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Reducing Avoidable Hospitalizations Among Nursing Facility Residents: Three Perspectives

June 26, 2015

1:00-2:00 PM Eastern

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica Policy Research and the Center for Health Care Strategies.

Presenters

- Jim Verdier, Mathematica Policy Research and ICRC
- Dr. Thomas von Sternberg, HealthPartners
- Susan McGeehan, HealthPartners
- Cheyenne Ross, Bridgeway Health Solutions
- Jennifer Clark, Centene Corporation
- Dr. Marilyn Rantz, Sinclair School of Nursing, University of Missouri

Agenda

- Brief Overview of April 2015 ICRC TA Brief
- Introductory Overview of Three Approaches to Reducing Avoidable NF Hospitalizations
- Moderated Panel Discussion
- Audience Questions and Answers

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April 2015 ICRC TA Brief

- *Reducing Avoidable Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options for States* (April 2015)
  - Available at: http://www.integratedcareresourcecenter.net/pdfs/ICRCReducingAvoidableHospitalizations%20508%20complete.pdf
  - Illustrates what states and health plans, working together, can do to address a long-standing problem for Medicare-Medicaid enrollees

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State Options to Reduce Avoidable Hospitalizations: Capitated Managed Care

- Include performance measures in health plan contracts
  - Plan all-cause 30-day readmission rate
  - High-risk medication use rate
  - Nursing facility urinary track infection hospital admission rate
  - Emergency department utilization rate
- Focus health plan performance and quality improvement projects
  - Work with state External Quality Review Organization and Medicare Quality Improvement Organization to coordinate performance and quality improvement projects
- Encourage and facilitate specific health plan efforts
  - Waiving requirement for three-day hospital stay to qualify for SNF-level reimbursement
  - Making greater use of nurse practitioners in nursing facilities
  - Encouraging more appropriate prescription drug use
  - Contracting with selected nursing facilities

State Options to Reduce Avoidable Hospitalizations: Medicaid Fee-For-Service

- Modify bed-hold policies
  - Policies pay nursing facilities to reserve beds of hospitalized residents
  - In early 2014, 33 states and DC had a bed-hold policy for Medicaid beneficiaries (MACPAC, 2014)
  - Eliminating bed-hold policies or making them less generous is likely to reduce hospitalizations and readmissions (Cai et al., 2010; Grabowski et al., 2010; Intrator et al., 2007; Unruh et al. 2013)
- Use case mix reimbursement system
  - Reimbursement system that pays Medicaid nursing facilities higher amounts per day for residents with higher needs
  - In early 2014, 39 states and DC had some form of acuity-base case mix reimbursement system (MACPAC, 2014)
  - Can make it more financially feasible for facilities to treat higher-acuity residents rather than hospitalizing them

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Overview of Three Approaches to Reducing Avoidable NF Admissions

HealthPartners

- Part of Minnesota Senior Health Options (MSHO) capitated managed care program for dually eligible beneficiaries age 65 and older
  - MSHO program covers all Medicaid benefits and up to 180 days of nursing facility benefits in capitated benefit package
    - State pays for NF benefits through FFS after 180 days
  - MSHO Medicaid plans leverage Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) as a platform to provide coordinated Medicare benefits for dually eligible beneficiaries
- HealthPartners had 3,161 enrollees in its MSHO Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) in June 2015

HealthPartners: An Integrated Organization

Health Plan

Senior Products *Government Programs*	Members	2015 STAR Rating
Medicare	50,146	4.5
Medicaid includes our fully integrated Medicaid & Medicare product, the Minnesota Senior Health Options (MSHO) program.	4,696	4.5

Care Delivery

Large multidisciplinary care system

50,000+ Medicare patients (not all HP)

56 clinics & three main hospitals

Legacy of caring for nursing home patients

HealthPartners®

Role of Health Plan

- Enrollment for community and long term care
- Contract with care delivery, hospitals and **long term care facilities**
- Benefit design - waive 3 day stay, palliative care benefit
- Community relations/long term care outreach

