Transitions and Long-Term Care: Reducing Preventable Hospital Readmissions among Nursing Facility Residents

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Agenda

- Housekeeping/Introductions
- An overview of INTERACT II
- An overview of a new CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents
- Resources/Next training
- Questions/Comments

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Presenters

- Joseph G. Ouslander, M.D., Professor and Senior Associate Dean for Geriatric Programs, Charles E. Schmidt College of Medicine; Professor (Courtesy), Christine E. Lynn College of Nursing; Florida Atlantic University
- Tim Engelhardt, Director, Models, Demonstrations and Analytics, Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services

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The INTERACT Program: What is It and Why Does It Matter?

Joseph G. Ouslander, M.D.,

Professor and Senior Associate Dean for Geriatric Programs, Charles E. Schmidt College of Medicine; Professor (Courtesy), Christine E. Lynn College of Nursing; Florida Atlantic University

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The INTERACT Program: What is It and Why Does It Matter?

The INTERACT Interdisciplinary Team

Joseph G. Ouslander, MD	Florida Atlantic University
Laurie Herndon, GNP	Mass Senior Care Foundation
Gerri Lamb, PhD, RN, FAAN	Arizona State University
Ruth Tappen, EdD, RN, FAAN	Florida Atlantic University
Sanya Diaz, MD	Florida Atlantic University
John Schnelle, PhD	Vanderbilt University
Sandra Simmons, PhD	Vanderbilt University
Annie Rahman, MSW	California Association of LTC Medicine
Jo Taylor, RN, MPH	The Carolinas Center for Medical Excellence
Mary Perloe, GNP	The Georgia Medical Care Foundation
Dan Osterweil, MD	California Association of LTC Medicine
Alice Bonner, PhD, GNP	Centers for Medicare & Medicaid Services

In collaboration with participating nursing homes

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The INTERACT Program: What is It and Why Does It Matter?

(“***Interventions to Reduce Acute Care Transfers”)***

Is a **quality improvement program** designed to improve the care of nursing home residents with acute changes in condition

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The INTERACT Program: What is It and Why Does It Matter?

- Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources
- The basic program is located on the internet:

http://interact2.net

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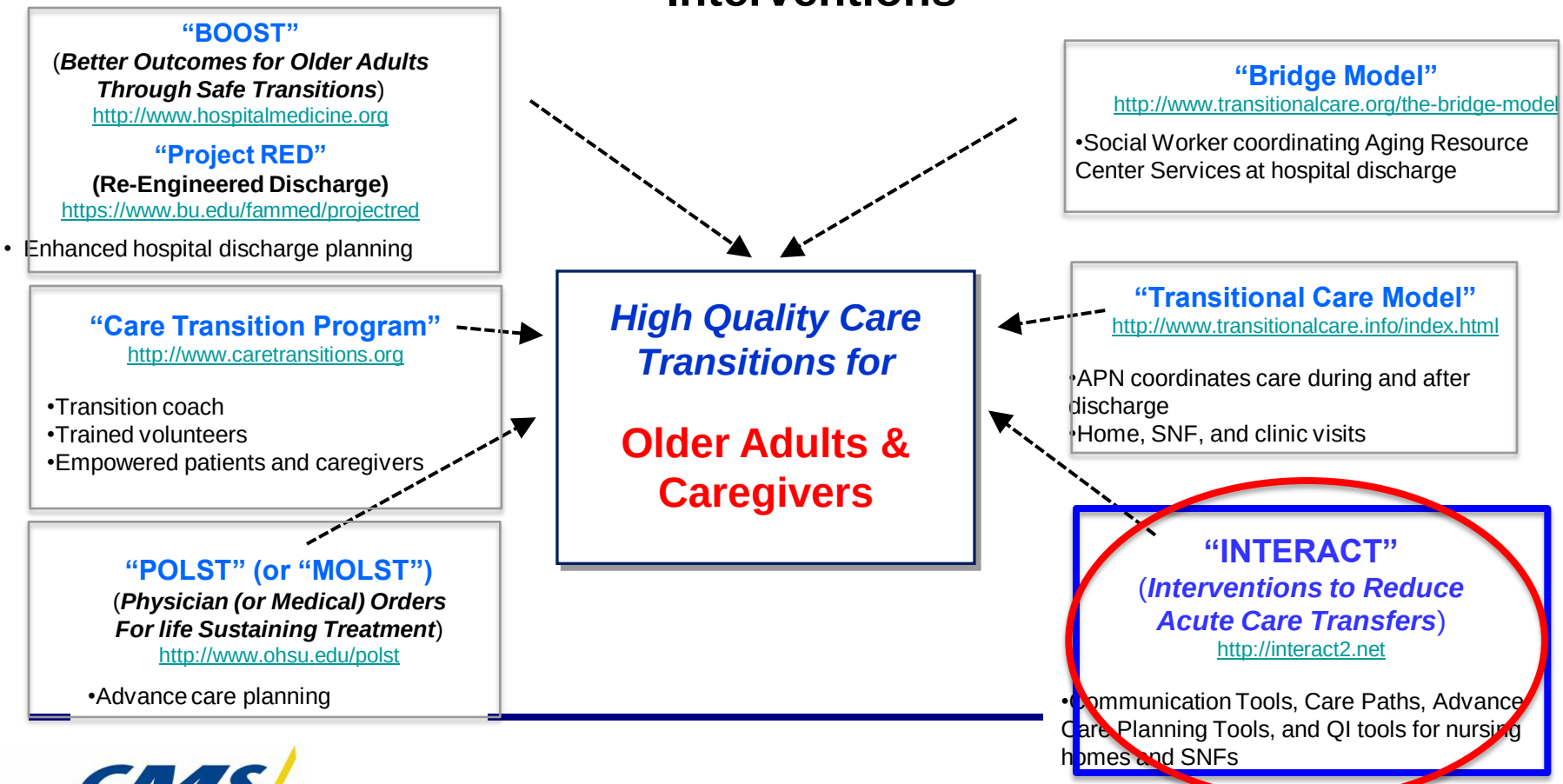
The INTERACT Program:

