Physician Advisor and UR Team Boot Camp

The Role of Case Management in Achieving Successful Reform

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Declarations

- No commercial declarations or disclosures
Objectives

- Briefly outline Healthcare Reform and implications of roll-out
- Address roles that Case Managers can play in this space to effect positive changes for the healthcare systems where we work
Spartanburg Regional Healthcare System

- Main Tertiary Hospital (400+ beds), Second center (40 beds), and rehab facility in upstate SC
- 500+ physician medical staff
- 125,000 visits/year Emergency Department
- Full scope Trauma Center

- Only Recertified SC Magnet Hospital of Nursing, #1 Robotics hospital in SC, first certified SC Chest Pain Center, first certified SC Stroke Center


Change is on the horizon

- Healthcare is in a state of “flux”
  - ....”crisis”? 
  - ....trying times?

- Much will change in healthcare
  + Delivery,
  + Operations,
  + Management,
  + Payment models,
  + Documentation,
  + Alignments

- Case Managers can help us navigate the course of change
危机
The Chinese word: Crisis

- First symbol:
  - Danger

- Second symbol:
  - Opportunity
Secrets to “change”

- Have a plan in place and a vision with an endpoint
  - Be flexible, plans change as they are rolled out
    - Cardiologist: “You changed the plan!!!”
    - “....I understand that you had to.”
  - Beware of “sacred cows” and deep-seated culture
    - Assess the culture, grade the cows to help make a workable plan
Secrets to “change”

- Be gradual with implementation if you can
  + ...and if you can’t, try to **look like you are**
    - “Fence riders” will follow if you give them time
    - Those on your side of the fence will grow to support you
    - Those stuck in the mud sink deeper if pulled quickly...
  + Watch for “change toxicity”
Be a “Change Leader”

- Be positive
  - Positive outlooks refresh, revitalize, energize
- Be able to juggle many plates
  - Look for options to enhance idea (proactive), when chaos hits stay focused and put plates down safely to think through options
- Don’t out work your leader
The US spends more on healthcare than any other country in the world
+ ($2.6 Trillion)
+ Life expectancy is behind developed nations

In America, the rate of obesity doubles that of other peer countries
Nationwide epidemic - obesity
The US spends more on healthcare than any other country in the world
   + ($2.6 Trillion)
   + Life expectancy is behind developed nations

In America, the rate of obesity doubles that of other peer countries

The US has the highest prevalence of diabetes from age 20-79

Similar poor performance with COPD, Asthma, obesity, diabetes
Health Systems have large under- and un-insured populations, limited access to primary care, and the available care is unaffordable.

Americans spend more $$ on healthcare and live shorter, unhealthier lives.

IOM report and National Research Council
Why the disjoined approach to healthcare?

- Institute of Medicine
  - ...patients are not engaged with the healthcare team. Those without a medical home will wander into any POS for any reason
- Not being “connected” with a team leads to more bad *clinical* decisions (lack of adherence to plan)
  - Most healthcare decisions are not made in the exam room
Ever increasing healthcare costs
  + Towers Perrin estimates 5.1% increase in average healthcare costs per employee (2013)

Presenteeism or absenteeism

Small businesses are at a disadvantage in the current market
  + Small businesses pay up to 18% more per worker at times due to broker fees, fixed costs, and adverse selection
  + Since 2000, decline in small businesses providing healthcare coverage is continuing

20-50% of work force does NOT have a PCP
  + Younger the population, the higher
Innovations that drive better value and give:

- Better health
- Better care
- Better costs
The transition started years ago

- Fee for service (do more, get paid more)
  - Mid-1980s
- Shift to inpatient prospective payment system (IPPS)
  - Payment based on diagnosis-related groups (DRGs)
- Cost continued to rise, so
  - MS-DRG was infused to attempt to limit cost
    - Failed
The Reality

- Research comparing the US to the world
  - Health systems built on strong primary care deliver care that is
    - More effective, efficient and equitable
  - Only 5% of the total US medical spend is devoted to primary care

- What seems to work:
  - Ease of access to coordinated, team-based care
  - Connected care: real time access to medical record
  - Long-term, continual relationship with provider team and patient in supportive self-management
  - Accountability of patient with support of employer
    - Disincentive for choosing non-compliance
  - Compensation model that encourages these ideals
The Healthcare “Fix”

- The Healthcare Reform
  - The Reconciliation Act of 2010
  - The Patient Protection and Affordable Care Act ("Affordable Care Act") of 2010

- Those two together = “ObamaCare” or “Healthcare Reform Law”
Focus on primary care and try to beef up providers on front line

- Better fee for service for payments
- More expanded insurance access
- More preventive care covered
- Pilots and demonstration projects

Few carrots and big sticks await us

- Quality care is tied to incentives and penalties
- Patient \textit{perception} is tied to incentives and penalties
How can case managers help find carrots?