Contracting & Quality Incentives

SNF Contracts - Partnership Homes

- Incent quality outcomes
- Per member per month payment and enrollment incentives
- Key – close partnership with facility social worker to help members determine best health plan fit
- Limitation - How to manage SMALL #s in facilities

Integrated Care System Partnerships

- Three way contract between care delivery, health plan and facility/organization

HealthPartners®

Intentional Relationships

Hot Spot Targeting for contracting

- High-volume facilities
- Section 8 low income apartments with services (like assisted living)
- Cultural Diversity Impacts - Specific facilities will have concentration of new immigrant populations

Expectations: Elements of Contract

1) **PMPM $** for improved outcomes

2) **Quality Metrics Measured** – falls with injury, facility acquired pressure ulcers

3) **Additional metrics** – hospitalizations, Advanced Directives completion

4) **Modifier** – growth incentives, ↑$PMPM

Health Plan Analytics

- Tracking census
- Admission rates
- Routine reporting
- Trending

- All limited based on SMALL size of population in specific homes

Care Delivery

On-Site Team

NP/MD teams onsite providing care for long term care and transitional care patients

HealthPartners pioneered this model 42 years ago

References

- The Effect of Evercare on Hospital Use. *Journal of the American Geriatrics Society,* 51(10):1427–1434, 2003.
- Models of Geriatrics Practice: Post-Hospital Sub-Acute Care: An Example of a Managed Care Model. *Journal of the American Geriatrics Society,* 45(1):87–91, 1997.

Care Model Process

- Attention to **high risk patients**
- Reduce high risk drugs
- Attention to **goals of care and advanced directives** – care plans around hospitalization
- Prevention of **re-admission** – first visit 48 to 72 hours after admit to nursing home
- Business rules on panel size and productivity, quality expectations of clinicians

In-Between Visit Care

- Overnight and weekend “on-call” **limited** dedicated team of clinicians
- Support nursing home to manage on-site
- Communicate to ER/hospital when patient sent in

Hospice and Palliative Care

- Critical element for this population
- Clinicians AND facility need to prioritize GOALS OF CARE and care plans that include considerations on alternatives to hospitalization
- Barriers – Culture and Ethnic norms
- ESRD pts special attention

Bridgeway Health Solutions

- Centene Corporation's affiliate in Arizona
- Part of Arizona Long Term Care System (ALTCS) capitated Medicaid managed care program
  - ALTCS Medicaid plans cover all Medicaid benefits (primary, acute, LTSS, Rx drugs, and behavioral health) for those requiring a nursing facility level of care
  - ALTCS Medicaid plans are required to be aligned with D-SNPs to provide coordinated Medicare benefits for dually eligible enrollees
- Bridgeway has approximatley 5,500 members in its Medicaid Managed Long Term Care program and nearly 1,500 enrollees in its Medicare D-SNP
  - 24% are residents of nursing facilities, and 76% are being served in the community

About Centene Corporation

Government Solutions	AZ	FL	GA	IL	KS	MI	NH[1]	OH	OR[2]	SC	TX	WI
Dual Demonstrations (including LTSS)				●		●		●		●	●	
Intellectually/Developmentally Disabled				●	●		●				●	
Long-Term Services and Supports	●	●		●	●		●	●			●	
Medicare Special Needs Plan	●	●	●			●		●	●		●	●

[1] *Waiver HCBS services and nursing facility services are anticipated to go-live during 2016.*

[2] *Entry underway with acquisition of Agate Resources anticipated to close in Q3 2015.*

Bridgeway has several strategies in place to prevent avoidable hospitalizations

bridgeway health solutions™

1) Bring care into the facility
   - Partner with Optum to place nurse practitioners (NPs) at NFs and ALCs; on call to visit nights/weekends to divert members from going to ED
   - SNFists help manage acute stays
   - Work with NFs to bring in mobile provider services (lab, x-ray)
   - Care managers ensure coordination, collect HEDIS measures, report quality concerns
2) "Skill" members directly to SNF
   - Bridgeway's partner Optum is able to "skill" a member from a custodial setting to a skilled setting without an ED visit