What is It and Why Does It Matter?

INTERACT is One of Several Evidence-Based Care Transitions Interventions



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The INTERACT Program: What is It and Why Does It Matter?

Acknowledgement

The INTERACT Program and Tools were initially developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a contract from the Centers for Medicare & Medicaid Services.

The current version of the INTERACT Program, including the INTERACT II Tools, educational materials, and implementation strategies were developed by Drs. Ouslander, Gerri Lamb, Alice Bonner, and Ruth Tappen, and Ms. Laurie Herndon with input from many direct care providers and national experts in a project based at Florida Atlantic University supported by The Commonwealth Fund. The Commonwealth Fund is a private foundation supporting independent research on health policy reform and a high performance health system.

The INTERACT Program: What is It and Why Does It Matter?

Why does this matter?

A national perspective (1)

- Emergency room visits, observation stays hospitalizations, and readmissions of nursing home residents are:
  - Common
  - Result in complications
  - Expensive

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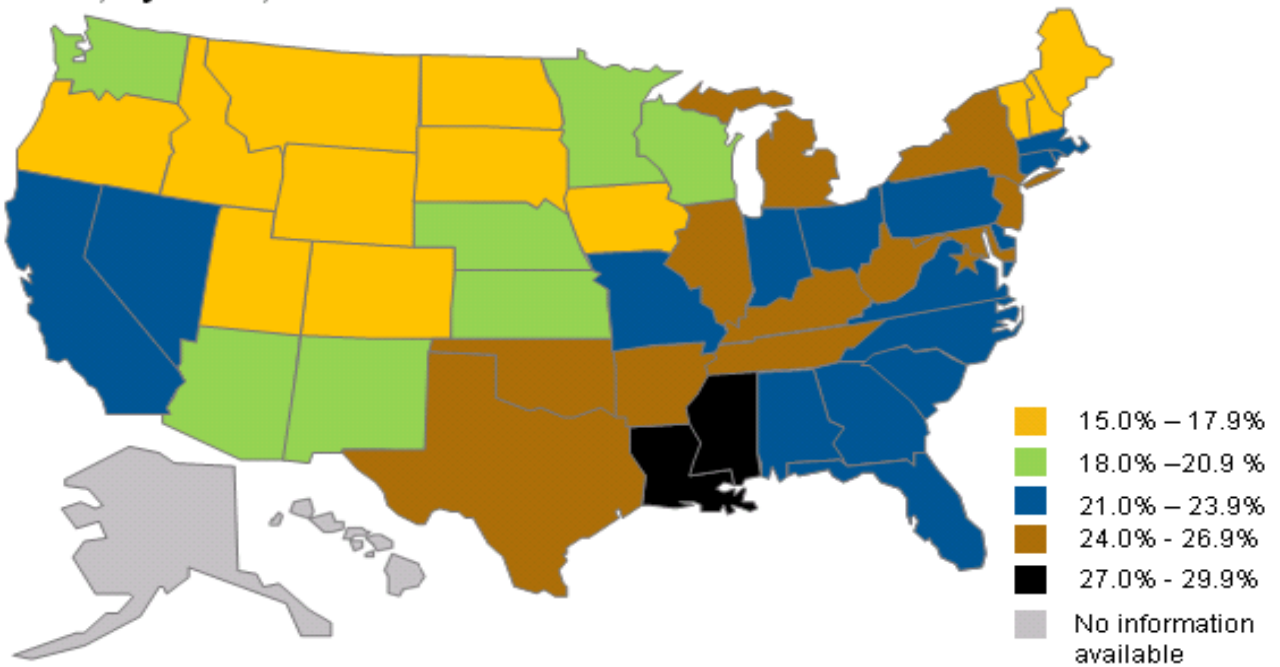
The INTERACT Program: What is It and Why Does It Matter?

1 in 4 patients admitted to an SNF are re-admitted to the hospital within 30 days at a cost of $4.3 billion

Figure 3: Frequency of Rehospitalization of Short-Stay Nursing Home Residents, by State, 2006



Source: Vincent Mor, et al. (2010) Medicare SNF Rehospitalizations: Implications for Medicare Payment Reform. Health Affairs.

Mor et al. Health Affairs 29: 57-64, 2010

The INTERACT Program: What is It and Why Does It Matter?