- To find the carrots, we must follow the patient
- In the outpatient world, opportunities exist
Patient Centered Medical Home (PCMH)

- Term coined by American Academy of Pediatrics 1967
- Primary health care that is
  + accessible,
  + family-centered,
  + coordinated,
  + comprehensive,
  + continuous,
  + compassionate, and
  + culturally effective
- AAFP joined forces with concept 2002
  + Added chronic disease management modules 2004
Patient Centered Medical Home (PCMH)

- NCQA initial group recognizing this
  - Practice process improvement initiative
  - Months to evaluate, plan, implement, test
- Some commercial payers are adding incentive bonuses to physicians/groups
  - SC BCBS $2000/site
- SC Business Coalition on Health
  - “Seek out PCP that are PCMHs”
Patient Centered Medical Home (PCMH)

- 2002 American Academy of Family Physicians
  - 2004 modified to add chronic disease management models
- 2012 COSEHC (Wake Forest)
  - One of very few integrated clinical pathways of care models (IMPACT)
    - Diabetes, Hypertension, Heart Disease, High Cholesterol (“Cardiometabolic Disease”)
PCMH Results, global

- **Lower medical costs**
  - 2 year engagement: 36% less cost

- **Financial**
  - Less use of ED, less hospital days, decreases in costs of imaging services, prescriptions and procedures

- **Clinical (HEDIS)**
  - 85% had improvement in BP, A1c (diabetes) and Cholesterol control rates

- **Patient indicators**
  - Satisfaction scores are high
Medial Home Recognition and Accreditation

- National Centers for Quality Assuredness (NCQA) is oldest (2008)
  - Joint Commission, URAC (Utilization Review Accreditation Commission), and AAAHC (Accreditation Association for Ambulatory Health Care)

NCQA assigns three levels

- Level I-III (III is highest)
- 3 year accreditation
- Process to attempt to achieve PCMH takes up to 2 years (assuming one achieves it)
  - SRHS project completed in less than 9 months

Higher level with more measures met
PCMH Certification Criteria

1. Access & Communication
   a. Access & Communication processes
   b. Access & Communication results

2. System for patient data mgmt
   a. Electronic system for clinical data
   b. Use of electronic data
   c. Organizing clinical data
   d. Identify important clinical conditions
   e. Use system for population mgmt

3. Care Management
   a. Implement evidence-based guidelines
   b. Identify high risk patients

4. Provide Self-care Support and Community Resources
   a. Support the self-care process
   b. Provide referrals to community resources

5. Track and coordinate care
   a. Test tracking and follow-up process
   b. Referral tracking and follow-up
   c. Coordinate with facilities and offer care transitions

6. Measure and improve performance
   a. Measure performance
   b. Measure patient/family experience
   c. Implement continuous quality improvement
   d. Demonstrate CQI
   e. Report performance
   f. Report data externally
   g. Use a certified EHR Technology
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“Must Pass” elements = Case Management “touches”

- The PCMH is seen as the best vehicle for efficient administration of quality, cost effective, patient-friendly outpatient health care
  - American primary care physician is in dire need of case management skills to tie the concepts/processes together
  - Patient-centered future from provider-centered
- Reimbursement models in pilot
Case Management in the patient pathway

- Pre-admission/Intake assessment:
  + ED Case Management
    - ED throughput, LWOT, “diversion”, patient perception (“face” of system)
    - Relationship with patient (and family) to quickly do care transition strategy (limits root growth)
    - Systems who have ED Case Management and then divest themselves of this skill set, see LOS increase by 15% or more
  + Pre-surgical assessment
    - Pre-payment audits are now commonplace
  + Pre-admission level of care determination
    - IP vs. OBS vs. Procedure only status
    - Observation Medicine understanding, LOS, etc.
    - External vs. Internal Physician Advisors – point person: CM
Physician Advising

