NFI 2

# CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents- *Payment Incentive*

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## Payment Incentive

Six Enhanced Care and Coordination Providers (ECCPs) entered into cooperative agreements with the Centers for Medicare & Medicaid Services (CMS) to test whether a new payment incentive for long-term care facilities and practitioners will…

- Improve quality of care by reducing avoidable hospitalizations
- Lower combined Medicare and Medicaid spending.

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## Enhanced Care and Coordination Providers (ECCPS)

1. Alabama Quality Assurance Foundation (AQAF)-Alabama
2. HealthInsight of Nevada-Nevada and Colorado
3. Indiana University-Indiana
4. The Curators of the University of Missouri-Missouri
5. The Greater New York Hospital Foundation-New York
6. University of Pittsburgh Medical Center (UPMC) Community Provider Services - Pennsylvania

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## Nursing Home Partners

A total of 40 nursing home partners in AL:

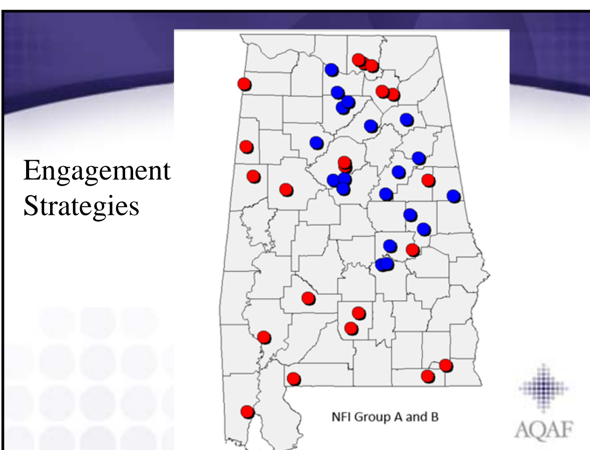
19 Clinical + Payment Incentive

21 Payment Incentive Only

The NFI grant funds several approaches to test ways to decrease avoidable ER transfers and avoidable hospitalizations:

- 19 of the facilities have an on-site Delta RN who perform ongoing assessments of the residents throughout the week. They also assist with advance care planning, polypharmacy education and teach best practices for QAPI.
- Enhanced engagement from NPs to proactively address conditions that may lead to an ER/hospital transfer
- Alternative payment model with enhanced reimbursement for treating 6 conditions in-house when appropriate.
- Ongoing monitoring of transfer/readmission rates
- Ongoing education with staff, administration and leadership via webinar and face-to-face visits

## Engagement Strategies



## Payment Incentive

CMS added new codes to the Medicare Part B schedule specifically for the Nursing Facility Initiative

•**Facility payment** - treatment of six qualifying conditions $218.00 per day up to 7 days

•**Practitioner payment** – Face to Face confirmation of six qualifying conditions **(G6985)**

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**Eligibility Chart for the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents-Payment Reform Phase II**

| Eligible | Non-Eligible |
| --- | --- |
| Resident has resided in the facility for at least 101 cumulative days (Note: If Resident transfers from another SNF, the 101 day count begins on admission to new facility) | Resident only has Medicare Part A OR Part B, not both |
| Resident has Medicare Part A & Part B | Resident only has Medicaid |
| Resident has Medicare Part A, Part B & Medicaid | Resident has a Managed Care Plan |
| | Resident has opted out of Initiative |
| Resident has Medicare A & B and receives VA Benefits | Resident receives Railroad Benefits |
| | Resident receives Hospice Benefits |
| Resident has resided at the facility for 101 days & has Medicare A & B and has not left the facility for more than 60 consecutive days. | Resident stay in facility is short term (REHAB) |

**UNUSUAL SITUATIONS**

If resident elects Medicare Hospice Benefits, but later discontinues that benefit their eligibility would be restored as long as the other criteria remained applicable. The days in hospice do not count toward the 101 minimum.

It is not required that the resident be in the facility for 101 consecutive days. However, gaps of 60 days or more are not permitted. If a resident is discharged, they will have to be in the facility 101 days to be eligible after readmission.

If a resident is enrolled in Medicare Advantage and later dis-enrolls, resident would have their eligibility restored. In this case, the residents days during the Medicare Advantage enrollment would count toward the 101 days.