- Hospitalizations can cause many complications:
  - Distress and discomfort for the resident and family
  - Delirium
  - Polypharmacy
  - Falls
  - Incontinence and catheter use
  - Hospital acquired infections
  - Unintentional weight loss and poor nutrition
  - Immobility, de-conditioning, pressure ulcers

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The INTERACT Program: What is It and Why Does It Matter?

Why does this matter?

A national perspective (2)

- Some hospital transfers, ER visits, observation stays, hospital admissions, and readmissions are "avoidable", "preventable", or "unnecessary"

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The INTERACT Program: What is It and Why Does It Matter?

CMS Special Study in Georgia – Expert Ratings of Potentially Avoidable Hospitalizations

Based review of 200 hospitalizations from 20 NHs

	Was the Hospitalization Avoidable?	
	Definitely/Probably YES	Definitely/Probably NO
Medicare A	69%	31%
Other	65%	35%
HIGH Hospitalization Rate Homes	75%	25%
LOW Hospitalization Rate Homes	59%	41%
TOTAL	68%	32%

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

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CMS Study of Dually Eligible Medicare/Medicaid Beneficiaries

CMS Study of Dually Eligible Medicare/Medicaid Beneficiaries

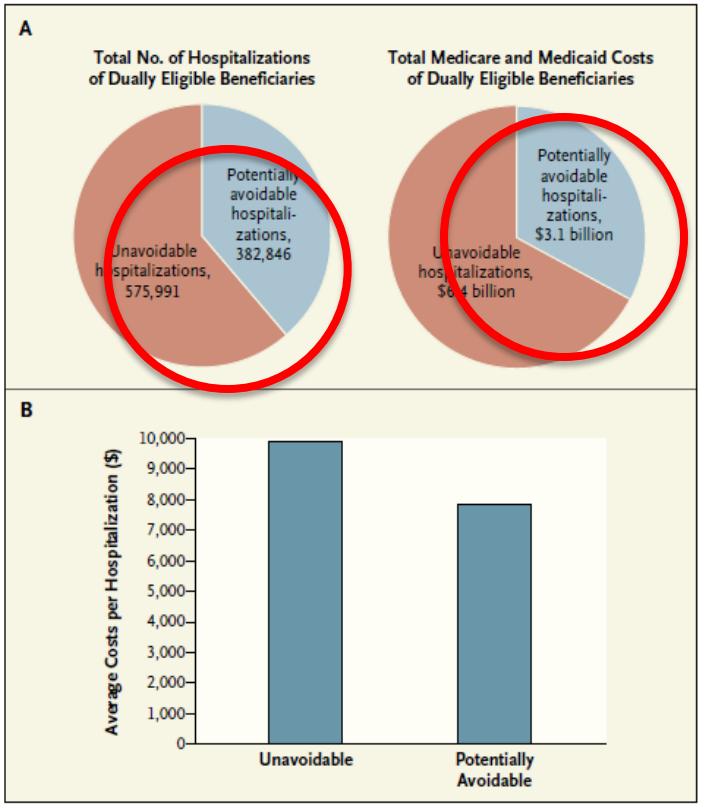
The NEW ENGLAND JOURNAL of MEDICINE

Perspective

SEPTEMBER 29, 2011

Reducing Unnecessary Hospitalizations of Nursing Home Residents

Joseph G. Ouslander, M.D., and Robert A. Berenson, M.D.



Unavoidable and Potentially Avoidable Hospitalizations of Nursing Home Residents Eligible for Both Medicare and Medicaid, 2005.

Data are based on all hospitalizations of 1,571,920 dually eligible Medicare and Medicaid beneficiaries in the year 2005. Of the total hospitalizations included, 72% were from nursing homes, accounting for 85% of the total costs of avoidable hospitalizations. Data are from the Centers for Medicare and Medicaid Services.

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The INTERACT Program: What is It and Why Does It Matter?

Maslow, K and , Ouslander, JG: Measurement of Potentially Preventable Hospitalizations. White Paper prepared for the Long Term Quality Alliance, 2012.

(Available at: http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//PreventableHospitalizations_021512_2.pdf)

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The INTERACT Program: What is It and Why Does It Matter?

How is a "Preventable", "Avoidable", "Unnecessary" Hospitalization Defined?

- **Diagnostic codes from administrative data**
  - Selected Ambulatory Care Sensitive Diagnoses (*AHRQ definitions*)
  - Modified lists of ACSD
  - Broader list of specific diagnoses (*used in the CMS report on dual eligible beneficiaries*)
- **Other methods**
  - Structured medical record review by experienced clinicians (*used in the CMS study in Georgia NHs*)