Bridgeway has several strategies in place to prevent avoidable hospitalizations (cont'd)

bridgeway health solutions

3) Improve communication and coordination
   - Centene's integrated care model ensures all relevant input is taken into account (e.g., SNFist, pharmacist, behavioral health clinician)
   - Centene partners with specialized organizations (e.g., Thresholds in IL and LifeShare in KS) to intervene in crisis situations and prevent unnecessary hospitalizations
   - INTERACT (Interventions to Reduce Acute Care Transfers) tools improve communication among NFs and providers
4) Leverage data to identify and address high ED/IP utilization
   - Integrated care team discusses patterns of high utilization and finds solutions to address it

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Missouri Quality Initiative for Nursing Homes (MOQI): A four-year Demonstration Sinclair School of Nursing University of Missouri

Marilyn J. Rantz, RN, PhD, FAAN
Curators' Professor of Nursing

ICRC Presentation
June 26, 2015

This project is supported by grant number 1E1CMS331080 from the Centers for Medicare and Medicaid (CMS) Innovations Center. The content is solely the responsibility of the authors and does not necessarily represent the official views of CMS. We also want to acknowledge the gracious participation of 16 nursing homes in the St. Louis area, their staffs, the APRNs and other staff of the MOQI Initiative. Without everyone's support and hard work, the advances in this Initiative would not be possible.

Project Funding and Goals

Funded by Centers for Medicaid and Medicare Services (CMS) Innovations Center to test an intervention for long-stay Medicare-Medicaid enrollees in our state to:

- Reduce the frequency of avoidable hospital admissions and readmissions;
- Improve resident health outcomes;
- Improve the process of transitioning between inpatient hospitals and nursing facilities; and
- Reduce overall healthcare spending without restricting access to care or choice of providers.

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Project Scope

In Missouri

- 16 participating nursing homes, all Medicare and Medicaid certified
- Full-time Advanced Practice Registered Nurses (APRNs) are embedded in each facility to guide the intervention
- The total enrolled residents per month averages about 1,500