- National movement to internalize programs
  - “Culture” using an outside vendor is often negative
    - Colleagues advising colleagues is more “tasteful”
    - Physician mindset needs to change in this area, active engagement in process of advising promotes this
    - Education doesn’t happen effectively with external vendors (counter to the external vendor business model)...why teach a man to fish....?
  - External vendors have value: experience, knowledge, rapid response, processes in place, current on Medicare rules/interim rules and interpretations
    - But, list serves are full of information and many strong case management departments can see a way to navigate these waters unlike 5 years ago
  - Economic benefit going forward of 50%+ savings
    - With the questionable ALJ appeals success (and bottleneck) and current IP/OBS environment, more systems are looking internally
Patient Flow in-house

- LOS issues abound in our hospitals
  - DRG payment means $$ lost or gained
  - Bed-block which causes system back-up of patients
- Quality metrics fall with prolonged stays
  - HACs
  - Patient satisfaction fades as we grow tired of patients
    - Our “front” drops with time
    - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) will bear this out
“Outcome” measure used in value based purchasing (quality adjustment of Medicare rate of payment)

First national, standardized, publicly reported survey of the patient’s perspective of their care

- 27 “outcome-based” questions
  - 18 core: communication w/ doctors and nurses, responsiveness, cleanliness, education about medications, overall rating, etc.
  - Administered 48h – 6 wks post discharge
  - Hospitals can add to this, but not exclude any questions

Case Managers need to be familiar with the questions from the tool
Patient Flow in-house

+ LOS issues abound in our hospitals
  - DRG payment means $$ lost or gained
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+ Utilization management
  - Right test – right time – right location
  - Physician outliers can be managed with collaborative effort with CM and Physician Advisor/CMO
  - Multidisciplinary rounding: “Field General”
Discharge (Transition) Planning

- Readmission penalties on the healthcare horizon
  - 1 in 6 Medicare patients admitted will be re-admitted for non-surgical reasons within 30 days
    - Estimates are 76% are preventable
    - 10-2012 pay reduction to hospitals for HF, AMI, pneumonia
      - Reduction year-over-year for 4th quarter 2012 (“working”)
    - [www.ama-assn.org/go/ambulatorysafety](http://www.ama-assn.org/go/ambulatorysafety)
      - Free download for ambulatory care transition strategies
- Focus: medication compliance and understanding, f/u care with provider, stress education at discharge, transition to ancillary services (HHN), indifference (encourage accountability and being part of the team)
- Transition Care Management Codes (2 new for ‘13)
Discharge (Transition) Planning

- Need to utilize effective team members
  - New: Palliative Care Specialists
  - Old: Parrish Nurse Programs, community support groups
- Help design “bridge” clinics
  - Primary care ramp-up will take time and reform will add to our volumes
Case Management in the patient pathway

- Quality/Finance
  - HCAHPS reports will affect finance
  - HACs and “present on admission” metrics and processes to assess and manage
- Documentation
  - Key in CMI and SOI
  - Here comes ICD-10........
### Other countries are ahead of US

<table>
<thead>
<tr>
<th>Country</th>
<th>Year Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>1995</td>
</tr>
<tr>
<td>France</td>
<td>1997</td>
</tr>
<tr>
<td>Australia</td>
<td>1998</td>
</tr>
<tr>
<td>Belgium</td>
<td>1999</td>
</tr>
<tr>
<td>Germany</td>
<td>2000</td>
</tr>
<tr>
<td>Canada</td>
<td>2001</td>
</tr>
<tr>
<td>United States</td>
<td>2014</td>
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### Differences Between the ICD-9 and ICD-10

<table>
<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>Diagnosis</td>
<td>13,000</td>
<td></td>
</tr>
<tr>
<td>Procedure Codes</td>
<td>3,800</td>
<td></td>
</tr>
<tr>
<td>Codes</td>
<td>3-5 characters in length</td>
<td></td>
</tr>
<tr>
<td>Flexibility</td>
<td>Limited space for adding new codes</td>
<td></td>
</tr>
<tr>
<td>Specificity</td>
<td>Lacks detail</td>
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<td>Diagnosis</td>
<td>13,000</td>
<td>68,000</td>
</tr>
<tr>
<td>Procedure</td>
<td>3,800</td>
<td>72,000</td>
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<tr>
<td>Codes</td>
<td>3-5 characters in length</td>
<td>3-7 characters in length</td>
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<tr>
<td>Flexibility</td>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Specificity</td>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
</tbody>
</table>
Severity of Illness (SOI) defined

The extent of physiologic decomposition, organ system loss of function, and/or mortality.