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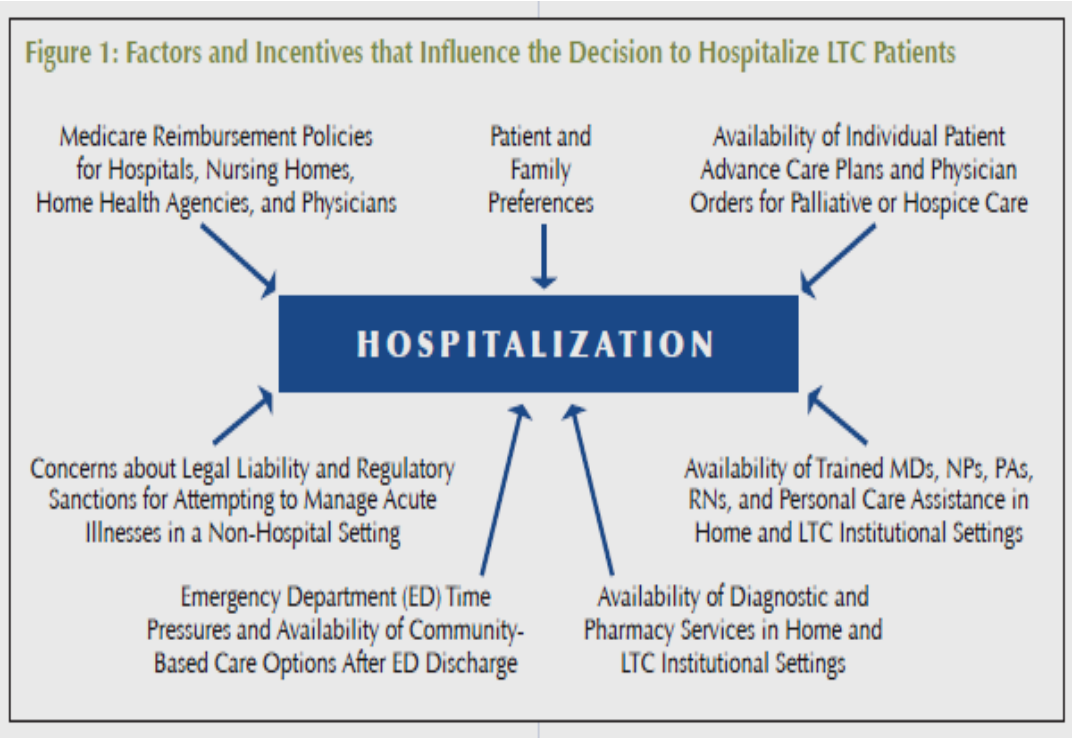
The INTERACT Program: What is It and Why Does It Matter?

- Defining “Preventable”, “Avoidable”, “Unnecessary” hospitalizations is challenging because numerous factors and incentives influence the decision to hospitalize

- Risk adjustment is very complicated



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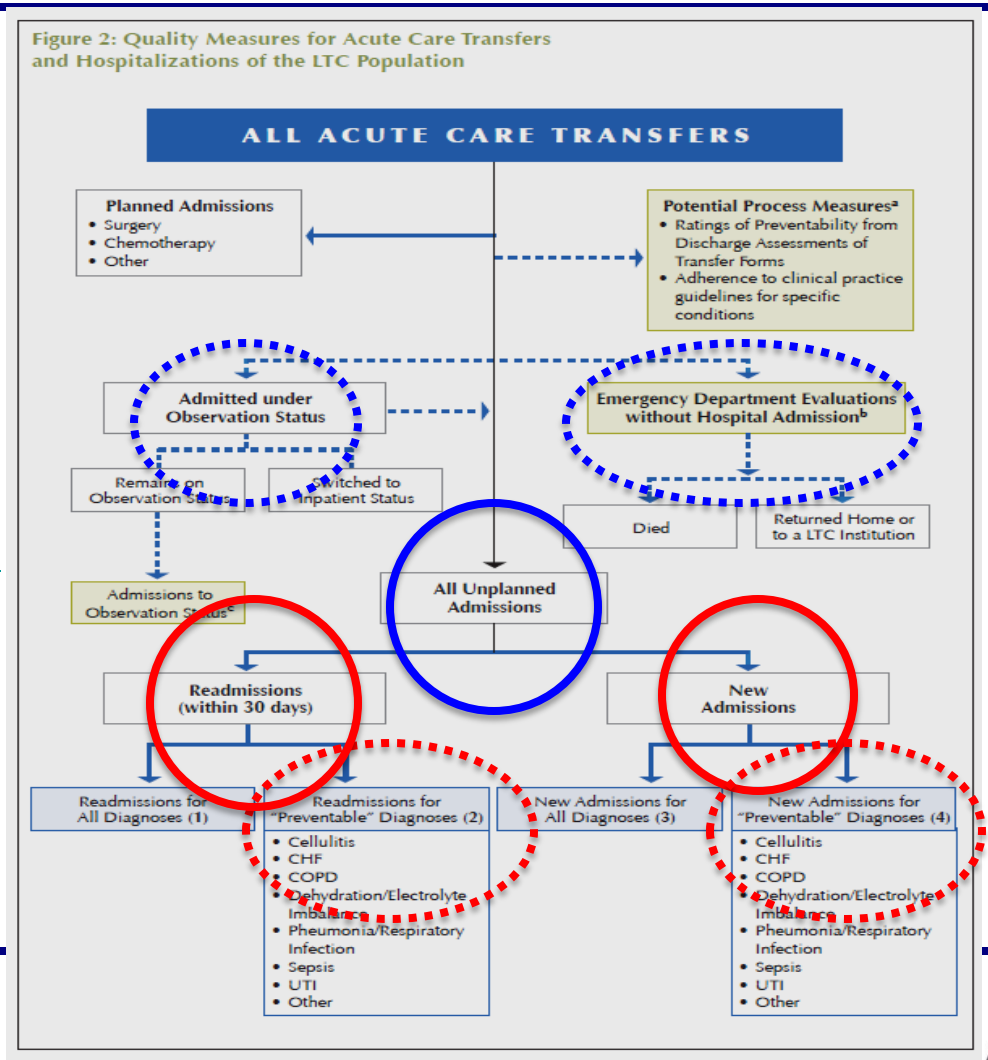

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The INTERACT Program: What is It and Why Does It Matter?