This Initiative is in progress in 7 states with variations in interventions

- Alabama
- Indiana
- Nebraska
- Nevada
- New York
- Pennsylvania

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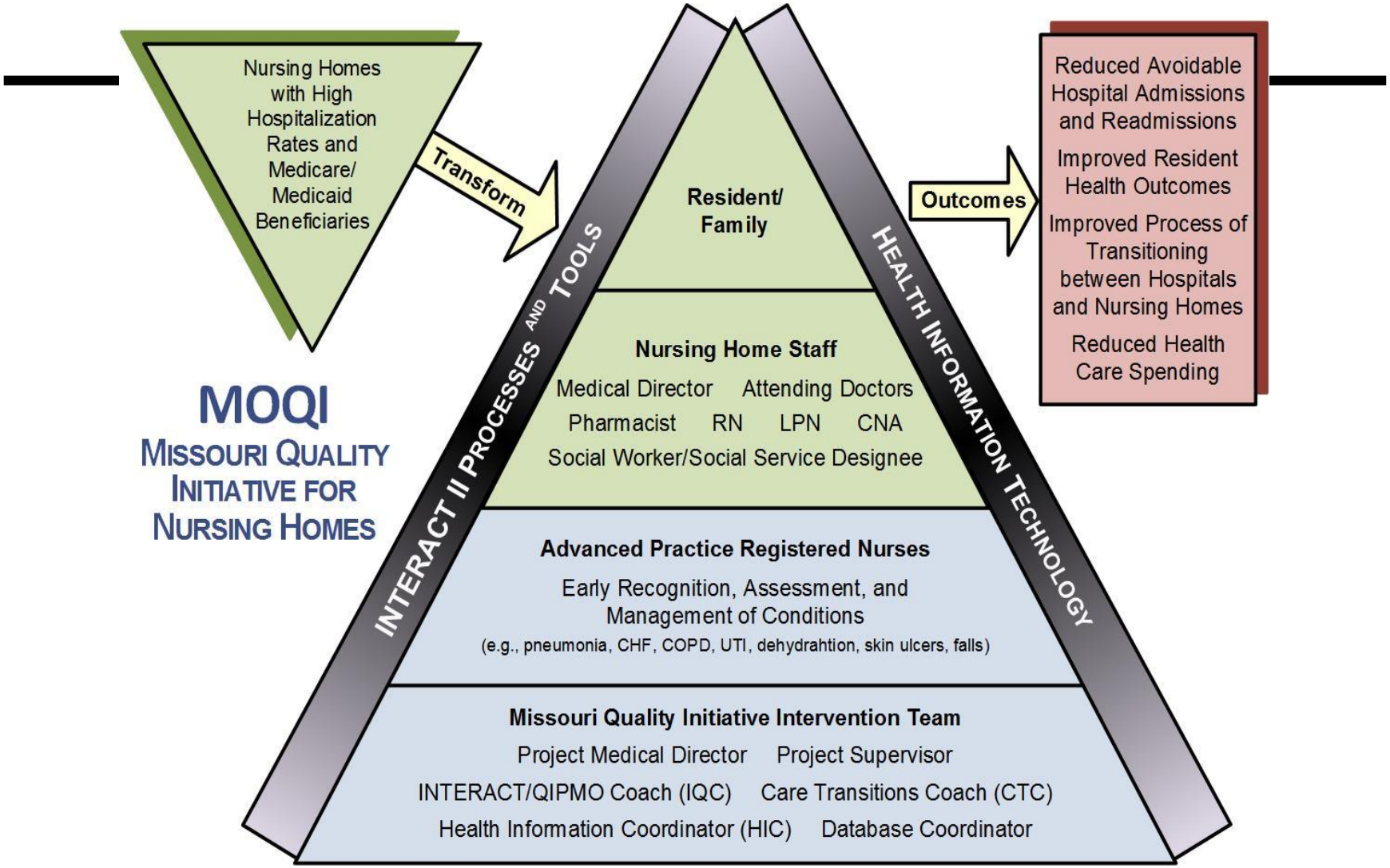

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Intervention Design and Goal

MOQI Primary Project Goal

- Reduce avoidable hospital transfers via four aspects of APRN Care Coordination
  1. Condition management
  2. Early illness detection
  3. INTERACT tool usage (Stop & Watch and SBAR)
  4. Goals of care and end-of-life discussions
- AND health information technology

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Intervention - APRN Care Coordination

Primary activities each day:

- ✓ Mentoring for NH nursing staff
- ✓ Role model clinical skills
- ✓ Education of NH staff

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Intervention - APRN Care Coordination

- ✓ Assessment and management of chronic and acute conditions
- ✓ Early illness recognition skills taught to nursing staff
- ✓ Teach and role model use of INTERACT tools (S&W and SBAR)
- ✓ Discussion on goals of care and EOL decision-making
- ✓ Work collaboratively to:
  - ✓ Reduce polypharmacy
  - ✓ Reduce antipsychotic med use in residents with dementia via gradual dose reduction
  - ✓ Contact providers with recommendations to achieve above

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Intervention - Work with Nursing Home Staff

1. Work to build care systems for early illness recognition and prevention:
   - ✓ Hydration
   - ✓ Mobility
   - ✓ Continence
2. Teach skills for illness treatment:
   - ✓ IV therapy
   - ✓ Hypodermoclysis
   - ✓ Lab monitoring
3. Work with leadership to strengthen relationships with clinical staff and staff stability for resident care

