enrolled participants with Medicare as the only public payer source at the beginning of the measurement period</td>
<td>quarterly</td>
<td>EMR</td>
</tr>
<tr>
<td>262</td>
<td>Quarterly Percent Change in Private Pay-Only Census</td>
<td>change in the number of enrolled participants, with only a private payer source, in the program over a defined period of time</td>
<td>participants with only a private payer source</td>
<td>year</td>
<td>enrolled participants with only a private payer source at the beginning of the measurement period</td>
<td>quarterly</td>
<td>EMR</td>
</tr>
</tbody>
</table>

**Dimension: Private Pay Only Census**
## Appendix 3
### Sample QI Work Plan

### PACE Quality Management

**Annual Work Plan for 20XX**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Quality Objective/ Rationale</th>
<th>Benchmark</th>
<th>Goal</th>
<th>Data Source</th>
<th>Responsible Person</th>
<th>Frequency of monitoring &amp; tracking</th>
<th>Frequency of Analysis and Reporting</th>
<th>QM Report Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Utilization:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disenrollment</td>
<td>To ensure that participants are not disenrolling based on dissatisfaction of services.</td>
<td>Pending (NPA)</td>
<td>&lt; 5% Voluntary disenrollments per year.</td>
<td>Disenrollment form</td>
<td>Social Services Coordinator</td>
<td>Monthly</td>
<td>Quarterly to Quality (by Social Services)</td>
<td></td>
</tr>
<tr>
<td>Readmissions</td>
<td>Prevent avoidable inpatient admits within 31 days</td>
<td>Pending (NPA)</td>
<td>(pending)</td>
<td>U/R Report</td>
<td>Medical Director</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td>Emergency (unscheduled care)</td>
<td>All participants seen for emergency care without admission are medically appropriate and PACE-managed.</td>
<td>Pending (NCQA- NPA)</td>
<td>&gt;80%</td>
<td>U/R Report, Reinstitute IURR</td>
<td>Medical Director</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td>Unscheduled Inpatient Admission</td>
<td>Avoid all inpatient admissions for Ambulatory Sensitive Conditions (ASC)</td>
<td>Pending (NPA)</td>
<td>&lt;5% of admissions for ASC.</td>
<td>U/R Report, Reinstitute IURR</td>
<td>Medical Director</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td><strong>Satisfaction Survey:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Satisfaction</td>
<td>Evaluation of participant satisfaction with services helps to identify opportunities for improvement and promote participant retention</td>
<td>Pending (Internal benchmark past year)</td>
<td>95% service satisfaction</td>
<td>Survey Tool</td>
<td>QI Coordinator</td>
<td>Yearly</td>
<td>Yearly</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Measures:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiological</td>
<td>Diabetic Management will be compliant with key indicators based NCQA: Hgb A1c / 6 mo</td>
<td>Pending (NCQA)</td>
<td>90%</td>
<td>QI Database from EMR</td>
<td>Medical Director</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Micral measurement / 12 mo</td>
<td>Pending (NCQA)</td>
<td>90%</td>
<td>QI Database from EMR</td>
<td>Medical Director</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Foot exams / 6 mo</td>
<td>Pending (NCQA)</td>
<td>90%</td>
<td>QI Database from EMR</td>
<td>Medical Director</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eye Exam/ 12 mo</td>
<td>Pending (NCQA)</td>
<td>90%</td>
<td>QI Database from EMR</td>
<td>Medical Director</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Health Care Wishes are documented for all participants and followed at the end of life.</td>
<td>National Rates</td>
<td>95%</td>
<td>Death summary forms</td>
<td>Social Services Coordinator</td>
<td>Quarterly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td><strong>Indicator</strong></td>
<td>Quality Objective/ Rationale</td>
<td>Benchmark</td>
<td>Goal</td>
<td>Data Source</td>
<td>Responsible Person</td>
<td>Report monitoring &amp; tracking</td>
<td>Frequency of Analysis and Reporting</td>
<td>Report Date</td>
</tr>
<tr>
<td>Effectiveness of Safety by Staff</td>
<td>Competency of direct care staff</td>
<td>N/A</td>
<td>100%</td>
<td>HR files</td>
<td>Center Manager</td>
<td>Quarterly</td>
<td>Quarterly to Quality</td>
<td></td>
</tr>
<tr>
<td>Infection Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Pneumococcal Immunizations**

Participants will be offered pneumococcal vaccine on admission and when eligible. All participants will have vaccine status documented.

<table>
<thead>
<tr>
<th>Percentage Administration</th>
<th>80%</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>EMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QI Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly to Quality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Influenza**

# participants receiving flu vaccines

<table>
<thead>
<tr>
<th>Percentage Administration</th>
<th>80%</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>QI Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yearly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Non Clinical:**

<table>
<thead>
<tr>
<th>Medical record</th>
<th>Assessments and Reassessments will be documented in EMR prior to Care Plan development.</th>
<th>NA</th>
<th>100%</th>
<th>EMR</th>
<th>HIM Coordinator</th>
<th>Monthly</th>
<th>Quarterly to Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidents</td>
<td>Reduction of participant (falls)</td>
<td>NPA</td>
<td>&lt;3.5/1000 participant days</td>
<td>Incident reports</td>
<td>QI Specialist</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
</tr>
<tr>
<td>Participants Deaths</td>
<td>Obtain peer review on all participant deaths to identify issues related to quality of care</td>
<td>N/A</td>
<td>90% (deaths with no quality of care no issues)</td>
<td>EMR-QI Database</td>
<td>Medical Director</td>
<td>As Occurs</td>
<td>Quarterly to Quality</td>
</tr>
<tr>
<td>Grievances</td>
<td>Tracking/trending issues by category assists in the early identification of potential problems. Timely/ prompt resolution of complaints promotes member satisfaction.</td>
<td>Pending (NPA)</td>
<td>90% (resolved within 20 days)</td>
<td>Participant grievance log.</td>
<td>QI Coordinator</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
</tr>
<tr>
<td>Appeals</td>
<td>Tracking appeals information regarding types of services requested but not covered and the financial/health implications on participants, participants’ family and care givers.</td>
<td>Pending (NPA)</td>
<td>90% (resolved within 20 days)</td>
<td>Participant appeals log.</td>
<td>QI Coordinator</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
</tr>
<tr>
<td>CarePlan</td>
<td>Ensure that all care plans include participant goals and that all participants share in the creation of those goals.</td>
<td>N/A</td>
<td>90% of care plans will be complete with participant goals.</td>
<td>Careplan documents</td>
<td>Care Plan Nurse</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
</tr>
<tr>
<td>QM Projects</td>
<td>Ensure that follow-up on IDT notes adequately reflect interdisciplinary teams collaborative efforts to provide care.</td>
<td>Pending</td>
<td>98% compliance with follow-up.</td>
<td>IDT notes</td>
<td>Center Manager</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
</tr>
<tr>
<td>Corrective Action Plan Requirements</td>
<td>Numerous additional projects and QI monitoring relate to 2008 CAP See reporting schedule details</td>
<td>NA</td>
<td>NA</td>
<td>As appropriate</td>
<td>Department Appropriate Staff</td>
<td>Monthly</td>
<td>Quarterly to Quality</td>
</tr>
</tbody>
</table>
Appendix 4
Sample QI Report

Diabetes Management Quarterly Report

Department: Primary Care  
Presenter: Dr. XXXXXX  
GMC Reporting Time Frame: Quarterly

Goal/Objective
Achieve and maintain high rates of recognized quality indicators associated with optimal care for diabetes, including monitoring with HbA1c levels, surveillance for microalbuminuria and nephropathy, foot examinations to detect neuropathy and PVD, and dilated fundal exams to monitor retinopathy status.

Background
Diabetes is highly prevalent (nearly 50%) among our PACE population and is responsible for much morbidity. Some evidence suggests that, while aggressive glucose control has limited benefit, avoiding poor control may be helpful to prevent complications and early detection and treatment of complications is beneficial.

Measure
Name: Diabetic Management

Operational Definition: Rates of compliance with multiple quality indicators: Monitoring HbA1c levels, assessing for nephropathy, foot exams for neuropathy and eye exams for retinopathy.

- HbA1c Numerator: Diabetics with HbA1c documented in previous 6 months
- Microalbumin Numerator: Diabetics tested for microalbuminuria
- Foot Exam Numerator: Diabetics with documented foot exam in past 12 months
- Eye Exam Numerator: Diabetics with documented dilated fundal exam in past 12 months
- Denominator: Participants with diabetes at the time of data collection

Exclusions (Data collected mid-quarter)

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
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<td>75</td>
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<td>0</td>
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<td>0</td>
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<tr>
<td>97</td>
<td>0</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

HbA1c Rate: 90.7%  
Microalbumin Rate: 79.7%  
Foot Exam Rate: 81.8%  
Eye Exam Rate: 83.4%

Diabetes Management Rates

Results

Issues/Findings
Q1 2006: HbA1c rates are good and the only participant without a value was a new_enrollee. Tests for microalbumin are lower than expected, due possibly to non-ordering, or evidence in recording results in lab section of chart. Also, the test is not indicated for diabetics with known proteinuria. The foot exam rate may not capture all exams as the procedure may not be routinely documented (nursing). The monoflow test for neuropathy is not specifically identified as a procedure.

Actions
Q1 2006: Continue to monitor HbA1c, and develop clinical element to document individualized A1c goals. Switch from in-house microlab testing to commercial lab testing, which will provide uniform data collection. Will verify which diabetics have existing proteinuria (and code as 563.87) and order fresh urine test for microalbuminuria on remaining diabetics. Will consider using podiatry for annual foot exams and gnl for all diabetics. Delinquent eye exams were scheduled for 2nd Quarter.

Evaluation/Follow-up
Q1 2006: Additional Quality Indicators are being developed along with a clinical QI database to better capture and monitor the above data elements and several more. This should be completed in Q2 2006. The impact of the above actions will be reviewed at the next quarterly report.
Appendix 5
P-D-C-A Cycle

Start

1. Identify outputs, customers and their expectations
2. Describe current process
3. Measure and analyze
4. Focus on an improvement opportunity
5. Identify root causes
6. Generate and choose solutions
7. Map out a trial run
8. Implement the trial run
9. Evaluate the results
10. Draw conclusions
11. Standardize the change
12. Monitor; hold the gains

PLAN

ACT

CHECK

DO

Decision matrix, pareto charts, voting
Brainstorming, Affinity charts, cause-and-effect, tree diagrams, relationship diagrams, force field analysis, focus groups
Brainstorming, decision matrix, tree diagrams
Brainstorming, force field analysis, action planning, tree diagrams, flow charting
Check sheets, logs, histograms

Flowcharts, focus groups
Brainstorming, focus groups, interviews.

Check sheets, logs, time charts, trend charts, histograms, surveys

Foros field analysis, brainstorming, action, planning, tree diagrams, flow charting

Pareto diagrams, focus groups, force field analysis

Check sheets, logs, surveys, focus groups, histograms, trend charts
Appendix 6
Sample Annual QAPI Program Evaluation Outline

Table Of Contents
Executive Summary
  Overview Of The Quality Improvement Program
  Overview Of The Effectiveness Of The Quality Improvement Program
Development, Approval And Monitoring Of The QAPI Program
  Quality And Compliance Committee
  Analysis Of Quality Improvement Process
  Overall Effectiveness Of The Quality Improvement Program
  Strengths And Accomplishments
  Opportunities For Improvement
Population Characteristics
  Race/Ethnicity
  Special Needs
  Languages Identified
Quality Indicators
  Performance Measures
  Trends In Pace Quality Indicators
  Pace Organization Specific Indicators
Accessibility Of Services
  Average Speed Of Answer
  Call Abandonment Rate
  Non-Routine Needs Appointments
  Routine Needs Appointments
  Access To Emergent And Urgent Care
Network Adequacy
  24 Hour Access/After Hours Availability
  Cultural Competency
  Requests To Change Practitioners
Fraud And Abuse
  Prevention, Detection, Investigation
  Training And Education
Record Management
  Part D Requirements
  Medical Records
  Contractors
Quality Management
  Participant Satisfaction
  Care Coordination
  Case Management
  Mental Health Care Management
  Clinical Practice Guidelines
Credentialing And Re-Credentialing
Medical Record Review
Subcontractor Monitoring

Rights And Responsibilities
Grievance And Appeal Management
Confidentiality

Utilization Management
Utilization Improvement Program Scope
Discharges Per Year
Inpatient Visits
Average Length Of Stay
Re-Admissions
Emergency Department Utilization
Outpatient Visits
Over/Under Utilization
Inter-Rater Reliability
Timeliness Of Care Delivery
Timeliness Of Prior Authorization/Certification Decision Making

Performance Improvement Projects (PIP)
Clinical
Non-Clinical
On-Going Interventions And Improvements
Effect On Health Outcomes And Member Satisfaction

Workplan For Next Year

Appendices
As mentioned in Chapter 6, PACE regulations state that it is the “medical director who is responsible for the delivery of participant care (resources), clinical outcomes, and …performance improvement.” Utilization Management (UM) is inextricably linked practically and philosophically to Quality Improvement (QI). An organization that seeks to reduce resource utilization apart from quality management will likely fail at both.

What is Utilization Management (UM)?

UM is a system that uses scalar, thus measurable or quantifiable, attributes of resources and outcomes (data) to identify absolute results. The system may then compare its own results to itself (over time) or to another entity for relative outcomes. Using outcomes data to evaluate and manage processes that then produce different results are what tie UM to QI (this demonstrates internal improvements). Utilization management is performed to gain efficiency in an effective health care delivery system. It should thus evaluate the costs and quality of medical services.
Goals of Utilization Management

1. Optimally achievable quality of care (outcomes)
2. Effective and efficient utilization of facilities and services (resources) through ongoing monitoring and education
3. Identification of patterns of utilization (i.e., under-, mis- and over-utilization)
4. Education of providers on appropriate and cost-effective use of health care resources
5. Fair and consistent utilization decision-making
6. Preservation of resources to continue the organizational mission

Data Collection

The first ingredient for UM success is that the Medical Director must like to count things (or at least look at what others count). Two complementary, and sometimes interchangeable domains of “countable” data are resources and outcomes. Examples of potential data:

<table>
<thead>
<tr>
<th>Resources</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care hours</td>
<td>Hospital days/LOS</td>
</tr>
<tr>
<td>Encounters for CNA, nurse, PCP, etc</td>
<td>LTC days</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>ER visits</td>
</tr>
<tr>
<td>Van ride-times or miles</td>
<td>Infections</td>
</tr>
<tr>
<td>Attendance rate or days</td>
<td>Specialists</td>
</tr>
<tr>
<td>Staffing ratios</td>
<td>Falls</td>
</tr>
<tr>
<td>Care plans/systems</td>
<td>Deaths</td>
</tr>
<tr>
<td>Clinic visits</td>
<td>Disenrollments</td>
</tr>
<tr>
<td>Dollars</td>
<td>Dollars</td>
</tr>
</tbody>
</table>
What to count?

1. Things that the program has some control over: drugs, HH hours, errors, staffing, encounters
2. Things the program might have influence over: specialists, institutional use, infections

It is helpful to look at counting common “indicators” that might be standardized with a common denominator for comparison among other centers. DataPACE II reporting guidelines include an evolving set of standardized indicators (including defined sources of numerators and denominators), some of which are related to utilization management, such as:

- Hospital days (standardized to an annualized rate per 1000)
- Pharmacy costs ($ per member per month -- PMPM)
- Nursing home use (% of capitated days)

Data values are useless if they are not consistently collected or if they don’t reflect the reality of either resource utilization or outcomes. Therefore, organizations that have well-defined processes for their clinical and other activities will be best suited to collect meaningful data.

Examples of outcomes related to process

- Pharmacy utilization
  - Routine reviews—count the same data each month
  - Focused reviews—drill down on high-volume or high-cost items of interest
- End-of-Life care
  - Healthcare wishes prevalence
Compliance with wishes

Institutional utilization review for “appropriateness” of hospital days, ER visits, etc. Every “event” is reviewed. There may be multiple events per episode and characterized as:

- over-utilization (e.g., avoidable days) – several types
- under-utilization (e.g., inadequate care, readmission for same problem)
- mis-utilization (e.g., misguided well-intentioned effort)
- appropriate utilization
- focused review of inappropriate utilization

Seven General Principles to Consider in Utilization Management

“High quality care usually is the least expensive in the long run.”

Utilization Management cannot be separated from Quality Improvement. Continuous improvements in design and delivery and quality of care will pay off with fewer misadventures and waste. What seems like an excess in the short run (extra home care hours, high-cost antipsychotic meds or psych referral, hospice consult to discuss palliative care with a resistant family) can prevent higher costs (e.g., institutional care) later.

“Why pay somebody else if we can do it as well ourselves?”

Whether it’s transportation, home care or clinical procedures, it is best to provide the services within the PACE Organization and avoid double payment for a service. Some services may be obviously out-sourced, such as certain elements of hospice care and hip surgery, but for the most part, services should be kept in-house.

“An institutional admission is a failure of care”
A main goal of the PACE Organization is to keep people living safely at home. The mission of the program is to avoid a hospital or nursing home stay. While this may not always be the easiest path to take, in the long run it is best for the patient.

“Just because we can do it doesn’t mean we should.”

Personalizing care is central to the PACE model. Thus, so-called “community standards” (or academic approaches or practice guidelines) can create a difficult atmosphere in which to practice the principles of the PACE Organization. It is important to ask, “Why work up a condition that will not have any clinical relevance on a person’s quality or quantity of life?” Every intervention carries a risk of harm, which is even truer in the case of frail elders.

“If you don’t turn over any rocks, you won’t find any snakes.”

Closely related to the preceding, this concept prompts clinicians to consider limiting clinical interventions. While the PACE Organization aims to limit unnecessary interventions, it is necessary to look for the “right” problems with the patient and produce clinically relevant results. This means being diligent in using evidence-based screening and preventive care. In the PACE population, there is usually little evidence to help guide diagnosis. Every time a physician writes an order (unless perhaps to discontinue something), the risk of misadventure and harm increases.

“Do the right thing.”

To balance the above, PACE strives to intervene with all the skills and benefits of medical knowledge to make a confident decision about the likely benefit. There are many gray areas, and the personal wishes of participants and families will modify the clinical paths to be followed. Care should not be limited when it will help achieve real participant benefit.
“Begin with the end in mind.”

Ongoing efforts to measure, document and comply with participant beliefs and values will help us effectively honor healthcare wishes.

**Seven General Practices to Consider in Utilization Management**

**Consistency of Care**

Many participants have one or more common chronic diseases and developing a consistency of practice among the PCPs has been a priority. Informally, by bedside or hallway consultations, communication among the PCPs with copies of reassessments is circulated. It is encouraged that physicians challenge each other professionally to explain deviations from routines. Some common routines are formalized in evidence-based carepaths or protocols.

**Intensity of Care**

By upgrading skills and being willing to adjust practice patterns, dependency on outside services is diminished. Examples include:

- Providing parenteral hydration in the clinic (IV or hypodermoclysis)
- Stat lab and Mobile x-ray availability
- Urgent care skills – suturing, casting
- Routine procedures – joint injections, podiatry
- Cardiac monitoring and dysrhythmia treatment
- Cryotherapy, electrocautery and excisional dermatological procedures
Measurements and Reporting

Most utilization data is readily available. By graphically reporting progress in utilization measurements to team members, the awareness levels remain high. With or without a strategically integrated quality improvement program, QI mentality and the general QI/UM process is widely and frequently referenced and reinforced among staff and managers.

Interpersonal Care

Strong interpersonal relationships are modeled and encouraged among the clinical staff and Integrated Interdisciplinary Team (IDT). Divisions of labor are intentionally overlooked in efforts to foster team spirit and cross-training. This spirit has direct and indirect effects on other aspects of care.

Specialty/Network Care

A small network of preferred specialists with good working relationships and understanding of the PACE model helps to reduce the “referral creep” so that PCPs maintain control (or at least the illusion of control) of all aspects of care. Aggressive daily follow-up (physician-to-physician) is de rigueur when participants are admitted to non-network hospitals and transfer (when appropriate) to a preferred hospital is routine.

End-of-Life Care

It is standard to ensure healthcare wishes are documented 100% of the time. The IDT frequently reassesses Present Directives and Advance Directives and thoroughly communicates DNR orders to all involved in the participant’s care. Comfort Care screening is done regularly as an “early warning system” to improve the opportunities to provide palliative care. Hospice is consulted when appropriate for skilled nursing and support needs at the end of life.
Caregiver Care

PACE provides close collaboration among the IDT, especially SWs and home care, for matters regarding caregiver strain, caregiving abilities, home safety and marshalling available resources to support the caregivers. The team maintains frequent contact with caregivers to discuss interventions (diagnostic or therapeutic) and potential complications vs. benefits. These contacts develop trust and may lead to less invasive approaches when appropriate. Frequent reinforcement and training of participants/caregivers regarding emergency care, hospitals of choice, nighttime and weekend care reduce unnecessary Emergency Department visits.
CHAPTER 9

Medication Management in PACE

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Key Points

• Medicare Part D provides for prescription drug coverage. The payment to the PACE Organization is determined by an actuarially certified bid for the anticipated costs for the following year for the dually-eligible and one bid for participants who are Medicare-only.

• Medicare Part A includes the coverage for medications that are provided in the hospital, during a sub-acute nursing home stay, and through hospice. As a result, it is typical that each of these providers is paid an all-inclusive rate by PACE to provide services which include medications.

• Medicare Part B medications include certain vaccines (influenza, pneumococcal, hepatitis B) and those medications administered as “incident to” a physician’s office visit.

• If a participant is not eligible for Medicare, then the Medicaid-only capitation would include an enhanced rate to cover the prescription drug benefit.
Medication management has always been complex, from prescription decisions to the dispensing and administration process, to ongoing medication management. As a result of the enactment of Medicare Part D, PACE Medical Directors have additional responsibilities. Prior to the Medicare Modernization Act (MMA) of 2003, Medicaid provided payment for pharmaceuticals for dually eligible seniors, but after the January 1st 2006 start of Medicare Part D, this responsibility shifted to the Medicare program.

Federal regulation, 42 CFR, Part 460.92 states that PACE Organizations (POs) are required to provide participants with all medically necessary “drugs and biologicals.” However, the PACE regulations do not specify how this process is managed. As a result much is left in the hands of PACE Medical Directors.

To begin a discussion of medication management in PACE some basic knowledge regarding the financial environment created by Medicare which goes beyond Medicare Part D is needed. From this understanding of Medicare a discussion can begin covering the process of prescribing, dispensing, administering and management of medications.

**Medication Finances**

Medicare is made up of four parts. PACE actually operates under the Medicare Part C program. Medicare Part C programs like PACE are responsible for providing all the benefits available under Medicare Part A (Hospital Insurance), Part B (Medical Insurance) and Part D (Prescription Drug Coverage).

1. **Medicare Part A**

Medicare Part A includes the coverage for medications that are provided in the hospital, subacute nursing home stay and through hospice. Usually each of these providers is paid an all-inclusive rate by PACE to provide services which include medications. Since these providers are receiving a lump sum their incentive is to use the least amount of medications and those at the lowest cost. Since this may be contradictory to the interest of
PACE and the participant, it is important that Medical Directors assure that the contract and practices of these providers are such that PACE participants are receiving the appropriate care. If a PO provides the medication to the nursing home for a subacute stay, those prescriptions are not included in their reporting of Medicare Part D medications.

2. Medicare Part B

Part B medications include certain vaccines (influenza, pneumococcal, hepatitis B) and those medications administered as “incident to” a physician’s office visit. A common example would be chemotherapy given in a physician’s office. However, the rules that differentiate Part B vs. Part D medications are dictated by who is purchasing the medication. Part B medications for example are purchased typically by a physician’s practice and billed “incident to” the physician office visit. The PACE Medical Director needs to understand these rules to assist in devising and monitoring a system to ensure proper contracting and allocation of the medications to Part A, B or D.

3. Medicare Part D

As mentioned, prior to the introduction to Medicare Part D, the PACE comprehensive medication benefit was funded by capitated Medicaid payments. Program participants who did not qualify financially for Medicaid paid the equivalent of the Medicaid capitation rate that included payment for drugs. The PACE Organization accepted full financial risk for prescription medications ordered for the participant. As a result of MMA, PACE Organizations were required to become Part D Providers and now receive risk-adjusted capitated payment for Part D-covered drugs. For PACE enrollees who are dual eligible and have had a period of time where they were not covered by Medicare Part D or creditable coverage, the normal late enrollment penalty (LEP) is waived.

Although participation in the Part D program is technically voluntary, a PO that does not participate would no longer generate reimbursement for the “drugs and biologicals” it is required to provide under PACE regulations. It should be noted that if a participant is not
eligible for Medicare, then the Medicaid-only capitation would include an enhanced rate to cover the prescription drug benefit.

The payment to the PACE Organizations is determined each year by an actuarially certified bid for the anticipated costs for the following year. NPA has brokered an arrangement between PO and an actuarial firm, Milliman, to calculate and certify these bids. PACE Organizations have to submit two bids, one for the dually-eligible and one for participants who are Medicare-only. For those who are dually eligible, all costs are shared by the state, Medicare, and the PO. The participant has no co-pay as PACE regulations prohibit them. This absence of co-pays represents a significant difference between PACE and other Part D programs that must charge the patient nominal co-pays for each.

For those participants who are Medicare-only, Part D becomes more complex. These participants must pay a substantial supplemental premium. Private pay individuals may be eligible for a Low Income Cost Subsidy (LICS) that might reduce that premium. Each PO will need to review Part D regulations concerning eligibility for LICS to determine the options for private pay participants.

At the end of each year, there will be a cost reconciliation between each PACE program and CMS comparing the actual cost of medications experienced by the organization with the bid amount. This reconciliation involves several different types of payments, for some of which the PACE Organization will be “at risk.” This at-risk amount is based on the RxHCC, similar to the HCC used to calculate Part A and Part B payments, except the codes are related to drug costs. Not all codes that count in the RxHCC will count in the HCC for A and B. For example, Alzheimer’s disease and senile dementia count in the RxHCC but not toward the HCC for A and B. It is important that Medical Directors assure that coding of each participant is correct so that appropriate reimbursements are received to cover the expense related to medication utilization.
The cost of the pharmaceuticals is tracked through the Prescription Drug Event (PDE), a file submitted to CMS that includes each Part D medication dispensed to a participant. This claims-based information is used to calculate the cost-based portions of Part D reimbursements, i.e., reinsurance and low-income cost-sharing amounts. The PDE reporting requirement is extensive in that it requires submission of approximately 30 data elements for each prescription dispensed. These data elements include beneficiary information, drug type, and cost information, thereby drawing from both plan and provider data.

Various classes of medications are not included in Part D. These include benzodiazepines, barbiturates, over-the-counter medications, and medications for erectile dysfunction. Most Medicaid programs included the first three classes of drugs under their Medicaid plans so many PACE Organizations get some payment for these from Medicaid. For benzodiazepines and barbiturates legislation was passed that would allow for these medications to be covered under Medicare Part D, but not until January 1st 2013.

CMS Data Submission

For PACE programs with a contract pharmacy, there will need to be an additional contract with a PBM (Pharmacy Benefit Manager). The PBM will charge PACE a small amount per prescription and will be responsible for collecting and submitting the PDE. If the PO has a formulary, then the PBM will adjudicate all prescriptions with the formulary. POs with their own pharmacy may still use a PBM, but then the dispensing pharmacy will be responsible for correcting any errors in the PDE. Another alternative would be to submit the PDE internally from the pharmacy software and have a system internally for submission to CMS.

The reporting of this information is important because of reinsurance and risk adjustments for program outliers, as well as for calculation of the true out of pocket expenditure (TrOOP). Part D rules require sponsors to track the beneficiary’s TrOOP.
costs and gross covered drug costs and correctly apply these costs to the TrOOP and benefit limits in order to correctly place the beneficiary in the benefit and provide the catastrophic level of coverage at the appropriate time. The TrOOP threshold and gross covered drug costs are calculated on an annual basis and must be transferred between Part D plans if a beneficiary disenrolls and re-enrolls at any time before the end of the coverage year. While PACE programs are exempt from automatic TrOOP transfer process, TrOOP related data will be transferred as follows:

• For beneficiaries enrolling into a PACE plan after disenrolling from another Part D plan the PACE plan will request from the beneficiary the most recent explanation of benefits provided by the prior Part D sponsor.
• For beneficiaries disenrolling from a PACE plan to enroll in another Part D plan, the PACE plan will report the data to the beneficiary to convey to his or her subsequent plan sponsor.

Formulary

The PACE Medical Director will need to decide whether a formulary is necessary for your program. Part D assumed that all providers would have a formulary as a standard method of controlling drug utilization. However, it became clear that small POs with few practitioners did not need one. To determine whether a PO needs a formulary, the PACE Medical Director will need to address the question of “steering.” Part D will ask if there is evidence that the program steers primary care providers towards certain specific medications within a class. If there is evidence of steering, then Part D would expect a formulary. For example, Total Long-term Care (TLC) in Denver has 16 primary care providers. At TLC, 80 to 90 percent of the prescriptions for ACE inhibitors are for one specific ACEI. The same pattern exists for other classes. TLC decided that this pattern would clearly be classified as steering, so it opted for a formulary. If a PO has only a few providers, then patterns may be due to similar practice patterns among this small group. The larger the group, the more difficult it will be to make that argument. Additionally, any center for which any type of preauthorization is required for a particular medication is considered to have a formulary. With a formulary come certain other requirements.
including a formal P&T committee and submission of the formulary for approval, or rejection, by CMS. The formulary has many restrictions and mandates inclusion of certain drugs and classes of drugs, even if the classes do not appear to pertain to a PACE population. If a formulary is needed, please consult Section 423.120(b) in the Part D regulations.

**Disenrollment Plan**

It is strongly recommended that each PACE Organization develop a specific “Disenrollment Plan” for participants who choose to disenroll from PACE. Federal regulation 42 CFR 460.168 states that all POs are required to “facilitate a participant’s reinstatement in other Medicare and Medicaid programs after disenrollment.” With the implementation of Part D, transition planning now needs to include providing assistance to beneficiaries in accessing a Part D provider in their service area.

