



## *FACT SHEET*

### **CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents**

#### **Overview**

On March 15, 2012 the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation announced the *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents*. Through this Initiative, CMS is partnering with seven organizations to implement strategies to reduce avoidable hospitalizations for Medicare-Medicaid enrollees who are long-stay residents of nursing facilities. The Initiative directly supports CMS’ ongoing work to reduce avoidable hospitalizations for Medicare-Medicaid enrollees.

#### **Background**

##### *Medicare-Medicaid Enrollees*

Improving the care experience for individuals who are Medicare-Medicaid enrollees – sometimes referred to as “dual eligibles” – is a critical priority for CMS. Currently, Medicare-Medicaid enrollees navigate multiple sets of rules, benefits, cards and providers (Medicare Parts A, B, and D and Medicaid). Total annual spending for their care exceeds \$300 billion across both programs. Medicare-Medicaid enrollees are among the most chronically ill and complex enrollees in both programs.

##### *Improving Care for Medicare-Medicaid Enrollees in Nursing Homes*

Hospitalizations can be disruptive, dangerous and costly for Medicare-Medicaid enrollees residing in nursing facilities. Research shows that nearly 45 percent of hospitalizations among this population are avoidable, meaning they could have been prevented or treated in a lower intensity care setting.

#### **Initiative Design**

The goal of this Initiative is to:

- Reduce the number of and frequency of avoidable hospital admissions and readmissions;
- Improve beneficiary health outcomes;
- Provide better transition of care for beneficiaries between inpatient hospitals and nursing facilities; and
- Promote better care at lower costs while preserving access to beneficiary care and providers.

Organizations selected to participate in the initiative are partnering with CMS to implement evidence-based interventions to accomplish these goals among Medicare-Medicaid enrollees who are residents of long-term care facilities. Participants in the model – called “enhanced care and coordination providers” –will implement and operate their proposed interventions over a 4-year period.

Each participant is required to partner with a minimum of 15 Medicare-Medicaid certified nursing facilities in the same State where the intervention will be implemented. Nursing facility participation is voluntary. A wide variety of entities are eligible to participate in the initiative, including: physician practices, hospitals, care management companies and health systems, among many others.

*Evidence-Based Interventions Requirements:*

Participants proposed evidence-based interventions to accomplish the goals of the initiative in their applications to CMS. The Initiative did not prescribe a specific clinical model for these interventions. However, all proposed interventions must:

- Improve beneficiary safety by better coordinating management of prescription drugs to reduce risk of polypharmacy and adverse drug events for residents, including inappropriate prescribing of psychotropic drugs.
- Bring onsite staff to collaborate and coordinate with existing providers, including residents' primary care providers and the staff of the nursing facility.
- Demonstrate a strong evidence base for the proposed intervention and potential for replication and sustainability in other communities and institutions across the country.
- Supplement (rather than replace) existing care provided by nursing facility staff.
- Allow for participation by nursing facility residents without any need for residents or their families to change providers or enroll in a health plan. Residents will be able to opt-out from participating, if they choose.

*Beneficiary Impact:*

Upon implementation we estimate the awarded interventions will reach more than 17,000 beneficiaries over the four years of the Initiative. This number is based on the current number of estimated long-stay beneficiaries in the partnering facilities.

**Application Process**

Applications were due June 14, 2012. CMS and a panel of independent reviewers conducted a thorough review of all applications, reviewing each of them against criteria detailed in the original Funding Opportunity Announcement (FOA).

Multiple panels reviewed applications. CMS and panelists considered criteria to ensure the final pool of awardees had the highest likelihood of meeting the Initiative's objectives. Some of these criteria included: diversity of clinical models, the number of nursing facility partners and size of targeted population, and the level of avoidable hospitalization rates for the location targeted for implementation, among many others. After evaluating applications, finalists were interviewed to determine the awardees.

Model participants were announced September 27, 2012. Selected participants are listed in Appendix A.

## Additional Resources

For more information on this initiative, please go to <http://innovations.cms.gov/initiatives/rahnfr/>.