(Funding for this NFI Community Learning document was made possible by Grant Number [illegible] from the Centers for Medicare & Medicaid Services (CMS). The views expressed in this document do not necessarily reflect the

## AQAF RNs

- Imbedded in 19 Facilities
- Round on Eligible Residents
- Collect Data
- Reports to Facilities
- Reports to Providers

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## AQAF RNs

- Educate Facilities, Residents, Families
  - Early identification of changes in condition
  - Use of SBAR
  - 6 Conditions

# SBAR Communication Form

*and Progress Note for RNs/LPN/LVNs*

### Before Calling the Physician / NP / PA / other Healthcare Professional:

- ☐ **Evaluate the Resident/Patient:** Complete relevant aspects of the SBAR form below
- ☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, $O_2$ saturation and finger stick glucose for diabetics
- ☐ **Review Record:** Recent progress notes, labs, medications, other orders
- ☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card**, if indicated
- ☐ **Have Relevant Information Available when Reporting**

  *(i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)*

## Stop and Watch
## Early Warning Tool

INTERACT Version 4.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

**S** Seems different than usual
**T** Talks or communicates less
**O** Overall needs more help
**P** Pain – new or worsening; Participated less in activities

**a** Ate less
**n** No bowel movement in 3 days; or diarrhea
**d** Drank less

**W** Weight change
**A** Agitated or nervous more than usual
**T** Tired, weak, confused, or drowsy
**C** Change in skin color or condition
**H** Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

*Patient / Resident*

*Your Name*

*Reported to* — *Date and Time (am/pm)*

*Nurse Response* — *Date and Time (am/pm)*

*Nurse's Name*

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## Successes in Transfer Reduction

- CNA Staffing
- Advance Directives
- Star Ratings
- Licensed Staffing

https://innovation.cms.gov/Files/x/rahnfr_foa.pdf

## Evidence that hospitalizations can be avoided

- Studies have estimated that 30% to 67% of hospitalizations among nursing facility residents could be prevented with well-targeted interventions (Jacobson, et. al., 2010).
- 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
- 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).

14

## NFI and Mortality Rate

### New study finds that nursing facilities can reduce avoidable hospitalizations without increasing mortality risk

October 02, 2018

**RESEARCH TRIANGLE PARK, NC—October 2, 2018 —** A new study finds that nursing facilities were able to reduce hospitalizations among residents without increasing their mortality risk. RTI International tracked 143 nursing facilities participating in the Centers for Medicare and Medicaid Services' Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. The results of the study were published in the October issue of *Health Affairs*.

https://www.rti.org/announcements/new-study-finds-nursing-facilities-can-reduce-avoidable-hospitalizations-without

## Payment Focus

- 6 "ambulatory sensitive conditions" account for 83% of avoidable hospitalizations
- These should be manageable in the NH with Part B-covered services.

| Condition | % of PAHs |
|---|---|
| Pneumonia | 30.5% |
| Dehydration | 12.9% |
| Congestive Heart Failure (CHF) | 16.8% |
| Urinary Tract Infection (UTI) | 11.7% |
| Skin ulcers, cellulitis | 5.9% |
| COPD, asthma | 5.5% |
| TOTAL | 83.3% |

16

## Other Components Of Model

Practitioner Payments:

- Aligning Practitioner and facility incentives to treat in place:
  - Incentivize more onsite presence
  - Recognizing site neutrality

17

## Converting Practice to Policy

- 42 CFR 483.35 Nursing Services: F-tag 726 Competent Nursing Staff
- Surveyor Investigative Pathways
  - CMS-20062 Sufficient and Competent Staff.pdf
  - CMS-20123 Hospitalization.pdf
- How are changes in a residents' care communicated to you and how do you communicate a resident's change in condition or concerns to other staff? Is there a structured tool (e.g., INTERACT or a process for identifying, communicating, and caring for changes in a resident's condition)?
- Did the facility adequately identify and address the resident's change in condition?
- Was the transfer to the hospital necessary (e.g., the resident's needs couldn't be met after facility attempts to address the needs, or the health or safety of individuals in the facility would be endangered if the resident stayed in the facility)?

