IntusCare

CASE STUDY

Managing Utilization at Midland Care PACE

Background

In 2007, Midland Care became the nation's 37th Program of All-inclusive Care for the Elderly (PACE), a national program providing community-based care and services to those who would otherwise need nursing home levels of care. The program served 27 participants in its first year and has grown to serve over 550 participants across twelve Kansas communities.

Midland Care PACE entered 2023 with a goal of reducing unnecessary utilization among their participant population. Mitigating preventable hospitalizations is a pivotal component to managed care as unnecessary utilization can expose participants to associated complications while driving up cost. These include hospital-acquired infections, medical errors, and significant functional decline. [Sources: Pub Med, CDC, BMJ]

When kicking off this initiative in January, Midland Care began working closely with Intus Care's Integrated Care Services (ICS) team to improve utilization collaboratively through innovative strategies.

MIDLAND CARE
Hope, Comfort and Support

550+
PARTICIPANTS SERVED

12
KANSAS COMMUNITIES

Challenges

The Midland Care team, in collaboration with Intus Care consultants, began by analyzing utilization data to target interventions. In this process, data fidelity became an immediate blocker to identify why participants were going to the ED and being hospitalized, subsequently making it difficult to form prevention strategies.

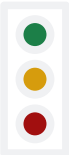
Solutions

Working with the Intus Care Software Analytics Platform, and Integrated Care Services, the teams collaborated to initiate data cleaning and documentation processes for improved consistency and accuracy.

With data work taking shape, root cause analysis was conducted on all relevant utilization events, accurately recorded. Upon analyzing data spanning multiple months, a discernible trend emerged with participants and/or caregivers frequently refraining from contacting Midland Care PACE prior to preventable hospitalization events occurring.

This prompted the team to initiate proactive measures aimed at educating participants and caregivers about engaging with the program before opting for direct hospital visits. The strategies outlined for education include:

- **Promoting a stoplight model** through resources readily available at the day center, as well as including it in materials brought to the participants' homes.



Green – when to call the PACE program on a regular clinic day with a symptoms list.

Yellow – when to call the on-call nurses' line.

Red – when to call 911 and/or go to the emergency room.

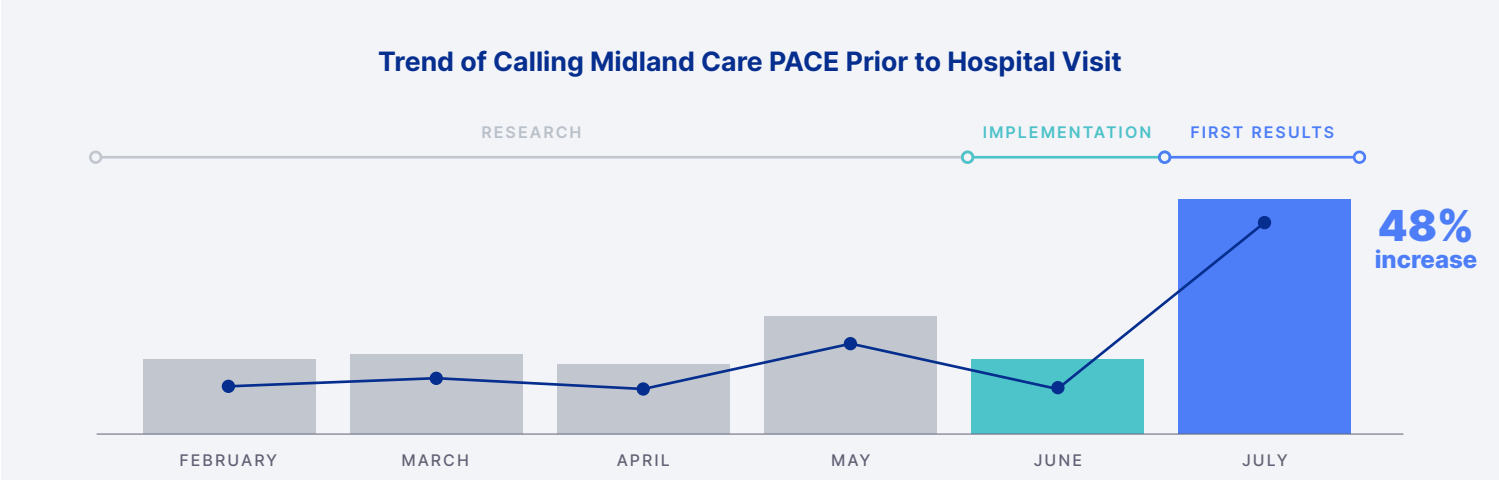
- **Programming the PACE on-call nurse line into participants' and caregivers' phones** to make it as easy to call as it is to dial 911.

The education strategies outlined plan to be repeated frequently with goals of keeping them top-of-mind among participants and caregivers.

Results and Outcomes

The first four months of dedicated Utilization Management work, February – May, was dedicated to data gap identification, process structuring, and root cause analysis. Throughout the month of June, education practices to promote calling PACE before an event entered the implementation phase. The following month of July showed immediate and significant results

Prior to education strategies (Feb-June) 23% of participants and/or caregivers called Midland Care PACE prior to an event. By July, the percentage grew to over one-third — a **48% increase** in calls to the program.



Case Study Example:

Beyond seeing a positive trend for all participants, the benefits of intervening in preventable utilization can increase quality of life for participants and keep them at home instead of in the hospital. As an example, one intervention involved a participant grappling with a swollen and painful foot. Alarmed by her mother's escalating discomfort since the prior night, her daughter reached out to the on-call line, concerned that her mother might require an emergency room visit. Upon contacting the on-call nurse line, the nurse recommended administering Tylenol and elevating the foot as much as possible. Despite the daughter's lingering apprehension, and her inclination towards the emergency room, the nurse sustained the conversation. The nurse advised the daughter to document the Tylenol dosage and time, assuring that the clinic nurse would return the call shortly with further guidance. The clinic RN initiated contact and conferred with the physician and was able to secure a same-day appointment for the participant to be assessed at the PACE clinic. There, the physician orchestrated necessary imaging and equipped the participant with a walker, easing her mobility while minimizing discomfort. The participant was pleased with the care she received, enabling her to remain in the comfort of her home and circumvent an ED visit or the need for hospitalization.

"At Midland Care PACE, we are constantly striving to innovate and improve our participants' quality of life," said **Lea Chaffee, executive director of Midland Care PACE**. "Through our partnership with Intus Care, we are integrating predictive analytics and utilization management consulting to mitigate unwanted and unnecessary utilization. This isn't just about improving efficiency; it's about enabling participants to enjoy healthy, fulfilling lives within their cherished communities. For PACE, this represents a remarkable opportunity to innovate the model of care."

MIDLAND CARE

About Midland Care Connection

For over four decades, Midland Care has been a pioneer and leader in responding to the most challenging health care needs in our community. Midland Care now offers an integrated community care delivery system addressing social, physical, and spiritual needs, improving quality of life for our aging population to keep older adults at home and independent longer, as a vital part of our community. Together, we ensure that our community's elders live with dignity, cared for by compassionate people in peaceful surroundings. Midland Care PACE began in 2007 with 27 participants in its first year. The program now serves over 550 Kansans across twelve counties.

IntusCare

About Intus Care

Intus Care leverages analytics and data-driven services to improve care for the healthcare system's most socially vulnerable and clinically complex patients. By integrating disparate data sources, highlighting patient risk, and implementing innovative processes, Intus Care empowers managed care organizations, including PACE programs and Special Needs Plans (SNPs), to make informed decisions and drive outcomes. Visit our website to learn more and connect for a conversation intuscare.com.