## Appendix A - Participants

- **HealthInsight of Nevada** will implement an intervention in 25 nursing facilities in Nevada. The intervention, named the “Nevada Admissions and Transitions Optimization Program” or “ATOP,” includes the creation of pods that consist of a physician extender (nurse practitioner or physician’s assistant) and two registered nurses (RNs) who will be physically on-site at nursing facilities. Each one of the five pods will provide enhanced care and coordination to residents in five facilities. Additionally, the intervention will include INTERACT (INTERventions to Reduce Acute Care Transfers) tools and use a resident risk assessment program whereby each beneficiary will receive the appropriate level of enhanced care and attention based on their individual risk level. HealthInsight of Nevada will also implement a medication management program to reduce polypharmacy and the inappropriate use of antipsychotics.
- **Indiana University** will implement an intervention in 20 nursing facilities in the Indianapolis region of Indiana. This organization has created a program called “OPTIMISTIC” (“Optimizing Patient Transfers, Impacting Medical quality, and Improving Symptoms: Transforming Institutional Care”) which includes the deployment of RNs and advanced practice nurses (APNs) to be on-site at the nursing facilities, allowing for enhanced recognition and management of acute change in medical conditions. RNs and APNs will coordinate with nursing facility staff and residents’ primary care providers. In addition to employing INTERACT tools, this enhanced staffing model will adapt and apply other evidence-based models which have proven to reduce hospitalizations in other settings.
- **The Curators of the University of Missouri** will implement an intervention in 16 nursing facilities in Missouri. In this intervention, advanced practice RNs (APRNs) will be assigned to facilities to provide direct services to residents while mentoring, role-modeling, and educating the nursing staff about early symptom/illness recognition, assessment, and management of health conditions commonly affecting nursing home residents. Additionally, the intervention includes the use of social workers who will work closely with each facility’s social worker, the residents’ primary care providers, nursing facility staff, and APRNs, to assure consistent communication about resident’s needs and preferences. Finally, RNs will implement INTERACT and QIPMA (Quality Improvement Program for Missouri), programs that have demonstrated positive results in the nursing facility environment.
- **Alabama Quality Assurance Foundation** will implement an intervention in 23 facilities in Alabama. In this intervention, RNs will be deployed in the partnering nursing facilities to implement the INTERACT tools. Additionally, the proposal includes the implementation of “EMPOWER” (Enhancing My Profession and Organization with Empathy and Respect), which is a training program to help nursing facility staff enhance their skills for managing workplace demands and professional relationships. Additionally, the intervention staff will

work with each facility to adopt and measure consistent assignment as defined by the Advancing Excellence in America's Nursing Homes campaign. The goals of EMPOWER and consistent assignment include reducing staff turnover and increasing awareness of residents' status and needs, which would improve the staff's ability to implement care plans and notice changes in residents' health.

- **UPMC Community Provider Services** will implement an intervention in 16 nursing facilities in the western region of Pennsylvania. UPMC Community Provider Services has created a program called "RAVEN" (Reduce AVOIDable hospitalizations using Evidence-based interventions for Nursing facilities in western Pennsylvania). This program will include facility-based nurse practitioners to assist with determining resident care plan goals, and conduct acute change in condition assessments. It will also implement evidence-based clinical communication tools such as INTERACT and others recommended by the American Medical Directors Association to assist in structuring and standardizing clinical assessments and recommendations. The intervention will also provide support from innovative telehealth and information technologies to connect participating nursing facilities into the Western PA Health Information Exchange.
- **Alegent Health** will implement an intervention in 15 nursing facilities in Nebraska. Alegent Health will deploy nurse practitioners in the partnering nursing facilities to enhance care by implementing INTERACT tools and a program to improve medication management based on the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. An innovative aspect of this program is the use of a dentist and dental hygienist to improve oral care for beneficiaries. This type of care is typically not provided in the nursing facility environment and contributes to better overall health, while also working to prevent other conditions that lead to avoidable hospitalizations.
- **The Greater New York Hospital Foundation, Inc.** will implement an intervention in 30 nursing facilities in the New York City metropolitan region. In this program, RNs will be deployed in the partnering nursing facilities to train the nursing facility staff on INTERACT tools and the American Medical Director Association Clinical Practice Guidelines on Acute Change in Condition. The project will also implement the use of an eINTERACT system to eliminate the need for the paper-based format and provide real-time access to beneficiary information to all providers across the continuum of care.