18

## G9685 Acute NURSING FACILITY CARE

Physician service or other qualified health care professional for the evaluation and management of a beneficiary 's acute change in condition in a nursing facility. This service is for a demonstration project.

**Key Components Required:**

- A comprehensive review of the beneficiary's history
- A comprehensive examination
- Medical decision making of moderate to high complexity.
- Counseling and/or coordinating care with nursing facility staff and other providers or suppliers consistent with the nature of the problem(s) and the beneficiary's and family's needs.

**Maximum Benefit Period: Code can be billed once per day for a single beneficiary.**

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### PRACTITIONER CONFIRMATION OF QUALIFYING CONDITION

**Facility to complete/Practitioner to confirm diagnosis(es) and sign**

***(Visit MUST be made within 2 days from the Change of Condition Date)***

Resident Name/ID ____________________

Date Acute Change of Condition identified ____________________

Qualifying Diagnosis Criteria ____________________

Symptoms____________________

Lab: ____________________

Xray: ____________________

Notes:____________________

Qualifying Diagnosis Confirmed by Practitioner:

| | | | |
|---|---|---|---|
| Fluid Electrolyte Imbalance | ☐ | Pneumonia | ☐ |
| COPD/Asthma | ☐ | Suspected UTI | ☐ |
| CHF | ☐ | Skin Infection | ☐ |

Other Diagnosis____________________

Practitioner Signature____________________ Date:__________

**(Practitioner to document assessment findings in progress notes)**

Complete this section at end of treatment:

**Date Treatment Concluded:** __________

**Reason for Conclusion of Treatment: Select one of the following**

- Condition improved and no longer met qualifying criteria ☐
- Hospital transfer; Other discharge ☐
- Another change in condition ☐
- Resident refused treatment and/or elected hospice ☐
- Death ☐
- Resident became ineligible ☐

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### Practitioner Documentation Check List G9685

**Resident:** **Date of Visit:** **Room#:**

Patient is an ________ yo M/F who resides in the nursing home for long term care with medical problems including

At baseline patient is able to ____________________

____________________ (ambulate w/walker, self propel in WC, bedbound, etc w/comment on cognition)

Patient experienced an acute change of condition on __________ (date) with ____________________

(what was the change?)

Currently patient is ____________________

(include pertinent positives & negatives relevant to hx)

**ROS:**

PE: Vital Signs

- General
- Eyes
- HENT
- Neck
- Respiratory
- Cardiovasc
- GI
- GU
- Peripheral Vascular
- Skin
- Neuro
- Cognitive

**Assessment:**

**Plan:**

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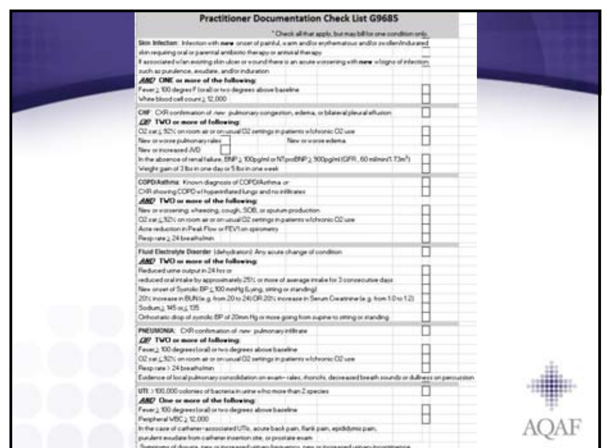


**Practitioner Documentation Check List G9685**

* Check all that apply, but may bill for one condition only

**Skin Infection:** Infection with **new** onset of painful, warm and/or erythematous and/or swollen/indurated skin requiring oral or parental antibiotic therapy or antiviral therapy

If associated w/an existing skin ulcer or wound there is an acute worsening with **new** s/signs of infection such as purulence, exudate, and/or induration

***AND*** **ONE or more of the following:**

- Fever ≥ 100 degree F (oral) or two degrees above baseline
- White blood cell count ≥ 12,000

**CHF:** CXR confirmation of *new* pulmonary congestion, edema, or bilateral pleural effusion

***OR*** **TWO or more of following:**

- O2 sat ≤ 92% on room air or on usual O2 settings in patients w/chronic O2 use
- New or worse pulmonary rales
- New or worse edema
- New or increased JVD
- In the absence of renal failure, BNP ≥ 100pg/ml or NTproBNP ≥ 300pg/ml (GFR , 60 ml/min/1.73m²)
- Weight gain of 3 lbs in one day or 5 lbs in one week