**Fraud, Waste and Abuse**

Another area of Part D in which Medical Directors may want to be informed relates to Part D fraud, waste and abuse (FWA) requirements. Because a large proportion of payment under Part D is cost-based, the program generates FWA concerns that do not exist elsewhere in the program. It is recommended that each PACE facility have a policy outlining measures taken to monitor fraud, waste and abuse. This may involve a description of how medications are filled and refilled, a chain of custody for medications which are being delivered, and a reporting hierarchy when a person suspects fraud, waste or abuse.

**Prescribing Medications**

Utilization of prescription drugs is driven by expectations of both healthcare providers and patients. The medical literature often provides guidance about when to start medications and which ones to use, but rarely, if ever, suggests when to discontinue
medications. Evidence-based guidelines may not be appropriate for PACE participants, given their multiple comorbidities, risk for polypharmacy and limited life expectancy. Additionally, consultants may prescribe medications without considering the frailty, vulnerability to adverse drug reactions (ADRs) and other medications of PACE participants. Controlling medication utilization can become labor intensive and time-consuming; therefore, thoughtful establishment and monitoring of pharmacy utilization is essential to avoid polypharmacy, ADRs, and excessive costs. A clinical pharmacist consultant can be helpful in controlling pharmacy cost and polypharmacy.

One area of prescribing where PACE programs need a clear process is in the area of prescribing controlled schedule II (CII) medications. For the prescribing of CII medications, verbal orders are not permitted unless an emergency situation exists. DEA regulations define an emergency situation as one in which the prescribing practitioner determines:

a) That immediate administration of the controlled substance is necessary, for proper treatment of the intended ultimate user; and
b) That no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under schedule II of the Act, and
c) That it is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance, prior to dispensing.

As such PACE program need to develop a process. This requires the ability to be able to fax prescriptions during off hours so that CII medications can be provided in a timely manner.

Section 101 of the Medicare Modernization Act requires Part D sponsors to establish electronic prescribing drug programs that provide for the electronic transmittal of prescription and prescription-related information to the prescriber and the dispenser in accordance with final standards specified by CMS. This includes information on insurance eligibility, specific prescription coverage, the drug being prescribed or dispensed, and other drugs listed in the medication history, as well as the availability of
lower cost and therapeutically appropriate alternatives. In PACE, since the prescriber is generally the participant’s primary care physician and employed by the PO, the prescriber would have ready access to this information and would not need to initiate an electronic transaction to acquire it. Similarly, because of the manner in which POs coordinate medications on behalf of their participants, the administration of the Part D benefit to PACE participants would not be enhanced by developing the capacity to electronically communicate a participant’s medication history to prescribers and dispensers.

**Dispensing Pharmaceuticals**

POs need to decide whether to contract out the pharmacy services or provide the services through their own pharmacy. Medications can be purchased for 30 to 40 percent less if the PO has its own pharmacy. The center will have better control of the pharmacy services so that those services can be catered specifically for a PACE population. These savings and service advantage have to be balanced against the overhead costs of operating a pharmacy.

Other variables to consider include access to 340B pricing (available to Federally Qualified Health Centers (FQHCs)), association with a school of pharmacy, availability of a good community pharmacy with which to contract and partner, and the philosophy of the organization. If the organization decides to operate its own pharmacy, then the State regulations need to be reviewed closely to determine, among other things, the type of pharmacy allowed (retail or long-term care), the square footage needed, linear feet of counter space per pharmacist, and the mandated staffing ratio of pharmacists to technicians. Ultimately, the dispensing pharmacy manager will need to be familiar with relevant state regulations and be able to review this information with the Medical Director.

If the center decides to contract with a local pharmacy, the contract will need to include certain specific items. Prescription costs will generally be based on some percentage of
the “AWP,” or Average Wholesale Price, with a larger discount for generics, and a smaller one for brand-name drugs. Certain medications qualify for Medicaid pricing which would be an even lower percentage off the AWP. Those prices are called “MAC,” Maximum Allowable Cost, or “FUL,” Federal Upper Limit. The contract should specify that MAC prices will be honored when available. There will be a dispensing fee charged in addition to the medication cost which should run about $3 to $4 per prescription, although, again, there will be variation across states.

There will need to be arrangements for prepackaged prescriptions, such as weekly medisets or monthly bubble packs. In some states and at POs, nurses at the center can fill medisets. If the pharmacy does the filling, then a flat fee for medisets is preferable to charging a dispensing fee each time a medication is placed in a Mediset. A long-term care pharmacy should have delivery routes to nursing homes and assisted living facilities already set up and a delivery fee should already be in the quoted rate without an additional charge. A retail pharmacy may charge to set up the delivery system. The contract will need to include evening and after-hours coverage, along with mechanisms to get medications to individuals at odd hours, either by emergency delivery or through a contract with a retail pharmacy to dispense the medication for the participant or family to pick up.

The delivery of medications to PACE participants is multi-faceted and can be more challenging than it may appear on the surface. Teaching participants and their families to notify the PO and not necessarily the pharmacy may take time. The PO will most likely deliver the prescriptions to the participant’s residence. Involving the transportation staff creates the need for “chain of custody” documentation and refrigeration for certain medications. This documentation can be NCR-type forms with the driver and participant signing for receipt of the medication. Coolers can suffice for transport. When a chain of custody is required, staff and families need to consider where to leave medications if family members are not at home to receive the medications.
Based on how the medications are administered PACE programs will need specific contracts with their pharmacy providers regarding packaging and splitting of medications supplied between the PO and participant’s home.

**Administering Pharmaceuticals**

Administering medications to PACE participants takes place on a daily basis both at the participant’s home as well as the PACE center. At the home administering medications can be assisted through the use of pill boxes, automated dispensing devices, telephonic reminders or educated family members. These forms of assistance are often needed, especially for participants with cognitive impairment and complex medication regimens.

The program must develop an approach to administering medications at the PACE Center. Some PACE programs have implemented a process whereby a single nurse is responsible for administering medications to all center attendees. At other PACE programs, nurses have responsibility for a group of participants; these responsibilities include medication administration in addition to general nursing functions such as assessment and education. Both systems have advantages and challenges, so the decision needs to be based on the specific characteristics of each program.

**Medication Management**

Clinical pharmacists can play an important role in medication management. Along with the dispensing pharmacy, the clinical pharmacist can develop reports that will monitor the total number of prescriptions, total costs, average cost per prescription and average number of medications per member per month. These basic data elements allow the Medical Director to track utilization over time. More specific data elements may include top medications dispensed by number of prescriptions, by cost, or by individual provider. Reporting of medication prescribing patterns within various classes is also important and
may highlight individual practitioner habits. How this information is used should be the discretion of the Medical Director and the management team. More complex evaluations may also include ICD-9 and RxHCC information. The Clinical Pharmacist can also conduct reviews of each participant’s medications to coincide with the semi-annual assessments and care planning meetings. Reviews can cover potential drug-drug interactions, drug-disease interactions, appropriateness of medications and cost-effective alternatives. Clinical pharmacists can also be available for consultation when prescribing questions arise.

Conclusion

Ongoing monitoring of medication utilization and staying abreast of changes in Part D and PACE policy are critical to the long-term financial success of any PACE Organization. The Medical Director must be involved in assessing performance and must stay informed of regulatory changes. Regular meetings with medical staff can encourage dialogue on medication choice and appropriate use. As the number of providers in the PACE network grows, the more critical it becomes to monitor trends. Attention to this detail can result in a successful pharmacy plan and high quality patient care.

Resources

The National PACE Association (www.npaonline.org) is a valuable resource for more specific information regarding Part D, including Part D bid submission, risk adjustment and PDE reporting. The Center for Medicare and Medicaid Services (CMS) website (www.cms.hhs.gov) is a second valuable resource for information regarding Part D (www.cms.hhs.gov/PrescriptionDrugCovGenIn/).
CHAPTER 10

Grievances and Appeals

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Key Points

- PACE participants have the right to express dissatisfaction and to request services.
- PACE Organizations must have formal written policies and procedures for handling Grievances and Appeals.
- A Grievance communicates a participant’s dissatisfaction with a service, while an Appeal addresses non-coverage of a service.

PACE organizations (PO) are required to encourage and assist participants in exercising their rights, including a careful and timely (within five business days) consideration of all service requests. Service requests are discussed by the inter-disciplinary team (IDT) and may be approved, denied, or a compromise solution may be decided.

An approved service is medically necessary and consistent with the participant’s care plan (e.g., an increase in personal care hours).

A denied request may be contraindicated by the care plan and not medically necessary (e.g., an electric scooter for a participant whose therapy goals include increasing ambulation and lower extremity strengthening).
When there is a conflict between the participant’s request and the IDT resources, a compromise is often possible (e.g., request for daily center attendance, with a compromise of three times a week attendance).

PACE participants have the right to a fair and efficient process for resolving differences with the PO. Grievances and Appeals are separate, formal processes used to resolve these differences. Information regarding the grievances and appeals processes must be provided to each participant upon enrollment and at least annually thereafter through participant meetings, newsletters, or individual conferences. Confidentiality of the participant’s grievance or appeal must be maintained. The PO must continue to provide care and services throughout the grievances and appeals processes.

**Grievances**

A *grievance* is a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care provided. Each PO must have a written grievance process, a method to track the process to assure grievances are resolved in a consistent and timely manner and formal grievance policy and procedures.

Data on grievance proceedings are tracked by the Quality Assessment and Performance Improvement (QAPI) coordinator and submitted to Health Plan Management System (HPMS) quarterly. The QAPI committee analyzes participant grievances at least quarterly. These QAPI analyses are very useful in making improvements in quality of care. (Regulatory Citation: PACE Reg. 460.120).

Appendix A provides a sample flow chart for the grievance process.

PACE sites can have many different approaches to the process but, at a minimum, the process must include procedures for filing, documenting, responding to, and resolving the grievance in a timely manner. *Although there is no established timeframe for resolving grievances, PO should make every effort to resolve the grievance in a timely manner.*
Appeals

An appeal is the action taken by the participant in regard to a PACE organization’s non-coverage of or nonpayment for a service. The appeals process is very similar to the grievance process. However, to prevent bias, an impartial third party must be appointed to review each appeal. The external reviewer must have expertise in the area being appealed. Examples are a geriatrician to review medical treatment or a physical therapist to review DME. Resolution of a standard appeal should be within 30 days. However, if the participant believes that the service is not furnished, his or her health is in jeopardy and an expedited appeal may be requested. The PO must respond to an expedited appeal within 72 hours. The participant or State Administering Agency (SAA) may allow more time if adequate information cannot be gathered within the 72-hour timeframe. In addition to reporting appeals to HPMS, they are also reported to the SAA. The QAPI committee analyzes all appeals. (Regulatory Citation: PACE Reg. 460.122-124).

If the impartial third party makes a determination in favor of the participant, the disputed service should be furnished as expeditiously as the participant’s health condition requires. A determination in favor of the PO requires immediate notification both verbally and in writing to the participant. The PO must also notify the SAA and CMS regarding the appeals denial. If a decision is wholly or partially adverse to the participant, the participant and/or representative have additional appeal rights under Medicare or Medicaid, but not both. The PO will notify the participant and/or representative of these additional appeals rights both verbally and in writing, as well as assisting the participant...
in choosing which appeals process to pursue, forwarding the appeal to the appropriate external entity and providing additional assistance with the appeals process as needed.

**Expedited Appeals Process**

Appendix B provides a sample flow chart for the appeals process. At a minimum, the process must include: filing, documenting, responding to the appeal as well as appointing an appropriately credentialed, impartial third party reviewer.
A complaint is received expressing dissatisfaction with service delivery or quality of care furnished. The participant, family member or representative completes the grievance form. The form is forwarded to the Operations Manager to review and forward to person designated to resolve the complaint. The individual resolving the complaint investigates alleged misconduct/poor service and discusses with the participant the steps and timelines for response. Were the actions of the service provider inappropriate? If yes, performance counseling takes place. The supervisor explains policies to participant and additional accommodations are made when necessary. The grievance form is documented with investigative findings and resolutions. Then returned to QAPI Coordinator for file, tracking, quality monitoring, and compliance purposes. Is the participant satisfied with the outcome? If yes, documentation is filed. Every effort will be made to reach a satisfactory compromise.
TriHealth SeniorLink
Appeals Policy

Participant is not satisfied with the coverage or payment of a service

Participant, family member or representative files Appeals Form with Operations Manager*

Participant believes life or function will be jeopardized if service not furnished

Operations Manager will acknowledge receipt of Appeals Form via written response within 10 working days and informs participant of timeframes and process

Yes

Participant informs Operations Manager in writing and Expedited Grievance Appeals Process is initiated

In-person assessment is conducted by appropriate members of the Interdisciplinary Team and resolution and reviewed by impartial third party

All appeals will be resolved within 30 calendar days.

All expedited appeals will be resolved within 72 hours after receipt of Appeals Form

*Staff that can assist participants in completing the Appeals Form include Administration, managers, nurses, social workers and professional staff.
TriHealth SeniorLink
Appeals Policy, Continued

QAPI Coordinator enters information into grievance and appeals database

If determination is wholly or partially adverse to the participant, Operations Manager will notify CMS and the State Administering Agency of the resolution in writing at the time the decision is made.

Is participant satisfied with the outcomes of the appeals process?

No

SeniorLink will assist in helping participant to initiate appeal to Medicare or Medicaid as appropriate.

Yes

End of Appeals Process
CHAPTER 11

Data

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Overview of PACE Program Data

The intent of this chapter is to provide the PACE medical director with a solid introduction to the universal data collection and submission activities that are currently performed by PACE organizations (PO) across the US.

These fall into two general categories:

A) Required Submissions, those mandated via existing federal and SAA (State Administering Agency) reporting regulations, which consist of:

1) Diagnostic Risk Adjustment The ongoing submission of diagnostic data incurred in the course of provider visits, hospital inpatient stays, and hospital outpatient encounters; and
2) **Health Plan Management System (HPMS)** Data collected and submitted for predefined areas of monitoring for plan performance and quality and required under regulation for PACE performance improvement activity.

B) **Voluntary submissions**, conducted in participation with National PACE Association-sponsored activities, intended to depict the common and differing characteristics of the demographics, operations, utilization, and clinical profiles of PACE programs.

1) **DATAPACE 2 (DP2)** -- Data submitted by NPA member programs in order to better understand the common and differing characteristics of demographic, clinical, and operational characteristics intended to reflect the array of service variation and similarity that underpins PACE experience across the US. Some states require PACE organizations to submit DP2 data.

2) **PACE Data Analysis Center (PDAC)** -- This is a voluntary submission (to this research center at the University of Rochester) of the same diagnostic data submitted to CMS for risk adjustment. The purpose is to provide ongoing, cross-site comparisons of PACE diagnostic trends and variations between programs.

It is essential that the Medical Director be familiar with all of these activities, because the Medical Director must work in conjunction with other PACE leaders in the PO to both guide and assist the successful collection submission and analysis of this information.

Purposes include:

a) accurate and precise payment (reflected by encounter diagnoses) (HPMS);

b) avoiding submission of fraudulent or incomplete data (Risk Adjustment, HPMS);
c) tracking of important quality markers, to identify areas of improvement (HPMS, PDAC); and
d) to determine areas of variance from other PACE programs to prompt a review for underlying explanations for that variance, or perhaps to identify a unique local experience (PDAC, HPMS, PDAC, Risk Adjustment)

The Medical Director must be aware of these important uses of the data, and work with others to develop the workflows and audit processes in order to successfully collect information, verify its accuracy, and insure that submission is timely and valid.

Because these topics (especially risk adjustment) are reviewed thoroughly in publicly accessible documents, this chapter will not provide an exhaustive review of the individual subjects, but will aim for the following:

a) provide the conceptual framework for data collection that should sufficiently educate the reader to the fundamentals of the subject;
b) refer to the primary source documents that provide the best grounding in each subject, and which explore subtopics in detail;
c) refer to other resources and personnel across the PACE community who can be of assistance in a subject area.
Risk Adjustment

IMPORTANT DOCUMENTS FOR THIS SECTION: The review of this section will be most useful if the following documents are first downloaded from their Web locations and referenced during the course of the reading. They will be specifically referred to where during the course of this chapter.

**Document 1: 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide.** In this chapter will be referred to as the Participant Guide.

Go the CMS Customer Service and Support Center (CSSC) home page at [www.csscoperations.com](http://www.csscoperations.com). From the links in the RAPS group (Risk Adjustment Processing System), click Training Information. In the selection entitled 2008 Risk Adjustment Training Information, select Participant Guide. This is a 229 page guide that is comprehensive, and is the definitive source on the subject. It encompasses all aspects of risk adjustment, including the history and rationale for it, frailty adjustor for PACE, ICD9 coding rules and technical aspects of data submission.

Downloading the *entire* guide, as well as the slides, will be very useful. However, in this chapter the reader will be directed to specific sections of this document that are useful to download and print in conjunction with this chapter. Modules 1, 3, 6, 7, and 8 are at minimum essential for printing and review.

**MODULE 1 – RISK ADJUSTMENT METHODOLOGY**
**MODULE 3—OVERVIEW OF DATA COLLECTION**
**MODULE 6-- DIAGNOSIS CODES & RISK ADJUSTMENT**
**MODULE 7 – RISK ADJUSTMENT DATA VALIDATION**
**MODULE 8 – VERIFYING RISK SCORES**

**Document 2: HCC_Coefficients_2009.csv**, which contains the 2009 current Hierarchical Coexisting Conditions (HCC) codes and the corresponding risk factors for these and demographic and disease interaction variables In this chapter will subsequently be referred to as the 2009 HCC/Demographics file

a) Use Winzip to extract the files at the following location on the CMS website: [http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/ratebook2009.zip](http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/ratebook2009.zip)

b) There are four files in the folder. The file that contains the HCC and demographic variables and their factors is titled HCC_Coefficients_2009.csv and can be opened in Excel and renamed as an Excel file.
Document 3: current model diagnoses.xls --the 2009 listing of all ICD9 codes and which designates those that are currently relevant for risk adjustment, with the corresponding HCC groups to which they belong. In this chapter will referred to as the 2009 ICD9—HCC Crosswalk File

a) Use WinZip to extract the files in the following link:

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/RAdiagnoses.zip

b) The file current model diagnoses.xls contains the current listing of those 5400+ codes that at one point or another have been used in the risk adjustment model for either Part C or Part D risk adjustment.

c) Refer to the far right columns to obtain those used in the current year for risk adjustment. For instance, if you proceed to the column entitled CMS-HCC Model Calendar Year 2009 Payment, and filter for those designated “yes”, you will have a filtered set of 2800 diagnoses.

Essentially, “submitting risk adjustment data” refers to a program’s timely electronic submission to CMS of all diagnoses, in ICD9 code format, that were addressed in all face-to-face participant encounters with clinical providers in a given calendar year, in the following settings and by the described providers:

- Hospital inpatient settings;
- Hospital outpatient settings;
- Physician services, both primary care and specialty;
- Clinically trained non physician services (e.g., psychologists, podiatrists).

PACE organizations, like all capitated models under Medicare & Medicaid, are prospectively paid for care, in monthly payments from both CMS and from their individual states.

These submitted diagnoses, compiled over 12 month intervals, contribute heavily to the collective information that determines the federal Medicare capitation payments for individual participants in the subsequent year.
While the formula for state reimbursement differs by state, the method of calculation for the Medicare portion of PACE reimbursement is common to all PACE providers. It has evolved since its inception, and continues to evolve as CMS scrutinizes the cost experience of its fee-for-service and managed care products.

The history of risk adjustment and its evolution is detailed in Module 1 of the Training Guide (see NOTE in beginning of this section) but the following is a useful synopsis.

CMS, after years of earlier models and analysis, ratified a system by which diagnoses, reflected in submitted codes of the International Classification of Diseases, (ICD9) would determine the payment to be made on behalf of individual beneficiaries. Note that this is a major departure from the more traditional fee for service model used to pay ambulatory providers, which is rooted in the CPT or E/M codes that describe intensity of service, and do not vary by diagnoses.

The move to risk adjustment for Medicare programs was a response to the lessons of the early experience of Medicare reimbursed managed care, in which it became apparent that in the absence of adjustment for illness burden, some Medicare capitated insurers were markedly overpaid for relatively well cohorts, while others underpaid for very sick individuals. The former method, which varied only by various demographic and county characteristics, provided incentives for plans to avoid sicker enrollees or entire geographic regions of the US where larger proportions of older, sicker, and thus more costly, enrollees resided.

Years of actuarial research on the diagnostic data submitted in the claims of Medicare beneficiaries has indicated, not surprisingly, that disease burden of an individual predicts differences in future expenditures for that individual relative to the “average Medicare beneficiary.” CMS has used its cost experience in the fee for service system, across all enrollees, to perform regression analyses to determine a finite and workable set of predictors for future cost.
The major variables that appear to account for most of the variance in expenditures are the following:

a) age;
b) how the beneficiary came to be eligible for Medicare (i.e. reaching the statutory age of eligibility, or earlier, by virtue of disability);
c) whether or not the participant is concurrently in a state Medicaid program;
d) residence in nursing home or in the community; and
e) diagnosis burden.

Further, it has been determined that the interaction of some of these variables also accounts for a degree of cost variance in different ways than their individual effects.

Some examples:

--Being in the Medicaid program predicts cost differently depending upon whether one attained Medicare status by virtue of disability versus statutory eligibility age;

--Having both CHF and Diabetes, contributes further incrementally to cost than the sum of either one alone;

--Having specific disease conditions (alcohol dependence, psychosis) AND having been assigned to Medicare via disability (rather than age) contributes incrementally to cost.

In conducting these analyses, CMS researchers have thus assigned multipliers, or risk factor coefficients, to groups of diagnoses and demographic factors that predict the majority of cost variation. These multipliers reflect a proportion of the added future cost of a given enrollee relative to the “average Medicare beneficiary” when his or her diagnoses and other factors are taken into account.
In order to simplify the classification of risk, it was found that cohorts with certain groups of related diagnoses (e.g., those related to hematologic illness), displayed enough similarity in their ability to predict future cost, that they could be “lumped together” in a group that would share the same risk factor. These groupings are termed “HCCs,” or Hierarchical Condition Coefficients.”

The demographic, HCC, and interaction coefficients for 2009 are listed below in Table 1, but if you have not already done so, you can obtain the file HCC_Coefficients_2009.csv, (Here referred to as the 2009 HCC/Demographics file as indicated in the NOTE at the beginning of this section). Please refer to the table as you read further.

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<td>0.637</td>
<td>0.704</td>
<td></td>
</tr>
<tr>
<td>90-94 Years</td>
<td>0.761</td>
<td>0.614</td>
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</tr>
<tr>
<td>95 Years or Over</td>
<td>0.771</td>
<td>0.457</td>
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</table>
### DEMOGRAPHIC FACTORS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Disease Group</th>
<th>Community Factors</th>
<th>Institutional Factors</th>
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<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-34 Years</td>
<td>0.12</td>
<td></td>
<td>1.03</td>
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<tr>
<td>35-44 Years</td>
<td>0.164</td>
<td></td>
<td>0.871</td>
</tr>
<tr>
<td>45-54 Years</td>
<td>0.217</td>
<td></td>
<td>0.871</td>
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<tr>
<td>55-59 Years</td>
<td>0.249</td>
<td></td>
<td>0.978</td>
</tr>
<tr>
<td>60-64 Years</td>
<td>0.389</td>
<td></td>
<td>1.015</td>
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<tr>
<td>65-69 Years</td>
<td>0.328</td>
<td></td>
<td>1.221</td>
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<tr>
<td>70-74 Years</td>
<td>0.413</td>
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<td>1.154</td>
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<tr>
<td>75-79 Years</td>
<td>0.517</td>
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<td>1.143</td>
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<tr>
<td>80-84 Years</td>
<td>0.597</td>
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<td>1.087</td>
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<tr>
<td>85-89 Years</td>
<td>0.692</td>
<td></td>
<td>1.001</td>
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<tr>
<td>90-94 Years</td>
<td>0.834</td>
<td></td>
<td>0.932</td>
</tr>
<tr>
<td>95 Years or Over</td>
<td>0.98</td>
<td></td>
<td>0.743</td>
</tr>
</tbody>
</table>

Medicaid and Originally Disabled Interactions with Age and Sex

| Medicaid Female Aged | 0.179 | 0.091 |
| Medicaid Female Disabled | 0.131 | 0.091 |
| Medicaid Male Aged | 0.166 | 0.091 |
| Medicaid Male Disabled | 0.077 | 0.091 |
| Originally Disabled Female | 0.204 | 0.023 |
| Originally Disabled Male | 0.168 | 0.023 |

### DISEASE FACTORS–HIERARCHICAL COEFFICIENT CODES(HCC)

<table>
<thead>
<tr>
<th>Disease Coefficients</th>
<th>Description Label</th>
<th>Community Factors</th>
<th>Institutional Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC1</td>
<td>HIV/AIDS</td>
<td>0.945</td>
<td>0.967</td>
</tr>
<tr>
<td>HCC2</td>
<td>Septicemia/Shock</td>
<td>0.759</td>
<td>0.764</td>
</tr>
<tr>
<td>HCC5</td>
<td>Opportunistic Infections</td>
<td>0.3</td>
<td>0.288</td>
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</table>
## DISEASE FACTORS—HIERARCHICAL COEFFICIENT CODES (HCC)

<table>
<thead>
<tr>
<th>Disease Coefficients</th>
<th>Description Label</th>
<th>Community Factors</th>
<th>Institutional Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC7</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>2.276</td>
<td>0.824</td>
</tr>
<tr>
<td>HCC8</td>
<td>Lung, Upper Digestive Tract, and Other Severe Cancers</td>
<td>1.053</td>
<td>0.47</td>
</tr>
<tr>
<td>HCC9</td>
<td>Lymphatic, Head and Neck, Brain, and Other Major Cancers</td>
<td>0.794</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC10</td>
<td>Breast, Prostate, Colorectal and Other Cancers and Tumors</td>
<td>0.208</td>
<td>0.182</td>
</tr>
<tr>
<td>HCC15</td>
<td>Diabetes with Renal or Peripheral Circulatory Manifestation (1)</td>
<td>0.508</td>
<td>0.459</td>
</tr>
<tr>
<td>HCC16</td>
<td>Diabetes with Neurologic or Other Specified Manifestation (1)</td>
<td>0.408</td>
<td>0.459</td>
</tr>
<tr>
<td>HCC17</td>
<td>Diabetes with Acute Complications (1)</td>
<td>0.339</td>
<td>0.459</td>
</tr>
<tr>
<td>HCC18</td>
<td>Diabetes with Ophthalmologic or Unspecified Manifestation (1)</td>
<td>0.259</td>
<td>0.459</td>
</tr>
<tr>
<td>HCC19</td>
<td>Diabetes without Complication (1)</td>
<td>0.162</td>
<td>0.248</td>
</tr>
<tr>
<td>HCC21</td>
<td>Protein-Calorie Malnutrition</td>
<td>0.856</td>
<td>0.374</td>
</tr>
<tr>
<td>HCC25</td>
<td>End-Stage Liver Disease</td>
<td>0.978</td>
<td>0.654</td>
</tr>
<tr>
<td>HCC26</td>
<td>Cirrhosis of Liver</td>
<td>0.406</td>
<td>0.384</td>
</tr>
<tr>
<td>HCC27</td>
<td>Chronic Hepatitis</td>
<td>0.406</td>
<td>0.384</td>
</tr>
<tr>
<td>HCC31</td>
<td>Intestinal Obstruction/Perforation</td>
<td>0.311</td>
<td>0.345</td>
</tr>
<tr>
<td>HCC32</td>
<td>Pancreatic Disease</td>
<td>0.403</td>
<td>0.309</td>
</tr>
<tr>
<td>HCC33</td>
<td>Inflammatory Bowel Disease</td>
<td>0.241</td>
<td>0.205</td>
</tr>
<tr>
<td>HCC37</td>
<td>Bone/Joint/Muscle Infections/Necrosis</td>
<td>0.535</td>
<td>0.497</td>
</tr>
<tr>
<td>HCC38</td>
<td>Rheumatoid Arthritis and Inflammatory Connective Tissue Disease</td>
<td>0.346</td>
<td>0.215</td>
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<tr>
<td>HCC44</td>
<td>Severe Hematological Disorders</td>
<td>1.015</td>
<td>0.493</td>
</tr>
<tr>
<td>HCC45</td>
<td>Disorders of Immunity</td>
<td>0.912</td>
<td>0.427</td>
</tr>
<tr>
<td>HCC51</td>
<td>Drug/Alcohol Psychosis (3)</td>
<td>0.274</td>
<td>0</td>
</tr>
<tr>
<td>HCC52</td>
<td>Drug/Alcohol Dependence (3)</td>
<td>0.274</td>
<td>0</td>
</tr>
<tr>
<td>HCC54</td>
<td>Schizophrenia</td>
<td>0.524</td>
<td>0.351</td>
</tr>
<tr>
<td>HCC55</td>
<td>Major Depressive, Bipolar, and Paranoid Disorders</td>
<td>0.353</td>
<td>0.293</td>
</tr>
<tr>
<td>HCC67</td>
<td>Quadriplegia, Other Extensive Paralysis</td>
<td>1.011</td>
<td>0.434</td>
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<tr>
<td>HCC68</td>
<td>Paraplegia</td>
<td>0.993</td>
<td>0.434</td>
</tr>
<tr>
<td>HCC69</td>
<td>Spinal Cord Disorders/Injuries</td>
<td>0.558</td>
<td>0.225</td>
</tr>
</tbody>
</table>
## DISEASE FACTORS—HIERARCHICAL COEFFICIENT CODES (HCC)