Changes in Medicare Financing

- **Pay-for-Performance** (“P4P”)
  - ✓No payment for certain complications; disincentives for avoidable hospitalizations
- **Bundling of payments** for episodes of care
- **Accountable Care Organizations** that include hospitals, physicians, home health agencies, and SNFs that are responsible for the care of a defined group of patients

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The INTERACT Program: What is It and Why Does It Matter?

Opportunities for You and Your Facility

- The Affordable Care Act mandates that each facility have a Quality Assurance and Performance Improvement program ***("QAPI")***
- The regulation and related surveyor guidance are being written
- Improving management of acute change in condition and reducing unnecessary hospital transfers is one potential focus of your QAPI

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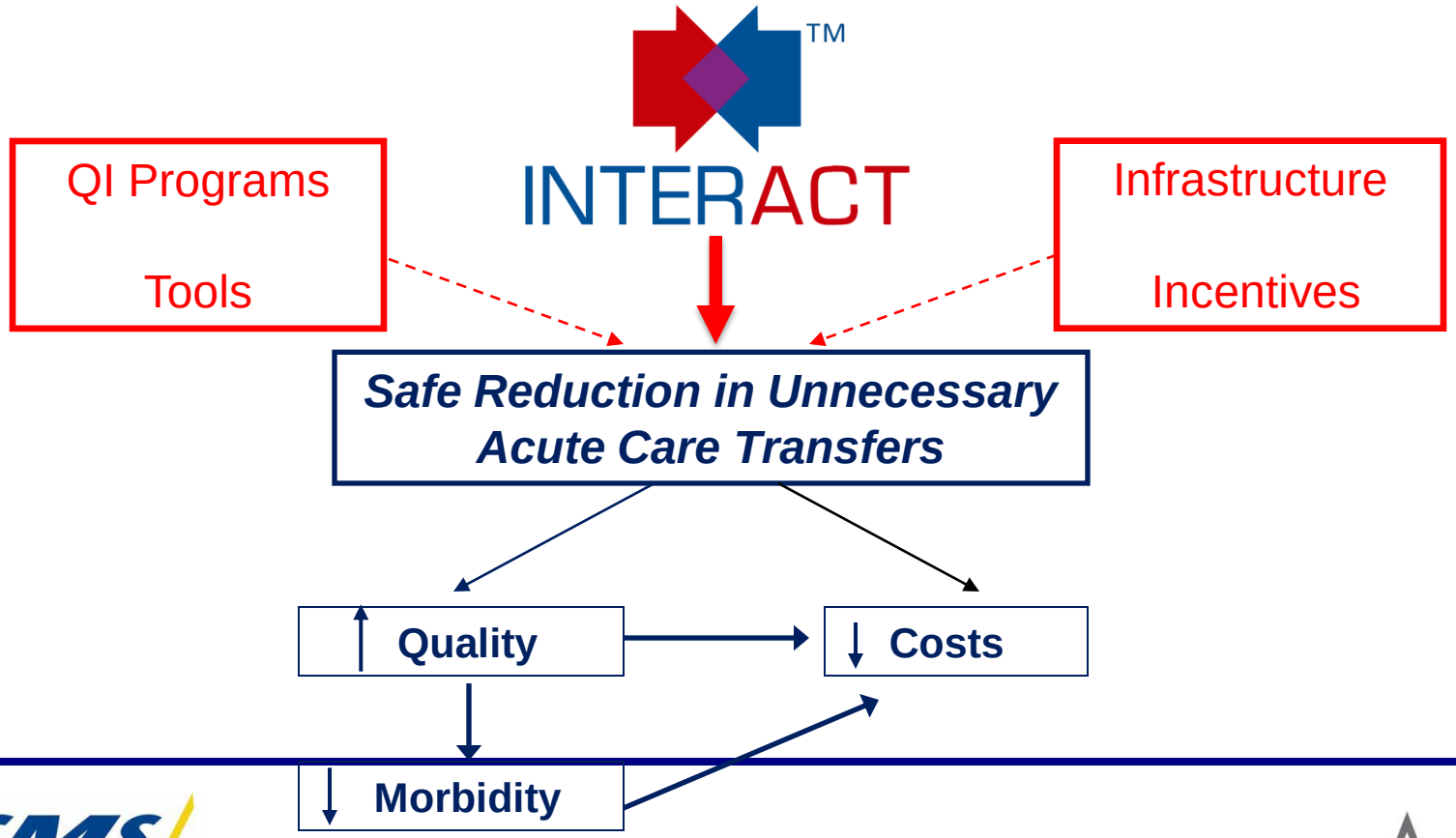
The INTERACT Program: What is It and Why Does It Matter?