**COPD/Asthma:** Known diagnosis of COPD/Asthma or CXR showing COPD w/ hyperinflated lungs and no infiltrates

***AND*** **TWO or more of the following:**

- New or worsening: wheezing, cough, SOB, or sputum production
- O2 sat ≤ 92% on room air or on usual O2 settings in patients w/chronic O2 use
- Acute reduction in Peak Flow or FEV1 on spirometry
- Resp rate ≥ 24 breaths/min

**Fluid Electrolyte Disorder** (dehydration): Any acute change of condition

***AND*** **TWO or more of the following:**

- Reduced urine output in 24 hrs or
- reduced oral intake by approximately 25% or more of average intake for 3 consecutive days
- New onset of Systolic BP ≤ 100 mmHg (Lying, sitting or standing)
- 20% increase in BUN (e.g. from 20 to 24) OR 20% increase in Serum Creatinine (e.g. from 1.0 to 1.2)
- Sodium ≥ 145 or ≤ 135
- Orthostatic drop of systolic BP of 20mm Hg or more going from supine to sitting or standing

**PNEUMONIA:** CXR confirmation of *new* pulmonary infiltrate

***OR*** **TWO or more of following:**

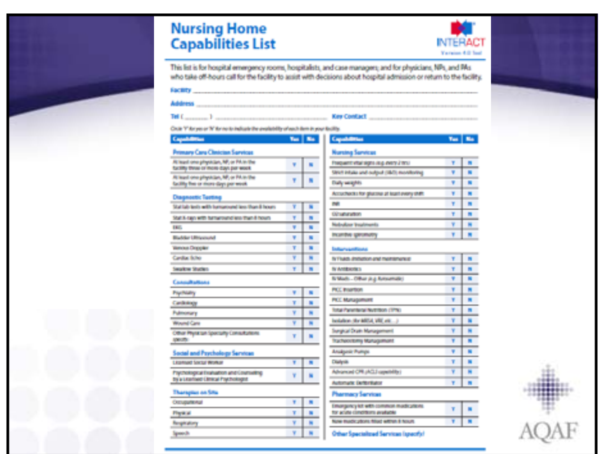
- Fever ≥ 100 degrees (oral) or two degrees above baseline
- O2 sat ≤ 92% on room air or on usual O2 settings in patients w/chronic O2 use
- Resp rate > 24 breaths/min
- Evidence of local pulmonary consolidation on exam- rales, rhonchi, decreased breath sounds or dullness on percussion

**UTI:** > 100,000 colonies of bacteria in urine w/no more than 2 species

***AND*** **One or more of the following:**

- Fever ≥ 100 degrees (oral) or two degrees above baseline
- Peripheral WBC ≥ 12,000
- In the case of catheter-associated UTIs, acute back pain, flank pain, epididymis pain, purulent exudate from catheter insertion site, or prostate exam
- Symptoms of dysuria, new or increased urinary frequency, new or increased urinary incontinence,





**Nursing Home Capabilities List**



This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility ______________________