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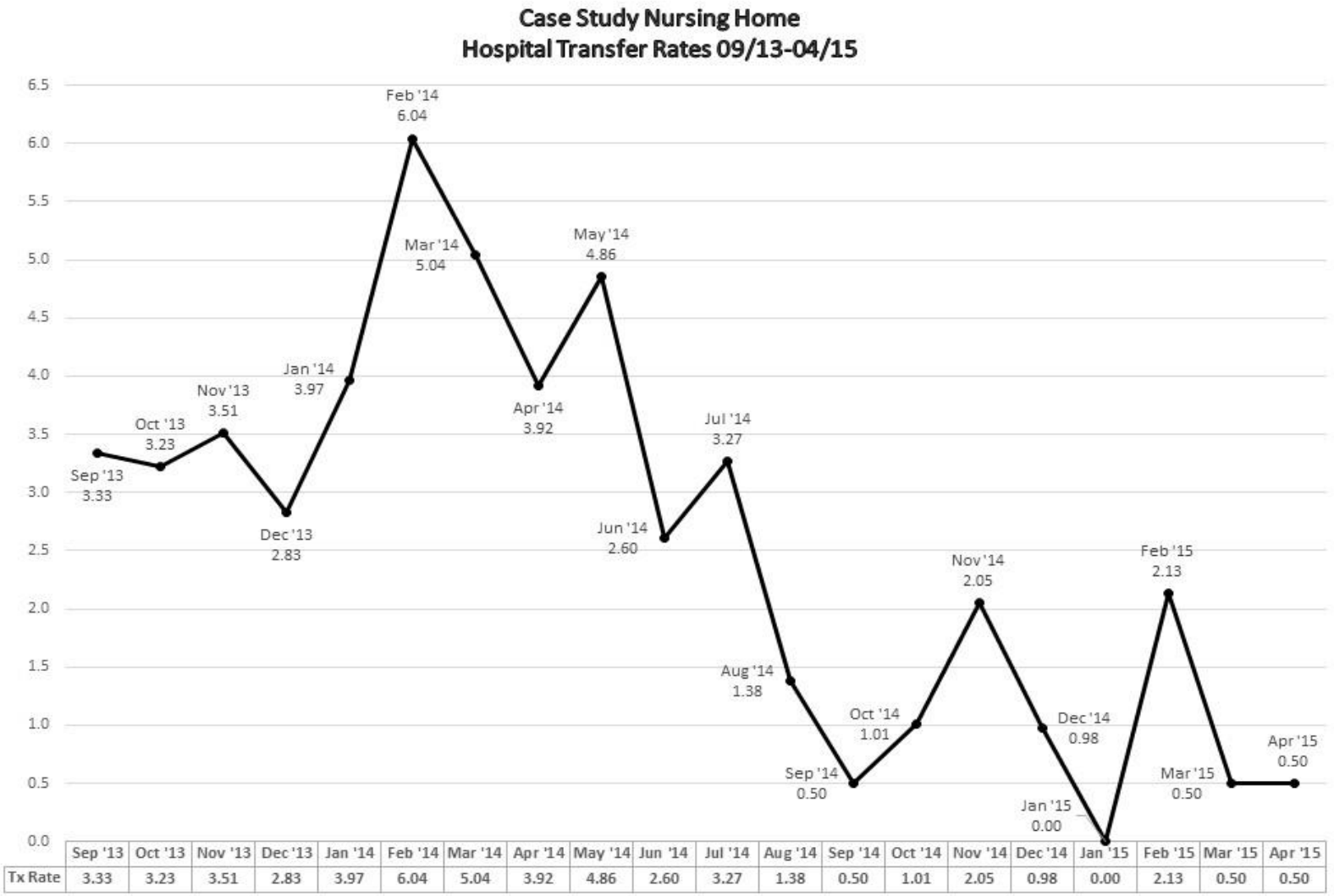