<table>
<thead>
<tr>
<th>Disease Coefficients</th>
<th>Description Label</th>
<th>Community Factors</th>
<th>Institutional Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC70</td>
<td>Muscular Dystrophy (3)</td>
<td>0.395</td>
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</tr>
<tr>
<td>HCC71</td>
<td>Polyneuropathy</td>
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<tr>
<td>HCC72</td>
<td>Multiple Sclerosis</td>
<td>0.599</td>
<td>0.145</td>
</tr>
<tr>
<td>HCC73</td>
<td>Parkinson's and Huntington's Diseases</td>
<td>0.592</td>
<td>0.092</td>
</tr>
<tr>
<td>HCC74</td>
<td>Seizure Disorders and Convulsions</td>
<td>0.267</td>
<td>0.177</td>
</tr>
<tr>
<td>HCC75</td>
<td>Coma, Brain Compression/Anoxic Damage (3)</td>
<td>0.415</td>
<td>0</td>
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<tr>
<td>HCC77</td>
<td>Respirator Dependence/Tracheostomy Status</td>
<td>1.867</td>
<td>1.559</td>
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<tr>
<td>HCC78</td>
<td>Respiratory Arrest</td>
<td>1.082</td>
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</tr>
<tr>
<td>HCC79</td>
<td>Cardio-Respiratory Failure and Shock</td>
<td>0.578</td>
<td>0.445</td>
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<tr>
<td>HCC80</td>
<td>Congestive Heart Failure</td>
<td>0.41</td>
<td>0.228</td>
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<tr>
<td>HCC81</td>
<td>Acute Myocardial Infarction</td>
<td>0.359</td>
<td>0.424</td>
</tr>
<tr>
<td>HCC82</td>
<td>Unstable Angina and Other Acute Ischemic Heart Disease</td>
<td>0.284</td>
<td>0.424</td>
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<tr>
<td>HCC83</td>
<td>Angina Pectoris/Old Myocardial Infarction</td>
<td>0.244</td>
<td>0.29</td>
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<tr>
<td>HCC92</td>
<td>Specified Heart Arrhythmias</td>
<td>0.293</td>
<td>0.207</td>
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<tr>
<td>HCC95</td>
<td>Cerebral Hemorrhage</td>
<td>0.324</td>
<td>0.179</td>
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<tr>
<td>HCC96</td>
<td>Ischemic or Unspecified Stroke</td>
<td>0.265</td>
<td>0.179</td>
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<tr>
<td>HCC100</td>
<td>Hemiplegia/Hemiparesis</td>
<td>0.437</td>
<td>0.039</td>
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<tr>
<td>HCC101</td>
<td>Cerebral Palsy and Other Paralytic Syndromes (3)</td>
<td>0.18</td>
<td>0</td>
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<tr>
<td>HCC104</td>
<td>Vascular Disease with Complications</td>
<td>0.61</td>
<td>0.482</td>
</tr>
<tr>
<td>HCC105</td>
<td>Vascular Disease</td>
<td>0.316</td>
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<tr>
<td>HCC107</td>
<td>Cystic Fibrosis</td>
<td>0.399</td>
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<tr>
<td>HCC108</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>0.399</td>
<td>0.359</td>
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<tr>
<td>HCC111</td>
<td>Aspiration and Specified Bacterial Pneumonias</td>
<td>0.703</td>
<td>0.573</td>
</tr>
<tr>
<td>HCC112</td>
<td>Pneumococcal Pneumonia, Emphysema, Lung Abscess</td>
<td>0.249</td>
<td>0.181</td>
</tr>
<tr>
<td>HCC119</td>
<td>Proliferative Diabetic Retinopathy and Vitreous Hemorrhage</td>
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<td>0.497</td>
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<td>Dialysis Status</td>
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<td>Nephritis</td>
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<td>HCC148</td>
<td>Decubitus Ulcer of Skin</td>
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<td>0.485</td>
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<tr>
<td>HCC149</td>
<td>Chronic Ulcer of Skin, Except Decubitus</td>
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<td>0.241</td>
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<tr>
<td>HCC150</td>
<td>Extensive Third-Degree Burns (3)</td>
<td>1.416</td>
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</tr>
<tr>
<td>Disease Coefficients</td>
<td>Description Label</td>
<td>Community Factors</td>
<td>Institutional Factors</td>
</tr>
<tr>
<td>----------------------</td>
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<tr>
<td>HCC154</td>
<td>Severe Head Injury (3)</td>
<td>0.415</td>
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<td>HCC155</td>
<td>Major Head Injury (3)</td>
<td>0.106</td>
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<tr>
<td>HCC157</td>
<td>Vertebral Fractures without Spinal Cord Injury</td>
<td>0.443</td>
<td>0.161</td>
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<tr>
<td>HCC158</td>
<td>Hip Fracture/Dislocation (3)</td>
<td>0.429</td>
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<td>HCC161</td>
<td>Traumatic Amputation</td>
<td>0.678</td>
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<td>HCC164</td>
<td>Major Complications of Medical Care and Trauma</td>
<td>0.296</td>
<td>0.309</td>
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<td>HCC174</td>
<td>Major Organ Transplant Status</td>
<td>0.705</td>
<td>0.92</td>
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<tr>
<td>HCC176</td>
<td>Artificial Openings for Feeding or Elimination</td>
<td>0.662</td>
<td>0.841</td>
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<tr>
<td>HCC177</td>
<td>Amputation Status, Lower Limb / Amputation Complications</td>
<td>0.678</td>
<td>0.26</td>
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<tr>
<td>D_HCC5</td>
<td>Disabled_Opportunistic Infections</td>
<td>0.623</td>
<td>1.016</td>
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<td>D_HCC44</td>
<td>Disabled_Severe Hematological Disorders</td>
<td>1.036</td>
<td>0.362</td>
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<tr>
<td>D_HCC51</td>
<td>Disabled_Drug/Alcohol Psychosis</td>
<td>0.729</td>
<td>0.299</td>
</tr>
<tr>
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<td>Disabled_Drug/Alcohol Dependence</td>
<td>0.31</td>
<td>0.299</td>
</tr>
<tr>
<td>D_HCC107</td>
<td>Disabled_Cystic Fibrosis (3)</td>
<td>1.097</td>
<td>-</td>
</tr>
<tr>
<td>INT1</td>
<td>DM_CHF (2)</td>
<td>0.154</td>
<td>0.125</td>
</tr>
<tr>
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<td>DM_CVD</td>
<td>0.102</td>
<td>0.028</td>
</tr>
<tr>
<td>INT3</td>
<td>CHF_COPD</td>
<td>0.219</td>
<td>0.194</td>
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<td>INT4</td>
<td>COPD_CVD_CAD</td>
<td>0.173</td>
<td>0.071</td>
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<tr>
<td>INT5</td>
<td>RF_CHF (2,3)</td>
<td>0.231</td>
<td>-</td>
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<tr>
<td>INT6</td>
<td>RF_CHF_DM (2)</td>
<td>0.477</td>
<td>0.358</td>
</tr>
</tbody>
</table>
A participant’s diagnostic risk profile—the sum of those coefficients to which he or she is assigned, is rooted in the clinical encounters of an index year, which modify the payment made to his or her PACE program on his behalf in the subsequent year.

More precisely, the sum of these coefficients is multiplied by a base payment rate specific to each county in the United States.

The demographic section of the profile is determined from the participant’s enrollment data in Medicare and Medicaid, how he or she came to Medicare eligibility, and whether or not the participant has lived for 90 consecutive days in a nursing facility, in which case the participant is considered to be a Long Term Institutional (LTI) enrollee.

Note the values of the coefficients for all variables vary for those who are institutionalized. (For the most part, institutionalized individuals are actuarily less costly to the Medicare program, even with the same disease profiles, and thus have lower risk multipliers for the same characteristic.)

How is a participant “assigned” an HCC and its subsequent coefficient or value? In completing the documentation of face-to-face clinical encounter, if a particular diagnosis is used by a provider, hospital, or specialist to code a visit (or coding personnel assigned this task, using required ICD9 accepted coding standards), that code is used to assign, or “trigger,” whether a particular HCC category applies to the participant.

Of the over 18,000 codes in the current ICD9 classification system, it has been determined that only a subset of them sufficiently explain cost variation when grouped into the 70 HCC categories in the table. While over 5400 of them have at various times been used to provide risk adjustment for either the non-drug (Part C) capitation or the drug (Part D) capitation, currently just over 2800 ICD9 codes are used for 2009 payment. These are thus considered “relevant” ICD9 codes because they contribute to future cost.
In order to obtain comprehensive listing of the ICD9 codes (which is highly recommended), refer to the NOTE at the beginning of this section to obtain the file *current model diagnoses.xls* (*the 2009 ICD9—HCC Crosswalk File*).

The file contains the current listing of those 5400+ codes that at one point or another have been used in the risk adjustment model for either Part C or Part D risk adjustment.

You need to refer to the far right columns to obtain those used in the current year for risk adjustment. If you set the Auto to the column entitled CMS-HCC Model Calendar Year 2009 Payment, and filter for those designated “yes”, you will have a filtered set of the current 2800 diagnoses.

Below, in TABLE 2, is a small abstraction of that file, with the columns for the years prior to 2009 removed, to illustrate the use of this file

**TABLE 2**

Sample Abstract of File: *current model diagnoses.xls* file

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD9_Description</th>
<th>Diagnosis Code Effective Date</th>
<th>CMS-HCC Model Category</th>
<th>RxHCC Model Category</th>
<th>CMS-HCC Model Calendar Year 2009 Payment</th>
<th>RxHCC Model Calendar Year 2009 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>4280</td>
<td>Chf Nos</td>
<td>1/1/1991</td>
<td>80</td>
<td>91</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4281</td>
<td>Left Heart Failure</td>
<td>1/1/1991</td>
<td>80</td>
<td>91</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>42820</td>
<td>Systolic Hrt Failure Nos</td>
<td>10/1/2002</td>
<td>80</td>
<td>91</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>42821</td>
<td>Ac Systolic Hrt Failure</td>
<td>10/1/2002</td>
<td>80</td>
<td>91</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>42822</td>
<td>Chr Systolic Hrt Failure</td>
<td>10/1/2002</td>
<td>80</td>
<td>91</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Note that the ICD9 codes are listed with the decimal points, but after the first 3 digits from the left, the decimal point should then be assumed when referring to your own storage of ICD9 codes.

The second column is a truncated description of the diagnosis description. Third party suppliers of ICD 9 codes like MediSpan may use a slightly different or expanded description.

The third column is the date when that code was first used in risk adjustment.

The fourth & fifth columns list the HCC category which is assigned for either Part C risk adjustment (CMS HCC) or Part D (RxHCC).

The final two columns confirm that that particular diagnosis is currently used for risk adjustment in the current year.

If you refer to the CMS-HCC Model Category column in Table 2, you will find the HCC that applies, or is “triggered” by that specific ICD9 code. Referencing the 2009 HCC/Demographics file already described (and included in Table 1), then provides the specific decimal coefficient that will be applied to the participant’s risk adjustment profile, as a result of having a visit in which that diagnosis was coded.

Note that this need occur only once in a given year. For example, if a participant is seen 20-30 times in a given year for CHF, the same single HCC coefficient is applied for the entire subsequent payment year.

An example illustrates how an individual’s risk score is created. The following risk adjustment factors apply to a 78 year-old female residing in the community who qualifies for Medicaid and has the following diagnoses: CHF, COPD and diabetes with neuropathy.
78 year-old female: .468
Medicaid eligible: .177
CHF (HCC80): .395
COPD (HCC108): .398
Diabetes with Neurologic or Other Specified Manifestation (HCC16): .452
Interaction between HCC80 and HCC108: .216
Frailty Adjuster: .566
Total Risk Score: 2.672

The total risk score of 2.672 is then multiplied by the appropriate county-level payment rate. NOTE: The county level payment rates for 2009 can be obtained using WinZip at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/RAdiagnoses.zip. The csv file containing these base rates is titled countyrate2009.csv, and can be opened using Excel and then saved to an Excel file.

The base payments (the sum to which risk adjustment is applied) varies according to the counties in the United States in which enrollees reside. There are additional actuarial adjustments that are applied that relate to the variance of health plan bids from regional average capitation amounts (for all the counties in a region), and the weighted average of variance of individual county bids. A detailed discussion of this is not necessary for fundamental knowledge of risk adjustment for the Medical Director, as it merely modifies the base payment to which diagnostic data is applied. However, a detailed discussion of this subject is available on pages 1-10 thru 1-14, (Module 1) 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide.

Specific Enrollee populations

There are other important subjects that are noteworthy to risk adjustment and to PACE reimbursement in particular. While they are not addressed in detail here, they are listed...
below with brief introductory comments, and a reference is given in parentheses to the specific section of the Participant Guide in which they are addressed definitively.

A. New Enrollees -- (Section 1.3.2, page 1.18) of Participant Guide

These are individuals who are newly enrolled to Medicare, or to capitated Medicare plans and only have a history in the fee for service system. The risk factors first assigned to them on enrollment to the plan can be either a predesignated “New Enrollee Factor”, or can be determined from the ICD9 codes submitted in the previous year. Each plan must choose which method to apply for all of its new enrollees. Once diagnoses are available while a member of the plan, the risk score is adjusted using those diagnoses.

B. Community Dwelling versus SNF residency -- (Section 1.3.3, page 1-19) of Participant Guide

A long-term institutionalized MA enrollee is defined as a participant who resides in an institution for more than 90 days as identified using the Minimum Data Set (MDS). As mentioned previously, the coefficients are typically less (but not always) for a given HCC if a participant is a nursing home resident. This reflects the likelihood that less aggressive medical intervention is pursued due to coexisting comorbidity and decline, and thus expenditures are less. Further, the frailty adjuster (see below) is not applied to the risk profiles of nursing home residents.

C. Frailty adjuster -- (Sections 1.3.4 thru 1.3.7, pgs 1-21 through 1-25) of Participant Guide

The area is an important component of PACE capitation, and is in evolution. During the years of risk adjustment, an additional coefficient has been applied to certain organizations, like PACE programs that care for disabled frail individuals. It is meant to account for expenditures, likely related to the additional costs of care for frail persons, that cannot explained strictly through other variables in the risk adjustment model.
The frailty factors vary based upon those Activity of Daily Living (ADL) limitations reported in interview by the participants, not by professional assessment. Section 1.3.4.4 of the Training Guide details the evolution of the sources of this interview data, which is in transition. PACE programs have expressed concern that the self reporting of functional limitation by participants, as well as the difficulty in obtaining full reporting from all enrollees, serves to underestimate frailty as expressed by this factor.

The table below, from page 1-23 in the Participant Guide, lists these coefficients for 2008 and 2009.

### TABLE 1J
2008 AND 2009 FRAILTY FACTORS (from Participant Guide)

<table>
<thead>
<tr>
<th>ADL LIMITATIONS</th>
<th>2008 FRAILTY FACTORS</th>
<th>2009 FRAILTY FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NON-MEDICAID</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>0</td>
<td>-0.089</td>
<td>-0.183</td>
</tr>
<tr>
<td>1-2</td>
<td>+0.110</td>
<td>+0.024</td>
</tr>
<tr>
<td>3-4</td>
<td>+0.200</td>
<td>+0.132</td>
</tr>
<tr>
<td>5-6</td>
<td>+0.377</td>
<td>+0.188</td>
</tr>
</tbody>
</table>

A single plan-level frailty factor is determined by the average of those assigned to a cohort of the plan’s enrollment who live in the community. This plan-level factor is added to the risk profile of community dwelling participants, but not to those who reside permanently in nursing homes.

**D. End Stage Renal Disease -- (Sections 1.3.5 thru 1.3.5.3 pages 1-26 thru 1-28) of the Participant Guide**
Those participants on dialysis, with a kidney transplant that is recent or distant and functioning, are placed into different models, with different base payments, that are subject to HCC adjustments that differ slightly from those in the non-ESRD model. There are very substantial base payment increases for those on dialysis.

The coefficients for dialysis status and kidney failure (HCC 130 and 131) do not apply, and the remainder of the HCC’s is applied to account for variation in cost among those on dialysis. Those participants with a new renal transplant (< 3 months old) and functioning graft (> 3 months) are rare in PACE programs, but do exist, and a different model applies to the reimbursement for these individuals.

E. Part D (capitated payment for medications) -- (Sections 1.3.6 to 1.3.6.2, pages 1-28 to 1-30) of the Participant Guide

This subject, which refers to those separate capitation payments applied to drug expenditures, is covered extensively in a separate section of this handbook. Note, however, that an HCC model of risk adjustment is applied to base payments for drug expenditures, to create a capitation that is separate from the Part C capitation.

The HCCs for this model overlap but there are additional ones in the so called RxHCC model that reflect the fact that some diagnoses increase medication costs, but do not increase non-drug expenditures (e.g., dementia, arthritis).

Practical Aspects of ICD9 Coding and Capture

In general, POs utilize one of two general approaches to identify, code and submit diagnoses. They either 1) identify and code diagnoses in connection with each physician encounter, or 2) utilize the routine reassessment process as an opportunity to identify all active diagnoses at the time of the assessment and to review the medical record for documentation of diagnoses that were identified since the last assessment but since
resolved. Regardless of the specific method used, it is crucial that all relevant diagnoses are identified, documented in the medical record, coded to their highest degree of specificity and then submitted to CMS for inclusion in the risk adjustment process.

Some organizations use electronic medical records in which documentation and coding all are completed using the same software. Other organizations use paper records for documentation, but complete encounter forms separately which are submitted either with codes, or for back-office processing by coding staff.

Whichever method is used, it is best that all diagnoses for all encounters are submitted, not merely those that are “relevant” to risk adjustment, as the CMS model is subject to constant revision, and the historical submission of diagnoses in PACE programs as well as other settings will likely contribute to those changes.

PACE organizations may choose to hire professional coding personnel trained in the specifics of risk adjustment to contribute to their diagnostic submission workflows. They can provide valuable assistance in insuring valid and timely data submission, and in insuring that the data reflect the true disease burden of the plan’s participants to the highest level of diagnostic specificity.

The NPA Superbill

NOTE: in concert with the discussion below, the reader should print the current version of the Superbill. It is located on the NPA member website at:
http://www.npaonline.org/website/article.asp?id=26 Log on using your site’s member username and password, and you will be brought to the Superbill page.

Many PACE organizations utilize the “NPA Model Superbill,” to assist clinicians with the collection of diagnoses and assignment of diagnostic codes. Created by PACE Medical Directors in 2001 and revised periodically, the Superbill provides a handy, one-
stop location for many of the diagnoses relevant to PACE practice and to risk adjustment; for specific codes not listed on the Superbill, there is room to enter them. The Superbill was designed to help clinical staff, at point-of-care, to assign ICD-9-CM codes to diagnoses identified in the course of a patient visit.

For some organizations, this Superbill may be the reference for direct ICD9 submission into the CMS risk adjustment system. For others, this document is sent to other staff, including professional coders, who review direct documentation for the specificity of the data, and then submit data supported by the documentation. For those with electronic medical records, it may be useful as a guide to formatting the diagnosis reference and selection area in the electronic medical record (EMR).

While there have been several revisions as codes have changed, the most recent updates have focused on the improved formatting of those disease areas (eg, diabetes, pressure ulcers, and cancer) in which the proper selection of the single most specific ICD9 code is important for both clinical specificity, and risk adjustment.

The Medical Director should review Table 1, or the 2009 HCC/Demographic File, for nuances in code selection that greatly affect the assignment of HCCs and corresponding risk coefficients. Attention to this can improve the specificity of data and ensure that the individual capitation payments for participants maximally reflect their disease burden. For example, HCC19, (Diabetes without Complications), is assigned when the ICD9 codes for diabetes are submitted that do not refer to complications of the disease. However, HCC 15 and 16, which refer to diabetes with associated complications, are assigned higher risk coefficients that reflect the greater cost of beneficiaries with complications of diabetes.
ICD9 coding, coding review, documentation standards  
(Module 6 and 7 of the Participant Guide)

These areas of the Participant Guide address the important subjects of documentation and ICD9 coding extensively. The Medical Director is strongly encouraged to review these modules, as they cover:

- minimum standards for documentation that support a submitted ICD9 diagnosis;
- the standards of code assignment itself (e.g., digit requirements, associated diagnoses);
- the rules regarding timely submission;
- the varying ways in which documentation is conducted and what makes those different examples acceptable or unacceptable as support for submitted diagnoses; and
- CMS system for auditing for validity of submission.

Submission of ICD9 Data to CMS  
(Module 2 and 3 of the Participant Guide)

Diagnostic codes are submitted electronically to CMS via the Palmetto Government Benefits Administration (PGBA), an organization contracted to collect and process the risk adjustment data before HCC assignment. While the details of this process are not presented here, they are covered in the Participant Guide. Additionally, CMS sponsors periodic trainings (using the Participant Guide and Slides) on RAPS (Risk Adjustment Processing System), and FERAS (Front End Risk Adjustment System) and announcements regarding future trainings are also available on the CSSC website (www.cssoperations.com) The Medical Director might consider attending one of these sessions to obtain further overview of the CMS-HCC risk adjustment model, but the
available Participant Guide referred to throughout this chapter is the comprehensive training manual for those sessions.

In general, PACE Organizations (PO) utilize one of two options to submit diagnostic data to CMS. They either enter data via an online data entry process or submit diagnoses for multiple participants simultaneously via a batch file submission process. In both cases, the data submitted proceed through a series of edits, and the PO is notified electronically as to whether each diagnosis has been accepted and stored in the CMS-HCC model. For those diagnoses that are not accepted, the PO will receive notification that they have been rejected, and any errors must be corrected in order for the diagnoses to be resubmitted.

The data submission schedule is listed in the table below from Module 2 of the Participant Guide.

**TABLE 2B – SUBMISSION TIMETABLE**

<table>
<thead>
<tr>
<th>CY</th>
<th>DATES OF SERVICE</th>
<th>INITIAL SUBMISSION DEADLINE</th>
<th>FIRST PAYMENT DATE</th>
<th>FINAL SUBMISSION DEADLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>July 1, 2009 through June 30, 2010</td>
<td>September 3, 2010</td>
<td>January 1, 2011</td>
<td>N/A</td>
</tr>
<tr>
<td>2012</td>
<td>July 1, 2010 through June 30, 2011</td>
<td>September 2, 2011</td>
<td>January 1, 2012</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Note that risk scores are created from 12 month periods that *ended 6 months earlier.*

Every 6 months (in January and July), new risk scores are created from the data of 12 month intervals that ended 6 months prior to January 1 and July 1.

The Final Submission Deadline refers to dates in which data that either has not yet been submitted, or which must be corrected, can then be submitted to be applied to an earlier reimbursement year. As the scores change in January and July, retroactive corrections are made to the capitation payments for beneficiaries, so that the “correct” risk score is applied to a full calendar year.

**Because the scores change in January and July, these are an ideal opportunity for the PACE Medical Director and the organization to analyze data from the CMS reports (see next section), and determine the effectiveness and precision of coding, documentation and submission workflows.**

**Risk Adjustment Data Reports**

(Module 8 from the Participant Guide)

Note: If there is a staff member in your organization who is already responsible for and conducting data submission and report review, it would be useful for the Medical Director to review with examples of the reports described below and in Module 8.

<table>
<thead>
<tr>
<th>Year</th>
<th>Start Date</th>
<th>End Date</th>
<th>Submit Date</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>July 1, 2011 through June 30, 2012</td>
<td>September 7, 2012</td>
<td>January 1, 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>2014</td>
<td>July 1, 2012 through June 30, 2013</td>
<td>September 6, 2013</td>
<td>January 1, 2014</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Following electronic submission of enrollees’ diagnoses to CMS, POs receive reports that provide the following information:

a) verification of receipt of diagnoses;
b) rejected submissions that do not include all necessary elements;
c) description of the cumulative submissions by an organization from month-to-month;
d) list of the risk coefficients currently being applied to the plan’s base payment for each of its members, and thus modifying their individual capitation payments; and
e) flags that indicate which participants are officially in the ESRD model (with different base payments and risk adjusters) and are considered nursing home residents for the purpose of risk adjustment.

There are two specific reports that the medical director should be familiar with:

The MMR, or *Monthly Membership Report*, identifies the active risk scores that are being used in calculating payment for each of a plan’s participants.

The MOR, or *Monthly Output Report*, identifies the specific demographic characteristics and HCC categories that were “credited to”, and used for calculating payment for each enrollee.

These reports together provide valuable information to the Medical Director and others involved in risk adjustment processes. They help to answer the following questions, among others:

a) Is diagnostic data for everyone in the plan successfully being submitted? What is the range and mean of risk scores at the six-month intervals? Do they coincide with the Medical Director’s perception of the illness burden of the enrollees, or subsets of them? Discrepancies might stimulate a review of coding education and workflows.
b) Are those on dialysis being appropriately assigned to the ESRD risk model, with its associated base payment change and risk factor profile?

c) Are persons appropriately assigned to community or LTI (long term institutional) status? (Remember that those residing in a nursing home are not credited with the frailty adjuster in their risk scores.)

d) Is there submission “dropout”—for example, those with CHF in one or several years suddenly not being assigned to that HCC in the next collection period, suggesting likely problems with coding, or submission?

e) Are there any clearly invalid HCC assignments that should be corrected?

POs should expend effort to develop a utilization review process that includes those from IT, the Medical Director, and finance to analyze this data systematically at these 6 month intervals, and implement workflow adjustments to improve observed gaps.

Examples of the reports are not reproduced here. However, review of Module 8 of the Participant Guide and its report examples, in conjunction with the actual MOR and MMR data files received by your organization, should provide sufficient grounding in the topic.

CMS offers downloadable software (see 8.2.3 “CMS-HCC Risk Adjustment Model Software” in the Participant Guide in which an organization can verify and predict risk scores. Many organizations, however, create their own internal electronic processes for storing diagnosis data, submission dates, and previous error corrections, so that these can be referred to later when scores are recalibrated and CMS sends the payment and HCC reports.

**PACE Data Analysis Center (PDAC)**

PDAC data submission is closely related to risk adjustment. Basically, participation in the center’s research is a voluntary activity in which interested PACE programs pay a fee, and then submit all ICD9 diagnoses to the Center that are concurrently being submitted to CMS for risk adjustment. The Center then combines all of the diagnosis data for all
participating organizations in one database, so that comparative information can be derived to assist programs and PACE nationally in the area of risk adjustment variation, diagnostic profiling, prediction of future capitation payments, national variations in medication use, potentially helping to provide a future “snapshot” of PACE clinical characteristics.

Included below is an NPA memorandum that explains the history and current activity of the Center as of June, 2009, and provides the Medical Director with a solid introduction to the Center’s purpose and output to date.

National PACE Association Document
(Courtesy of Christine Van Reenen, PhD, Director of Public Policy, National PACE Association)

PACE Data Analysis Center (PDAC) Overview and Processes

With the implementation of CMS-Hierarchical Condition Categories (HCC) risk adjustment for PACE organizations in 2004, the National PACE Association (NPA) initiated the collaborative PDAC project involving PACE organizations, the University of Rochester Department of Community and Preventive Medicine, and NPA. A primary objective of PDAC is to evaluate the impact of the CMS-HCC risk adjustment model on PACE organizations’ Medicare Part A and B payments. Using data sources readily available to PACE organizations, the PDAC undertakes analyses of PACE organizations’ risk scores, both across sites and over time. PDAC allows sites to benchmark their plan average risk score and payments to those of other sites and assists them in tracking their scores and payments over time. This information may guide PACE organizations in identifying areas for improvement in diagnostic coding and data submission. Further, analyses of diagnostic level data submitted to PDAC make it possible to predict future risk scores, which is useful information for budgeting and other purposes. With implementation of Part D in January of 2006, PDAC expanded its focus to include analyses of RxHCC and Prescription Drug Event (PDE) data.
Examples of specific types of analytic reports that PDAC provides to participating PACE organizations are the following:

- Mean HCC (Hierarchical Conditions Category) Risk Scores for PACE organizations’ enrollees overall, as well as for distinct subgroups including community, long term institutional and new enrollees.
- Mean total Part A/B Risk scores incorporating PACE organizations’ frailty factors.
- Estimated mean Medicare per member per month Part A and B payments.
- Analyses of HCC-level information.
- Analyses of RAPS diagnostic data for selected conditions.
- Mean RxHCC Risk scores for Part D payment.
- Information on volume of Prescription Drug Event (PDE) submissions over time.

PDAC staff also provides participating programs with consultation on the HCC and RxHCC risk-adjusted payment models and how to access and interpret Monthly Membership and Model Output Reports.

PDAC supports PACE organizations’ Part D bid development, working collaboratively with Milliman, Inc. to share Part D risk score and Prescription Drug Event data essential to the bid development process. By doing so, PACE organizations participating in PDAC are not required to duplicate effort by transmitting data to both PDAC and Milliman. More recently, PDAC has performed analyses linking diagnostic data with prescription drug event information, illustrating the potential for these data to guide PACE organizations’ quality improvement activities.

The results of PDAC analyses are distributed to participating PACE organizations throughout the “PDAC year” (March – February). In addition, conference calls are scheduled periodically to discuss results. The reports distributed by PDAC include no participant-level information. The program-level data that are distributed is sent to
PDAC participants only, who are able to identify program-level results by PACE organization name. PACE organizations participating in PDAC commit to using PDAC reports for internal purposes only.

Beyond the benefits of PDAC to individual participating sites, PDAC results are also extremely valuable to NPA. PDAC provides timely payment data to NPA that is used for both advocacy and member education purposes. NOTE: Participating organizations’ individual-level program data is not disseminated by NPA and is shared only among programs participating in the PDAC project.

The analyses distributed by PDAC are for the use of PDAC participants only and not for distribution. Further, PDAC subscribers and their agents are prohibited from using the PDAC analytical reports as resources when providing consulting services, and from sharing the reports with non-PACE entities and non-subscribing PACE programs. NPA and its agents will only use de-identified PDAC analytical report data to support advocacy, research, and presentation activities in support of PACE and will, under no circumstances, disclose site-specific data to entities not participating in PDAC.