Refers to:
- How sick is the patient?
- How difficult is the patient to manage?
- What types of interventions are required?
- What is the intensity of resources utilized?
Risk of mortality (ROM) defined

An estimate of the likelihood of in hospital death for a patient.

Risk-Adjusted Mortality: The ratio of observed mortality rate (actual mortality) to severity-adjusted (or risk-adjusted) expected mortality rate.

\[
\text{Mortality index} = \frac{\text{Observed mortality}}{\text{Expected mortality}}
\]

\text{Observed mortality} is driven by quality-of-care initiatives

\text{Expected mortality} is driven (in large part) by documentation of secondary diagnoses.
## Documentation Guidelines: Heart Failure

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>High Severity</th>
<th>Moderate Severity</th>
<th>Low Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure “CHF”</td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>Rheumatic heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Left heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Unspecified systolic and/or diastolic heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Chronic systolic and/or diastolic heart failure</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Acute systolic and/or diastolic heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Acute on chronic systolic and/or diastolic heart failure</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CC and MCC: Secondary dx that affects severity

CC: Complication/Comorbidity
MCC: Major Complication/Comorbidity

**CC = Complication/Comorbidity**
A condition that, when present, leads to substantially increased hospital resource use:
- Significant acute disease
- Acute exacerbation of significant chronic disease
- Advanced or end-stage chronic diseases
- Chronic diseases associated with extensive deilities
# MS-DRG Structure-CV Surgery

- **Heart Valve Procedures**
  - DRG 218 w/o CC/MCC: $34,284
  - DRG 217 with CC: $40,743  
    - Difference: $6,459
  - DRG 216 with MCC: $61,081  
    - Difference: $20,338

- **Major Chest Procedures**
  - DRG 165 w/o CC/MCC: $11,500
  - DRG 164 with CC: $16,806  
    - Difference: $5,306
  - DRG 163 with MCC: $32,849  
    - Difference: $16,043
Simple Pneumonia
- DRG 195 w/o CC/MCC: $4,541
- DRG 194 with CC: $6,414
  Difference: $1,873
- DRG 193 with MCC: $9,556
  Difference: $3,142

Complex Pneumonia
- DRG 179 w/o CC/MCC: $6,287
  Difference: $1,746
- DRG 178 with CC: $9,242
  Difference: $2,955
  Difference: $2,828
- DRG 177 with MCC: $13,185
  Difference: $3,943
  Difference: $3,629

CHF
- DRG 293 w/o CC/MCC: $4,332
- DRG 292 with CC: $6,438
  Difference: $2,106
- DRG 291 with MCC: $9,736
  Difference: $3,298

*Simple to Complex PNA
Medicare Spending Per Beneficiary Measure (MSPB)

  - Combination of resource utilization and quality
    - Target best outcomes for best cost
    - Efficiency model of care with hopes to improve value of care
- Assessed Part A and B “per Beneficiary” episode of care over period of 9 mo (5-15-2010 → 2/14/11)
- CMS will define resources, but will look at snapshots of care from 3d prior to admission to 30d after
  - Measure is adjusted for age and SOI
- CMS will develop a ratio of spend
  - 1 is ~average, <1 is less spend (good), and > 1 is more spend (bad)
ICD-10 will allow us to correctly define conditions

- Each specialty needs to create CHEAT SHEETS: “Long lists” and “Short lists” of the most commonly used codes
- **cms.gov** has free programs with GEMS (general equivalence mappings)
- **ICD10Data.com** is a good web site for crosswalks
- Must use I-10 correctly to capture the severity and specificity of the condition
- Much more granularity with I-10
Most definitely

Multiple areas presently need to be re-assessed and new ground to evaluate as we help manage the change in America
THANK YOU for allowing me to be here—

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