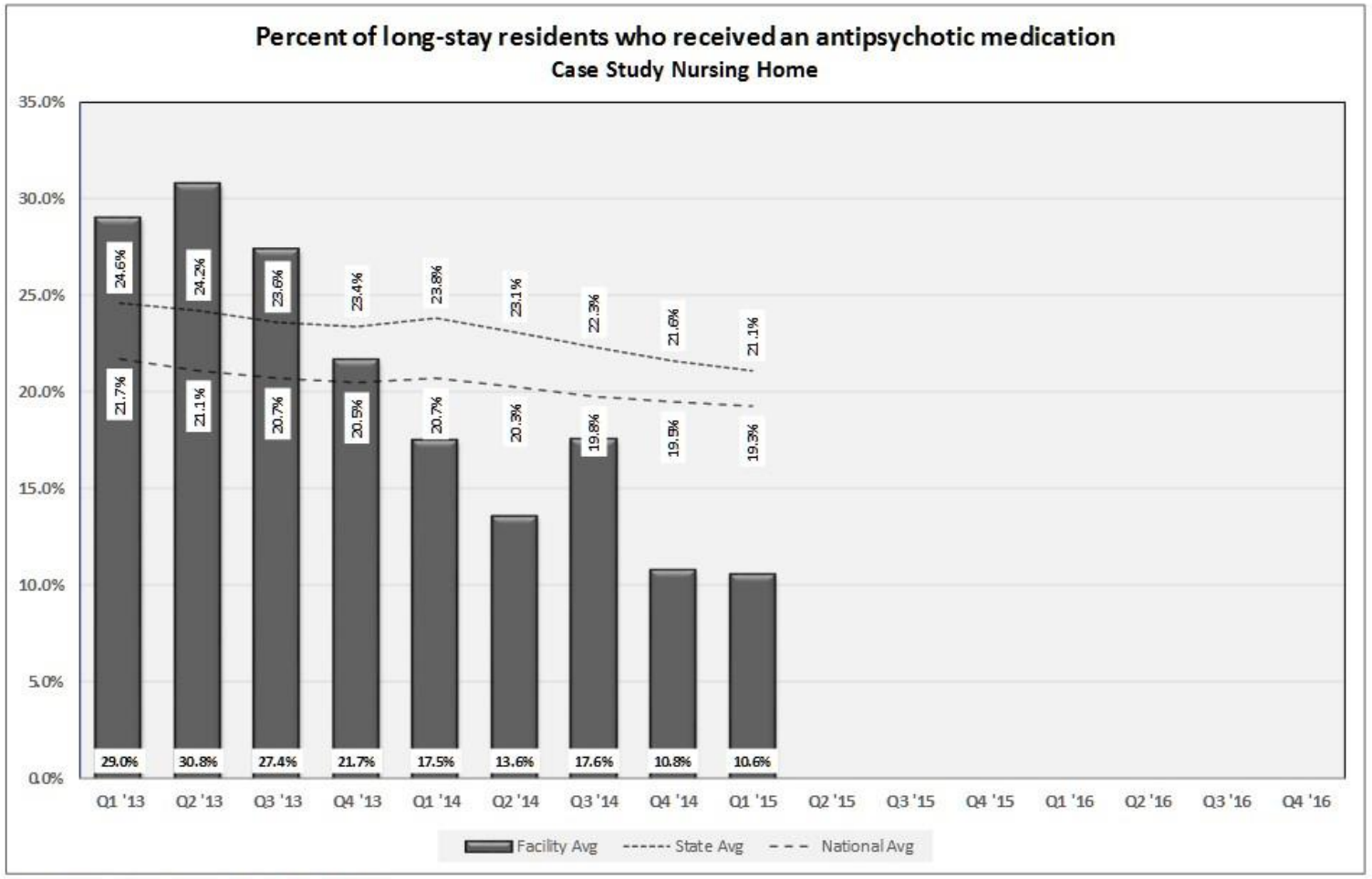
Exemplar Nursing Home Achieving Goals