**PDAC Staff:** PDAC staff is made up of Helena Temkin-Greener, Ph.D., Associate Professor, University of Rochester Department of Community and Preventive Medicine, who is the PDAC project director, and Jill Szydlowski, who provides needed expertise in computer programming and data analysis. Chris van Reenen and Shawn Bloom work closely with PDAC staff and participating NPA members to identify PDAC priorities.

**PDAC Data Requirements:** All PDAC participants provide the University of Rochester with their Monthly Membership Reports (MMRs), Model Output Reports (MORs), RAPS Return files, and DDPS Return files. The MMRs and MORs should be submitted on a monthly basis as you receive them from CMS. RAPS and DDPS Return files should be submitted as soon as you download them from the CSSC (Customer Support and Service Center at Palmetto Government Benefits Administration). Important Note: Due to HIPAA restrictions, PACE organizations must not submit any of these reports to
PDAC until Business Associate Agreements between your program and NPA have been signed.

How to Submit PDAC Data to the University of Rochester: All of the files discussed above are submitted to PDAC electronically by uploading them to a secure University of Rochester web-page. PACE organizations newly participating in PDAC should contact Jill Szydlowski at the University of Rochester for more information (Jill_Szydlowski@urmc.rochester.edu or 585-275-3394).

**Health Plan Management System (HPMS)**

In order to comply with the PACE regulation, §460.140 and §460.200, all POs must meet external quality assessment and reporting requirements as specified by CMS and the State Administering Agency.

HPMS, or the Health Plan Management System, is a secure web portal for information and data exchange that must be used by all Medicare managed care organizations for a variety of processes, including bid submissions, quality reporting.

For the purposes of this section “HPMS” refers specifically to the specific PACE Monitoring module within HPMS. Using this module, PACE organizations submit, on each calendar quarter, a defined set of data elements intended to provide a marker for performance across PACE programs.

Note: It is recommended that the reader go to the CMS website, and to the PACE—Additional Resources page at: [http://www.cms.hhs.gov/PACE/09_AdditionalResources.asp](http://www.cms.hhs.gov/PACE/09_AdditionalResources.asp), and download the **HPMS PACE Users’ Guide—Fall, 2005**, which provides the detail regarding the data elements required for submission.
On that page, click the User Instruction Manual [PDF 2.7 MB] link. The user guide contains screen images of the HPMS site data entry pages, and the guiding principles for the various data elements. Note that HPMS will be overhauled and revised in 2010.

For more detailed information on connectivity to this secure website, go to: Connectivity Guide [PDF 160 KB] & Connectivity Instructions for States [PDF 75 KB]. Personnel at your site responsible for data submission or contracting may already be familiar with the process of connectivity to CMS data systems. It is important that the Medical Director be very familiar with this site, if not an active user.

The HPMS data portal is at http://gateway.cms.hhs.gov. Users must already have been granted CMS access before using the site. Passwords expire every 60 days and must then be changed.

Following are specific points related to the collection and entry process:

a) Each PACE organization (designated by an H number) is granted access for as many users are necessary to submit and review data.

b) Those users must be trained to submit manually, no mechanism for automated uploads of data is available. Sites may designate a specific person for the entry of all data, or this task might be divided among several staff.

c) Some of the data domains are aggregate totals that are calculated by the site from its own collection system and entered (e.g., immunization aggregates, medication errors, falls).

d) Some areas require the entry of each individual circumstance (for example, each grievance, appeal, emergency room visit). No patient identifiers are submitted, but a plan may wish to create a unique flag that is placed in the individual HPMS entry and links it back to the program’s internal data.

e) The data must be submitted quarterly, no later than 28 days AFTER the end of a calendar quarter (e.g., April 30 is the deadline for the January to March Quarter).
- An exception to this is the influenza immunization data, which is collected over the 6 months of the flu season, and is reported once annually at the end of the second quarter (Jan thru March). Aggregate data is submitted for the period from October 1 thru March 31. All of this data is thus due by the end of April of that year.

f) The HPMS Help Desk is available at 1-800-220-2028 for technical assistance on the use of the web portal of general questions regarding the reporting of PACE data elements

The data elements required for submission as noted in the HPMS PACE Users’ Guide—Fall, 2005, span the following areas:

1) GRIEVANCES AND APPEALS
2) ENROLLMENTS
3) DISENROLLMENTS
4) PROSPECTIVE ENROLLEES
5) READMISSIONS
6) EMERGENCY (UNSCHEDULED) CARE
7) UNUSUAL INCIDENTS FOR PARTICIPANTS AND THE PACE SITE:
   (The following are categories of “unusual incidents”)
   
   Falls at Home
   Falls in the Adult Day Health Center
   Falls while Getting into the Van
   Van Accidents other than Falls
   Participant Suicide or Attempted Suicide
   Staff Criminal Records
   Infectious or Communicable Disease Outbreaks
   Food Poisoning; Fire or Other Disasters;
   Participant Injury that Required Follow-up Medical Treatment
   Participant Injury on Equipment
   Lawsuits
8) PARTICIPANT DEATHS

The submission format for each of these data areas is specified in the User Guide, and will not be addressed here. However, there are several important points for the Medical Director:

1) The manner in which the data for the various elements is collected and aggregated for submission is left to the PACE organization to develop. The Medical Director and leadership staff should carefully construct their program’s operational workflows and processes for each data element.

2) Further, the leadership should ensure the validity of its submitted data, and that the data submitted is reflected in organizational performance improvement data that can be referenced easily for comparison. CMS looks to see that an organization uses this information in its performance improvement plans.

3) Each organization should internally document in it operational policies and procedures, and be prepared to describe, its methods for collecting, validating, and submitting the data from each area.

4) Note that data is submitted for each individual site (or center) in a program. The digital portal provides entry areas for each site that the organization designates as its sites of care.
5) Several different staff members may be responsible for the collection and monitoring of different data elements, but the organization should create a central mechanism to insure that timely and valid collection of all data occurs.

6) The PO should incorporate the HPMS activity into its quality assessment program—reviewing the data with all organizational and center staff for which it is relevant, and use the information to enhance organizational workflows and processes. It is assumed that HPMS data is only a subset of a larger array of performance improvement initiatives that comprise the annual performance improvement plan.

**DataPACE 2**

DataPACE 2 (DP2) describes PACE nationally, identifies site variations and offers opportunities for improvement. DataPACE is a data collection program that seeks to describe the PACE enrollee and demonstrate the effectiveness of the PACE model. The original DataPACE was initiated in 1990 as a locally installed software-based product. DP2 (in operation since 2007) is an internet-based service. All POs can access DP2 data as part of their NPA membership privileges.

Complete DP2 Training Materials are available in the “Members Only” section of the NPA website (www.npaonline.org).

**Components of DP2**

1. **Data Sources**

Data Sources include RAPS (Risk Adjustment Processing System), HPMS (Health Plan Management System), HOS (Health Outcomes Survey) and MARx (Medicare Advantage
and Prescription Drug) system and claims data. Fortunately, the PO is already generating these federally-required reports, so no extra effort at primary data collection is required.

2. Data Elements

A Data Element is an individual/single field of relevant collectable data from participant/program records (i.e. enrollment date, date of birth, disenrollment reason). A Crosswalk is a database device used as an intermediate tool to insert data from unique/custom PO data files into the unified DP2 database.

3. Measurement Sets

Data is organized into three distinct categories;

a) Participants served: describes the age, gender, race/ethnicity, health profile and payer source of the participant as well as the acuity and frailty indices.

b) Quality: reports customer satisfaction, safe and effective care and quality of life.

c) Service utilization: fully describes every possible service the participant receives including encounters for primary care, specialists, therapists, social workers, skilled home care, and personal care. Counts hospital and nursing home days, PACE center attendance, transportation trips, average number of prescriptions and meals.
Level Two Reporting & Management for PACE

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Introduction
PACE organizations are required to report unexpected incidents that result in serious adverse participant outcomes or negative national or regional notoriety related to the PACE program. These incidents are defined by the Centers for Medicare and Medicaid services (CMS) as “Level Two” events. The policy and reporting guidance was released in 2010 and replaces the prior 2004 Sentinel Events Reporting Policy. By doing so, CMS has discontinued the use of the term “sentinel events” and has replaced it with a reporting paradigm that distinguishes between Level One (HPMS reporting elements) and Level Two external reporting to the CMS Central Office (CO), the Regional office (RO) and the State Administering Agency (SAA). The full Reporting policy and guidance may be found at:
Level Two Reporting

The definition of a Level Two event includes:

- incidents that lead to death;
- injuries, including falls, resulting in hospitalization of five days or greater;
- injuries for which the determination is made within 48 hours of permanent loss of function;
- Stage III, IV or unstageable pressure ulcers;
- adverse drug events that result in serious injury or fit the criteria for reporting under the FDA’s Medwatch program;
- elopements of greater than 24 hours or those that result in a serious outcome;
- food-borne infections that affect three or more participants;
- equipment failures that result in serious injury;
- suicides;
- negative media-related events; and a catch-all

- adverse outcomes: serious, undesirable and unexpected outcome of participant’s care or treatment that is not otherwise listed, that meet the thresholds of hospitalization greater than five days or an expected permanent loss in function realized within 48 hrs of the event.

The Policy and Guidance document provides a table with details for reportable incidents, addressing each type of incident or outcome that may trigger Level Two reporting. It is important to note that reporting by the PACE organization (PO) does not assume fault or error on the part of the PO or providers. In the past, there was often reluctance on the part of the POs to report events they felt “were out of their control.” The goal of the revised guidance is to foster reporting of unexpected outcomes that adversely affect participants or the organization, regardless of degree of organizational control over the process. The purpose of the Level Two reporting is NOT to assign blame or accountability, but rather to allow CMS and the SAA to be aware of such events and to have the PO explore the incident in more detail and identify potential future safety risks or opportunities to improve the process of care and service delivery. Thus the reporting of such events is not limited to incidents that occurred at the PACE center. For example, if a significant event
results in serious harm or death of a participant in an acute hospital or nursing home, the
PO may well look to the facilities’ own internal investigation and reporting process – but
would still want to gather as much information as they could for reporting to CMS and the SAA. This is a change from prior CMS guidance, where such events that occurred within acute hospitals were reported through the hospital’s patient safety process.

When an incident meets a Level Two reporting threshold, the PO must complete the following:

1) Within 24 hours (or next business day) of determining the threshold for Level Two reporting has been met, notify CMS via e-mail at the dedicated PACE mailbox (pace@cms.hhs.gov) and copy the SAA and the RO.

2) Undertake an internal investigation of the incident. This investigation must be initiated within one business day of reporting and must be concluded within 30 days of reporting the incident. In most cases it is expected that the PO’s investigation will include a root-cause analysis (as described in the Policy and Guidance Document). It may be that the PO feels that a root cause analysis is not indicated for the event. If so, the PO is to consult promptly, by telephone, with its CMS RO Account Manager. Together they will determine if such an analysis is appropriate or unnecessary.

3) Notify CMS, with a copy to the SAA and RO, that the internal investigation is completed.

Some POs have expressed concerns about liability and risk management when documenting a Level Two incident. It is important to document in the PACE medical record all participant-specific events such as the nature of the injury, the interventions, or changes in treatment plan. The documentation should include a simple statement of the event (e.g., participant suffered third degree burns over both lower extremities up to the knee as a result of a house fire), assessment findings, diagnoses and treatment plans. However, any statements as to causality, care quality, contributing factors or care delivery deficiencies do NOT need to be included in the medical record and should be recorded in a separate quality assurance file related to the investigation. State discovery
procedures and freedom of information laws vary with regard to protection of peer review data, with which each PO should be familiar.

While the CMS policy stipulates mandatory reporting of an event, the goal of the policy is not about assigning blame for the specific event. The policy is best viewed as an effort to align practices in POs with a national effort to improve patient safety.

There are a number of beliefs in the patient safety canon, which include: a) identification of the errors that occur; b) analysis of each error to determine the underlying factors -- the "root causes" -- that, if eliminated, could reduce the risk of similar errors in the future; c) compilation of data about error frequency and type and the root causes of these errors; d) dissemination of information about these errors and their root causes to permit health care organizations, where appropriate, to redesign their systems and processes to reduce the risk of future errors; and e) periodic assessment of the effectiveness of the efforts taken to reduce the risk of errors.

Included in the patient safety canon is the belief that reporting and aggregating data will lead to systems improvements that will make patients safer. Central to these beliefs is that the reporting of severe adverse events, of which one can view Level Two events as a subset, needs to be blame-free and protected. Thus, there is a conflict between viewing Level Two events narrowly with attached mandatory notification and viewing the events broadly as part of an effort to identify broader system trends resulting in system redesign.

The revised policy is intended to resolve this conflict towards a broader view.

For the PO, but not for CMS policy, the conflict also extends to “near misses,” events where a Level Two event would have occurred, but for fortune. An example would be a PACE participant who was given a medication intended for another participant because the pharmacy mislabeled the name, but who did not take the wrong medication because her alert daughter called and asked why a new pill was sent home. A “root cause analysis” of the events that led to the medication error would be appropriate, even though no harm occurred.
Root Cause Analysis

In conducting an investigation, the PO needs to identify what happened, the personnel, equipment and processes involved directly and indirectly in the event, and consider how the functioning of those resources might be modified (e.g., system redesign). While the policy suggests an interdisciplinary meeting after the data has been collected to review and explore system improvements, a number of PACE Organizations have found it useful to convene an interdisciplinary working group of the relevant participants in order to gather the initial information. The CMS policy identifies a number of questions that may be of assistance in conducting an intensive investigation, though they focus more on the “active errors” related to an event.

The CMS policy provides an outline for conducting a root cause analysis. The National Center for Patient Safety, an AHRQ-funded program housed in the Department of Veterans Affairs, has a number of cognitive aides and tools to assist programs in determining what occurred along with why the event occurred. These include developing an event-flow diagram (what), as well as a cause and effect flow diagram (why).

http://www.va.gov/ncps/CogAids/RCA/index.html

http://www.va.gov/ncps/CogAids/Triage/index.html#

The first center has diagramming aids; the second center has a set of triage questions to help focus on the relevant domains for finding relevant latent errors.

There is a substantial amount of basic work on the causes of accidents and errors from a variety of settings that underlie the patient safety movement, which, in part can be viewed as attempting to apply this work to the health care setting. As with most areas of specialized study, a vocabulary has developed to support work within the paradigm. This vocabulary may appear as jargon to those not in the field. However, a few of the terms provide useful insights into conducting a “root cause” analysis. The Patient Safety
Paradigm’s view of errors and adverse events does not necessarily map directly to root causes.

**Latent Errors vs. Active Errors**

Within the Patient Safety Paradigm, there is recognition that errors will occur. Errors are viewed as the failure of a planned action to be completed as intended (an error of execution) or the use of a wrong plan to achieve an aim (an error of planning). Attention in post-event investigations often focuses on “active errors,” which occur at the level of the front line operator (what someone or something did to “cause” the harm). The front line operator is often termed the “sharp end” of a causal chain of errors. “Active errors” very often (although not always, as in the case of equipment failure) involve actions committed by humans. There are several types of active errors, including slips, lapses, and violations. “Slips” are when someone performs an action not as planned, while “lapses” are when someone fails to remember to perform an action. For example, not checking a patient’s allergy profile before prescribing an antibiotic would be a lapse, while prescribing an antibiotic to which the patient was allergic (because the checked profile did not include the allergy) would be a slip. Thus, slips tend to be observable, whereas lapses are noticeable for their absence, and harder to detect. “Violations” occur when the rules, or procedures, are not followed.

“Latent errors” are errors in the design, organization, training or maintenance that lead to operator errors. Their effects can be dormant in a system for lengthy periods of time, as they are often part of the design of a system or procedure. A virtue prevalent in health care is resourcefully working around barriers to “get the job done.” The need for a “work-around” is often a flag for a latent error.

In the Patient Safety Paradigm, adverse events are seen as the coincident occurrence of numerous errors, any of which individually would not have led to the adverse event. In this sense, the notions of “system failed” and “root cause” do not always mesh appropriately. It is only when all the errors have occurred that an adverse event occurs.
This view has sometimes been termed the “Swiss cheese” model of errors, because it is only when all the holes in the slices of Swiss cheese line up that harm occurs. In this view, latent errors are holes in the individual slices.

Charles Perrow has developed the acronym DEPOSE to characterize the domains one may wish to explore in reviewing the occurrence of numerous errors within a system. The elements are: Design, Equipment, Procedures and processes, Operator (humans), Supplies and Environment (what’s outside the system).

One common misconception is that if active human errors are identified, this “systems” view does not allocate responsibility. “Responsibility” is allocated in the familiar “blame and train” model, typical of health care, to the human at the sharp end of a causal chain. It is important for Medical Directors and others in senior management to realize that in
considering latent errors, they (or their predecessors) are the ones often responsible. Further, any “active” human errors occur in system-human interfaces. While fixing the human side may be an obvious approach, often redesigning the system side of the interface may result in more durable improvements. The conventional wisdom in patient safety has a hierarchy of actions of different strength. Weak actions tend to be “educational,” and focus on “fixing the person.” Intermediate strength actions tend to focus on improving system-human interfaces (such as checklists to make procedures routine). Stronger actions tend to re-design systems so that the “default mode” is the safer one.

This hierarchy is reflected in one of the “Five Rules of Causation” (Table 1) to be considered when conducting a root cause analysis: never stop a root cause analysis at a human factor. For example, at one PO, a member fell while boarding the van to go home, fracturing several ribs. Initial investigation focused on the diver’s “lapse” in not sufficiently assisting the member. More detailed review indicated that the “boarding procedure” had three tasks assigned to two individuals, a driver and an aide: a) getting members into line, b) tending to members in line, and c) assisting members onto the van. The incident happened when the aide was off doing (a), leaving the driver to tend both the line (where an oxygen-dependent member had trouble at the same time an unstable member was boarding). Rather than “train” the driver, the boarding procedure was revised so that one worker wouldn’t be left with the potential for two concurrent critical activities.

A further concern raised by the above case is the tendency for systems to revert back to prior practices through drift and inattention. In the above example, after several years, and increased pressures on transport and caregiver staff, the same conditions emerged (two staff for three tasks), which was subsequently remedied (when discovered as a latent error). This is not an uncommon occurrence, even with pure “engineering” solutions. At one teaching hospital, the “error” of having a tube feeding connector compatible with an IV hub, resulting in the death of a patient who received intravenous tube feeding, was “solved” by making the two incompatible. Over a decade of ordering tube and IV
connectors by different departments, they again became compatible, resulting in a second patient death. Not only was a narrow engineering solution needed, but a larger system engineering solution (coordinated specifications).

The area of violations brings challenges to the view of “blameless error.” “Violations” occur when the rules, or procedures, are not followed. A tendency is to view errors that occur due to violations as solely the responsibility of operator error, with the “corrective action” usually focused on the operator (“blame and train”). In review of a Level Two event, attention should not stop on identifying violations; the review should also consider the role of human interfaces, and the extent to which individuals adopt heuristics (that might have failed in the event under investigation) in order to navigate what may be unnecessarily complex rules. While a common outcome of a Level Two event investigation is to write new policies and procedures, this may often add complexity to the organization leading to other potential errors. In reviews of many “error analyses” in health care, the problem lay not in the procedures in place, but in the heuristics individuals used to apply (or not apply) the procedures. Furthermore, new complexity creates new opportunities for error and requires continued evaluation for new “latent errors” introduced into the system. Addressing the reasons underlying such heuristics, again, may result in more durable improvements.

The investigation of a Level Two event or potential Level Two event (a near miss) provides an opportunity for a PACE Organization to review its systems, not only to identify active errors, but also to identify latent errors, that may not have been involved in the index adverse event. These can be particularly opportune moments to effect system change, because of focus on system practice because of a Level Two event. At one PO, a frail, cognitively impaired woman fell and broke her hip in the lobby of a nursing home, waiting to be picked up by the PACE van. While the sharp end focused on supervision of participants in the facility, she was volume depleted (and significantly orthostatic) because of a urinary tract infection, with a limited number of effective interventions to correct her volume status available in that particular facility. Expansion of those options represented an important opportunity for durable intervention.
As organizations evolve in complexity, with new leaders assuming senior roles, these investigations can afford an opportunity to identify and correct by redesign such errors. The investigation, rooted in principles of the patient safety movement, also affords the Medical Director an opportunity to help advance a “culture of safety” within the organization. The key elements of such a culture include open communication across authority gradients, active use of that communication to identify “near misses” and responsiveness of the organization to re-design so as to avoid the latent errors identified by the “near misses.” While PACE is unique among health care settings in having a minimal authority gradient, other barriers to a “culture of safety” such as working around errors, defensiveness in review of actions and organizational resistance to change can be impediments. The Agency for Health Care Research and Quality has developed a benchmarked survey to assess dimensions of a patient safety culture within an organization. While no specific survey covers all the domains of care that PACE deals with, there are specific surveys for hospital care, clinic care, and nursing home care. The survey and benchmark data can be located at:

http://www.ahrq.gov/qual/patientsafetyculture/.

Cognitive Errors

The first decade of the Patient Safety paradigm focused on systems engineering. Recently, expanded attention has been given to cognitive errors, which do not fit as easily into an engineering paradigm. These “cognitive dispositions to respond” include a number of perceptual biases, inappropriate reliance on heuristics (or failure to recognize when a heuristic doesn’t fit) and anchoring biases. (See Croskerry for a comprehensive listing). PACE medical directors are in a distinctive position to identify and help remediate such errors, not only among primary care providers, but among all staff. Most interventions tend to be weak (education) to intermediate (decision aides) strength actions. While most such cognitive errors will not result in Level Two events, they represent a significant potential source of such events.
Summary

While mandatory external reporting of events or incidents that fall under Level Two reporting criteria may seem burdensome and intrusive, they serve an important role in safety and quality of care. By providing an organized and structured review, as described above, the PO may indentify “latent errors”, flaws in the design of care delivery and lead to a culture of improved focus on safety. The PACE Medical Directors are key leaders in this essential activity and should be involved in the investigation process, as much as possible, and be informed of the conclusions. It is often the Medical Director who can best help “translate” the findings into opportunities to improve clinical care.

Resources


Cliff Notes version:

Kohn L, Corrigan J, and Donaldson M, eds. To Err is Human: Building a Safer Health System, Chapter 3. Institute of Medicine, National Academy Press, Washington, D.C., 2000

PACE Level Two External Reporting Guidance Appendix A: Examples of Level Two reporting
PACE Level Two External Reporting Guidance Appendix B: Glossary of Terms
Agency for Healthcare Research and Quality http://www.ahrq.gov
  Clinical practice guidelines
  Preventing medical errors
  Quality care
  Safe care

Centers for Disease Control and Prevention http://www.cdc.gov
  Injury, violence and safety
  Older adults and seniors health issues
  Research publications

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Centers for Medicare & Medicaid Services
Quality initiatives and research

http://www.cms.gov

PACE regulations (42 CFR 460)
http://www.gpoaccess.gov/CFR/

Food and Drug Administration
Drug safety
Medical device and equipment safety
MedWatch reporting

http://www.fda.gov

Institute of Medicine
Aging issues
Healthcare and quality issues
Research publications

http://www.iom.edu

The Joint Commission
Participant safety
Root cause analysis process
Sentinel event alert reports

www.jointcommission.org

National Pressure Ulcer Advisory Panel
Research and guidelines on pressure ulcer management

http://www.npuap.org

National Institute of Aging
Research publications
Safety issues

http://www.nia.nih.gov

Institute for Safe Medication Practices,
http://www.ismp.org/

National Association of Boards of Pharmacy
Links to State Boards

http://www.nabp.net/

American Society of Consultant Pharmacists
LTC Pharmacists

http://www.ascp.com/

Department of Veterans Affairs
http://www4.va.gov/ncps/CogAids/RCA/index.html
National Patient Safety Center
Failure Mode Effect Analysis
Root Cause Analysis tools
Table I

The Five Rules of Causation

Rule 1: Clearly show the cause and effect relationship.
(i.e. If you eliminate or control this root cause/contributing factor will you prevent or minimize future events?)

Wrong: The home care nurse did not check on the member’s medication stock.
Correct: The home care nurses are used for limited, specific tasks, but are asked to follow a comprehensive set of activities when needed, without the aide of procedural checklists or other aides to prevent lapses in practice.

Rule 2: Use specific and accurate descriptors for what occurred, rather than negative and vague words. (i.e. Avoid words such as poorly, inadequately, haphazardly, improperly, carelessness, complacently)

Wrong: Poorly written manual.
Correct: The training manual was not indexed, used a font that was difficult to read, and did not include any technical illustrations; as a result the manual was rarely used and did not improve performance by the clinic staff.

Rule 3: Identify the preceding cause(s), not the human error. (i.e., never stop a causal chain at the human error)

Wrong: The driver failed to prevent a member’s fall while boarding the van.
Correct: The boarding procedure had two staff performing 3 critical functions, resulting in one function not being performed with all 3 functions were needed simultaneously.

Rule 4: Identify the preceding cause(s) of procedure violations.

Wrong: The nurses did not check for an order for a new medication before delivering the medication to a member from the pharmacy.
Correct: The filing system for new medication orders, and multiple processes for medication orders to get to the pharmacy, makes it unreliable for nurses to identify new orders, leading to violating this dispensing check at the Center.

Rule 5: Failure to act is only causal when there is a pre-existing duty to act.

Wrong: The home care nurse failed to have the patient to take his lactulose before he became encephalopathic.
Correct: The absence of an established procedure for renewal of “prn” medications led the patient to run out of his lactulose, become encephalopathic.

From the National Center for Patient Safety,
http://www4.va.gov/ncps/CogAids/RCA/index.html
CHAPTER 13

PALLIATIVE AND END-OF-LIFE CARE IN PACE

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Key points

- The PACE model has the essential elements for quality palliative and end-of-life care: an interdisciplinary team, a person-centered, holistic approach, comprehensive care planning and care delivery that meets a participant’s needs and supports family and caregivers.
- Advance care planning and identifying the goals of care are core practices in PACE.
- PACE organizations employ diverse approaches to providing palliative and end-of-life care that range from providing all services within PACE to collaborative relationships with hospice organizations.
- Measuring outcomes is an essential feature of assuring quality in end-of-life care in PACE.

Introduction

PACE serves frail elderly persons who are eligible for nursing home care. Frailty may be a result of multiple chronic medical conditions, cognitive impairment, or dependence on assistance for activities of daily living (ADLs). Federal regulations require PACE programs to meet all health care needs from the point of enrollment until disenrollment due to death or other reasons. Research has shown that the majority of PACE participants experience a prolonged trajectory of gradual decline in function in the year
before they die.\(^1\) This implies that by early recognition of irreversible decline, the PACE Interdisciplinary Team (IDT) has the opportunity to develop a palliative care plan for the majority of participants. Most participants remain enrolled through the dying process, the PACE organization meeting their care needs directly or in collaboration with contract hospice providers. On average, participants are enrolled in PACE for approximately four years prior to death. Across PACE organizations nationally, the annual death rate averages 13 percent.

The goals of PACE are closely aligned with those of palliative care, “to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs, and practices.”\(^2\) The palliative care model can be pictured as a continuum with an increasing emphasis on symptom relief and decreasing emphasis on curative care as a life-threatening condition progresses. Outside PACE, most patients receive palliative care services through their primary care physicians or through episodic consultation with a palliative care specialist or hospice team.\(^3\) In the PACE model, the same primary care team is able to shift the goals of care to palliation when appropriate and continue to manage the participant’s care through the dying process.

The National Consensus Project in 2009 updated the Clinical Practice Guidelines for Quality Palliative Care which serve as benchmarks for evaluating end-of-life care.\(^4\) These include patient and family-centered care, timing of palliative care, comprehensive interdisciplinary care, attention to relief of suffering, effective communication skills, skill in caring for dying and bereaved, continuity of care across settings, equitable access, and quality improvement. The PACE model practices these essentials of excellent end-of-life care and is able to provide a seamless transition to palliative goals by the same interdisciplinary team. The frequent contact with participants and the emphasis on prevention facilitates early recognition of irreversible decline. An emphasis on advance care planning assures that participants’ preferences are honored and prevents unwanted hospitalization and interventions.\(^5,6\) Integration of financing and care delivery in PACE
encourages creative care planning and removes obstacles to assembling needed services. For example, PACE programs are able to begin palliative care services even when the prognosis is likely to exceed six months, overcoming a major limitation of the Medicare Hospice Benefit.\textsuperscript{3,7}

There is a high degree of family involvement in and satisfaction with end of life care in PACE.\textsuperscript{8} Dying at home has been described consistently as an important component of a “good death”.\textsuperscript{9,10} According to 2003 data for all PACE programs, 48 percent of all PACE enrollees die at home.\textsuperscript{11}

Federal regulations require PACE programs to meet all health care needs from the point of enrollment until disenrollment due to death or other reasons. While all PACE programs care for participants through the dying process, they vary in approaches to end-of-life care. Some programs contract with local hospices for some services for selected participants, while others provide all palliative care through their own IDTs. The following case studies illustrate a variety of approaches to end of life care in PACE.

\textbf{Models of PACE Interdisciplinary Teams Providing Palliative Care}

\textit{1. Providence ElderPlace, Portland: Palliative Care Program}\textsuperscript{8}

Providence ElderPlace in Portland serves 830 participants in five centers. On average, ElderPlace IDTs provide care for approximately 125 participants through the dying process each year. In 2008, 88 percent of ElderPlace participants who have capacity had appointed a Durable Power of Attorney for Health Care (DPAHC). In addition, 98 percent of participants had signed Physician’s Orders for Life-Sustaining Treatment (POLST) available in the event of an emergency. The POLST is a portable doctor’s order sheet that specifies the appropriate emergency response to decisions about CPR, endotracheal intubation, hospital transport, IV fluids, and feeding tubes.\textsuperscript{5} The original POLST form is kept with the participant and a copy is kept in the electronic medical record so that it is accessible at all times to the participant’s PCP or physician on call.
For 85 percent of ElderPlace participants, the POLST specifies “do not resuscitate (DNR).” Fifteen percent of participants prefer comfort care and do not want to be transported to the hospital, 68 percent would want limited hospital interventions to reverse an acute illness, and 17 percent would want full hospital interventions, including ICU, if appropriate. A preference for no tube feedings is expressed by 45 percent of participants.

