High Touch, Low Tech: Optimal Care in PACE through Utilization Management

NPA Annual Conference
October 24, 2016
Presentation Overview

- Understanding optimal care for the elderly
- Identification of clinical and financial optimal care utilization data metrics
- Utilizing data and obtaining care team buy-in
- Practical examples of utilization management
- Group exercise - utilization management case study
Optimal Care for the Elderly

Presented by: Laura Ferrara
Changes in Health Care

• Older adults with multiple chronic conditions comprise 66 percent of Medicare fee-for-service beneficiaries and account for 93 percent of total Medicare expenditures.

• Individuals with both chronic conditions and functional limitations requiring long-term services and supports are at highest risk for poor outcomes and high health care expenditures.

• Community based organizations help individuals manage chronic diseases and meet overlooked social needs.
Hazards of Hospitalizations

• Study of 60 functionally independent individuals > 75 years admitted to the hospital from home:
  • 75% were no longer independent on discharge
  • 15% were discharged to nursing homes

• Effects of hospitalization:
  • Decreased muscle strength and aerobic capacity
  • Bed rest results in the loss of plasma volume -> postural hypotension and syncope
  • Bed rest reduces adequate ventilation -> reduced oxygenation
  • Bed rest increases bone demineralization -> increased risk for fractures
  • Many environmental barriers lead to urinary incontinence
  • Bed rest causes increase in pressure ulcers
  • Bed rest and therapeutic diets lead to malnutrition
The combination of IDT care and caregiver engagement provides the elderly the opportunity to age in place in the community.

6 core PACE care practices improve quality of life, prolong independence and community living, and decrease hospitalization rates:

1) Management of red flags
2) End of life management
3) Caregiver support
4) Care coordination
5) Medication management
6) Participant and caregiver health care system literacy
Management of Red Flags

• Management of clinical issues that can progress and require a higher level of intervention – evaluation and management of red flags

• PCP visits prior to and immediately after ED/hospital visits

• Evaluation of the events leading up to ED visits and hospitalizations – develop hospital prevention strategies for each participant
End of Life Management

- Completion of advance directives
- Assessment of health care wishes (goals of care) and interventions consistent with goals
- Preference for location of death
Care Giver Support

- Interventions to prevent burnout – respite days
- Emotional support for caregivers
- Soliciting and listening to caregiver input (caregiver surveys)
- Expenses toward home improvements
Care Coordination

• Transition of participant from ED, hospital, or nursing home
• **Timing of PCP visit pre and post ED/hospital/SNF**
• Timing of assessment of specialist recommendations from appointment
Medication Management

• Elimination of unnecessary and inappropriate medications
• Management of medication compliance
• Hospital/SNF medication reconciliation
• Total prescriptions used
• Psychotropic drug use
Participant and Caregiver Health Care System Literacy

- Appropriate use of healthcare resources
- Identifying participant and caregiver knowledge regarding the health care system at each assessment
- Management of participant/caregiver expectations within the managed care model
Clinical and Financial Optimal Care Utilization
Data Metrics

Presented by: Alex Lueth & Ken Welch
Census Overview

- Filling our program’s physical space and state cap is key (for mission purposes and financial purposes!)
- Need to spread risk over as many participants as possible
- Need to spread fixed costs (building, administrative, etc.) over as many participants as possible
### Census

<table>
<thead>
<tr>
<th>Member Months</th>
<th>June</th>
<th>Budget</th>
<th>Variance</th>
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<tbody>
<tr>
<td>Calhoun</td>
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<tr>
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<table>
<thead>
<tr>
<th>Member Months</th>
<th>Year-to-Date</th>
<th>Budget</th>
<th>Variance</th>
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<tr>
<td>Total</td>
<td>2,369</td>
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Note: Each member month covers approximately $2,650 in fixed costs
Current month lost net income is approximately $145,750
Budget to Actual Enrollment
(as of end of quarter)
Budget to Actual Enrollment
(as of end of quarter)

Kalamazoo Enrollment - Budget vs. Actual

- KZ Actual Enrollment
- KZ Budget Enrollment
Skilled Nursing Facility Overview

• Cost of a short-term rehab can range from $400-$800+ per day
• Typical SNF stay can last 30 or more days
• Our team aims for a stay of 15 days or less, with continued rehab at PACE center
• Long-term facility placement should be a last resort and is against the PACE mission
# Short Term Skilled Nursing Days (PMPM)