What Do You and Your Facility Need to Take Advantage of These Opportunities?



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The INTERACT Program: What is It and Why Does It Matter?

- Can help your facility safely reduce hospital transfers by:
  1. ***Preventing conditions from becoming severe*** enough to require hospitalization through early identification and assessment of changes in resident condition
  2. ***Managing some conditions in the NH*** without transfer when this is feasible and safe
  3. ***Improving advance care planning*** and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents

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The INTERACT Program: What is It and Why Does It Matter?

- The goal of ***INTERACT*** is to improve care, ***<u>not</u> to prevent all hospital transfers***
  - ✓In fact, ***INTERACT*** can help with ***more rapid transfer of residents who need hospital care***

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The INTERACT Program: What is It and Why Does It Matter?

- Originally developed in a project supported by the Centers for Medicare & Medicaid Services (CMS)
- Revised based on input from staff from several nursing homes and national experts in a project supported by The Commonwealth Fund

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The INTERACT Program: What is It and Why Does It Matter?

- Communication Tools
- Decision Support Tools
- Advance Care Planning Tools
- Quality Improvement Tools

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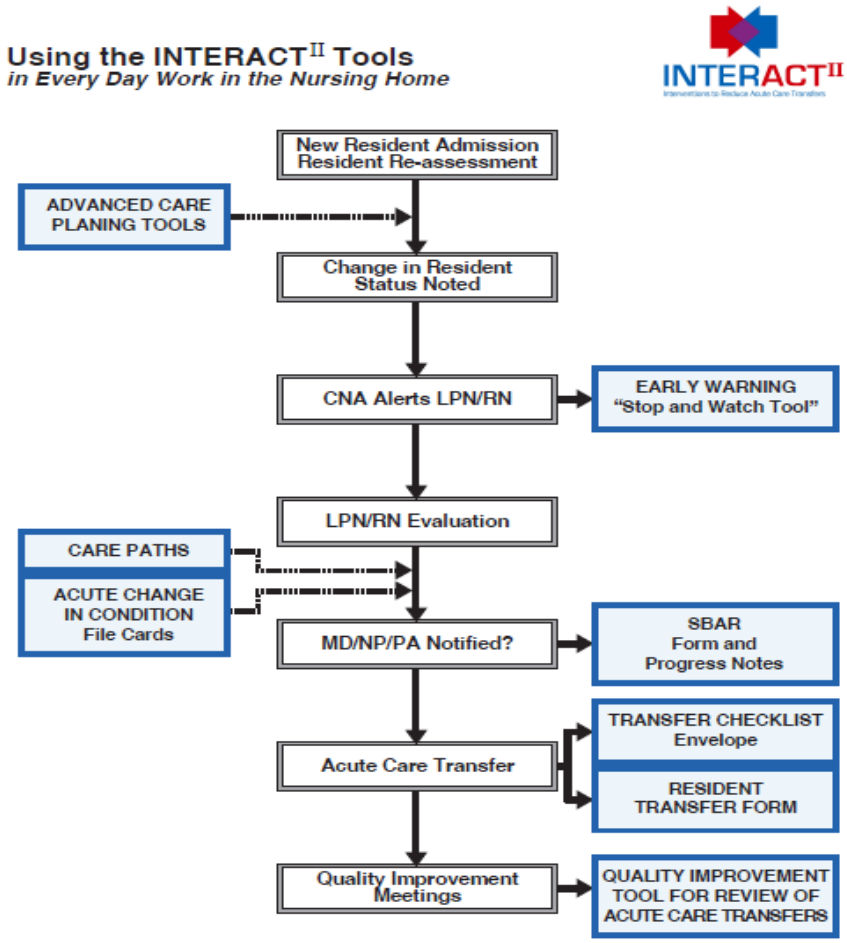
The INTERACT Program: What is It and Why Does It Matter?

The ***INTERACT II*** tools are meant to be used together in your daily work in the nursing home

http://interact2.net



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The INTERACT Program: What is It and Why Does It Matter?

Implementation Model in the Commonwealth Fund Grant Collaborative

- On site training (part of one day)
- Facility-based champion
- Collaborative phone calls with up to 10 facility champions twice monthly facilitated by an experienced nurse practitioner
  - Availability for telephone and email consults
- Completion and faxing of QI Review Tools

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The INTERACT Program: What is it and Why Does It Matter?

Commonwealth Fund Project Results

Facilities	Mean Hospitalization Rate per 1000 resident days (SD)		Mean Change (SD)	95% Confidence Interval	p value	Relative Reduction in All-Cause Hospitalizations
	Pre intervention	During Intervention				
All INTERACT facilities (N = 25)	3.99 (2.30)	3.32 (2.04)	- 0.69 (1.47)	-0.08 to -1.30	0.02	17%
Engaged facilities (N = 17)	4.01 (2.56)	3.13 (2.27)	- 0.90 (1.28)	-0.23 to -1.56	0.01	24%
Not engaged facilities (N = 8)	3.96 (1.79)	3.71 (1.53)	- 0.26 (1.83)	-1.79 to 1.27	0.69	6%
Comparison facilities (N = 11)	2.69 (2.23)	2.61 (1.82)	- 0.08 (0.74)	- 0.41 to 0.58	0.72	3%

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

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The INTERACT Program: What is It and Why Does It Matter?