In 2002 ElderPlace developed and implemented the Supportive Care Program (renamed Palliative Care Program in 2008), a model for improving end-of-life care. The Palliative Care Program recognizes three phases of decline that precede death for most frail elderly participants. Stage 1 is a period of functional decline identified by specific criteria that persists despite evaluation and interventions to reverse it. Stage 2 is organ system failure, dementia, or failure to thrive that follow hospice guidelines for predicting a 6 month prognosis. Stage 3 is active dying. When an IDT member recognizes that Palliative Care may be appropriate for a participant, the primary care provider (PCP) verifies that the participant meets criteria for a particular stage and desires a shift to palliative care goals. If so, the primary care team meets with the participant and family to develop a palliative plan of care appropriate to the stage and overall health status.

The goals of a palliative care plan are to ease physical and emotional symptoms, support function and autonomy, address spiritual needs, prevent inappropriate medical interventions, support family and caregivers in caring and in bereavement. Each palliative care plan is consistent with the participant’s preferences, cognition and function, and underlying conditions. It is routine to revisit the POLST and advance directives when the goals shift to palliative care. Some participants in Stage 1 or 2 still wish to be hospitalized when an acute illness appears reversible, while others may opt strictly for comfort care at home. The PCP documents the basis for the decision, the criteria, and the care plan in the electronic medical record and places “Palliative Care Stage 1, 2 or 3” at the top of the medical problem list for easy reference.
The same care team, including PCP, primary nurse, community care nurse, social worker, and chaplain continue to care for the participant after the shift to Palliative Care in the same residential setting as long as his/her care needs can be met there. ElderPlace works closely with contracted residential care and assisted living facilities and adult foster caregivers to develop skill and comfort caring for people through the dying process with support from ElderPlace staff. A Steering Committee oversees the Palliative Care Program, initiating improvements and staff education as needed.

ElderPlace monitors outcomes to evaluate end-of-life care for participants. These indicators include the percentage of participants receiving palliative care at the time of death, hospital and ICU admissions in the last year of life, location of death, and family satisfaction with end-of-life care. All deaths are peer reviewed by PCPs to evaluate the quality of care, both the prevention of untimely deaths and the quality of palliative care when death is expected.

2. Hopkins ElderPlus End of Life Program

Hopkins ElderPlus (HEP) in Baltimore serves 135 participants in one center. In 2003, HEP designed a performance improvement initiative around end-of-life care. They developed a structure for providing end-of-life care directly by the PACE team. HEP staff developed protocols, policies, information notebooks, and comfort care bags to use as tools to guide team members, participants, and caregivers. They opened a Comfort Care Suite for end-of-life care at an assisted living facility that HEP operates. They added a chaplain to the IDT and educated their staff about issues related to advance directives, signs of active dying, pain management, mobility, nutrition and hydration at the end of life.

The HEP Comfort Care Policy defines eligibility for comfort care as either terminal diagnosis or team consensus that over two quarters, six of 11 criteria are met: continuous decline, decreased appetite, weight loss, social withdrawal, increase in functional dependence, frequent hospitalizations, PACE-at-home status, decreased Braden score,
increased sleep, biweekly clinic visits, emotional and spiritual distress. The policy assigns specific responsibilities to key team members. For example, Intake staff members ask for copies of advance directives and provide an Advance Directive Guide. The PCP introduces the concept of comfort care to participant and caregiver, if appropriate, and documents health care proxy, code status, and other preferences for end-of-life care, including location of death. The social worker reviews preferences regarding a health care agent and works with the participant and/or agent on funeral planning. The chaplain completes a spirituality assessment.

Once a Comfort Care Plan is in place, the PCP completes comfort care orders and makes home visits as needed. The nurse implements comfort care orders and the plan of care, instructs participants and caregivers about symptom management, orders equipment and makes home visits as needed. Social work facilitates a family meeting to discuss the comfort care plan and gives the family the comfort care guide and kit. The comfort care bags contain objects such as relaxation tapes and aromatherapy, as well as a photo sleeve and journal to promote comfort and connectedness for the participant and caregiver, life review, and relaxation. Both chaplain and social worker assess the participant’s and caregiver’s emotional and spiritual needs and intervene as needed, including home visits monthly or as needed. Recreation and rehabilitation staff members provide interventions as specified in the plan of care.

Interdisciplinary team members share thoughts and feelings after a death in the morning meeting. The IDT sends a sympathy card. Social work provides bereavement counseling for less complicated cases and makes referrals for more serious bereavement issues. The chaplain periodically provides IDT bereavement counseling and collaborates with social work on the family/caregiver post-death survey. Recreation staff coordinates an annual memorial celebration for participants who have died in the previous year.

HEP measured improved outcomes, including percent of participants who reported that they were comfortable talking about death, and the percentage of participants who wanted to include loved ones in end-of-life care decisions. They also observed
improvements in the percentage of caregivers who had discussed end-of-life issues with HEP staff, were aware of loved one’s wishes for end-of-life care, and felt satisfied with end-of-life care. After the initiative, the percentage of participants who died in nursing homes decreased due in part to the availability of the Comfort Care Suite. Other measures included improvement in staff skills, knowledge and comfort providing end-of-life care and palliative care planning. HEP reviews all deaths as part of their ongoing improvement plan.

3. Palmetto SeniorCare

Palmetto SeniorCare in Palmetto, South Carolina, serves 360 participants. Their Comfort Care Committee identified the need to develop a uniform process for assuring that comfort is always a goal of care, identifying a specific time of transition to comfort care, and providing comfort care within the context of the long-term supportive and caring relationships their IDT develops with participants.

The committee established written practices for end-of-life care. The foundation with the participant is established early by clarifying health care wishes, documenting a values history, providing education about illness and the PACE process, and developing relationships of trust. All decisions and care planning are guided by the principle of ensuring comfort from the start. This is accomplished by assessing and discussing the benefits and burdens of all proposed interventions, considering participant values, medical issues, social framework, and logistics. It also includes goal setting as part of each care plan and developing an emergency care plan for each participant.

Excellent communication between IDT, participant and caregiver is essential, as is choosing the appropriate location for care. The IDT, which includes a chaplain, provides assistance with funeral planning, visitation after death, and burial. Bereavement support includes a home visit with remembrance from staff as well and anniversary visits, calls, and cards. Staff receive bereavement support within the IDT, may attend the burial, and participant in an annual PSC Memorial Service.
PSC provides for ongoing evaluation of participant satisfaction with end of life care and pain management. They also review all deaths to evaluate whether end of life care was consistent with the participant’s wishes. They have found that having a formal process prevents overlooking details, that building a support system before it is needed works best, and that thinking about a comfort care plan that is not contingent on code status is most person-centered. Challenges in providing end-of-life care within the PACE IDT include limited after hours resources, working with participant’s and caregiver’s spiritual resources, and the frequency of ethical dilemmas. Providing excellent end-of-life care increases demands on team resources.

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While participants cannot be enrolled simultaneously in both PACE and hospice, CMS does allow PACE organizations to contract with hospice organizations for “non-hospice” services, such as pain and symptom management, education, and bereavement services for PACE participants. Many PACE organizations have developed unique working relationships with local hospice programs to provide these specialized services when participants have a need for such expertise. Special considerations come into play when a PACE organization is considering contracting with hospice.

Because the average length of stay in PACE is approximately 4 years, PACE interdisciplinary team members form very close working relationships with participants, their families and caregivers. Disenrollment from PACE to enroll in hospice could result in loss of Medicaid community-based services and possible admission into a nursing home, as well as loss of continuity of services and care providers within the PACE program. Therefore, it is in the best interests of participants to make state-of-the-art palliative care available as part of the comprehensive package of PACE benefits. PACE organizations consider the capabilities of hospice and PACE staff to provide palliative care services, as well as other factors, in deciding whether to contract with a hospice or to provide those services internally.
Case Studies: Models of PACE – Hospice Collaboration

1. Providence ElderPlace, Seattle

Providence ElderPlace in Seattle contracts with one local hospice. They pay a negotiated rate per diem for a range of services as needed. These hospice services, called the “PACE Comfort Care Benefit” by ElderPlace, include availability of a nurse as a clinical consultant to the PACE IDT, as well as 24-hour on-call nursing, chaplain, bereavement and volunteer services.

The PACE team maintains care management responsibility. When this arrangement is initiated for a participant, the PACE home health nurse and the hospice nurse make a home visit together and the hospice nurse documents enough information so that the on-call hospice nurses are able to respond appropriately as needs arise. A high level of communication is maintained among the IDT members and the hospice team via email, facsimile and telephone conversations. The PEP-Seattle team has also developed comfort care kits containing information for families and caregivers, as well as standing orders. The availability of 24-hour nursing has made it possible for more participants to die in their own homes. In 2008, 81 percent of deaths occurred in the participant’s residence; the remaining 19 percent were hospital deaths.

On Lok, San Francisco

On Lok in San Francisco currently serves 1,040 participants in San Francisco, Fremont and San Jose. When the end-of-life care needs of a participant exceed the capacity of On Lok’s home care nurses and in-home health workers, they contract with community-based hospice organizations. The contracts may be for specific services, such as RN or LVN care in the evenings or weekends for pain and symptom management, or the contract may be for full hospice care, if the needs of the participant cannot otherwise be met. The contracts vary, based on the requested service and needs. The structure ranges
from an hourly rate, when only specific RN or LVN services are needed, to a per diem rate for full hospice care. The On Lok IDT retains responsibility for primary care when participants are receiving contract hospice services. On Lok provides all medications that are not covered as part of the hospice package for treatment of a terminal condition.

While On Lok has contracts with 4 hospice providers, one particular program is used almost exclusively. In 2008 there were 14 hospice contracts, 9 were for partial or specific services, and 5 had the full hospice program. One challenge that On Lok has faced involves state regulations for residential care facilities. When a participant is in such a facility (commonly referred to as a board-and-care home) and they are on a terminal trajectory, the facility MUST have a licensed hospice provider involved in the care of that person. On Lok has been able to work many of these facilities to assure them that the PACE model does cover whole-person end-of-life care. However, when that is not successful, then a hospice contract is pursued in order to avoid requiring the person to move to a different setting in the last days of life.

*Elder Service Plan of the North Shore, Boston*

Elder Service Plan (ESP) of the North Shore in Boston contracts with one local hospice for selected participants who need specialized care. The contract specifies a daily rate that includes the full outpatient hospice benefit, including home health services, DME and medications that pertain to the dying process. The hospice nurse reports back several times weekly to the PACE team. The PACE team stays involved by continuing to address needs and supplement the hospice team’s provisions.

For participants who are dying in a hospital or skilled nursing facility, ESP North Shore uses the services of the palliative care consultant from the same hospice. The hospice then bills ESP on a consultant fee basis. The hospice contract also has a provision allowing participants and families access to a grief center, where additional grief counseling is available. ESP serves nearly 500 participants and enrolls approximately 10 participants per year in hospice. In most cases, ESP provides end-of-life care directly through their interdisciplinary team and does not involve hospice.
Summary

The majority of PACE participants are cared for by the PACE interdisciplinary team through the dying process. The goals of PACE are closely aligned with the goals of palliative care. The PACE model allows for early identification of irreversible decline, palliative care planning, and a smooth transition to end-of-life care. Advance care planning, family involvement, and in-home services allow a large percentage of PACE participants to die in their homes. When more specialized palliative care services are needed, PACE programs have the option of contracting with hospice providers for those services. The continuity of care that PACE provides makes it a unique model for excellence in end-of-life care.

References


CHAPTER 14

Medical Records

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- PACE requires a comprehensive Medical Record for each participant
- The EMR planning and implementation process has several basic components
- PACE Medical Directors play an integral role in the Medical Records process

§ 460.210 Medical records.
(a) Maintenance of medical records. (1) A PACE organization must maintain a single, comprehensive medical record for each participant, in accordance with accepted professional standards. (2) The medical record for each participant must meet the following requirements:
   (i) Be complete.
   (ii) Accurately documented.
   (iii) Readily accessible.
   (iv) Systematically organized.
   (v) Available to all staff.

Purpose of the Participant Medical Record

All PACE programs utilize a highly integrated interdisciplinary team (IDT), consisting of physicians, nurses, social workers, therapists and others involved in the care of PACE participants. While this team-based approach offers tremendous benefits to participants, it requires an efficient method for compiling information within a common record, allowing members of the IDT to coordinate activities, maximize efficiency and maintain ongoing
communication. PACE Medical Directors must be skillful at creating, revising and evaluating the components of the medical record.

**Contents of the Participant Medical Record**

The medical record should contain sufficient information to identify the participant, justify the treatment, support the diagnoses submitted for risk-adjustment purposes and eligibility for admission to the program, document the participant’s progress, note results of treatment, and promote continuity of care among health care providers. All notes should be properly signed and dated using a unique identifier for the primary author.

All interventions should be recorded in the medical chart. This includes direct patient encounters (initial assessment, re-assessment, routine and urgent visits), plans of care, individual and group sessions, phone calls, receipt of messages, correspondence with contractors and caregivers as well as the enrollee and team discussions. Primary care providers and other professional staff should document all relevant conversations with caregivers and participants whether they are in person or by phone. Results of contracted services such as labs, imaging, diagnostic tests, and consultations, emergency room and hospital records must also be included.

**Team Communication**

A great deal of critical decision-making results from team communication. This may occur in regular settings (such as daily morning meetings or weekly IDT meetings), or in more spontaneous exchanges between disciplines. Medical Directors should participate in all efforts to encourage and structure the optimal method for documenting these efforts. Documentation of team decision-making and its justification is helpful for everyone involved. Because there is typically such a deliberative process that seeks to ensure fair and appropriate use of services and products, it is important that PACE
programs have captured that effort. Specifically, it is important that the terms “team process” and “team discussion” be used when appropriate.

Support for Coding Decisions (Financial)

Excellent documentation in the participant’s record is not just important for care management, it is also vital to the financial status of the program. Risk-adjustment for Medicare capitation is based on medical diagnoses given to a participant. These diagnoses (submitted to CMS as ICD-9 codes) must be properly documented in the record. Audits are conducted by CMS to specifically evaluate the adequacy that documentation and deficiencies may lead to adjustments in capitation or other effects.

Optimal coding depends on clear and comprehensive documentation, and all codes submitted must be linked to a discrete encounter. It is clear that justification of diagnostic codes submitted to CMS for HCC risk-adjustment is a challenge to providers. It requires specific mention of the severity and inter-connectedness of all related conditions. For example, clinicians must specifically document the causal relationship between diabetes and renal insufficiency in order to code for diabetes with renal complications.

It is also important to document the status of conditions, even if they are relatively asymptomatic. For example, depression that is not symptomatic but is managed by ongoing counseling or drug therapy should be documented as such, allowing for proper coding.

Medico-legal

PACE programs, like other medical providers, are vulnerable to certain medico-legal risks. As has been well documented, one’s risk for lawsuits is not well correlated with poor care (or “malpractice”); awards are more highly correlated with adverse outcomes. The best protection for providers is clear and comprehensive documentation. This allows
for a recording of the clinician’s thoughts and actions as they happened, regardless of the outcome. Timely entries that are properly dated and timed are also critical.

**Quality Improvement/Internal Audit Process**

The Medical Director plays a pivotal role directing the PO’s Quality Assurance Program Improvement (QAPI). Many aspects of QAPI pertain to proper documentation of activities and care. It is important to incorporate the significance of documentation into any QI initiative, not only for the purpose of tracking and benchmarking, but also to be certain that outside reviewers can understand the successes of any initiatives. The PACE Organization (PO) should have an established internal auditing process for medical records. Audit criteria could include items such as signing and dating entries, completing required assessments and care plans, documenting advance directives, and including appropriate records from nursing homes, consultants and hospitals.

**Research**

Research is an important part of the PACE mission. It is an important way to demonstrate successes and weaknesses of the model that will allow for continual improvement. Many research projects will involve review of existing records. The accuracy of these findings depends on proper documentation throughout the record. For example, completion of routine re-evaluations allows researchers to utilize these documents for monitoring certain aspects of participant’s care through periodic collection of data. Incomplete or intermittent recording of this information is problematic for research purposes, as well as patient care.

**Electronic Medical Record (EMR)**

Most PACE programs are either using EMR or considering it. There is intense interest from the Obama Administration to implement EMR for outpatient and hospital services.
The 2009 economic stimulus bill directs $17 billion through CMS to assist EMR implementation for providers and hospitals. Starting in 2011, providers and hospitals can receive financial incentives for “the meaningful use of a certified EHR” (1). CMS also plans to fine providers who have not implemented EMR by 2015. The Institute of Medicine has identified information technology as one of the principal ways to improve quality of care. Despite strong interest from lawmakers and regulatory agencies, it is estimated that only 17 percent of providers and 10 percent of hospitals have even basic EMRs (Blumenthal D. Stimulating the Adoption of Health Information Technology. NEJM 2009:360:1477-79).

There is no single EMR product that is suitable, available and affordable for every PACE program. There are, however, basic components of the planning and implementation process that would apply to most PACE Sites. The Medical Director plays an integral role in the process regardless of the EMR product used. Expected benefits from EMR include: enhanced communication and records access, easier auditing, ability to create reports for clinical and quality studies, improved data submission to regulatory agencies, and legible records.

(See Figure 1 Sample Electronic Medical Record Timeline, special thanks to Joanne Townsend, SeniorLink QAPI coordinator, for creative assistance)

Planning

1. Request for Proposal (RFP)

In recent communications, CMS has strongly indicated that PACE plans should not utilize multiple medical record systems (i.e., a combination of paper and electronic). PACE plans should take this into consideration when formulating their RFP, ideally including all IDT members as users. An RFP should, at a minimum, include the complete scope of work expected during the project including hardware and software needed,
training expected, and the cost of on-going licensing fees, estimated number of users and support. PACE plans should include enough information on their RFP to allow vendors to submit a complete proposal. Some planning with the PACE team should be conducted prior to submitting the RFP to ensure a comprehensive RFP can be completed. Completion of a Return on Investment (ROI) analysis of the EMR project can be helpful in securing financing for the project.

2. **Vendor Selection/Contract Signed**

PACE plans should investigate any EMR systems their sponsor organizations are currently utilizing. The Certification Commission for Health Information Technology (CCHIT) is a private organization that provides standards for the EMR industry. The American Medical Association, American College of Physicians, and American Academy of Family Physicians endorse the CCHIT certification process. CCHIT certified EMR’s can be found at: [http://www.cchit.org/choose/ambulatory/08/](http://www.cchit.org/choose/ambulatory/08/). A minimum of two vendors should be evaluated on a cost and quality perspective. Look for flexible software packages that can meet the needs for every discipline, as opposed to those that focus too much on primary care.

3. **In-house Support and IT Teams Identification**

It is helpful to establish one in-house team member (at SeniorLink this is the Medical Records Manager) to take the lead on the EMR project. Ideally the in-house support team includes at least one member from each department/discipline. IT support will likely come from offsite, either from the vendor or the PO’s sponsoring organization.

4. **Basic Computer Skills Staff Training**

Basic computer skills training are essential for any staff that is not comfortable with using a computer. Offer basic computer training as early as possible, realizing there may be a
large number of middle-aged staff that had no exposure to computers during their formal education.

5. **Hardware Infrastructure**

A comprehensive inventory of hardware needed should be completed prior to sending out the RFP. Factors to be considered include desktop configurations, wireless configurations for on-call staff and conference rooms, etc. A spreadsheet outlining all the hardware needs is useful in keeping track of the cost and location of needed hardware.

6. **Software Configuration**

In-house support and IT need to work with each discipline, creating templates that meet their specific documentation needs. The templates need to be flexible enough to capture all the required data elements for demographics, assessments, re-assessments, and ongoing care encounters. Workflows assist users in effective systems use (see Figure 2).

7. **EMR Staff Training**

EMR staff training should be implemented prior to going live with the system. A schedule of training should be established for all users. Try to time this training right before the activation date.

8. **Interface Identification/Records Abstraction**

The EMR must be able to interface with all key outside data sources including scheduling, labs, imaging, pharmacy, medical records, billing, and coding. The Medical Records department will require scanners for the initial abstraction of the existing paper chart as well as scanning of future paper records received. The Medical Director can assist in identifying key records in the paper charts that need to be abstracted.
Implementation

1. Hardware Installed

Hardware installation should be completed with the assistance of the vendor and the organizations IT department personnel.

2. Software Deployed/Testing

Software deployment and testing is completed just prior to activation. The in-house team may need to make final adjustments to ensure a smooth transition to the EMR system.

3. Activation

Understand that activation will be stressful! Attempt to provide a fun and relaxed environment and allow yourself a few glitches.

It is critical that the PACE leadership team, the EMR vendor, and IT personnel are on hand and available during activation to provide support to the PACE team during this critical period. Activation can be implemented in stages by department or by center, depending on the size and capabilities of the PO.

4. Ongoing In-house Support Team

In-house support needs to meet on a regular basis, evaluating and “trouble-shooting.” Staff members need to feel comfortable going to their support person. Medical Directors can play a supporting role for providers as well as other clinical staff.
5. Ongoing IT Support Team

The vendor contract should clearly outline the amount and scope of on-going support. Staff should have ready access to the IT support personnel. Once implementation is complete, ongoing meetings to both problem solve issues and enhance the EMR system are necessary. Re-training should be on an as needed and individualized basis. EMR training should be included in the orientation of all new users.

6. Quality Assurance

EMR has the ability to generate data reports that facilitate the PO’s QAPI program. Medical Directors can strengthen their quality initiatives through EMR -generated data for clinical outcomes such as falls, wound care and infection control. One of the CareLink QAPI indicators for 2009 was smoking cessation education for all diabetic smokers. Tracking this type of data prior to EMR would have been quite burdensome. Working with IT staff to create a smoking cessation “order” was much easier with an EMR.

A Word of Caution About Over-documentation

It’s tempting to create a voluminous, depersonalized flow of mostly useless information in an EMR, with just a few clicks of the mouse. There’s nothing more frustrating than reading through a multi-page history and physical exam (HEENT, CV, ABD, etc) template for a focused problem like “foot pain” and still not find any useful information about the foot. Most EMR systems fail to incorporate protections against incorrectly using “shortcut tools” (a normal pelvic exam can be inserted effortlessly into a male patient’s record with a click of the wrong shortcut). PO’s need an effective auditing process to ensure focused and accurate documentation.
Presentations on EMR

It’s helpful to see how individual PACE sites have tackled the EMR implementation task. Five presentations at recent NPA Annual Conferences are listed below; please refer to the conference CD to review the presentations. *A common theme of these presentations is the need to budget and staff appropriately for training, implementation, and ongoing support.*

- “EMR - Not if…But When and What?,” Community Care Inc. and Providence ElderPlace, NPA 2006
- “PACE and the Selection of an Electronic Health Record,” ONLOK NPA 2007
- “Case Study: Selecting and Implementing a Comprehensive EHR Solution for a New PACE Program,” LIFE St Francis NPA 2007
- Electronic Record Implementation: “Strategies and Lessons Learned from Those Who Have Been There,” LIFE at the University of Pennsylvania NPA 2008

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OCCUPATIONAL THERAPY WORKFLOW AND ORDER TRANSMITTAL

Figure 1/TriHealth SeniorLink

Participant requires OT therapy

Participant in clinic

Participant Need via telephone message

Provider places order

Team Lead places order

Send

Send one report to Team lead

Send one report to OT pool

OT therapy
Sample Electronic Medical Record Timeline

**PLANNING**
- RFP
- Vendor Selection / Contract Signed
- In-house Support and IT Teams Identification
- Basic Computer Skills Staff Training
- Software Configuration
- Interface Identification / Records Abstraction
- Software Deployed / Testing
- Hardware Installed

**IMPLEMENTATION**
- EMR Staff Training
- Ongoing In-house Support Team
- Ongoing IT Support Team
- Q.A.
Chapter 15

Education in the PACE Environment

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There are essentially three important aspects of education in the PACE environment:

- Using PACE as a training center for students in the various disciplines represented in PACE
- Training other PACE providers
- Providing ongoing training opportunities for PACE staff

Students and Trainees

The richness of the PACE environment is evident in the educational opportunities that the organization consistently provides. The frailty of PACE participants requires a great variety and depth of pathology – individual illnesses, geriatric syndromes, both typical and atypical presentations of disease. Furthermore, because of the continuous and comprehensive nature of PACE care, students can follow the course of an illness through multiple stages and can appreciate its impact across a broad spectrum, from caregiver to participant to friends, from hospital to nursing home to assisted living to home, and from disease specific symptoms to functional impact of the disease process. As one of the most comprehensive interdisciplinary team models of care, PACE is an ideal environment not only to learn geriatric content, but also team skills and processes.

There are several challenges to teaching in PACE. Foremost of these is the combination of informal and formal interactions, which can increase the difficulty of scheduling. The
extensive nature of the care giving network can also pose challenges because of the need to utilize information from so many sources. In addition, the relative intimacy of the relationship between PACE families and providers may make the role of the student more difficult, in that the student may be perceived as an outsider.

Despite the challenges, the advantages are overwhelming and the Palmetto Senior Care (PSC) PACE Organization has offered educational rotations for medical students, residents and fellows, nursing students and nurse practitioners, social workers, pharmacists, public health students, and various rehabilitative specialists. The content of these rotations is a mixture of several areas, namely general discipline specific content, geriatric content, team skills and process content, and exposure to interdisciplinary quality improvement processes. Developing this curriculum is an important part of the process and is addressed below.

The rotation will most often be based at the PACE center, but may also utilize affiliated facilities and the home environment. Each of these environments has its own requirements for student credentialing and oversight.

The following section provides a step-by-step guide to processes PSC has for student rotations.

- The first step is to establish an administrative relationship between the PACE Organization and the student learner’s home institution. In the simplest case, PACE can piggyback onto an established affiliation agreement. For the PSC program, as part of a hospital system with several established affiliation agreements, this has been the most common route. When this is not available, the program needs to establish another formal mechanism. This provides needed structure for registration, reporting, evaluation, supervision, and other aspects of the rotation, and establishes the framework within which other tasks must be accomplished. As a general rule, agreements with broad terms allow greater
flexibility in building rotations and can sometimes be used for multiple disciplines. Key issues to address in the agreement include:

- Timing of the rotation, including dates and hours for the student to be present
- Clarification of the student’s role at the PACE Organization, which may include responsibilities, need for supervision, and level of independence
- Type of oversight to be provided by PACE
- Level of involvement of the home institution (Some institutions may send a preceptor with a group of students)
- Any financial considerations
- Nature and timing of evaluations

Once an administrative framework is in place, identification of the preceptor/mentor and rotation coordinator is needed. These are the individuals who will carry out the more detailed planning, oversight, communication, evaluation, and problem solving required for the rotation. These roles may be combined in a single person, or separated among two or more staff members. Sometimes the student’s institution sends a preceptor, which reduces the work for PACE staff but may also limit the educational experience since these preceptors may have limited understanding of the PACE model. Whether this is a problem depends on the level of the student(s) and the goals of the rotation.

- The next step is to define goals and objectives for the rotation. This is best carried out cooperatively involving staff from both PACE and the student’s institution. The goals and objectives typically involve a combination of knowledge and skills, and hopefully will lend themselves to pre- and post-testing. They should be defined in writing and presented to the student learners no later than the start of their rotation. It is imperative that the goals and objectives address any accreditation requirements from the student’s institution and be sure that they are reasonable for the length of the rotation and the current level of training of the students.
The mentor/preceptor needs to have or develop teaching methods based on the PACE environment and the established goals and objectives.

- The next step is developing an adequate orientation program. If an orientation program is already in place for volunteers, this is a good place to start since many of the same issues must be addressed (e.g. overview of PACE, HIPPA requirements, physical layout, off-site activities, and parking), but must also include details related to: access to charts and participants, supervision, documentation, reporting, and discipline specific issues. This is also the opportunity to customize the rotation based on the learner’s personal needs and objectives and pretest results while not compromising any mandatory requirements.

The learning experience itself is typically the most straightforward part of the process. Immersion in the PACE team, awareness of goals and objectives, and an open mind are usually more than adequate to assure a successful PACE experience. Periodic review of progress (every 1-2 weeks) will allow for early recognition and correction of any problems.

- An evaluation of the student should take place at the end of the rotation. This should be multi-phased, and include a post-test developed from the goals and objectives, as well as the preceptor’s evaluation of the learner’s performance, knowledge, skills, and attitude. It should also include input from all team disciplines with which the student interacted and input from the participants and caregivers. The student should have an opportunity to evaluate the preceptor and both should evaluate the rotation itself. The students’ evaluation of the rotation and of their experience can then feed into the center’s Quality Improvement program, providing valuable input from another perspective.
Technical Assistance

Much of the approach used for students and trainees applies to training staff from emerging PACE centers. The administrative framework is simpler, and is generally part of the technical assistance agreement. The contact time is shorter and focused on more discreet objectives that are identified prior to the visit. Accreditation testing is not an issue, although feedback remains critical for both sides. Finally, the goal is generally related to understanding program operation and process, not specific participant care issues.

Staff Education

Continuing education for PACE staff is a separate issue. It involves combining discipline-specific needs for performance, licensing, and/or certification with program needs usually identified as part of the quality improvement process. These needs are met with some combination of program wide in-services, center-based learning opportunities, and outside seminars. There are several resources within the program to help meet these needs, including professional PACE staff. In larger healthcare systems, the system usually offers a range of educational resources. Developing a program that identifies educational needs, coordinates resources to meet those needs, and monitors results is an important educational aspect of comprehensive quality improvement, and thus another responsibility of the Medical Director. Furthermore, the Medical Director has an important role in establishing an ongoing, informal learning environment where members of each discipline educate members of other disciplines. This mutual education occurs at team meetings and in casual encounters, and contributes to the richness of the PACE Center environment and to the satisfaction of PACE staff.
CHAPTER 16

Research

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Key Points

- Research involving PACE is conducted at the program level as well as the national level
- Since the origin of PACE, data collection has been a priority, starting with “DataPACE” and continuing today with DataPACE II
- The National PACE Association (NPA) plays an important role in promoting research activities through its committees and data coordination efforts

Types of Research Within PACE

1. Traditional

There is a long history of research within PACE that has followed the traditional approach to research whereby a question is asked, a hypothesis is created, a specified methodology and analysis are followed, and conclusions are drawn from study results. Many of these studies have been published in respected, peer-reviewed journals. A select bibliography of PACE research can be found at the end of this chapter.