## FY16 Skilled Nursing Facility Short-term Days PMPM

<table>
<thead>
<tr>
<th>Quarter</th>
<th>BC Actual Days PMPM</th>
<th>KZ Actual Days PMPM</th>
<th>NPA 25th Percentile</th>
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<td>0.20</td>
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<td>0.60</td>
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<td>1.00</td>
</tr>
<tr>
<td>Q4 - 2015</td>
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<td>0.22</td>
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<tr>
<td>Q1 - 2016</td>
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<td>1.40</td>
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<tr>
<td>Q2 - 2016</td>
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<tr>
<td>Q3 - 2016</td>
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<tr>
<td>Q4 - 2016</td>
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Long-term Skilled Nursing Facility Placement

FY16 Percent of Census in Skilled Nursing Facility Long-term Placement

- Q4 - 2014: 3.0%
- Q1 - 2015: 4.7%
- Q2 - 2015: 5.2%
- Q3 - 2015: 5.9%
- Q4 - 2015: 6.5%
- Q1 - 2016: 5.8%
- Q2 - 2016: 3.6%
- Q3 - 2016: 3.2%
- Q4 - 2016: 3.2%

Target: 3.5% of Census

BC Actual % of Census
KZ Actual % of Census
Nearly 50% of older adults take one or more medications that are not medically necessary.

A participant taking more than 5 medications has the following consequences:

- Almost 4 times as likely to be hospitalized from an adverse drug effect
- Reduced ability to perform IADLs
- Increased impaired cognition
- Increased risk of fall
- Non-adherence
- Urinary incontinence
- Impaired nutrition

Although medications are cost-reimbursed in PACE, there is a portion that is risk-based with CMS.

For every $1 Medicare spends on NH medications, it spends $1.33 addressing medication induced problems.
Average Rx Per Participant

Average Rx per Participant

<table>
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<tr>
<th>Quarter</th>
<th>BC Rx per Participant</th>
<th>KZ Rx per Participant</th>
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<td>10.1</td>
<td>8.7</td>
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<tr>
<td>Q3 - 2016</td>
<td>10.4</td>
<td>9.1</td>
</tr>
<tr>
<td>Q4 - 2016</td>
<td>10.0</td>
<td>8.4</td>
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Emergency Department Overview

• ED feeds other high cost settings (i.e. IP, SNF, etc.)
• ED treat and release is a failure we can prevent
• Utilization review by care team is important
• Important to have a good communication and relationships with ED physicians
• Participant and care giver education about emergency on-call process is crucial
ED Treat & Release as a Percent of Census
EXPENSIVE: Our average IP claim paid at 100% Medicare rates is ~ $12,800

Average daily rate of ~ $2,400

Authorization process is key: observation vs. IP admission

Monitor IP participants daily and consider rounding

Strong relationships with utilization nurses and hospital discharge planners are very important
Hospitalization Rate as a Percent of Census
Monthly Inpatient Days

<table>
<thead>
<tr>
<th>Month</th>
<th>Days</th>
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<td>July</td>
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<tr>
<td>August</td>
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<tr>
<td>September</td>
<td>24</td>
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<tr>
<td>October</td>
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<td>March</td>
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<td>April</td>
<td>31</td>
</tr>
<tr>
<td>May</td>
<td>88</td>
</tr>
<tr>
<td>June</td>
<td>113</td>
</tr>
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• Home care hours should be allocated based on medical necessity

• Consider developing a tool for consistent authorization of home care hours based on medical need

• Review participant home care summary for outliers with very high needs that may be better served in an AFC or SNF
Average PMPM Home Care Hours

<table>
<thead>
<tr>
<th>Month</th>
<th>Average PMPM Home Care Hours</th>
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<tbody>
<tr>
<td>July</td>
<td>43.79</td>
</tr>
<tr>
<td>August</td>
<td>45.48</td>
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<tr>
<td>September</td>
<td>45.59</td>
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<tr>
<td>October</td>
<td>46.44</td>
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<tr>
<td>November</td>
<td>45.00</td>
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<tr>
<td>December</td>
<td>38.84</td>
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<tr>
<td>January</td>
<td>37.69</td>
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<td>February</td>
<td>39.30</td>
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<td>March</td>
<td>34.61</td>
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<tr>
<td>April</td>
<td>31.66</td>
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<tr>
<td>May</td>
<td>29.40</td>
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<tr>
<td>June</td>
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Utilizing Data and Obtaining Care Team Buy-In

Presented by: Therese Saggau & Laura Ferrara
What is optimal care?