Commonwealth Fund Project Results - Implications

1. **For a 100-bed NH, a reduction of 0.69 hospitalizations/1000 resident days would result in:**
   - 25 fewer hospitalizations in a year (~2 per month)
   - $125,000 in savings to Medicare Part A (using a conservative DRG payment of $5,000)

2. **The intervention as implemented in this project cost of ~ $7,700 per facility**

3. **Net savings ~ $117,000 per facility per year**
   - Medicare could share these savings to support NHs to further improve care

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

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The INTERACT Program: What is It and Why Does It Matter?

Commonwealth Fund Project Results-Implications

Getting Started: Tracking Hospital Transfers and The Quality Improvement Review Tool

ACUTE CARE TRANSFER LOG

INTERACT II
Interventions to Reduce Acute Care Transfers

Facility Name _____ Month/Year _____/_____

Resident Room Number	Date of most recent admission to the facility	Admitted to the facility from* (circle)	Status at time of Transfer* (circle)	Date of Transfer	Time of Transfer (circle a.m. or p.m.)	Outcome of Transfer (check which applies)		Hospital Diagnosis for ED visit or admission
						ED visit only (returned to facility)	Admitted to the hospital	
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			

*Hosp = Hospital
H = Home
O = Other

* S = Skilled (Medicare Part A)
LT = Long-term (Medicaid, private pay)
O = Other (e.g. managed care)

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Getting Started: Tracking Hospital Transfers and The Quality Improvement Review Tool

QUALITY IMPROVEMENT TOOL

The goal of this tool is to review transfers in order to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers, and when feasible and safe, to prevent transfers to the hospital. This tool is intended to be completed retrospectively after the transfer to look back and identify opportunities for improvement in reducing preventable transfers.

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The QI Review Tool: 5 Sections

1. Background Information
2. Change in Condition
3. Evaluation and Management
4. Transfer Information
5. Opportunities for Improvement

Getting Started: Tracking Hospital Transfers and The Quality Improvement Review Tool (continued)

The Quality Improvement Review Tool

Section 5: Opportunities for Improvement

Section 5: OPPORTUNITIES FOR IMPROVEMENT

a. After review of how the new symptoms, signs, or other change were evaluated and managed, has your team identified any opportunities for improvement? ☐ No ☐ Yes **If yes, describe briefly**

_____

_____

_____

b. In retrospect, does your team think this transfer might have been prevented?

☐ No ☐ Yes **If yes, check all that apply and describe briefly**

☐ The new sign, symptom, or other change might have been detected earlier
☐ The condition might have been managed safely in the facility without transfer
☐ Advance directives and/or palliative or hospice care could have been discussed
☐ Other (specify)

_____

_____

_____

_____ _____/_____/_____

Name of person completing form **Date of completion**

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The INTERACT Program: What is It and Why Does It Matter?

- Questions?
- Comments?
- Suggestions?

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Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

Tim Engelhardt

CMS Medicare-Medicaid Coordination Office

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Avoidable hospitalization among nursing facility residents

- Nursing facility residents are subject to frequent avoidable inpatient hospitalizations.
- These hospitalizations are expensive, disruptive, and disorienting, and nursing facility residents are vulnerable to risks that accompany hospital stays and transitions between nursing facilities and hospitals.
- 2/3 of nursing facility residents are enrolled in Medicaid, and most are also enrolled in Medicare (Medicare-Medicaid enrollees).
- 45% of hospital admissions among Medicare-Medicare enrollees receiving Medicare skilled nursing or Medicaid nursing facility services could have been avoided (Walsh et. al, 2010).
  - 314,000 potentially avoidable hospitalizations
  - $2.6 billion in Medicare expenditures in 2005

Evidence that hospitalizations can be avoided

- Avoidable hospitalizations among nursing facility residents stem from multiple system failures.
  - Inadequate primary care, poor nursing facility quality of care, poor communication among providers, family preferences, and others.
  - Compounding these problems, financing arrangements between Medicaid and Medicare are not well aligned.
- There is widespread consensus that a high percentage of these hospitalizations are avoidable.
- Studies have estimated that 30% to 67% of hospitalizations among nursing facility residents could be prevented with well-targeted interventions (Jacobson, et. al., 2010).
- Past interventions have proven effective:
  - Evercare reduced hospital admissions by 47% and emergency department use by 49% (Kane, et. al, 2004).
  - Nursing facility-employed staff provider model in NY reduced Medicare costs by 16.3% (Moore & Martelle, 1996).
  - INTERACT II reduced hospital admissions by 17% (Ouslander, et. al., 2011).