Funding for original research is critical and has been somewhat of a barrier to research within PACE. It takes time to write grants to obtain funding and often this is not possible
for providers busy with clinical and other administrative duties. Often, PACE providers and clinicians have collaborated with researchers to conduct studies. Some research has been supported by external funding, such as the National Institutes of Health (NIH), while some has been funded by smaller foundations. Another route of support is directly from individual PACE programs, including “sweat equity.”

Many of these research projects involve analysis of patient and program-level information from data sets, such as DataPACE (discussed later in this chapter). Historically, PACE has been a good source of data for its specific enrollee population, i.e., frail, nursing home eligible, older adults. This has attracted researchers who are interested in analyzing data which describe this population.

When any research involves direct contact with patients or patient data, approval from a local Institutional Review Board (IRB) is usually necessary. Most PACE sites do not have their own IRBs and, therefore, rely on affiliated institutions that do.

### 2. Quality Assurance

Because all PACE programs are committed to improving care, one important activity is to evaluate the quality of service by measuring outcomes. This is often done at the local (program-specific) level but also has been done at the national level. Through this quality assurance process, programs use data to define areas of strength and weakness, and work toward better outcomes. DataPACE and DataPACE 2 have served as the established sources of data for this purpose. The use of this data to evaluate care and measure outcomes is essentially research on a smaller scale. Many PACE programs and professionals have presented this type of work at national meetings, including the annual meeting of the NPA.
3. Patient Care Experiences

Another form of “research” activity involves the descriptions of certain care scenarios and how care is provided within the PACE model, such as case presentations or case series. These are often very valuable ways to illustrate how certain interventions or care plans have been associated with particular outcomes at the program-level. Sharing this type of knowledge with others through publication or presentation at NPA’s Annual Meeting is another way that PACE providers can share expertise and increase awareness of PACE within the larger health care community.

NPA Committees Involved in Research

Research evaluating the PACE model is important to providers within PACE organizations, as well as scholars and policy-makers outside of PACE. Certain NPA-level committees have the potential to engage with research activities in different ways and to foster new ideas for research. The Research, Education and Primary Care Committees all have a direct role and opportunity to contribute to research activities. Specifically, members of these committees are responsible for identification of important aspects of care provision that warrant evaluation and analysis, as well as dissemination of findings to PACE providers and the larger scientific, policy and provider communities. Membership on these committees is approved by the NPA Board of Directors.

The Research Committee is dedicated to promoting research activities originating from within the PACE network, as well as those conducted by outside scholars. Membership on this committee is through nomination by PACE programs, with final approval by the Board of Directors. Communication within this committee is primarily through email, as well as conference calls. A meeting also occurs in conjunction with NPA’s Annual Meeting. Recently, a research proposal review process has been adopted within the Research Committee, as well as a mechanism to encourage collaboration and manuscript preparation.
The *Primary Care Committee* (PCC) plays a key role in development of “Best Practices” and other care standards that should be evaluated. In recent years, members of the PCC have developed “Best Practices” for the management of congestive heart failure (CHF) and diabetes. These important documents have the potential to alter practice and outcomes within the PACE population and thus warrant evaluation.

The *Education Committee* coordinates several activities (including the Annual Meeting and the PACE Learning Series) that strive to present the most current scientific/scholarly information (typically based on research in peer-reviewed literature). This serves to promote the “translation” of research to direct care of PACE participants.

**Sources of Data**

Because PACE is a unique model of care delivery and is funded primarily through capitation by the Medicare and Medicaid programs, there has always been an emphasis on the need for data to demonstrate benefit and value. In response to a mandate from the Centers for Medicare and Medicaid Services (CMS) for PACE program data collection and submission, On Lok established “DataPACE” in 1989. This effort was supported by a grant from the Hartford Foundation.

1. **DataPACE**

   During the PACE “demonstration phase” (1990-1998), CMS required that all participating programs collect and submit data to a central data repository referred to as DataPACE (DP). Data elements included: participant demographics as well as clinical and functional characteristics, services provided to participants, as well as utilization measures (including hospital and nursing home days). These data were primarily used by CMS to monitor the care provided by PACE programs and later to convey the benefits of the PACE model from both clinical and policy perspectives. An important method of conveying this message of benefit has been through analysis of this data by researchers.
DP I has been the source of data for many important studies and publications\(^3,9\)-12,15-18,20,22-24,27,31,35. Initially, these data were available only to PACE providers and investigators directly affiliated with PACE programs (see history). In 1998, data from DP I became available in the public domain. For a small fee, outside (non-PACE affiliated) investigators were able to obtain this data and evaluate various aspects of PACE.

After PACE achieved “provider status,” there was no longer a requirement that data be submitted to CMS. As a result, participation in DP declined significantly. Validation of the data was also no longer required or monitored. As a result, data collected after 1998 has not been used widely for research purposes. However, until 2006, NPA continued to make available “cross-site comparisons” of data submitted to DPI to contributing PACE organizations.

2. DataPACE 2 (DP2)

Although DataPACE participation by PACE programs declined significantly after mandatory submission ceased in 1998, the NPA Board and membership recognized that a systematic process for data collection describing the PACE model was necessary. Hence, plans for DataPACE 2 (DP2) were initiated in 2003, with the proposal endorsed by the NPA Board of Directors. The goals for DP2 have been to: support performance improvement (PI) efforts & research and provide information for advocacy.

Participation in DP2 by individual programs is voluntary. Although programs are not “required” to submit data, financial support for DP2 is included in annual NPA membership fees for all PACE programs. While “participation” (submission of data) is voluntary, it is strongly encouraged by the NPA Board of Directors and technical support is provided by NPA staff. One interesting exception to voluntary submission of data to DataPACE is when its submission is required by state agreement (as is the case for PACE organizations in Louisiana, Pennsylvania and Virginia).
Generally speaking, the DP2 measurement set is designed to answer the questions:

- Who do we serve?
- What is the quality of care?
- What services do we provide?
- Is the PACE organization growing?

The primary data domains for DP2 include:

- *amount of medical “acuity”* (e.g., numbers of medical conditions, degree of cognitive impairment);
- *census/growth data* (e.g., enrollments, disenrollments/deaths);
- *falls*;
- *institutional utilization* (e.g., admissions to skilled nursing facilities and psychiatry units);
- *rates of certain medical conditions* (e.g., diabetes, hypertension, depression);
- *predictors of morbidity and mortality*;
- *measures of quality of life*;
- *satisfaction*; and
- *behavioral health indicators*, as well as several other domains.

PACE programs that submit data are able to access the data and compare themselves to other programs. This allows for benchmarking and quality improvement initiatives. It also has great potential as a data source for research purposes. DP2 provides “program-level” data in most areas, as well as the potential for some “participant-level” data (diagnosis information from Risk Adjustment Payment System information as well as medication information from Prescription Drug Event information). Important DP2 concerns at this time include: comprehensiveness of the data (percentage of participants included) and accuracy of the data (validation of the accuracy by individual sites after data have been submitted). These issues are being addressed by NPA staff; a sustained commitment by PACE programs to minimize these concerns is required.
3. PACE Data Analysis Center (PDAC)

Participant-level diagnostic information is submitted to CMS to establish capitated payments under Medicare. Since 2004, PDAC has been invaluable in helping PACE organizations understand their experience under the CMS-HCC risk adjustment model. With implementation of Part D in 2006, PDAC expanded its efforts to include analyses of Part D payments, risk scores and Prescription Drug Event (PDE) data submissions. Through PDAC, PACE organizations and NPA have been able to understand changes in key payment variables over time and compare the experiences of PACE organizations. PDAC analysis has been instrumental in helping PACE organizations identify areas to improve upon in the risk adjustment data collection and submission process and in identifying discrepancies in CMS payment calculations. There is also potential to use these data for answering important research questions regarding PACE and payment methodology.

History of Research Involving PACE

Since the inception of the National PACE Association (NPA) in 1994, research activities have been integral to the strategic priorities of this organization. The NPA Board of Directors has always been responsible for approving membership on the Research Committee.

In the early years, membership on this committee included established researchers in health and social sciences and public policy, such as Leonard Gruenberg, PhD, who had published widely on policy and health care services utilization in nursing homes and community-based demonstrations such as Social Health Maintenance Organizations. A second group exemplified by Helena Temkin-Greener, PhD, from the University of Rochester shared similar interests in public policy and saw the potential of PACE for important primary research. A third group of early committee members were physicians practicing in PACE organizations with affiliations in established academic geriatrics programs eager to study clinical issues that were specific to the PACE population. This
latter group of pioneer PACE clinician researchers included G. Paul Eleazer, MD, Darryl Wieland, PhD, and Carlton Hornung, PhD. from the University of South Carolina Medical School.

Clinicians were drawn by the wealth of clinical data found among PACE programs and by the geographic and ethnic diversity of PACE enrollees. These researchers utilized the demographic data gathered in DataPACE and supplemented this with primary data gathered by collaborating clinicians across PACE sites. This coordination among PACE clinicians was no small feat, considering that most clinicians were focused on keeping their clinical programs alive and growing in the early 1990’s. The period 1994-1998 can be considered the “grass-roots” research era during which there was no formal funding, a lot of ideas and an incredible amount of drive. There was also a great deal of collaboration in writing papers for publication. Research was motivated by the desire of clinicians to study, define, and disseminate information about the uniqueness of the PACE healthcare delivery system and the PACE enrollees. The target audiences were both health policy experts and the medical establishment.

During the period of 1994 to 1998, the NPA Board’s compelling agenda was to transition PACE from a demonstration program to permanent status under the Medicare and Medicaid programs. To do this, NPA and its membership had to influence policy makers through written work and publications in peer-reviewed journals. DataPACE was an invaluable source of data. These activities contributed to PACE’s achievement of permanent status as a Medicare provider and voluntary state option under Medicaid with passage of the Balanced Budget Act of 1997. DataPACE, research and publications in respected journals made a significant contribution to the passage of this legislation.

The medical establishment was more difficult to influence, but there were breakthroughs here as well. Under the leadership of Dr. Paul Eleazer of Palmetto SeniorCare, PACE research broke through with a publication on the relationship between ethnicity and advance directives in PACE in the Journal of the American Geriatrics Society in 1996.
Dr. Catherine Eng of On Lok and other PACE medical directors published the seminal policy article on PACE in the *Journal of the American Geriatrics Society* in 1997.

In 1998, after passage of the PACE provider legislation in 1997, the Research Committee set the following priorities for the subsequent years:

1) revisiting the background of PACE primary care physicians to determine what characteristics they have, what attracts them to PACE, and what retains them as PACE primary care providers;
2) comparing PACE to other/external, non-PACE organizations/programs;
3) studying the applicability of clinical pathways and protocols to the PACE population;
4) studying programs’ adherence to preventive health guidelines;
5) studying the use of advance directives, place of death, compliance with health wishes;
6) Grade of Membership (GOM) research; and
7) studying implications of Medicare rate setting methodology and alternatives.

These were very ambitious priorities, and there was not enough horse-power or money to rev up the research engine. With so many “priorities,” the energy there was dissipated. Consequently, only a few of these objectives came to fruition. The ideas that did gain traction were again from the policy perspective, such as the Medicare rate setting methodology and its effect on PACE. Clinical research faded to the background. In retrospect, a fundamental flaw was the lack of coordination between the Research Committee and the Primary Care Committee (PCC). The latter is a membership committee, comprised of PACE Medical Directors and a few non-director primary care physicians. The focus of the PCC became one of identifying key elements of PACE practice with the goal of helping new PACE organizations develop primary care services. During this period of time, there was a rush of new sites resulting from the passage of PACE provider legislation. Again, site start-up, growth and survival took precedence over research activities. There was, however, a natural intersection of the two
committees: PACE preventive health guidelines. This intersection of interests still holds promise for clinical research in the future.

In 1998, DataPACE entered the public domain and became accessible to researchers at large. One research group which took a keen interest in DataPACE centered at University of California – San Francisco, Division of Geriatrics. This group was led by Kenneth Covinsky, MD, a lead clinician researcher in the SUPPORT study, in collaboration with Catherine Eng, MD at On Lok Senior Health Services. The UCSF group, which included faculty and geriatrics fellows based at the San Francisco VA Medical Center, became prolific in analyzing DataPACE and published its findings during the period 1998-2002. Another group, centered at the University of Rochester School of Medicine, led by Susan Friedman, MD and Helena Temkin-Greener, PhD, also analyzed DataPACE and focused on quality of life and end of life care.

In 2002, the NPA Board revised its Bylaws and eliminated the research Committee as a standing committee of the Board. It was a move to streamline the Association’s operations and to re-allocate staff resources. The Board’s commitment to research has remained undiminished, however. It was at this juncture that movement began, under the leadership of PCC chair Kirk Panneton, MD, and his successor, Adam Burrows, MD, to coordinate the activities of the PCC and the Research Committee. Several joint meetings have been held.

Since 2004, the Research Committee has been under the leadership of Matt McNabney, MD, a clinician researcher at the Johns Hopkins School of Medicine and Medical Director of the Hopkins’s Elder Plus PACE program. Efforts were made to energize this committee in a way that would generate research ideas and manuscripts from within the community of PACE providers, as well as outside researchers. The strategies of the current research agenda are: 1) improving communication on research issues; 2) “jump starting” collaborative cross-site research; and 3) supporting and promoting each PACE organization’s research capacity as a means to improve quality of clinical care.
The past ten years have seen PACE transform from a demonstration program into provider types under both the Medicare and Medicaid programs. PACE has drawn new clinicians and researchers into its fold and has extended spheres of influence in multiple diverse arenas. There is now a critical mass for original clinical investigation of the PACE population. This presents a rich context for clinician-researcher collaboration.

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CHAPTER 17

Community Physicians in the PACE Program

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Key Points

- Consider whether your PACE Organization benefits by including community primary care physicians in the practice
- Be knowledgeable of the CMS waiver requirements for inclusion of community Primary Care Physicians (PCP’s) on the Interdisciplinary Team (IDT)
- Be knowledgeable of the Medical Director’s oversight role for community PCP’s

As the PACE program has grown, the model has adapted to different situations, such as rural settings and staff shortages. One situation that can arise is the desire of a PACE Organization (PO) to occasionally work with contracted community Primary Care Physicians (cPCPs.) This approach may come about for a various reasons:

- The PO may open a site in a rural area, or in a competitive market where there are not enough resources to hire a full-time or part-time physician; or
- PACE staff-employed physicians might not have admitting privileges at the local medical system where a new PACE site has opened up.
These circumstances may lead a PO to ask CMS to grant a waiver from PACE regulations, allowing it to use community physicians.

When developing a model that includes the use of community physicians it is important to be aware of the PACE regulations and develop a program that will meet these requirements. In addition the PO needs to make sure that the use of community physicians will lead to the same quality and financial outcomes that the traditional PACE staff model has demonstrated.

The 1999 PACE Regulations (Federal Register, Vol. 64, November 1999 pages 66234-66304) required the PACE multidisciplinary team to serve primarily PACE participants (§460.102(d)(3)) and include employed primary care physicians (§460.102(f)(1)). However, §460.102(g)(1)(i-ii) allowed waivers to these regulations. In the 2006 Final PACE regulations (Federal Register, Vol. 71 December 8, 2006, pgs. 71244-71337), these sections were replaced with § 460.26 and §460.28, which details the waiver submission process and requirements related to CMS review of waiver requests (pgs. 71254-71257).

CMS was explicit in describing waivers for use of contract community PCP’s on the PACE Team (http://www.cms.hhs.gov/PACE/Downloads/finalreg.pdf Federal Register 71(236) page 71256 December 8, 2006):

“Although we have permitted the use of community-based PCPs, we require that effective and consistent communication be maintained. Whenever we have received a request for waiver pertaining to use of community-based PCPs, the PO has had to provide in-depth justification and meet our conditions for waiver. Among other conditions for waiver approval, the community-based PCP must perform all the requirements of the staff PCP including but not limited to participation in IDT meetings related to their participants’ participation in Quality Assurance and Performance Improvement (QAPI) activities and agree to PO oversight by the medical director.”
The PO that contemplates the use of cPCPs must obtain the necessary waivers. The requirements include: justification of the need, policies and procedures on selection and orienting cPCPs to the PO, practice protocols including attendance of IDT meetings, and participation in QAPI activities. The guidelines in this chapter provide a roadmap for requesting waivers and implementing the inclusion of cPCPs in PACE once the waivers are approved.

There are many ways that a PO can integrate cPCPs in practice. There are currently three PACE programs utilizing these waivers: Community Care (CC) in Milwaukee, Chronic Care Management (CCM) in Metropolitan New York and On Lok in the San Francisco Bay Area. These POs can be resources for others. Each organization has taken a different approach. At CC, the NP plays an important bridging role. At CCM, advance practice nurses and a provider relations staff play a similar bridging role. On Lok uses a staff geriatrician and a nurse practitioner to play coordinating and consultation roles.

The outcomes of incorporating cPCPs in PACE practice are encouraging thus far. With the PO’s Medical Director providing close oversight, the quality of care appears to be high. As expected, the utilization of acute care and other medical services can be high initially, but ultimately can be controlled. IDTs and cPCPs have generally favorable impressions of this practice arrangement (Reardon et al, 2008).

Most PACE programs agree that having an employed staff physician is still the “gold standard” for quality and utilization. For that reason, it is very important that a PACE program first develop a staff model with an employed physician, before requesting waivers and developing a community physician model. In this way, the PO is able to establish benchmarks for quality, clinical, and financial outcomes to which the cPCP approach can be compared.

The role of the Medical Director is also very important here. Because a community physician serves as the PCP, there will need to be additional oversight and
communication with that community PCP. The organization should set up Policies and Procedures that carefully outline how the community PCP will work with the organization. These policies should outline how the cPCPs will work in their role as PCPs, how they will relate and interact with the IDT, and how they will collaborate with NPs (if the organization uses them). The policies should also designate an employed physician to be part of the IDT on all teams with cPCPs.

**Roadmap to Requesting Waivers and Incorporating cPCPs into a PACE Organization**

Examples of some of policies and protocols that the organization may want to develop include:

1. **Selection of the physician (or group of physicians)**

The criteria for choosing cPCPs to contract with are similar to those for hiring employed staff physicians. These include:

- Excellent clinical skills that cross all aspects of medicine
- Comfortable with outpatient care and in-patient medicine
- Outstanding skills in assessing information from specialists and deciding how to integrate the information into the participant’s plan of care
- Adept at communicating with colleagues, team members, and administration
- Able to relate to others on the team as peers, combining confidence with humility

The PACE Medical Director must also be aware of the practice style of the group or organization from which the contracted physician comes. Each physician practice is
different as to how they work together, how they cover for each other and take calls. In addition their clinics may operate differently. It is very important to understand all of these differences as not all practices or physicians are comfortable with the team approach to care. As such, it is vital that there should be a shared vision of the role of the physician with the team. The cPCP must be willing to work in a team approach and be willing to communicate with the NP and IDT as needed.

2. **Items to Discuss with the cPCP Prior to Contracting with Them**

   1. Shared mission and vision of physician role, holistic and team approaches
   2. Negotiation of fees for participant visits, team meetings and other potential team and NP interactions
   3. 24 hour access to cPCP from team and participant

3. **Orientation Plan for the cPCP and Coverage Group**

   1. Orienting the physician to the PACE model of care, your organization, and their responsibilities.
   2. Need for regular ongoing interaction between the cPCP, Medical Director and the IDT.
   3. Orienting the physician’s office staff to the PACE model and team and developing effective means of communication.

4. **Protocols for how the cPCP and IDT will work together**

   1. Develop a protocol for sharing clinical information and maintaining a complete PACE record, as well as for giving critical information to the physician for their medical record.
      a. PO maintains a comprehensive medical record and shares all pertinent medical information with the cPCP.
b. cPCP maintains their own medical record and provides PO with copies of all progress notes for physician visits and test results.

2. The cPCP needs to be part of the initial and periodic reassessments.

3. Evaluation and treatment of episodic illnesses in participants as needed.

4. Maintain 24 hour on-call responsibility.

5. Collaborative practice with the PO NP to provide all medical care for their participants.

6. Referral to medical specialists as needed and per PO guidelines.

7. Follow all PO screening and treatment guidelines.

8. cPCP will attend team meetings as needed to provide continuity of care.

9. Team meeting attendance in person or telephonically when their participant has a significant change in condition or treatment change is discussed by the I & A team.

10. Provide Acute Care and Nursing Home Coverage within their practice.

11. Consultation may be done with the physician in attendance or via telephone as needed to provide primary medical care.

12. All treatment plans, whether recorded in the progress notes or in periodic reevaluations are discussed with the physician at periodic intervals based on the acuity of the participant’s condition.

13. The PO NP and cPCP will assure that all PO protocols, guidelines, standards and Primary Care policies are followed.

14. Medical Director or site physician designee is available for case consultation as needed.

15. NP supervisors review cases with PO NP’s as needed and oversight quality care guidelines, adherence to PO policies for care, competencies and standards of practice for the NP’s who work with cPCP’s.
5. **Collaborative Practice Agreement for cPCPs and NP’s or other mid-level providers**

1. Develop a written collaborative Practice Agreement between the cPCP and the NP.
2. Certain conditions require the direct evaluation by the cPCP.:
   a. Any acute unstable medical condition.
   b. Acute myocardial infarction or severe chest pain.
   c. Gastrointestinal bleeding.
   d. Significant alteration in neurological status.
   e. Major trauma.
   f. Symptoms of an acute abdomen.
   g. Serious infections.

3. PACE NPs who work with cPCPs will be on a team with an employed PACE Physician who will be available for consultation and oversight as outlined.

6. **Employed PACE team physician/Medical Director Responsibilities for Oversight of the cPCP practice**

1. Employed PACE physician attends team meeting regularly and is available to review difficult cases as needed.
2. Discipline-specific QA review of the cPCP charts are done in conjunction with annual review and as needed to maintain quality and clinical outcomes.
3. Liaison with cPCP and team/NP as needed regarding difficult cases or treatment plans.
7. Writing the waiver request

The next step is to write the waiver request. This should incorporate the rational for why the PO is requesting the waiver along with the protocols and procedures that demonstrate how the PO will select and orient the physicians and define the practice protocols for team IDT attendance and participation in QAPI activities. The PO should also specify the number of physicians and sites they are requesting to be included in the waiver. CMS will then evaluate the request and possibly ask for additional information to make the determination.

Conclusion

Including community physicians in PACE primary care practice has rewards and challenges. A PACE Organization’s geographic location or need for further growth may be compelling reasons to seek CMS waivers to develop this practice. Once developed, the Medical Director is pivotal in monitoring quality of care and service utilization patterns.

References


CHAPTER 18

Ethical Issues in the PACE Model of Care

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• Federal regulations require each PACE Organization (PO) to establish an Ethics Committee, though the regulations do not fully define its role and responsibilities.
• Ethical conflicts encountered frequently in PACE can be organized into three broad categories: autonomy vs. beneficence, advocacy for PACE participants vs. responsibilities to other parties, and involuntary disenrollment.
• As the PACE model grows, there will be an increasing need to develop familiarity, competency, and consistency in addressing the unique ethical issues that arise in the care of PACE participants.

PACE Ethics Committees

PACE Provider Regulations (PACE Final Rule 2006, Section 460.138) require POs to have an Ethics Committee with community input, but they do not otherwise specify the structure, composition, and role of the committee. The committee must address ethical decision-making, including end-of-life issues and implementation of the Patient Self-Determination Act of 1990, but the regulations are silent about other issues. In Massachusetts, four of the state’s six PACE Organizations, which together serve over 1400 participants in twelve PACE
Centers, address their regulatory obligations and consulting needs and through a joint Ethics Committee.

The joint Massachusetts PACE Ethics Committee is composed of official members from outside the PACE community drawn from the fields of philosophy, law, nursing, and gerontology. In addition to the official committee members, administrative leaders and direct care providers from the four participating PACE Organizations attend the meetings and contribute actively to the discussions. The chair of the committee is a professor of philosophy at a local university who teaches courses on medical ethics; the chair assumes responsibility for educating committee members and PACE providers about ethical principles and approaches to addressing ethical conflicts.

Because PACE Provider Regulations are not prescriptive with respect to Ethics Committees, the Massachusetts PACE Ethics Committee enjoyed broad latitude in elaborating an approach to its responsibilities. The committee adopted the approach of providing a regular forum where PACE Teams could seek guidance and education about cases with which they were struggling. The committee recognized that this approach might introduce the possibility that PACE Teams would use the committee for care management consultation purposes. However, the committee felt that one of its important roles would be to help teams identify ethical conflicts that are often embedded in difficult management problems so that, over time, the teams would become more skilled at recognizing ethical issues. This outcome would enable PACE Teams both to address issues on their own and, when necessary, to seek appropriate guidance from the committee. In defining its role and approach, the committee also explicitly recognized the value of accompanying its recommendations with care management suggestions; this function is enhanced by the presence and active involvement of PACE clinicians on the committee.

The committee meets monthly and considers one case at each meeting, with PACE Teams rotating case presentations. In advance of each meeting, the presenting team distributes a summary of the case and the team’s ethical questions. The committee maintains participant anonymity in all written material and throughout all discussion. Meetings proceed through of
a sequence of case exposition and discovery, elucidation and refinement of the ethical issues, and open discussion. Members of the presenting team respond to questions and provide additional information as needed. The committee arrives at its conclusions and non-binding recommendations through consensus; on rare occasions when the committee cannot reach consensus, the official committee members are polled. It is the responsibility of the presenting team to communicate the recommendations of the committee to other members of their organization as well as to participants, families, and, when appropriate, other parties.

The Massachusetts PACE Ethics Committee serves several key functions. The primary function is to advise PACE Organizations and PACE Teams with respect to particular ethical conflicts. A second function is to help resolve disagreements that may arise among team members about the most ethically appropriate course of action, for example when the ethical obligations of one discipline are perceived to be at variance with the obligations of another, or when commitments to individual participants present concerns about organizational obligations to other parties. A third function is to establish consensus around common ethical dilemmas, such as when it might be appropriate for a PACE Organizations to involuntarily disenroll a participant. A fourth and vital function is to educate PACE leaders and team members about ethical principles, so that they become more aware of ethical issues as they arise and better able to resolve issues on their own.

Cases and questions cover the range of ethical issues faced in community-based long-term care. However, certain unique features of the PACE model influence the nature of the discussion.

**PACE Features and Ethical Implications**

1. **Mission**

PACE Organizations are mission-driven health care provider organizations that seek to enable functionally disabled adults who are at nursing home level of care to remain living in their home and communities. PACE team members are highly committed to this mission,
and participants enroll in PACE or are enrolled by responsible family caregivers because their goals align with the PACE mission. Thus, there is a strong bias toward community-based care among participants, caregivers, and providers, even in the presence of risk that might be less tolerated in other models (Burrows 2004). The approach to risk in PACE is negotiated among participants, caregivers, and providers at the time of enrollment and whenever there are changes in health status and social situation.

2. Financing

PACE Organizations are financed through pre-paid capitation and assume full financial risk for all aspects of care. PACE Organizations cannot bill for services or derive revenue beyond monthly capitation payments. PACE Organizations therefore seek to limit their reliance upon expensive institutional resources by reducing preventable hospitalizations and delaying or averting permanent nursing home placement. To this end, PACE teams generously deploy community-based resources, such as home health, day health, primary care, social support, preventive interventions, and rehabilitation services. Although PACE teams recognize that a greater intensity of resources will need to be targeted toward those in greatest need and at highest risk, concerns may arise about just and equitable distribution of limited resources and about program financial viability.

3. Enrollment

PACE regulations oblige POs to enroll all applicants who meet PACE eligibility criteria. PACE Organizations cannot deny enrollment based on medical complexity, psychosocial characteristics, or care needs. Furthermore, once participants enroll in PACE, they remain in PACE for life, unless they disenroll or move out of the service area. Because of the all-inclusive nature of PACE, PACE Organizations cannot shift care or costs elsewhere. In effect, PACE Organizations establish lifelong commitments to participants and families.
4. Team

The key element in the PACE service delivery model is the PACE interdisciplinary team (IDT). The IDT is the locus of care management, problem-solving, and resource allocation. Teams are composed of representatives from multiple disciplines with diverse educational backgrounds and professional status, yet, in theory and practice, decision-making is a collective responsibility. There remains, however, the potential for disagreement, conflict, and tension, especially around sensitive ethical issues. There is also the risk of hierarchical heavy-handedness and disregard for important voices (Temkin-Greener et al 2004).

5. Intimacy

Most PACE participants are socially isolated, and many lack involved family caregivers; 30 percent of PACE participants live alone. Through the functions of the PACE Center, PACE Organizations reconstruct a social environment and facilitate the establishment of new social connections and roles for its participants. Relationships develop among participants but also between participants and staff, and an unusual degree of intimacy develops between team members and the participants they serve. As a consequence, clinical and ethical decision-making can assume a strong emotional component.

6. End-of-Life

The average life expectancy for PACE participants from the point of enrollment is four years; the vast majority of participants remain in the program until death. Compared to other care systems, POs are very successful at anticipating and managing end-of-life care (Schamp and Tenkku 2006). In Massachusetts, over 90 percent of PACE participants have identified a health care proxy, and over 60 percent have had a documented discussion about their preferences with respect to resuscitation, mechanical ventilation, and feeding tubes (Massachusetts Executive Office of Elderly Affairs, personal communication). Nearly half of PACE participants die at home, compared to 21 percent of the Medicare population at large (Temkin-Greener and Mukamel 2002). PACE Organizations provide most end-of-life
care themselves, relying infrequently on contracted hospice providers. Thus, there is an unusually high degree of comfort and competency around end-of-life issues in PACE. As a result, end-of-life ethical dilemmas do not arise as often as might be expected for the population served.