Ensuring participants have the RIGHT services at the RIGHT place at the RIGHT time
Optimal Care is Best Practice

• Supports our mission and vision
• Increases participant and caregiver satisfaction
• Allows delivery of care at the least restrictive setting
• Proactive care
• Anticipates potential problems
• Allows program growth and sustainability
• Expectation of CMS and State
Messaging for the TEAM
Ongoing TEAM Involvement

• Involve all levels of staff in the solution
• Q and A Sessions
• Update on a regular basis with meaningful data and meaningful examples
• Celebrate optimal care successes
Practical Examples of Utilization Management
Utilization Management Meetings

• Weekly meeting with Medical Director
• Review events leading up to the hospital admission/ED visit
• Identify possible contributing factors:
  • End of life management – could end of life discussions prevented the hospitalization?
  • Nursing assessment
    • Could a nursing assessment have been beneficial?
    • Could care have been provided in home?
    • Could admission have been prevented with more in home nursing care?
Utilization Management Meetings

• Nursing home admission
  • Could the same care have been given in a SNF?
  • Could hospitalization have been prevented with a SNF admission?

• Outpatient management
  • Was there outpatient management that could have been used?
  • Would more aggressive outpatient management have prevented admission?
Utilization Management Meetings

- Participant/family education
  - Did participant/family overlook PACE program instructions?
  - Would more education with participant/family have avoided admission?

- In home monitoring
  - Could participant have benefited from more in-home monitoring?
  - Would that more aggressive in-home monitoring have prevented admission?

- Facility education
  - Did admission occur while at a facility?
  - Did facility overlook PACE program instructions or education?
  - Could admission have been prevented with more facility education?
Utilization Management Meetings

• Evening/weekend on call
  • Did admission occur after hours?
  • Could care have been prevented in the clinic?
  • Could admission have been prevented if it occurred while clinic was open?

• Preventative/routine care
  • Was this admission related to any form of preventative or routine care?
  • Could admission have been prevented with more preventative or routine care?

• Other
  • Were there any other issues that could have prevented this admission?
Daily E-mail Content

• On-Call information
• Recent deaths (past 30 days)
• Participants on end-of-life services
• Current IP hospitalizations
  • Admitting date
  • Diagnosis
  • Hospital Course
  • Discharge planning
• 5 star list
Daily Spotlight

Daily Spotlight- daily email informing all staff of all major changes with participants for better coordination and information sharing

Headings include: Hospitalizations, ER, Short Term SNF, End of Life, Short Term AFC, Respite, Upcoming Procedures, Daily Wound Care, On Call Assignments, Suspended Attendance, Disenrollments
• RAD formalizes decision making for medically necessary services, treatments or interventions
• Considers medical, psychological and emotional needs of the participants
• Considers the impact on participant’s health, safety and independence
• RAD ensures consistency in decision making across teams and employees
• Allows the interdisciplinary team to consider individual circumstances to best provide optimal care
Home Care Allocation Tool (H-CAT)

- An objective tool used to determine the services needed to support the participant and caregiver to remain in their home for as long as possible. PACE services should supplement, not replace, the assistance already being provided by family, friends and neighbors.

- Allows an objective measure to help guide the interdisciplinary team on home care decisions.

- Allows the interdisciplinary team to consider individual circumstances.
Conducted for all participants who are transferring to long-term placement (ALF, AL, or SNF)
• Assessments performed by all disciplines
• Meeting held where two IDT’s review and discuss
• Form includes:
  • Why does the requestor think consideration of placement is necessary?
  • Who initiated the placement consideration: team or family? (be specific)
  • Is the participant decisional specifically regarding their living situation?
  • When was this determination made (provide date of documentation and PCP name)?
Form includes (continued):

- Does the participant wish to remain in their current environment?
- What is the participant’s goal of care pathway? (Longevity, functional, palliative)
- When was this conversation held (provide date of documentation and PCP name)?
- Define the issues surrounding the request for consideration of placement (based on current situation/issues, not risk projection):
  - Medical
  - Psychiatric
  - Social/Cultural
  - Environmental
  - Safety
  - Caregiver
Form includes (continued):

- What does the participant score on the home care needs assessment tool?
- Review the recent PT and OT assessments which are based on performance (“what the participant actually does”). List the ADLs and IADLs that require assistance, and what type of assistance is required.
- What are the ppt’s skilled nursing needs? Do they require licensed LPN or RN?
- Are there active behavior issues?

