OBJECTIVES:
1. Understand utilization management in PACE
2. Be able to develop a utilization management plan
3. Identify the role of the medical director in overseeing utilization management
Utilization Management

**What**

- Knowledge and understanding of cost drivers
- Ability to monitor and analyze outcomes
- Using measurable outcomes —— identify results
- **Cannot separate UM from Quality**
- Any attempts to reduce utilization apart from quality will likely fail at both
Through the QAPI program, PACE organizations should evaluate the effectiveness of the wide range of services furnished by PACE organizations and use data to identify, improve and maintain program performance. CMS believes that each PACE organization should have the flexibility to design an internal QAPI that would best meet the needs of its enrolled participants and their caregivers; therefore, CMS neither specified a standardized quality assessment tool nor dictated the data-driven outcome measures that PACE organizations should internally collect, analyze, and act on to improve performance. However, CMS did provide in 42 CFR § 460.132 (and discussed in section 20.1) the minimum requirements that must be addressed in the PACE organization’s written plan for the internal QAPI program, including the requirement that the plan be reviewed annually and revised by the respective PACE governing body to assure organizational oversight and commitment.

A PACE organization’s QAPI program must include, but not be limited to, the use of objective measures to demonstrate improved performance with regard to five areas: 1) utilization of services (e.g., decreased inpatient hospitalizations and emergency room visits), 2) participant and caregiver satisfaction, 3) outcome measures that are derived from data collected during participant assessments, 4) effectiveness and safety of staff-provided and contracted services, and 5) non-clinical areas including grievances and appeals.

Utilization of Services. Collected utilization data such as hospitalizations and emergency room visits can be used to evaluate fiscal well-being, as well as evaluate quality of care. It can also be used to target reviews of PACE centers whose utilization data suggest, for example, that participants may be receiving fewer services than necessary to achieve expected outcomes. The purpose for including utilization data in the PACE organization’s QAPI program is to help the PACE organization ensure that participants receive the appropriate level of care through their PACE center. Additionally, by collecting and analyzing information regarding utilization of and reasons for emergency care and hospital and nursing home admissions, the PACE organization can identify areas for improvement.
## DATA COLLECTION

### RESOURCES
- Home care hours
- Pharmaceuticals
- Staffing ratios
- Care plans/systems
- Van ride-times
- Clinic visits
- DHC days
- Dollars

### OUTCOMES
- Inpt days, ER visits
- LTC days
- Specialist visits
- Falls
- Deaths
- Advanced directives
- Disenrollments
- Dollars
Utilization Management

GOALS:
1. Optimally achievable quality of care (outcomes)
2. Effective and efficient utilization of facilities and services – 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
Principles in Utilization Management

- High quality care usually is the least expensive in the long run
- Why pay somebody else if we can do it as well ourselves
- An institutional admission is a failure of care
- Just because we can do it doesn’t mean we should
- If you don’t turn over any rocks, you won’t find any snakes
- Do the right thing
- Begin with the end in mind
WHERE TO START?

*Develop a UM workgroup
  - Emphasize that Utilization is everybody’s responsibility
  - Have the right people at the table
  - Make it a requirement NOT an option
  - Use models that work” Reflective Utilization”
  - If at first you don’t succeed “try again”
  - Think out of the box
  - Hold IDT accountable
  - The buck stops with the medical director
MODELS OF UM

- Reflective Model – Community Care
- Utilization Management Team Model – PACE SEMI
Reducing Hospital Admissions:
Reflecting on your Practice
Deepening your understanding

Mary Parish Gavinski, MD
Chief Medical Officer Community Care
What is reflection

- "Active, persistent and careful consideration of belief, knowledge, or experience.”  "Thinking with a purpose.”  Dewey.
- “Thinking back on what we’ve done...to **discover** how our ‘knowing in action’ may have contributed to an unexpected outcome.”  Schoen.
- “A process of reviewing an experience of practice in order to **describe**, analyze, evaluate and **so inform learning about practice**.”  Reid
The processes of reflection

- **Awareness** of an event, situation, experience that bears examination – causes discomfort
- **Critical analysis** of the situation
  - Openness to new information and perspectives
  - Thoughtful examination of the experience
- Development of a **new perspective**
  - Changes in thoughts, feelings, actions
Reflective Practice Frameworks

- Simply a guideline for approaching “how” we do reflection.
- Provide a systematic approach to the process
- Key components of any framework:
  - Description of what happened
  - Evaluation of that event
  - Actions that occur as a result of the reflection – So What??????
PACE SEMI Experience