**Ethical Conflicts in PACE**

Although every situation has its own unique clinical and social features, it is possible to organize the most common ethical conflicts into three broad categories.

1. **Autonomy vs. Beneficence**

A common ethical conflict in PACE, as in any model of community-based long-term care, is the tension between autonomy – the control of an individual over his or her destiny – and beneficence – the impulse to do good for others. In a health care context, autonomy is a right of patients and beneficence is an obligation of care providers. When well-intentioned care providers disregard the goals and preferences of those they serve, beneficence can become intrusive and look more like paternalism, with providers imposing their will upon others (Wetle 1995).

Conflicts between autonomy and beneficence typically arise around issues of safety and risk; they reach their clearest expression when a vulnerable elder wants to live at home while others believe that this choice carries unacceptable risks and that institutional care is necessary to optimize safety (Cooney et al 2004; Carrese 2006). Yet safety can be an elusive concept; as Rosalie Kane has written, “differing views of safety and its importance are at the root of ethical conflicts in long-term care.” (Kane 2002; Kane and Levin 1998).

Because PACE arose as a response to the preference expressed by older Americans to receive long-term care services at home (Mattimore et al 1997), there is a natural tendency in the PACE community toward respecting participant preferences and accepting some measure of risk. PACE organizations, by virtue of their flexibility in allocating resources, are also
uniquely capable of mitigating, if not eliminating risks, thereby reducing the potential for ethical conflict (Arras 1995). Issues arise, however, when participants lose the capacity to make fully informed decisions because of dementia or mental illness (Applebaum 2007). They also arise when consensus is lacking among caregivers or among members of the PACE team.

The following three cases illustrate the conflict between autonomy and beneficence as it applies to decisions about community-based long-term care vs. nursing home placement in the PACE context

**Case 1**

TI is an 84-year-old man with advanced dementia, autonomic dysfunction with possible Multiple System Atrophy, and visual loss from glaucoma who had consistently expressed an aversion to living in a nursing home and a strong desire to remain at home. TI lives alone in subsidized housing. His wife died shortly before his enrollment in PACE eight years ago. He has two daughters with whom he had been close in the past but who have become estranged more recently. When he was more cognitively intact, TI had selected one of his daughters as his health care proxy. TI requires assistance in all ADLs; he can only tolerate sitting for brief periods and had developed upper and lower extremity contractures. As his condition deteriorated, TI’s attendance at the Day Center was reduced and his home-based care plan was intensified with health aides three times daily. Nonetheless, the building management has expressed concern about TI living alone. After a health aide feared TI was having stroke and called 911, TI was hospitalized briefly at an out-of-network hospital that insisted on discharging him to a nursing home. When visited by the PACE team, TI appeared comfortable and content, but he became angry when informed that he was in a nursing home, insisting he was at home and demanding that he be allowed to stay there.

The PACE Team brought the following questions to the Ethics Committee: given that TI does not appear currently to be in any emotional distress, should the team keep
him at the nursing home or should his prior statements regarding nursing home placement be honored? Also, how should the estranged daughter and health care proxy be included in the decision-making process?

The Ethics Committee concluded that TI’s previous statements regarding nursing home placement, which were well-documented and consistent over time, functioned as the equivalent of advance directives, and, in the interest of autonomy, should guide decision-making now that he is unable to make informed decisions. However, the committee urged the PACE team to make every effort to include the daughter in the decision-making process and to obtain her acceptance of the care plan before proceeding with discharge to home.

Case 2

JA is an 80 year-old man with AIDS, diabetes, dementia, and a gait disorder. He lived in an apartment and received home services twice daily for personal care, meals, and medication reminders. JA did not have any involved family members and had few social contacts outside paid or volunteer caregivers. He displayed a long-standing behavioral pattern of embracing then rejecting caregivers and of accepting then refusing care interventions. This pattern of behavior led to unmet personal care and nutritional needs, multiple falls, and recurrent diabetic complications, resulting in a series of hospitalizations, after which JA would either return home directly or following short-term nursing home stays, with promises to accept care and support. However, it became apparent that JA was declining physically and cognitively as a result of these repeated episodes and that he was unable to change his behavior. After the last of his hospitalizations and subsequent nursing home stays, the PACE Team decided that JA lacked insight into the consequences of his behavior and that it was in his best interest to remain at the nursing home. JA was unhappy with this recommendation and repeatedly asked PACE Team members who visited him to allow him to go home. PACE staff were divided about how to respond, torn between their concerns for JA’s health status, which clearly improved at the nursing home with consistent meals, medication, and personal care, and their sense of obligation to respect JA’s wishes, despite the predictable consequences.
The PACE Team brought the following question to the Ethics Committee: this participant with impaired cognition in whom there is a well-documented history of adverse health consequences of living at home as well as evidence of beneficial health effects of living in a nursing home, how should the PACE Team respond to his request to return home?

The Ethics Committee, while acknowledging the mission of PACE to support at-risk older adults in their homes, was concerned about the ability of JA to make an informed decision about the risks and benefits of returning to the community. The committee recommended an independent assessment from a consulting psychiatrist about JA’s capacity to make this decision and, if he was found to lack capacity, to obtain a guardian who could make a surrogate decision on his behalf after reviewing the evidence and speaking with JA.

Case 3

VM is a 95 year old divorced woman with severe kyphoscoliosis, associated gait and mobility problems, hearing loss, and a long-standing delusional disorder. When VM was no longer able to live alone, she lived with a succession of relatives, eventually settling in with her grand-niece Maria and Maria’s two pre-teen children. After an initial period of peaceful coexistence, VM became increasingly paranoid and belligerent, accusing Maria of mishandling her money, food, and medications, Maria’s son of theft, and Maria’s daughter of sexual impropriety; the accusations were unfounded. The PACE Team tried to mediate disputes, address VM’s paranoia, and counsel VM to adopt better behavior; none of these measures were successful. Two years after moving in with Maria, VM developed an acute illness, for which she declined assessment or care outside the home. She suffered a major nutritional and functional decline, ultimately leading to the development of an end-of-life palliative care plan. VM recovered from the illness, however, after which she expressed regret for her prior behavior and appreciation for the support provided by Maria and her family. This period of benevolence was short-lived, and, as VM regained strength, she resumed her accusatory and abusive behavior, eventually leading Maria to conclude
that VM needed to leave. Because of VM’s care needs and the unwillingness of other family members to offer shelter, the PACE Team advised nursing home placement, which VM refused, threatening self-harm if the Team forced her to go.

The PACE Team brought the following question to the Ethics Committee: In this disabled and vulnerable elderly woman, do we compel her to move to a nursing home, even if that would require force, a possible declaration of incapacity, and the risk that she would carry through on the threat to harm herself? Or do we locate an apartment where she could live alone with PACE services even though this might mean she would be at risk for falls, injuries, and, because of her history of paranoia and belligerence toward personal care providers, unmet care needs? On the other hand, should we exert pressure on Maria to keep VM in her home and continue in her caregiving role?

The Ethics Committee, citing VM’s history of willingness to accept health risks, even to the point of death, as well as her ability, despite her long-standing paranoid disposition, to understand the potential risks and benefits of different alternatives, advised the PACE Team to move VM to an apartment and to offer as much support as VM would be willing to accept. In their recommendation, the Ethics Committee not only cited VM’s personal values history (Doukas and McCullough 1991), but also invoked a broader definition of safety, one that recognizes the importance of psychosocial safety as well as the more familiar category of physical safety (Collopy 1995).

2. Advocacy for PACE participants vs. responsibilities to other parties

The primary responsibility of the PACE Team is toward the participants for whom it provides care. Similarly, the individual members of the PACE Team have discipline-specific responsibilities to each participant, as in the context of physician-patient and social worker-client relationships. However, the PACE Organization also has obligations to other parties, whether they be other participants, caregivers, staff members, contracted partners, or the community in which the PACE Organization operates.
The case of VM, while primarily an issue of autonomy vs. beneficence, also raised the issue of the obligation of the PACE Team to VM’s niece and family. For how long should the PACE Team have asked Maria to offer shelter and support to VM, recognizing the benefits to VM but also aware of the deleterious effect on Maria’s household? In this regard, the case also brought into consideration the ethical principle of justice, with the recognition that VM was unduly taxing the limited emotional resources of Maria’s family and that both VM and the PACE Team needed to respect the legitimate needs of her family (Jecker 1991).

The following cases illustrate other examples of ethical issues that arise when obligations to individual PACE participants conflict with obligations to other parties.

Case 4

KS is a 77 year old woman with vascular dementia, depression, painful osteoarthritis of her hips and knees, and urinary incontinence. ES required assistance with bathing, dressing, and grooming, but she refused personal care and displayed complete disregard for her personal hygiene. Multidisciplinary efforts by the PACE Team produced significant improvements in mood, comfort, and mobility, but KS continued to refuse personal care at home and the PACE Center. Attempts to bathe, wash, and change KS at the PACE Center were met with physical aggression that exposed staff members to risk of injury. Other PACE participants attending the Center complained of offensive odors, and there were concerns about fecal contamination at meals. On the other hand, family caregivers experienced increased stress for which PACE Center attendance by KS provided the only respite.

The PACE Team brought the following questions to the Ethics Committee: Is it ethical to deny KS attendance at the PACE Center in deference to the sensibilities of other PACE participants? Is it ethical to refrain from providing personal care to KS if it subjects staff members to personal danger? If the outcome of denying KS attendance at the PACE Center is increased caregiver stress leading to nursing home placement, has the PACE Organization failed in its obligations to KS and her family?
The Ethics Committee, while urging all efforts short of physical or chemical restraint to clean KS, advised the Team that its obligations to KS and her family did not justify subjecting staff members to potential harm or other participants to health risks and markedly unpleasant experiences. The committee recognized that the outcome might be permanent nursing home placement for which the PACE Organization would be responsible, but it affirmed the principle that the PACE Team has obligations to other members of the community, namely its employees and other participants.

Case 5

CB is a 69 year old well-educated but formerly homeless man with bipolar disorder, chronic obstructive lung disease, and alcohol, cigarette, and prescription pain medication dependencies, who developed affection for another participant, FS, an 87 year old woman with Alzheimer’s disease, hearing loss, and limited vision. At the PACE Center, CB demonstrated his affection for FS by physical displays, such as hand-holding, hugs, and kisses, and by giving gifts and sending love notes expressing his desire to establish a lasting relationship. FS always appeared comfortable with the physical demonstrations of CB, reciprocating in kind, as she would with staff members, though, when asked, she expressed no recollection of CB or his actions. CB, however, indicated that he understood the physical responses of FS to be signs of mutual affection. The PACE Team was divided; some members celebrated the physical contact between CB and FS, while others were uncomfortable and felt protective toward FS. The Team asked the Ethics Committee whether it should place restrictions on the behavior of CB.

The Committee affirmed that the PACE Team has obligations to protect its most vulnerable participants from potentially threatening encounters that may arise from the community environment established by the PACE Center. It argued that FS lacked the capacity to make an informed decision about engaging in the intimate relationship that CB, perhaps as a consequence of his chronic mental illness, thought possible. The committee advised permitting limited physical contact between CB and FS as long as staff was able to observe
the encounters, but curtailing contact if CB attempted further interaction or if FS showed any signs of distress.

Case 6

AD is an 85 year old former machinist and inventor with multiple chronic medical conditions, who, following an acute illness and functional decline, had increased care needs requiring daily nursing visits. AD and his daughter, an unmarried paralegal who lived out-of-town but visited often, were very demanding and insisted on maintaining control over most aspects of care, often rejecting the recommendations of the PACE Team with respect to medical management, rehabilitation strategies, and personal care. The daughter called the PACE Team frequently to discuss her concerns and sent regular memos by fax, outlining her sources of dissatisfaction and listing her requests for supplies, services, and medication changes. The PACE Team accommodated AD and his daughter to the extent possible, recognizing that AD needed to assert control over his dependent situation to have any chance at recovery and that his daughter, whose emotional support was also necessary, was under enormous stress trying to influence outcomes from afar. The PACE Team was uncomfortable, however, with requests by AD and his daughter that AD only receive care only from selected nurses when it became apparent that their requests had a racial profile. The PACE Team asked the Ethics Committee whether it should accommodate such requests.

The Ethics Committee commended the PACE Team for its patience, flexibility, and willingness to accommodate the demands of AD and his daughter. It also praised the Team for respecting the autonomy of AD in making decisions and exerting control over his care. However, it advised strongly against acceding to any requests that would result in staff assignment based on racial preferences. The Committee affirmed that the PACE Organization has an obligation to support its staff and to reject any acquiescence to racial intolerance. The Committee also expressed concern that accepting race-based requests would have a deleterious effect on Team morale and could adversely affect the care of others in the program. The Committee recommended informing AD and his daughter that the PACE
Team would potentially utilize all members of its Team in the care of AD, and that AD could disenroll if he no longer accepted the principles of the PACE model and care delivery from the entire PACE Team.

3. Involuntary Disenrollment

PACE Teams may experience frustration in caring for participants who engage in behavior that is harmful to their own welfare or who decline recommendations of the PACE Team; this frustration may lead to Team members to consider involuntarily disenrolling self-harming or non-compliant participants (Kornblatt 2002). PACE Teams may bring their concerns to the Ethics Committee and ask for the Committee’s guidance in interpreting the PACE regulations and determining whether it is ethically defensible to pursue involuntary disenrollment.

The PACE regulations specify the conditions under which a PO may involuntarily disenroll a participant, as well as the procedures it must follow, including obtaining advance approval of CMS and the state Medicaid authority (PACE Final Rule 2006, section 460.164).

The conditions include several non-controversial administrative situations:

- Failure to pay premiums
- Moving out of the PACE service area for more than 30 days
- No longer meeting the nursing facility level of care clinical eligibility requirement
- Termination of the PACE program agreement with CMS and the state
- Inability of the PACE organization to offer services due to loss of licenses or contracts

However, the regulations also permit involuntary disenrollment for less well-defined clinical situations: “disruptive or threatening behavior, defined as a participant who engages in behavior that jeopardizes his or her health or safety, or the safety of others; or as a participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.” (PACE Final Rule 2006, Section 460.164 (b))
The regulations stipulate that a PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others. The regulations state that noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments. The regulations also stipulate that if a PO proposes to disenroll a participant who is disruptive or threatening, the organization must document the reasons for proposing to disenroll the participant and all efforts to remedy the situation.

Through its reviews of cases over the past ten years, the Massachusetts PACE Ethics Committee has established the principle that, notwithstanding the regulatory ambiguity, the only ethically defensible grounds for involuntary disenrollment are situations in which PACE participants subject others, be they staff, other participants, or members of the larger community, to harm or the risk of harm. The committee has affirmed the principle that it is the obligation of health care providers, in this case the members of the PACE Team, to inform patients of care options and to recommend courses of action it believes will yield the best outcomes, but it is the right of patients with decision-making capacity to decline recommendations, assume risks, and make choices that care providers might believe are poor decisions. The Committee has repeatedly affirmed that failure to adhere to a recommended care plan is a situation that calls for ongoing education, counseling, and encouragement by the PACE Team, but it does not constitute ethically-defensible grounds for involuntary disenrollment. The following case illustrates this principle.

**Case 7**

*TM is a 62 year old man who was separated from his wife and estranged from his daughters. He attended the PACE Center four days a week, twice for full days, and twice for brief medical checks. TM has a long history of alcoholism; his medical history also included chronic obstructive lung disease, chronic heart failure, atrial fibrillation, diabetes mellitus, and depression. Drinking placed him at risk for destabilization of his chronic medical conditions with resulting need for hospitalization. In its assessment of TM, the PACE Team identified alcoholism as a*
key problem; the care plan set abstinence as a goal, with interventions including outpatient treatment programs, counseling, and attendance at AA meetings. AM participated in two courses of outpatient alcohol treatment and attended AA three times a week, but he continued to drink and was hospitalized several times for medical complications. Counseling was discontinued because of inadequate commitment by TM. The PACE Organization asked for the committee’s guidance in determining whether it had sufficient grounds to involuntarily disenroll TM for his persistent self-harming behavior and his failure to adhere to the care plan, which called for abstinence as a goal, especially in light of the medical expenses incurred by the PACE Organization as a result of TM’s behavior.

In the discussion of the case at the Ethics Committee meeting, it emerged that TM, despite failing to demonstrate a consistent commitment to abstinence, was nonetheless experiencing other benefits of the PACE care plan. The PACE Physician expressed his belief that close medical monitoring at the PACE Center had facilitated early recognition of medical problems and has enabled TM to achieve greater medical stability than he would otherwise. Other team members observed that TM has been able to establish relationships with staff and participants that have contributed to enhanced social and emotional stability. The Team expressed frustration with TM’s drinking and pessimism about his commitment to sobriety, but acknowledged that PACE offered the best hope for TM to reduce his self-destructive behavior, however unlikely that outcome might be.

The Committee admitted that the regulatory language, strictly interpreted, gave the PACE Organization latitude to involuntarily disenroll TM. Consistent with its opinion on other cases, however, the Committee argued that to deny TM access to PACE would be ethically indefensible. In offering its opinion, the Committee cited the multiple benefits that TM derives from PACE, as well as the possibility that these benefits might ultimately yield some modest improvement in AM’s drinking behavior. The Committee also noted that alcoholism is a chronic illness and that the PO enrolled TM in full awareness of his medical history. To have denied enrollment initially because of a medical condition would have violated
regulations, the PACE mission, and basic ethical precepts; to involuntarily disenroll TM based on his alcoholism would be no more defensible.

The Committee also cited the dangers of denying enrollment based on moral judgments about self-harming or non-compliant behavior. Followed to its logical conclusion, a literal interpretation of the regulations would permit PACE Organizations to disenroll smokers who don’t quit, diabetics who overeat, patients with heart failure who salt their food, obese patients who fail to exercise, and patients who don’t take all of their prescribed medications. To grant broad discretion to disenroll based on self-harming or non-compliant behavior would allow these definitions to be applied in selective, inconsistent, and indiscriminate ways; the Committee warned that such an approach would lead the PACE community down a treacherous slope.

Last, the Committee dismissed the idea that one should consider the utilization of medical resources by TM and the need for the PACE Organization to absorb the associated costs as factors in support of involuntarily disenrollment. The ethical principle of justice calls for fair distribution of resources; inequitable distribution of resources could potentially limit the ability of a PACE Organization to meet the individual needs of all participants. Yet as long as utilization by one participant does not directly threaten the ability of the PO to meet the needs of another participant, then the principle of justice is not violated, and there is no justification to ration resources based on scarcity. The PACE model facilitates the creation of individualized care plans that direct resources based on individual need; in this case, hospitalization met the healthcare needs of TM. Although the PACE Organization was unhappy with the resources consumed by TM, it acknowledged that its operations were not threatened by the costs of his utilization, nor was the ability of other participants to receive care and services compromised.

One year after the PACE Organization presented the case of TM, it provided an update to the Ethics Committee:
The PACE organization accepted the recommendations of the Ethics Committee and refrained from further discussion of involuntary disenrollment. The team committed itself to establishing a therapeutic alliance, building trust, and counseling TM about the risks of drinking. In doing so, they adopted a harm reduction approach and abandoned the goal of abstinence. One year later, TM continued to drink but had moderated his intake. He attended the PACE Center on a regular basis and maintained close relationships with staff. His chronic medical conditions were better controlled and he was hospitalized less frequently.

Conclusion

The unique nature of the PACE model results in unique ethical problems. PACE Ethics Committees are essential to resolving ethical conflicts, educating PACE Teams about ethical principles, and establishing consensus around controversial ethical issues. As the PACE model grows nationally, there will an increasing need to constitute PACE Ethics Committees, provide access to ethical consultation, and assure the consistency of ethical decision-making across PACE Organizations and Teams. Meeting this growing need will be an important responsibility of the PACE Provider community.

The cases discussed are based on actual cases presented to the Massachusetts PACE Ethics Committee. The initials of the patients have been changed.

References


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CHAPTER 19

Unique Issues in Developing a Rural PACE Program

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Key Points

- Enrolling patients into a rural PACE program requires a very different paradigm than urban programs. The Medical Director must develop collaborative relationships, often at a distance, with community primary care physicians who may view PACE as competition.

- Developing a successful provider (primary care and specialty) network needs creativity (e.g. enhanced reimbursement) and flexibility (e.g. telemedicine and teleconferencing).

Rural PACE programs must contend with unique geographic, social, and health challenges, but the PACE mission of supporting “aging in place” conforms well to the values of rural communities.
Building Census

Having a robust enrollment is critical to the success of any PACE program. Rural programs face some unique challenges in identifying potential participants, educating the community about PACE, and ultimately enrolling participants. While the physician is not formally involved in the mechanics of marketing and enrollment, the Medical Director can be a key person in building a program’s reputation, encouraging physician, nurse, and social work colleagues to make referrals, and supporting growth of the organization.

Health disparities, most often associated with urban ethnic and racial populations, persist in rural America as well. Over 20 percent of the United States population lives in rural areas, and higher rates of chronic illness and poor overall health are found in those communities when compared to urban populations. Rural residents are older, poorer, and have fewer physicians to care for them. This disparity is even more profound in the elderly due to the changing demographics of rural populations. Compared to more populated areas, rural communities have a higher proportion of elderly due to out-migration of their younger citizens. Despite their growing numbers, older rural people, by almost all economic, health, and social indicators, are poorer and less healthy than their non-rural counterparts. They have more substandard housing, fewer options in personal and public transportation, and significantly more limited access to health professionals and to community-based programs and services. In short, the rural elderly have more chronic illness and co-morbidities, worse health outcomes, and lower incomes than their urban counterparts. (National Rural Health Association, 2008)

Rural elders commonly live in their same communities all of their lives. The independent streak that led them to embrace the rural, self-reliant lifestyle has not disappeared with aging. This pride and independence forms the backbone of their desire to remain in their homes until they die. The rural elderly often live out their lives without complaint and without assistance from anyone except their closest family members. In 2005 almost
two-thirds of rural citizens over 75 years old were women, and over half of them lived alone. The rural elderly were the original proponents of “aging in place”!

Rural PACE programs have noticed a “bull’s eye” phenomenon in enrollment – the closer one lives to the PACE Center, the greater likelihood of enrollment. We have found that the very remote rural elderly are harder to reach and less likely to enroll in PACE. Rural sites have also seen a seasonal variation in enrollment, with a sharp downturn in enrollment when the weather is bad. Access to rural homes is much more difficult in snow and ice, due to unpaved and poorly maintained secondary roads that do not get cleared.

While it is difficult to recruit and retain physicians in rural communities, many rural areas have longstanding, though aging, primary care providers who have cared for patients and families for many years. For good reason, prospective enrollees may be reluctant to leave their primary physicians. It is helpful to have a compelling PACE Medical Director, who can explain the many benefits of the Interdisciplinary Team (IDT) and PACE approach while tactfully pointing out that potential participant would likely lose their primary care physician anyway if required to enter a nursing home.

Local health care agencies may worry about losing business when a PACE program moves in. Those who may perceive threats to their business include physicians, home health agencies, hospice agencies, long-term care facilities, adult day health centers and health departments. Helping to build trusting and collaborative relationships with these agencies is part of the PACE Medical Director’s job.

The isolation and independent nature of the rural elderly, plus the potentially difficult relationships with local providers and health agencies that view PACE as a threat, make it challenging to get the word out about the unique nature of PACE and its services. Some rural PACE start-ups have experienced slower than expected enrollment; and have not been able to keep up with their enrollment projections.
Given the mismatch between the need for comprehensive services for frail elderly in rural communities and the obstacles to enrollment to PACE, one must be realistic with enrollment projections. It may be helpful to hire local talent with nursing home, hospice or home health experience, or to hire staff with PACE experience.

The Medical Director should begin work before the PACE Center opens its doors – setting up clinical operations, helping with community relations, and recruiting participants. The Medical Director can start building relationships with local physicians, especially those who care for the frail elderly or work in SNFs. As the Medical Director begins to address hospital admissions and finds local physicians to share call, he/she can begin educating physicians about PACE. Visits with hospital discharge planners, ER physicians, caregiver groups, contracted skilled nursing facilities, health boards, health departments, and community health centers are also useful, as is joining the local medical society, obtaining hospital privileges and attending medical staff meetings.

As with existing PACE sites, the most important ingredient for enrollment is word of mouth – from participants who receive services, from caregivers, and from your own staff. In addition, one must recognize that becoming part of the community and building trust and relationships takes time. A patient, low-key, non-competitive approach, with a focus on high-quality care, is worth the effort over the long haul.

**Barriers to Building the PACE Network**

1. **Specialists**

One of many challenges facing rural PACE Medical Directors is the development of a network of specialty medical providers. In most rural areas there are a limited number of specialty providers and those that are available are extremely busy and may not be willing or able to accept new patients. Many of these providers are not familiar with PACE and their fear of the unknown may become a barrier to successfully negotiating contracts.
Furthermore, Medicare and Medicaid rates may not be adequate to entice the most desirable providers. Many disciplines may not be available locally. It may be necessary to contract with providers who practice a significant distance from the PACE service area. Unfortunately, many frail PACE participants may be unable or unwilling to travel relatively long distances for care on an ongoing basis.

In spite of these challenges, there are some strategies that may help overcome many of them. The most important tool a PACE medical director can wield in building a network is a good personal relationship with desirable providers. Medical directors with a longstanding presence in their community can often build on the professional and personal relationships they have established over years. Directors that are new to an area need to develop rapport with as many key providers as soon as possible. One strategy is to develop a well-connected medical advisory committee early in the PACE program and to use these key providers to assist with broadening professional and personal relationships.

Another effective strategy is to partner with large regional healthcare systems for assistance in facilitating contracts with their affiliated specialty providers. It is usually possible to convince administrators in these systems that there are mutually beneficial goals. Once a good relationship is established, administrators are often willing to embrace strategies to facilitate contracting with their affiliated specialists.

It is often very beneficial in rural areas to focus on large, well-respected, influential groups of medical providers. Contracting with these key groups enhances the reputation of PACE, making it easier to get other providers to follow suit.

Reimbursement rates will always be an issue, and it is important to emphasize Medicare approved reimbursement rates, which are higher than Medicaid rates. In some markets, unfortunately, it may become necessary to pay more than Medicare approved rates to certain key providers in order to round out a network.
A PACE program’s reputation as a payer can be a driving factor in its ability to grow a provider network. Therefore, it is especially important for young programs to process claims expeditiously from their first providers to establish reputations as reliable and fair payers.

Addressing issues associated with the fact that some required specialty providers are located significant distances from a PACE service area may be more difficult. It’s generally not feasible, at least initially, for these providers to travel and provide services at the PACE Center. Therefore, one compromise is to negotiate with these providers to minimize the need for follow-up visits in their offices by allowing PACE clinicians to provide interim follow-ups as much as possible. This may entail phone e-mail consultations with the specialists which should be appropriately remunerated. Such arrangements require finesse to maintain sustainable mutually beneficial and respectful relationships.

2. Therapy Services

Rural programs also face unique challenges providing therapy services—physical, occupational, and speech. There’s a shortage of these providers and the providers available in rural areas are generally employed by larger healthcare organizations. Therefore, rural PACE programs are often in the awkward position of contracting for these therapists’ “leftover time.” These providers generally require several months to become familiar with the PACE model. Because of their experiences in the fee for service model and the part-time nature of their relationship with PACE, it’s often difficult to get them to embrace providing PACE-appropriate services as a priority.

Many therapy providers may not have the available time or the will to make a commitment to reliably provide needed PACE services. For the providers who do make time and do provide good service, it is often difficult for them to expand their availability
as PACE programs grow. This only perpetuates the arduous cycle of hiring and educating other part-time providers.

Rural PACE medical directors need to assist their programs with recruiting and retaining quality therapy providers. Medical directors must educate these providers regarding the model and help them embrace the differences between PACE and the fee for service world with which they’re familiar. For example, therapists may enjoy the ability to function with greater autonomy and without the typical restraints that exist in the usual fee for service environment. Emphasizing the unique professional opportunities in PACE may help prospective therapists recognize how richly rewarding the experience can be. It is key that rural medical directors assist these providers in transitioning to the PACE paradigm as rapidly as possible. They must learn to tailor their services to meet each participant’s unique needs in a PACE-appropriate manner and avoid “cookie-cutter” evaluations and care plans.

Because therapy resources are scarce in fledgling rural programs, it is mandatory that utilization be diligently monitored. Medical directors must constantly ensure that resources are focused on genuine needs. To achieve this goal, it is important that care plans be dynamic and that they transition from the utilization of costly, scarce professional services to less-costly, more available paraprofessional services, such as maintenance exercise programs, as soon as appropriate.

In rural programs, it is often necessary to acknowledge that, because of their limited availability, professional therapists will not be able to monitor all participants. Therefore, it is important to develop processes that utilize full-time clinical and daycare staff to closely monitor participants for changes that warrant new referrals to one of the professional providers. It is important to detect significant problems early and to facilitate expeditious referrals and interventions to avoid preventable adverse outcomes, such as loss of functional status (PT and OT), nutritional decline (dietary/nutrition services), or aspiration pneumonia (speech therapy). In between mandated PT and OT assessments and reassessments, it is appropriate to develop case loads for these providers.
These need to be constantly updated based on the changing needs of the participant population.

Some rural programs have been more successful obtaining OT than PT services. These programs have found it helpful to supplement PT services through OT. Because the disciplines overlap, OT is often able to focus on other functional issues in addition to the ADL issues they traditionally address. This allows for more efficient use of resources by allowing the limited PT services to be utilized in a more targeted way.

The services of pharmacists and dietitians/nutritionists are also often difficult for rural programs to provide on a full-time basis. Nutrition input is mandated for all assessments and reassessments while pharmacy input, while extremely valuable, is optional. Many programs will not have the “luxury” of having sufficient professional services in these key areas to monitor all participants on an ongoing basis. In these situations, it again is appropriate to focus these valuable resources on the participants most likely to benefit. This, too, can be accomplished by developing and constantly updating appropriate case loads for these professionals. When necessary, rural PACE medical directors must take ownership of this process to ensure that participants receive appropriate care with adequate input from these disciplines while optimally utilizing their valuable time.