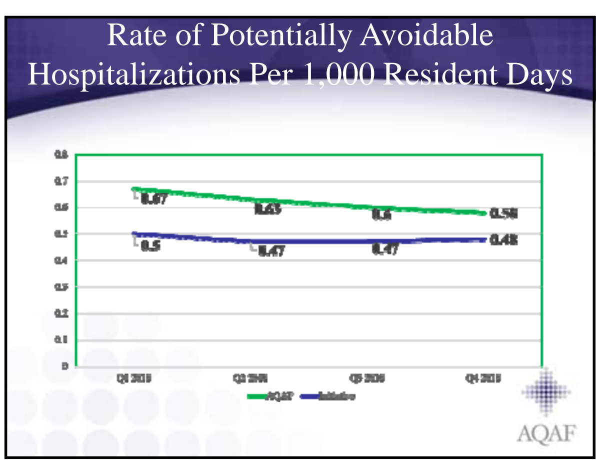
Address ______________________

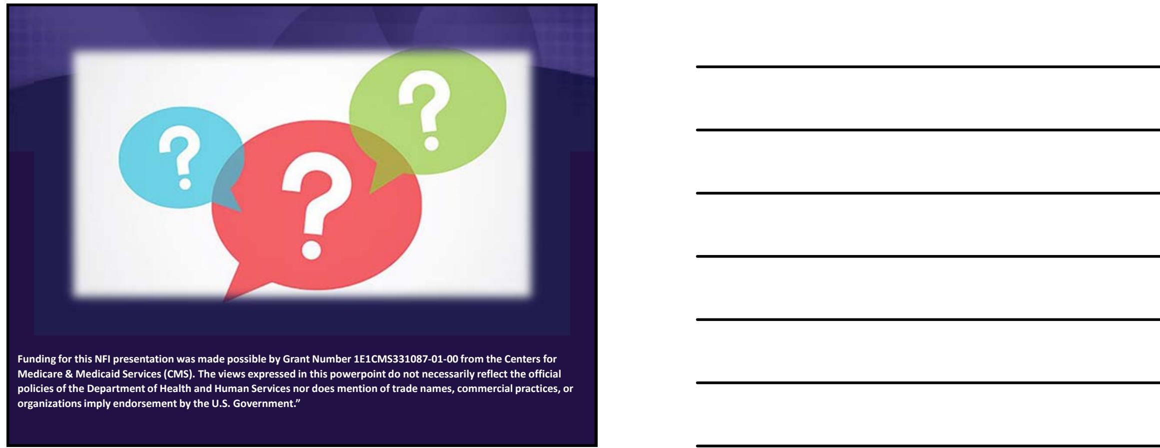
Tel ( ______ ) ______________ Key Contact ______________

| Capabilities | Yes | No |
| --- | --- | --- |
| **Primary Care Clinician Services** | | |
| At least one physician, NP, or PA in the facility three or more days per week | Y | N |
| At least one physician, NP, or PA in the facility five or more days per week | Y | N |
| **Diagnostic Testing** | | |
| Stat lab tests with turnaround less than 8 hours | Y | N |
| Stat X-rays with turnaround less than 8 hours | Y | N |
| EKG | Y | N |
| Bladder Ultrasound | Y | N |
| Venous Doppler | Y | N |
| Cardiac Echo | Y | N |
| Swallow Studies | Y | N |
| **Consultations** | | |
| Psychiatry | Y | N |
| Cardiology | Y | N |
| Pulmonary | Y | N |
| Wound Care | Y | N |
| Other Physician Specialty Consultations specify | Y | N |
| **Social and Psychology Services** | | |
| Licensed Social Worker | Y | N |
| Psychological Evaluation and Counseling by a Licensed Clinical Psychologist | Y | N |
| **Therapies on Site** | | |
| Occupational | Y | N |
| Physical | Y | N |
| Respiratory | Y | N |
| Speech | Y | N |

| Capabilities | Yes | No |
| --- | --- | --- |
| **Nursing Services** | | |
| Frequent vital signs (e.g. every 2 hrs) | Y | N |
| Strict intake and output (I&O) monitoring | Y | N |
| Daily weights | Y | N |
| Accuchecks for glucose at least every shift | Y | N |
| INR | Y | N |
| O2 saturation | Y | N |
| Nebulizer treatments | Y | N |
| Incentive spirometry | Y | N |
| **Interventions** | | |
| IV Fluids (initiation and maintenance) | Y | N |
| IV Antibiotics | Y | N |
| IV Meds – Other (e.g. furosemide) | Y | N |
| PICC Insertion | Y | N |
| PICC Management | Y | N |
| Total Parenteral Nutrition (TPN) | Y | N |
| Isolation (for MRSA, VRE, etc...) | Y | N |
| Surgical Drain Management | Y | N |
| Tracheostomy Management | Y | N |
| Analgesic Pumps | Y | N |
| Dialysis | Y | N |
| Advanced CPR (ACLS capability) | Y | N |
| Automatic Defibrillator | Y | N |
| **Pharmacy Services** | | |
| Emergency kit with common medications for acute conditions available | Y | N |
| New medications filled within 8 hours | Y | N |
| **Other Specialized Services (specify)** | | |



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