2016: growth to 3 sites
Utilization: Inpt and ED rates were out of control
Met with each ID and showed the results and ask for input from every member of the team.
Developed a work plan with timeline
Reviewed Reflective Practice
Instituted UM at each site
- Meeting weekly
- Review all ED and inpt
- Put plan in place to avoid next admission
- Reviewed dashboards and PMPM
## Utilization Work Plan

<table>
<thead>
<tr>
<th>TASK</th>
<th>PRIMARY RESPONSIBILITY</th>
<th>START DATE</th>
<th>COMPLETION DATE</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Utilization Workgroup</td>
<td>Dr. Graddy/ Rosalind Miles</td>
<td>05/01/17</td>
<td></td>
<td>UM workgroup made up of IDT from each location. UM workgroups meet weekly to review all ED and Inpt visits. This information is then given to Med Director to look at Avoidable vs unavoidable ED visits.</td>
</tr>
<tr>
<td>2. Education Campaign</td>
<td>Dr. Graddy/ Dept. Heads</td>
<td>05/01/17</td>
<td></td>
<td>Meet with each department about ways to disseminate the MEP information. Examples: RNCM: home visits and placement of MEP and white magnet board. Social work: weekly calls and calls after ED visits to review MEP, Transportation signs on vans. Recreation: daily reminders, ED Bingo, ED trivia, calendar notification and speakers series. Primary Care, Caregiver onboarding. Med Director met with each department manager to review our Utilization and ask them for suggestions on improving our UM. Each Department’s suggestions were reviewed and processes developed as indicated.</td>
</tr>
<tr>
<td>3. Communication: MEP</td>
<td>Laurie Arora</td>
<td>06/07/17</td>
<td></td>
<td>Implement “Call ‘Em All” To consider other methods to reinforce and as remindersie: bracelet, signs, a jingle etc. See Appendix A</td>
</tr>
<tr>
<td>4. RNCM-Distributing MEP</td>
<td>Linda McCarver</td>
<td>05/01/17</td>
<td></td>
<td>RNCM to make certain that MEP is in the home and that it is reviewed bi-annually.</td>
</tr>
<tr>
<td>5. Implement post ED and post inpatient visits</td>
<td>Linda McCarver/Rosalind Miles/ Dr. Graddy</td>
<td>06/19/17</td>
<td></td>
<td>Implement post ED and Post Inpt visits. Process 24-48 hour post visits. RNCM, Clinic, Primary Care. MEP to also be reviewed in the clinic at regular routine visits.</td>
</tr>
<tr>
<td>6. ID High Utilizers (HU)</td>
<td>Dr. Graddy/ Susie Amato</td>
<td>05/01/17</td>
<td></td>
<td>List of HU generated for each site to the directors of operations. HU list to be applied to #7. High utilizers defined as &gt;=2 per month or 1 visits per month for 3 consecutive months.</td>
</tr>
<tr>
<td>TASK</td>
<td>PRIMARY RESPONSIBILITY</td>
<td>START DATE</td>
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<tr>
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</tr>
<tr>
<td>7. Apply (Root cause analysis)RCA to High Utilizers</td>
<td>Directors of Operations</td>
<td>06/10/17</td>
<td></td>
<td>Once HU are identified DOO will apply the RCA. They will also discuss at daily team. After the RCA the causes leading to ED will have process implemented. DOO will provide weekly report of HU with the following: problem, solution, implementation and outcomes. These can be used to develop system wide process.</td>
</tr>
<tr>
<td>8. Telehealth Grant</td>
<td>Laurie Arora/Adam</td>
<td>05/15/17</td>
<td></td>
<td>Develop workgroup, identify which chronic diseases to track which will include: CHF, COPD, ESRD, DM. Please refer to the Appendix B</td>
</tr>
<tr>
<td>9. Medstar EMS</td>
<td>Mary Naber/Dr. Graddy/Rosalind Miles, Linda McCarver/Rosalind Miles</td>
<td>06/19/17</td>
<td></td>
<td>After hours answering service/dispatch and EMS as needed. The process starts with call to MedStar who will go through protocol and if non-Emergent it will be triaged on to PACE. Based on information provided MedStar may be mobilized to the home to do an assessment. Initially daily meetings will occur.</td>
</tr>
<tr>
<td>10. Reinstitute High Alert Pt HAP List</td>
<td>Directors of Operations</td>
<td>06/10/17</td>
<td></td>
<td>List of pts at risk for ED/inpt. This include but not limited to: New enrollees for the first 3 months. Discharge from Inpt/ED. Missing days at the center. Any other problem that the staff identify as a concern. This will be reviewed on Fridays at team and proactive phone calls will be implemented. It is expected that each person on the HAP list will receive a phone call on Friday.</td>
</tr>
<tr>
<td>11. Utilization Management RNCM</td>
<td>Tracey Diroff/Dr. Graddy Duana Frazier</td>
<td>05/15/17</td>
<td></td>
<td>Utilization Nurse manager will have the ED/Inpt as her caseload. She will see all inpt within 24 hours and connect with the inpt discharge plan and provide contact information for PACE to staff and back to PACE. She will see pts 2-3 times per week RNCM to monitor all ED and inpt visits, visits to all ED staff.</td>
</tr>
<tr>
<td>12. ED staff educate on PACE and MEP</td>
<td>Dr. Graddy/Duana Frazier</td>
<td>06/12/17</td>
<td></td>
<td>Meet with ED staff to review PACE/MEP. Will schedule meeting with all health system that our participants will potentially be admitted to. Will take Utilization management nurse.</td>
</tr>
</tbody>
</table>
PACE SEMI Experience
Hospital 30 Day Readmissions 2017 vs. 2018

Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 | Q1 2018
---|---|---|---|---
21% | 28% | 25% | 13% | 16%
## Medical Services Per Member Per Month (PMPM) 2018 vs. 2017

<table>
<thead>
<tr>
<th></th>
<th>Medical Services Dollars</th>
<th>Participant Months</th>
<th>YTD PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southfield</td>
<td>$1,993,357</td>
<td>818</td>
<td>$2,436.87</td>
</tr>
<tr>
<td>Rivertown</td>
<td>$1,943,711</td>
<td>748</td>
<td>$2,598.54</td>
</tr>
<tr>
<td>Warren</td>
<td>$674,159</td>
<td>414</td>
<td>$1,628.40</td>
</tr>
<tr>
<td>Dearborn</td>
<td>$468,701</td>
<td>168</td>
<td>$2,789.89</td>
</tr>
<tr>
<td>CONSOLIDATED</td>
<td>$5,079,928</td>
<td>2,148</td>
<td>$2,364.96</td>
</tr>
</tbody>
</table>

**March 2018 Medical Services PMPM**
CALL PACE Southeast Michigan (PACE SEMI) or
AFTER HOURS ON-CALL NURSE: 1-855-445-4554

HOME HEALTH CARE

CASE MANAGER: _____________________________ OFFICE#: 1-855-445-4554 - 24 hours a day / 7 days a week
PHYSICIAN NAME/
NURSE PRACTITIONER: _____________________________ OFFICE#: 1-855-445-4554 - 24 hours a day / 7 days a week

MY EMERGENCY PLAN

***This plan is a guide only and may not apply to all participants and/or situations.
This plan is not intended to take the place of participant/family decisions in seeking care.

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL PACE SEMI: 1-855-445-4554</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hurt</td>
<td>• New pain OR pain is worse than usual&lt;br&gt;• Unusual bad headache&lt;br&gt;• Ears are ringing&lt;br&gt;• Unusual low back pain&lt;br&gt;• Chest pain or tightness in chest that feels better after rest or medication</td>
<td>• Pain in neck, jaw, back, one or both arms, or stomach&lt;br&gt;• Chest pain with sweating/nausea&lt;br&gt;• Sudden severe headache&lt;br&gt;• Severe, sudden chest pain or pressure &amp; medications don’t help OR Chest pain went away &amp; came back&lt;br&gt;<strong>PLEASE INFORM PACE SEMI 855-445-4554</strong></td>
</tr>
<tr>
<td>I have trouble breathing</td>
<td>• Cough is worse&lt;br&gt;• Harder to breathe when I lie flat&lt;br&gt;• Chest tightness less after rest or medication&lt;br&gt;• My inhalers don’t work&lt;br&gt;• Different color, thickness, smell of spit</td>
<td>• I can’t breathe&lt;br&gt;• Pass out&lt;br&gt;<strong>PLEASE INFORM PACE SEMI 855-445-4554</strong></td>
</tr>
<tr>
<td>I have fever or chills</td>
<td>• Fever is above <strong>100.5° F</strong>&lt;br&gt;• Chills/can’t get warm</td>
<td><strong>PLEASE INFORM PACE SEMI 855-445-4554</strong></td>
</tr>
</tbody>
</table>
Lessons Learned

- Don’t assume it will just happen
- Have a plan
- Put metrics on your outcomes
- Don’t forget to tie them to QAPI
- Revisit often and make adjustments as needed
Summary

- Start at the beginning
- Know what your numbers are
- Get to know your CFO
- Regular meetings with the Director of Quality
- Get monthly reports
- Share info with the chief players
- Remember your goal is not to save money- your save is to provide the highest quality of care
Integrated Service Delivery = Utilization Management

Interdisciplinary Teams

- Social Services
- Pharmacy
- Home Care
- Activities
- Nutrition
- Primary Care
- Personal Care
- Transportation
- OT/PT