3. Pharmacy

Some rural PACE programs have struggled to fulfill their Medicare Part D mandate and provide appropriate pharmacy services. Mountain Empire PACE was initially encouraged to partner with a long-term care (LTC) pharmacy service, which had a good track record of serving nursing home clients. For many reasons, this proved to be most unsatisfactory. The drug delivery window to the PACE Center was very narrow with limited after-hour delivery options. Medications were brought to the PACE Center and catalogued until PACE participants picked them up. The onerous tracking process overwhelmed the nursing staff and significantly detracted from their ability to attend to other clinical responsibilities. Furthermore, medications were not labeled for home use
and instead were packaged and labeled for use by medication nurses in nursing homes. The responsibility of providing any requested medication information sheets was also thrust onto the PACE clinical staff. Unfortunately, the program was not able to resolve these issues.

The solution was transitioning to a pharmacy benefits manager (PBM) which has resolved the listed problems. Our participants and our staff are very satisfied with our PBM services which enable participants to obtain medications from local pharmacies and enable us to better track cost and utilization. LTC pharmacy services are not appropriate for those small rural PACE programs without full-time in-house pharmacists.

4. Mental Health

While rural PACE programs face varying challenges obtaining access to specialty care, one common need, geriatric psychiatric services, can be difficult to access for virtually all programs. Local mental health agencies, unfortunately, are often overwhelmed by crisis intervention responsibilities and large case loads, which preclude the provision of consistent, high-quality, geriatric psychiatric care. Providers are generally located at significant distances from rural PACE centers and often have full practices. Furthermore, frail PACE participants with psychiatric illnesses are often reluctant to repeatedly travel long distances for care. Nevertheless, several strategies may be helpful in meeting geriatric psychiatric needs in rural PACE.

For one, expanding the roles of PACE physicians and social workers in providing psychiatric care, for all but the most demanding cases, has the potential to address many of these needs. However, this requires that clinicians have psychiatric training and experience sufficient to develop needed clinical competencies. Family practitioners often have more psychiatric training than internists, and thus may feel more comfortable caring for psychiatric cases. PACE physicians not comfortable managing psychiatric issues may require extra training to develop the needed skills. Social workers in rural programs also
need clinical competencies to assist with psychiatric assessments, monitoring, and counseling.

Another option, that has the potential to meet the needs of some participants, is the utilization of contracted RNs with psychiatric competencies to specifically monitor and case manage high-risk participants with psychiatric illnesses. This option may be particularly helpful in monitoring participants whose psychiatric illnesses impact compliance with medication and other therapies, including regular attendance in the PACE clinic for monitoring.

One of the most exciting strategies for addressing geriatric psychiatric needs in rural PACE is telemedicine. Psychiatric care appears ideally suited for this technology. Mountain Empire PACE recently partnered with the University of Virginia Health System to offer this service to our participants. Our first impressions are very positive and indicate that this technology is easy to set up and use and rapidly becomes transparent to providers and participants alike. It enables the University of Virginia to fulfill its rural outreach mandate and delivers top tier psychiatric care for our rural PACE participants. From the geriatric psychiatrist’s standpoint, the program provides challenging and stimulating cases for her and for psychiatric fellows receiving training in telemedicine.

Telemedicine at rural PACE sites has the potential to meet most complex geriatric psychiatry needs in a cost-efficient manner, while at the same time providing extremely high-quality care. This requires an interested and willing academic or private provider to contract to provide this service on a regular basis. It also requires that PACE programs acquire the needed equipment, broadband connectivity, and technology skills to seamlessly link to the provider. Another requirement is that PACE physicians acquire the competencies needed to properly select cases, to adequately share relevant clinical data, and to assist with monitoring and managing cases between consults. This service cannot replace hospital-based psychiatric care which, unfortunately at times, may need to be arranged in conjunction with local mental health services on an emergency basis.
However, quality psychiatric telemedicine services certainly appear to have the potential to significantly decrease the need for inpatient psychiatric care.

Academic centers may be able to assist POs in obtaining financial grants for the equipment and/or connectivity. Fortunately, the technology is easily mastered and the skills required to work with geriatric psychiatrists can, with reasonable effort, be mastered by PACE clinicians.

The Rural PACE Interdisciplinary Team

An Interdisciplinary Team (IDT) is essential for the care of frail older patients. But, what does it mean to be interdisciplinary? Most of us understand that a team is a group of people working together on a shared goal (e.g., football team). By analogy, an interdisciplinary team is a group of people from diverse professional backgrounds (e.g., physician, nurse, social worker, physical therapist, speech pathologist, pharmacist, etc.) working collaboratively to move a patient toward a desired goal (e.g., regaining ambulation, resolution of pain, comfortable death).

However, in order to reach a major goal (e.g., win the Super Bowl) every member of the team must be absolutely committed to the same goal (100% of the team, 100% committed to a shared goal). Some teams lose because they can’t get their team members to work in a tight-knit, collaborative fashion. Some IDTs do not succeed for similar reasons. For example, physicians are accustomed to working independently and giving orders. Thus, they sometimes fail to recognize that they need to be a team player. Likewise, other team members don’t always understand how to subjugate their personal view for the common goal. For example, a dietitian may want to see an underweight patient gain weight, but this may be an unrealistic goal toward the end of life. Steering all members of the team toward the most realistic goals is a challenge for whoever is orchestrating the IDT.
Implementing and guiding an IDT is even more complicated for a new PACE program in a rural setting. For example, especially when starting out, PACE programs typically do not have all the necessary team members on staff. Thus, PACE programs typically have part time medical directors, rehabilitation therapists, pharmacists, etc. Part time staff will always be pulled in various directions; PACE is not their sole priority. Divided loyalty hinders development of a winning team. However, accepting this reality, discussing it, and finding ways to overcome this challenge are essential for the success of a PACE IDT. This typically requires devoting time and effort to team building exercises so that each member understands his/her role, the need to avoid ego and other conflicts, how to listen, and the necessity of working together in a collaborative fashion.

1. Using Community PCPs

The problem of divided loyalties is especially challenging when PACE programs in a rural setting must depend on community physicians to be their PACE primary care physicians. As outlined above, physicians are accustomed to working independently and giving orders; they are not accustomed to subjugating their views to a team. Community physicians will have an unremitting commitment first and foremost to the success of their own practice. Thus, getting community physicians to subjugate their priorities to the common good of the PACE program is a difficult task. One way to do this is to find PCPs with a reputation for good communication skills, willingness to work with other health care professionals, and skill in the care of frail older adults. However, these PCPs may be difficult to find. Another option to stimulate PCP participation is to pay the physician for his/her time commitment to the IDT. But to really get his attention, the PCP needs to be paid more than he typically generates in his practice for the same amount of time. PACE team members may also need to cater to the time constraints of community physicians because they are extremely busy. Thus, inclusion of community PCPs in the IDT requires a great deal of commitment and flexibility.
2. Teaming with the Community

Developing teamwork with other community healthcare providers, who view PACE programs as competition, is yet another challenge. For example, the goal of PACE is to keep patients healthy enough to avoid needlessly expensive medications and procedures, avoid unnecessary hospitalizations, and stay out of nursing homes. This may conflict with the financial objectives of other rural providers.

A for-profit medical supply company that sells motorized wheelchairs wants to sell as many motorized wheelchairs as possible. PACE, on the other hand, strives to keep patients ambulatory and limits power-operated vehicles to those patients with a true need. Likewise, a for-profit nursing home needs to keep its beds filled. In contrast, PACE strives to keep patients well enough so they avoid the need for long-term nursing home placement. On the other hand, PACE programs need to rely on high-quality nursing homes when short-term needs arise. There will also be times when a PACE participant can no longer remain in the community and must be placed in a nursing home. In addition, there are respite needs that a nursing home facility can fulfill.

There is no easy solution to the conflict between PACE and for-profit community healthcare providers. The best approach is to understand the conflicts and contract with entities willing to collaborate in a mutually beneficial way. This typically requires clear communication, honest negotiation, and time to build collaborative relationships. It may also sometimes require changing contracted providers when things don’t work out as planned.

Despite the challenges, some of which may seem impossible to conquer, there is no doubt that, “teamwork makes the dream work.” Improving one life or easing the path of death for one patient can make it all worthwhile.
In this chapter we explore the management of alcohol use disorders in PACE, including screening, treatment, and managing the associated risks when participants continue to use alcohol after enrollment. First let us define the terms *alcohol abuse* and *alcohol dependency*. For the purposes of this chapter, it is important to differentiate the two.

*Alcohol abuse* is defined in the DSM-IV as the repeated occurrence over the last 12 months of one or more of the following:

- risk of bodily harm (nearly always the case)
- relationship trouble
- role failure
- run-ins with the law

*Alcohol dependency* is defined as meeting three or more of the following criteria over the last 12 months:

- unable to stick to drinking limits
- unable to cut down or stop, displayed tolerance
- shown signs of withdrawal
- kept drinking despite physical or psychological problems
- spent a lot of time drinking, less on other matters
Alcohol Abuse in Elders: Under the Radar

Alcohol abuse and dependence in older adults often go undetected by providers. Studies show that older problem drinkers and patients with alcoholism were correctly identified only 33 percent of the time by hospital medical staff in Australia (McInness, 1994) and house officers in the United States (Curtis, 1989), respectively. The greater difficulty detecting alcoholism in older compared to younger drinkers may be related to physiological changes in the elderly, including a decrease in total body water, which can make the amount of alcohol consumed an unreliable measure of abuse or dependence. In addition, the majority of ambulatory visits by older persons with alcohol use disorders are to medical personnel, who may be less expert at detecting alcohol use disorders than mental health personnel. Furthermore, symptoms of abuse or dependence may be less pronounced in older persons and assumptions that older persons do not abuse alcohol may interfere with the recognition of alcohol problems in elders. (Beullens, 2004).

Screening Tools

We recommend quantifying the amount of alcohol consumed, the risk, and the duration of abuse (e.g., short-term or life-long) as the first intervention for prospective enrollees. There are several effective outpatient screening questionnaires available that are brief and fairly easy to administer. These include: the CAGE, Alcohol Use Disorders Identification Test (AUDIT), and the Michigan Alcohol Screening Test (MAST).

The CAGE is a four item screening instrument yielding “yes” or “no” responses. Each “yes” is scored one point. A score of one or more points is considered a positive screen for problem drinking. The AUDIT involves ten items administered as an oral interview or written questionnaire covering the frequency of drinking, alcohol dependence, and common problems caused by alcohol. Scores range from zero to forty with a score of
eight or more points considered positive (Aertgeerts, 2001). The MAST is a 24-item questionnaire with a score of five or greater indicating alcohol abuse or dependence (Beullens, 2004). Of the three, the MAST-G, a derivation of the MAST tailored to older adults, appears to have the most reliability in a small pilot project at our ADHC.

Laboratory confirmation of current drinking can be done at the ADHC with immediate results with an alcohol detection mouth swab, reporting consumption up to 80 hours before test. This helps with sobriety counseling.

**Counseling and Detoxification Programs**

Research has shown that older adults who engage in risky drinking, but who are not dependent on alcohol can successfully reduce alcohol use and related problems through relatively simple, brief primary care counseling. Older adults with more significant alcohol problems (e.g., alcohol dependence) respond well to treatment, completing treatment at higher rates than younger adults (SAMHSA 1998).

Often older drinkers are use alcohol to cope with losses experienced in their lives. Friends made at the ADHC and the solicitude of staff can aid in healing and achieving sobriety for these individuals. Participants who have life-long alcohol abuse are at the highest risk of harmful drinking. Their care plans should include frequent primary care visits and counseling.

At Elder Service Plan of the North Shore, we have started a pilot alcohol support group with much success. This weekly, closed and confidential group, facilitated by a staff social worker, is held on-site and employs motivational interviewing (Miller and Rollnick, 1991) and the stages of change (Prochaska and DiClemente, 1997) model in its clinical approach. The group uses worksheets from the NIAAA, which employs behavior modification techniques. These inexpensive counseling tools can be purchased from www.niaaa.nih.
This group is not a 12-step group and does not adhere to the Alcoholics Anonymous (AA) model. It has minimal structure and is primarily client-driven, with topics ranging from drink refusal skills and coping with relapse to replacing negative thoughts and feelings with positive and validating internal scripts. AA groups are available to our participants in the community although most participants require assistance to attend them. Participants in AA also are free to attend the PACE support group.

In addition to support groups, individual counseling may be beneficial for some participants who wish to stop drinking. This is provided by social worker or other professionals who are experienced and licensed to practice psychotherapy. Resources are available through local directories of mental health and aging coalitions. Some PACE participants benefit from intensive outpatient hospital programs and a select few have experienced admissions to alcohol detoxification programs.

In-patient hospitalization is reserved for acute detoxification, for those at risk for delirium tremens. Alcoholics with predictable courses of detoxification can be placed in skilled nursing facilities directly for nursing care and functional assistance during period of detoxification. Acute detoxification treatments require the participant’s agreement and active participation. The person who abuses alcohol has the right to refuse treatment.

**Medication as an Intervention**

In addition to screening and counseling, medication management should be offered to those at the so-called action stage, which Prochaska and DiClemente characterize as the stage where people are actively involved in changing their negative behavior.

Participants need not abstain to be considered for medications such as Topiramate and naltrexone, although most sobriety agents are more effective when a participant is sober for a period of time. Acamprosate is only approved for patients who are abstinent at the start of treatment, but is more tolerable and can have a mood improving quality. Disulfiram (Antabuse) is contraindicated in patients who wish to continue to drink. Given
the risk of drinking with disulfiram, it should never be used in for participants who are cognitively-impaired or require help in medication management. Disulfiram can be sedating. Given Disulfiram’s multiple risks and sedating qualities, it has only been used in a young cognitively intact participant, with positive benefits in the past.

**Alcohol Treatment: Additional Issues for PACE Organizations**

Alcohol use disorders can lead to a host of medical complications, difficult primary care relationships, and staff burnout. While PACE regulations do not allow refusal of enrollment because of alcohol abuse; PACE organizations can refuse enrollment to a potential participant for whom a safe care plan cannot be developed.

On the other hand, PACE can succeed in cases where other systems of care have failed, because of the comprehensive, coordinated, team-based approach to care.

Participants who regularly attend the ADHC often improve in functional status and reduce medical risks. At Elder Service Plan of the North Shore, we invite prospective participants who have alcohol use disorders pre-enrollment for extra visits to the center in order to help us evaluate their safety in the community. Delaying enrollment may help an alcoholic reevaluate his/her desire to enroll as well as give the team time to discuss the prospective care plan.

In addition to observing attendance, PACE IDTs may choose to contract with potential enrollees, clearly spelling out consequences of continued alcohol abuse. Contracts cannot be binding on participants rarely prevent relapse or unsafe drinking. The state Medicaid authority will rarely support involuntary disenrollment or refusal to admit a potential participant to the program strictly based on alcohol abuse.

In Massachusetts, a PACE provider is required to report an individual (age 60+) to an Elder Protective Service agency if the participant with alcohol abuse fails to meet minimal safety standards, are at risk despite attempts at rehabilitation, counseling, and
medications, and the concern is that the participant will injure him or herself or others. For younger participants, the Disabled Persons Protective Commission should be called for imminent risk of life or property. Guardianship and placement may be appropriate, requiring a court petition and legal services, however the guardianship process can be lengthy.

A quicker form of protection is a “Section 12,” which stipulates for imminent harm unrelated to alcohol intoxication, physicians are able to send a participant for a 3 day hospital evaluation against his/her will. Otherwise, the alcohol abuser can be placed in a facility for alcohol treatment by court order under Section 35. This order involves a 30 day mandatory locked program. This procedure usually involves arresting the participant. He/she will be brought to court in handcuffs and the PACE physician and supporting family/witnesses would spend a day petitioning the court. The participant would need to truly be an obvious danger to himself or others. An example of this was a participant who was drunk employing a motorized saw to cut down a tree over his neighbor’s car.

**Summary**

Alcohol use disorders are prevalent in PACE. Often the added resources of the adult day center and the PACE interdisciplinary team improve the chances of success for participants who want to stop drinking. The same resources can help manage the risks for those who continue to drink. Alcohol treatment can be offered in the day center and clinic (medications, groups, therapy), by referral to 12-step and other outpatient treatment resources, and when necessary, by inpatient detoxification. Only in rare cases can a person be denied enrollment or involuntarily disenrolled because of alcohol abuse.
References


McInnes, E and Powell, J. Drug and alcohol referrals: are elderly substance abuse diagnoses and referrals being missed? BMJ, 1994;308:444-446.


Screening Tool Sites

MAST

MAST-G
http://www.ssc.wisc.edu/wlsresearch/pilot/P01-R01_info/aging_mind/Aging_AppB5_MAST-G.pdf
CAGE

AUDIT
www.niaaa.nih.gov/guide
CHAPTER 21

Substance Abuse

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Key Points

- PACE organizations need to raise internal awareness of substance abuse issues.
- Poor interpersonal relationships, lack of supportive social networks, and chronic mental health conditions complicate treatment and impair long term recovery.
- PACE organizations must build a comprehensive network of inpatient and outpatient behavioral health/substance abuse providers in order to meet participants’ needs.

The U.S. Department of Health and Human Services 2007 report entitled Substance Abuse Among Older Adults states that substance abuse affects up to 17 percent of older adults. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that one in four older adults has a significant mental disorder - a prevalence that is strongly associated with substance abuse among elderly individuals. Substance abuse can be defined as dependence. With PACE enrolling younger participants, programs are encountering more substance abuse and misuse issues with illicit drugs or prescription narcotics. The literature tends to focus on young adults with severe use and drugs such as
heroin. Therefore this discussion will focus on assisting PACE medical directors to identify the “overlooked” substance abuse and to raise awareness among staff.

**Abuse and Use of Prescription Drugs**

Older adults use and abuse more prescription drugs and over-the-counter products than younger adults. Percocet abuse has been an issue primarily for our program’s female participants.

Opioid drugs are narcotics such as morphine, codeine, oxycodone (OxyContin), propoxyphene (Darvon), hydrocodone (Vicodin), and hydromorphone (Dilaudid) that can cause euphoria and have addictive potential. Chronic use results in tolerance. But some signs of addiction - such as memory loss, confusion, and various physical ailments - are often confused with symptoms of other age-related conditions. Symptoms of withdrawal include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps and involuntary leg movements. Treatment of addiction is detoxification. Detoxification in itself is not a treatment but controlled management withdrawal symptoms. Methadone, naltrexone and buprenorphine have been used very infrequently in our program but may play a selective role. Naltrexone at 50 mg day can decrease the craving for opioid or benzodiazepines dependent drug-seeking participants.

PACE providers generally have increased vigilance with benzodiazepines and antihistamines but we need to have increased awareness with all sedative-hypnotics. Participants’ requests for sleeping pills must be countered with safety education on side-effects of residual decreased attentiveness and memory as well as increased risk for falls and motor vehicle accidents. Our program tries to limit to a quantity of sedative-hypnotics dispensed to 14 pills per month. We also require all participants on benzodiazepines for scheduled long-term use to be have their medications approved by our geriatric psychiatrist. As discussed in the alcohol section of this chapter, we need to encourage PACE participants to avoid consuming alcohol in combination with their medications or illicit drugs.
Abuse and Use of Illicit Street Drugs

PACE participants’ use of illegal drugs includes recreational intermittent use and chronic ongoing dependence. Snorting or smoking crack cocaine is much more common than intravenous injected cocaine. This is probably due to cost. Cocaine can also be used directly on mucous membranes or combined with alcohol. Smoked crack cocaine is a sulfate salt that gives a powerful rush. If one snorts cocaine, the peak effects are felt in about ten minutes, and last for about a half hour. On call participants will report acute chest pain or shortness of breath. After a weekend or shortly after arrival of the monthly social security check, the participants present in the center with tachycardia, hypertension, wheezing, nosebleeds, muscle twitches, nervousness, paranoia, hallucinations and increased physical aggression. Cocaine-related emergency department visits include chief complaints of chest pains, palpitations, dyspnea, seizures and delirium. Cocaine has been a significant issue primarily for our male participants who have easy urban access to purchasing cocaine. One dealer goes around the senior high rise knocking on doors and giving it for free if it is near the end of the month.

Staff perception of participants who chronically use drugs includes the following descriptions:

- Lack of general social skills
- Less interaction with other participants at center
- Social isolation at home
- Self hatred
- Depression
- Apathy
- Guilt
- Frequently needing money
- Lack of adherence to care plan
The above bullets describe a picture of an individual with a history of repeated failure leading to self-loathing, possible self-neglect and overall feelings of shame and guilt. A history of poor judgment can lead to continued drug use and subsequently may lead to more impaired decision-making, such as medication non-compliance for their chronic co-morbid conditions or leaving their door unlocked. Participants have also been robbed and beaten while purchasing drugs.

**Participant behavior and treatment barriers**

- Family relationship problems - estranged from family because of life-long poor choices leading to problematic family dynamics and relationship strain, leading to a lack of family support during recovery periods
- Lying - telling therapist and social worker what they want to hear
- “Drugging alone” - a sign of more advanced dependent use and abuse
- Getting sick frequently but still continue to misuse their preferred substance
- Poor center attendance - usually worse after SSI check on first of the month
- Reluctance to admit to the existence of a problem
- Difficulty changing long-time habits
- Concurrent psychological issues of loss, depression, and isolation
- Forgetfulness adversely affecting medication compliance
- Not addressing co-morbid mental health issues

**Network treatment issues**

Through a contracted arrangement, Mercy LIFE secured a more comprehensive mental health and substance abuse network that includes the following:

- Inpatient detoxification
- Inpatient psychiatric care
• Outpatient individual therapy
• Outpatient group therapy
• Intensive outpatient treatment (3-4 days/ week for 4-6 hours/day)

There are significant treatment barriers to access all levels of outpatient and inpatient care. Reasons for inability to access care generally do not include financial arrangements, but rather the following issues:

• Denying treatment for lack of wheelchair accessibility
• Denying treatment for “complex medical conditions” that LIFE staff could not validate
• Denying treatment because of communication issues i.e. post-stroke expressive aphasia
• Slow approval by facilities
• No opening or availability

Treatment Issues

Staff Burnout
• Staff feels like they are begging our substance abuse providers (inpatient, outpatient and intensive outpatient) to help participant. It is very labor intensive and resource intensive.
• Relapse is common. Securing help one time does not mean the problem goes away. A participant may have a limited positive response with abstinence or decreased short term use, but the cycle re-occurs.

• PACE cannot involuntary disenroll a participant because of failure to follow the care plan or for mental health or psychiatric conditions, unless these conditions place others at risk of harm. We can only encourage involuntary disenrollment but
this conflicts with ethical obligations and raises issues of abandonment (see Chapter ___ on Ethical Issues).

Demographic Contributors to Substance Abuse

- Isolated male common issue
  - Very consistent with known substance abuse risk factor of socially isolated male
- Difficult to address social living situation
  - Mercy LIFE has been unable to move them to alternative low income housing

Treatment Recommendations /Interventions

- Empathic care by all IDT members
- Ongoing non-confrontational follow-up primary care appointments
- Effectively treat co-morbid mental health conditions, i.e. bipolar disorder and depression with assistance of geriatric psychiatry
- Have participant agree to surveillance urine and/ or serum drug screens on a monthly or random basis
- Dispense one to two week supply of narcotics at a time. Our policy limits us to dispensing a maximum of a 14 day supply at one time. We can order a month supply, but store the remaining supply in locked narcotic cabinet.
- Limit monthly funds to weekly allowances
- Monitor cash flows and tax reimbursement or other one-time checks
- Involve family if possible
- Complete a safety contract stating that the participant cannot attend the center under the influence of any substance. Contracts are simply a piece of paper stating acceptable behavior in understandable language. Then the participant and at least
one IDT member, usually a social worker, co-signs the note for permanent medical record entry.

- Put participant on 3-day suspension from center attendance if they attend under the influence
- Institute a home care policy that states if there is suspicion of drug use in the home, all home care services can be withdrawn until negative drug screen. This protects staff from risk of criminal exposure and violence.
- Expand services offered
  - Outpatient rehab/intensive day programs. Encourage longer programs, e.g., a minimum of four months
- Short term SNF stay in a nursing home “scare tactic” or “tough love”
  - This works at times to send a powerful signal to a vulnerable participant. Their will to live independently after a drug free holiday prevents short term heavy use and long term institutionalization

**Conclusion**

The substance abuse literature is lacking data on use/misuse/abuse in PACE comparable populations. This chapter attempts to provide a summary of real life IDT team experience that may be valuable to other PACE organizations.

**References**

Substance Abuse Among Older Adults, U.S. Department of Health and Human Services 2007.


CHAPTER 22

Start-Up “To Do” Check List for New Medical Directors

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For a new PACE Medical Director, the task at hand may appear daunting and overwhelming. Expectations of PACE Medical Directors differ somewhat from expectations of Medical Directors of long-term care facilities. A typical PACE Medical Director acts as a clinician, as well as an administrator responsible for the delivery of participant care, regulatory compliance, and the implementation and oversight of Quality Assessment & Performance Improvement (QAPI).

This chapter presents a check-list of the steps to go through a PACE program is established.

1. Obtain and Read the Medical Director’s Handbook

The Medical Director’s Handbook has been a valuable source of information that is directed specifically to medical directors of PACE programs. The chapters, all written by PACE Medical Directors, capture all the essential dimensions of medical directorship in PACE programs. The handbook defines standards of practice expected of every PACE Medical Director. It also includes the e-mail addresses of the authors who are always available if there is need for further clarification.
2. Then Go to the Internet

The CMS and National PACE Association websites are very helpful.

http://www.cms.hhs.gov/PACE/LPPO/list.asp
http://www.npaonline.org

3. Attend a National PACE Association Annual Meeting

The National PACE Association (NPA) has a series of meetings throughout the year. The Annual Fall Conference and the Primary Care Summer Conference are held in cities across the country where there is a PACE program. The Spring Policy Forum is always held in Washington, DC. The meetings provide educational as well as networking opportunities for all different levels of PACE staff. There is an extensive array of topics tailored to serve the needs of PACE programs at different stages of development. New medical directors should attend the Annual Meeting in the fall, especially the Primary Care Symposium and sessions that cover PACE basics.

4. Establish relationships and network with existing medical directors from other PACE programs

At the NPA Annual Meeting, there are opportunities to meet to other medical directors with various levels of experiences. One day is dedicated to a Primary Care Symposium, where there is opportunity to brainstorm with other Medical Directors on current issues encountered in caring for PACE participants. The interaction and discussions are quite unique since there is no other place where fifty or more PACE Medical Directors are gathered in one venue.

NPA also has a “blog” called NPA e-communities that are organized for different disciplines in the PACE organization, e.g., primary care, nutrition and recreation.
therapy. The Primary Care e-community allows the user to post a question and receive answers from PACE organizations all over the country.

5. Visit as Many PACE Sites As Possible

Every “medical director to-be” should visit as many PACE sites as possible. This is a good source of education and provides direct exposure to different norms or practices. Keep in mind that what may work in one site may not necessarily apply at another. As a new PACE site is developed, there will be opportunities to select which practices are applicable to the program.

6. Establish a PACE network of specialists, hospitals, and nursing homes.

Many in the medical community may not be familiar with the PACE model. It is essential to choose a network of specialists, hospitals, and nursing homes that will be attuned with the PACE mission of maintaining quality of life for frail elders and enabling them to stay in the community. This task alone will require numerous conversations and ongoing education about the PACE model. As a medical director, you will have to decide which cardiologist or gastroenterologist shares the PACE philosophy. The network of specialists and facilities chosen should be committed to maintaining open lines of communication with the final objective being high quality care for participants.

7. Obtain Licenses for PACE Facility such as CLIA- waiver, DEA License

The PACE center is the hub of all PACE activities. The medical clinic of a PACE program will have many functions that are not usually seen in a regular doctor’s office including blood draws, CLIA-waived tests, intravenous fluid administration, and nebulizer treatments. Medications will be stored,
administered, and distributed at the PACE centers. To accomplish these various functions, the PACE center, through the Medical Director, has to apply for various licenses. Regulations vary from state-to-state, so be sure to check with local state regulations.

8. **Choose a Medical Record**

In the start–up process of any PACE program, an important decision is whether to use electronic or paper records. With President Obama’s American Recovery and Reinvestment Act of 2009, most PACE organizations are leaning towards electronic medical records, although at this time it is still uncertain if PACE programs will be eligible for Medicaid and/or Medicare payments. The medical record chosen should be able to capture all the essential information for every participant. There are several vendors of electronic medical records available; some claim to be more PACE-specific than others. Criteria for selection should include functionality, convenience, ability to capture necessary data, and affordability.

9. **Educate Medical Community about PACE Programs**

PACE programs are very unique models of care. A principal reason why PACE is successful is because care is centralized and overseen by an interdisciplinary team. Education of the medical community about the model is imperative not only to explain this type of care but also to erase any fears of “stealing” patients from their practice. This can be achieved through hosting a Grand Rounds and inviting primary care physicians, specialists, social workers, and other health care personnel involved in the care of the elderly; through casual meetings in the hallways of the hospital, or even just a plain phone call to say “Hello!” The PACE medical director will act as liaison to the local health care community. The lines of communication to connect and educate the medical community are
important to alleviate any worries from other physicians once your program starts running. It can also provide an invitation for future referrals.

10. Establish and Review Policies and Procedures Regarding Operations in the PACE Clinic, QAPI, Credentialing, Pharmacy and Medications

Many PACE programs have years of preparation and dialogue with regulators prior to opening of their doors to the general public. This is not unusual as the unique nature of PACE programs entails education for everyone. Regulations vary from state to state and it is beneficial to familiarize yourself with what rules apply to PACE. While the core principles of PACE are standard across the country, applying them to local conditions is key to establishing a successful program.