	Sep '13	Oct '13	Nov '13	Dec '13	Jan '14	Feb '14	Mar '14	Apr '14	May '14	Jun '14	Jul '14	Aug '14	Sep '14	Oct '14	Nov '14	Dec '14	Jan '15	Feb '15	Mar '15	Apr '15
Tx Rate	3.33	3.23	3.51	2.83	3.97	6.04	5.04	3.92	4.86	2.60	3.27	1.38	0.50	1.01	2.05	0.98	0.00	2.13	0.50	0.50

Exemplar Nursing Home Achieving Goals



Data source: CASPER, www.nursinghomehelp.org

Reporting period for facility data is 3 months; comparison reporting period for state/national avg is 6 months, beginning 3 months ***prior*** *to facility data date*

Q1 *facility data is Jan-Mar; Q1 comparison data is Oct-Mar.* ***Q2*** *facility data is Apr-June; comparison data is Jan-June.*

Q3 *facility data is July-Sept; comparison data is Apr-Sept.* ***Q4*** *facility data is Oct-Dec; comparison data is July-Dec.*

5/20/15

Additional Information about MOQI

- Rantz, M., Alexander, G., Galambos, C., Vogelsmeier, A., Popejoy, L., Flesner, M., Lueckenotte, A., Crecelius, C., & Zwygart-Stauffacher, M. (2013). Initiative to test a multidisciplinary model with advanced practice nurses to reduce avoidable hospitalizations among nursing facility residents. *Journal of Nursing Care Quality,* 29(1):1-8.
- Alexander, G.L., Rantz, M., Galambos, C. Vogelsmeier, A., Flesner, M., Popejoy, L.L., Mueller, J., Shumate, S., & Elvin, M. (2015). Preparing nursing homes for the future of health information exchange. *Applied Clinical Informatics,* 6:248-266.
- Rantz, M.J., Flesner, M.K., Franklin, J., Galambos, C., Pudlowski, J., Pritchett, A., Alexander, G., & Lueckenotte, A. (In press). Better care, better quality: reducing avoidable hospitalizations of nursing home residents. Submitted to *Journal of Nursing Care Quality.*

- Handout - Talking Points (http://nursinghomehelp.org/moqi/MOQITalkPts.pdf)

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Moderated Panel Discussion

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Main Features of Your Approach

- What are the major things you are now doing to reduce avoidable hospitalizations for nursing facility residents?
  - Are there other things you have done in the past that you did not find to be effective?
- How do you determine which hospitalizations are avoidable?
- What kind of cooperation do you need from nursing facilities? How do you get it?
- What kind of cooperation do you need from hospitals? How do you get it?
- What resources (staff, data and information systems, communication channels, etc.) are needed to make your approach work?
- How do you track and monitor the effectiveness of what you do?
  - Do you report this regularly? If so, to whom?
- *(For HealthPartners and Bridgeway)* What kind of support or encouragement have you received from the state?
  - What more could they do?

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Some Specific Issues

- Do you have nurse practitioners or other clinical staff that work on site with nursing facilities and/or hospitals to help reduce avoidable hospitalizations?
  - What specifically do they do? Are they available overnight and on weekends?
  - Do you use this approach in all the nursing facilities and/or hospitals you work with, or only some of them?
- Do you have pharmacists who review the Rx drug use of nursing facility residents?
  - If so, how do they work with or coordinate with the nursing facilities' consulting pharmacists?
- What kind of information on the care needs and Rx drug use of nursing facility residents do you regularly obtain?
  - Do you share that information with hospitals when the residents are hospitalized?
- What kind of information on diagnoses, Rx drug use, and treatment do you receive from hospitals when nursing facility residents are hospitalized?
  - How timely is that information?
  - Do you share it with the nursing facility? With the resident's primary care provider(s)?

Some Specific Issues *(Cont.)*

- *(For HealthPartners and Bridgeway)* Do you waive the Medicare three-day hospital stay requirement for SNF services?
  - Selectively, or in all cases?
- *(For HealthPartners and Bridgeway)* How do you determine how many days (up to 100) you will pay for at Medicare SNF rates?
  - Do you have specific guidelines to determine when skilled care is and is not needed?
- *(For the University of Missouri)* How much of what you do would be easier, or harder, if you were a capitated managed care plan, as opposed to operating in a fee-for-service environment?

Advice for States and Health Plans

- What are the major lessons you have learned?
- In retrospect, are there some things you would have done differently? Pitfalls to avoid? Missed opportunities?
- Based on your experience, what advice do you have for states and for health plans that are at risk for both Medicare and Medicaid services for dually eligible beneficiaries in nursing facilities?

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Audience Questions and Answers

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About ICRC

- Established by CMS to advance integrated care models for dually eligible beneficiaries
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send additional questions to: integratedcareresourcecenter@chcs.org

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