Initiative to Reduce Avoidable Hospitalizations among NF Residents

- Joint Initiative of the Center for Medicare and Medicaid Innovation (Innovation Center) and the Medicare-Medicaid Coordination Office (MMCO).
- Primary objectives
  - Reduce the frequency of avoidable hospital admissions and readmissions
  - Improve resident health outcomes
  - Improve the process of transitioning between inpatient hospitals and nursing facilities
  - Reduce overall health care spending without restricting access to care or choice of providers

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Intervention Requirements

- CMS will select sites through a competitive process.
- CMS is not prescribing a specific clinical model.
- However, all interventions must include the following activities:
  - Hire staff who maintain a physical presence at nursing facilities and partner with nursing facility staff to implement preventive services;
  - Work in cooperation with existing providers;
  - Facilitate residents' transitions to and from inpatient hospitals and nursing facilities;
  - Provide support for improved communication and coordination among existing providers; and
  - Coordinate and improve management and monitoring of prescription drugs, including psychotropic drugs.

Intervention Requirements (cont.)

- Demonstrate a strong evidence base.
- Demonstrate strong potential for replication and sustainability in other communities and institutions.
- 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.

Target Population

- Primary target population is fee-for-service, long-stay Medicare-Medicaid enrollees in nursing facilities.
- Clinical interventions will focus on long-stay residents rather than those likely to experience a brief post-acute stay and then return home.
- Applicants must describe how they will target their proposed intervention to long-stay beneficiaries.

Eligible Applicants

- CMS will make cooperative agreement awards to “enhanced care & coordination providers” to implement interventions.
- Eligible applicants may include but are not limited to:
    - Organizations that provide care coordination, case management, or related services
    - Medical care providers, such as physician practices
    - Health plans (although this Initiative will not be capitated managed care, and will not apply to beneficiaries enrolled in Medicare Advantage)
    - Public or not-for-profit organizations, such as Aging and Disability Resource Centers, Area Agencies on Aging, Behavioral Health Organizations, Centers for Independent Living, universities, or others
    - Integrated delivery networks, if they extend their networks to include unaffiliated nursing facilities
- Non-profit and for-profit organizations are eligible to apply.
- Nursing facilities are not eligible to serve as enhanced care & coordination providers. But, nursing facilities will be important partners in implementing this Initiative.

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Nursing Facility Partnerships

- Success in achieving the aims of this Initiative will depend on both the strength and efficacy of the clinical intervention and the effectiveness of engagement between the enhanced care & coordination provider and its partnering nursing facilities.
- Applicants must demonstrate a high level of engagement with the nursing facilities included in their application.
- Applications must include letters of intent from a minimum of 15 nursing facilities within the same State, with an average census of 100 residents or more per facility.
- Preference for implementation in locations with high Medicare costs, high hospital readmission rates, and where Medicare-Medicaid enrollees represent a high percentage of nursing facility residents.
- Model should be implemented consistently across all nursing facilities.

State Role

- States are critical partners in achieving this Initiative's objectives.
  - Play significant role in setting payment policy and monitoring quality of care for nursing facility services.
- Requirements for Initiative application:
  - All applicants must obtain a letter of support from their State's Medicaid director and Survey and Certification director.
  - States may, at their discretion, offer support to multiple applicants.
- State role during implementation of the Initiative:
  - In States where enhanced care & coordination providers are selected, CMS will sign an MOU with relevant State agencies.

Funding

- Overall Initiative size: Approximately 7 cooperative agreement awards to implement the Initiative in approximately 150 nursing facilities.
- Total funding is up to $128 million plus $6.4 million in supplemental funds that may be allocated based on operational, quality, and savings criteria.
- Awards expect to range from $5 million to $30 million for each entity over a 4-year period.

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Evaluation

- CMS will contract with an outside evaluator.
- It will include a broad set of evaluation measures, such as:
  - Hospitalization rate
  - Readmission rate
  - Quality of care
  - Patient experience
  - Medicare expenditures
  - Medicaid expenditures

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Next Steps

- Mandatory, non-binding Notice of Intent to Apply due April 30th
- Applications due June 14th
- Awards anticipated August 24th
- Initiative begins immediately upon award
- Start-up activities, including readiness reviews, must be completed before implementation begins
- Anticipated period of performance: August 2012 to August 2016

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More Information

- Visit our website for the solicitation: http://www.cms.gov/medicare-medicaid-coordination/09_ReducingAvoidableHospitalizationsAmongNursingFacilityResidents.asp#TopOfPage.
- Solicitation can also be found at on http://www.grants.gov by searching for CFDA Number 93.621.
- Email questions to: NFInitiative2012@cms.hhs.gov.
- Upcoming informational webinar:
  - Tuesday, April 3 from 2:00 to 3:00 PM EST
  - More details forthcoming

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Resources: Care Transitions

- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform page – where archived webinars are stored)
- http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx (AoA's The Aging Network and Care Transitions: Preparing your Organization Toolkit)
- http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/index.aspx (AoA's Aging and Disability Resource Centers Care Transitions page)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers Technical Assistance Exchange care transitions page)
- http://www.cfmc.org/integratingcare/ (Integrating Care for Populations and Communities Aim National Coordinating Center website)

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Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page – where webinar recordings, transcripts and slides are stored)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/ (Affordable Care Act text and related information)

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Next Training

- *Transitions and Long-Term Care (continued)*
  - Date TBD
  - Watch your email in early-mid April for registration information

Questions/Comments/Stories/ Suggestions for Future Webinar Topics?

Send them to:

AffordableCareAct@aoa.hhs.gov

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