Based on the above information, what is the core issue? *GET TO THE WHY*
• Options to support least restrictive environment:
  • Have alternate caregivers been sought?
  • Has the caregiver been offered education and support services?
  • Has the role of natural supports been explored?
  • Are there community resources that may be appropriate?
  • Has respite been used?
  • Have we maximized our interventions with ADL, IADL and skilled nursing support in the home?
  • How would this issue be met if the participant were not in the program?
  • What is the participant’s ability to address the core issue?
• Final decision-making and next steps:
  • Is there benefit to the participant remaining in their current environment?
  • Is this suggested placement the least restrictive environment?
  • Is there medical necessity to support this placement?
  • Is there missing information to be addressed prior to the final decision?
  • What has the peer review team agreed upon?
  • What are the next steps (action items) for the team, participant and family?
Average Daily Census

- The participant’s weekly attendance should be based on medical necessity and social needs.
- Maximization of census served by each location = maximization of bottom line net income.
- New programs should be careful not to give participants more care than necessary as this is difficult to reverse when census increases.
- Set timeframes and monitor temporary changes in day center attendance for specific participants.
5 Star Risk Stratification Process

• 5 star participants: at extremely high risk for hospitalization
• Interventions: 5 star participants are brought into immediately or seen in the home the same day for any medical complaint
• 5 star criteria:
  • 1 or more hospitalizations within the last 1 week
  • 2 or more hospitalizations within the last 1 month
  • 3 or more falls within the last 1 month
  • PCP clinical suspicion of high risk
  • Acute worsening of ambulation or cognitive status
Group Exercise – Utilization Management Case Studies
Practical Tools

- Utilization Review
- Daily Spotlight/Daily Email
- Resource Allocation Determination Tool
- Homecare Allocation Tool
- Peer Review Process
- Average Daily Census
- 5 Star Risk Stratification
Scenario #1 – Home Care

- Mrs. Joseph was receiving 10 hours per week of home care for showering and for assist on and off the bus on PACE days. Her daughter was providing all other care.

- Her daughter informed the team she had to go into the hospital and would be unable to provide the care for her mom for one week.

- IDT supported a temporary increase of home care hours to 20.

- The daughter was out of the hospital after one week and able to resume her caregiving responsibilities.

- 3 months later upon review of home care hours, Mrs. Joseph was still receiving 20 hours.
Scenario #2 - SNF Short-Term Stay

• Mr. Lake experienced a mild stroke and needed short term rehab to get back to baseline.

• IDT agreed to a 2 week stay in a SNF. Mr. Lake was also in agreement as he wanted to continue to live independently at home and knew he needed rehab for this to happen. He had no cognitive deficits.

• After 4 weeks Mr. Lake is still in the SNF and asking why he is not yet home.
Scenario #3 – Hospital/ED Visit

- 77 year old female living at home with her caregiver grandson
- Diagnoses include:
  - Chronic respiratory failure, oxygen dependent
  - Recurrent pneumonia
  - Diabetes
  - Depression
  - Chronic kidney disease
  - Hx CVA
  - Frequent falls
  - Acute 25# weight loss
- DNR status 2/4/2016
- Hospice care ordered 6/26/2016, participant expressed strong desire to die at home
Scenario #3 – Hospital/ED Visit

• 9/13/2016 Grandson reported left sided weakness and some slurred speech.

• 9/13/2016 Hospice nurse evaluated participant and reported to grandson that she likely had a stroke.

• 9/13/2016 Participant’s son (recently appointed DPOA) called EMS to transport participant to ED.
  • Head CT done – negative for acute change

• Participant opted to return home and wants no more hospitalizations.
Mrs. Smith gets hot in the summer and is uncomfortable in her trailer. She requests an air conditioner from the IDT.

Mr. Jones has COPD and frequently visits the ED due to exacerbation of his COPD in the hot, humid summer months. He requests an air conditioner from the IDT.

Should the requests from Mrs. Smith and Mr. Jones be approved by the IDT?