Preventing Avoidable Re-Hospitalizations:
Where Do You Fit in the Quality Care Puzzle?

The Institutional Special Needs Plan: The “EverCare Model”
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By the end of the session, participants will be able to:
• Discuss the frequency of hospitalizations and re-hospitalizations of nursing home residents
• Describe the frequency of potentially avoidable hospitalizations of nursing home residents
• Review the history and operation of the Institutional Special Needs Program, AKA the “EverCare” Model

Why Do I Care?
• Hospitalizations are expensive
• Hospitalizations are harmful to nursing home residents
• Hospitalizations negatively impact nursing home census
• Hospitalizations are increasingly being viewed as a measure of nursing home quality
• CMS, Health Plans and Referral Sources, such as hospitals, WILL start looking at hospitalization and rehospitalization rates as measures of quality

OIG Recommendations
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  – “The OIG recommends that CMS develop a quality measure that describes hospitalization rates for residents of nursing homes.”
  • CMS Response: “The CMS Concurs.”

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  – “The OIG recommends that CMS instruct state agency surveyors to review rates of hospitalization for nursing home residents as part of the survey and certification process.”
  • CMS Response: “The CMS Concurs.”

Question #1
According to a 2000 study by Saliba et. al. in the Journal of the American Geriatrics Society, how many nursing home hospitalizations were considered inappropriate?

A. 10%
B. 25%
C. 45%
D. 63%
Many Hospitalizations are Avoidable

- As many as 45% of admissions of nursing home residents to acute hospitals may be inappropriate.

- In 2004 in NY, Medicare spent close to $200 million on hospitalization of long-stay NH residents for "ambulatory care sensitive diagnoses.
  - Grabowski et al., *Health Affairs* 26:1753-1761, 2007

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Potentially Avoidable Hospitalizations of Nursing Home Residents

- Of 200 hospitalizations in Georgia NHs, 134 (67%) were rated as potentially avoidable.
- Causes:
  - Lack of on-site availability of primary care
  - Inability to obtain timely labs and IV fluids
  - Problems with quality of care in assessment
  - Uncertain benefits of hospitalization

Reasons for Hospitalization of SNF Residents

- Physician/NP in NH at least 3 days/week
- NP availability
- Exam within 24 hours
- RN providing care
- Availability of labs
- Hypodermatoclysis
- IV therapy
- Pulse oximetry
- Respiratory therapy
- Psych consultation
- TPN
- Patient-controlled analgesic pumps
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**Question # 2**

Which of the following is NOT a complication experienced by elderly nursing home residents when hospitalized?

A. Increased plasma volume  
B. Increased pulmonary closing volume  
C. Pressure ulcers  
D. Iatrogenic infections, including *C. diff*  
E. Sensory deprivation

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**Cognitive decline after hospitalization in a community population of older persons**

"In old age, cognitive functioning tends to decline substantially after hospitalization even after controlling for illness severity and prehospital cognitive decline"  
— Neurology 2012;78:950-956

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**Why Reduce Avoidable Hospitalizations?**

- Decrease emotional trauma to the resident and the family  
- Decrease complications of hospitalization  
- Reduce overall health care costs  
- Keep the nursing home beds full!

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**The Challenge**

- How do we implement care models that will:  
  - Reduce hospital transfers  
  - NOT increase morbidity or mortality  
  - Maintain trust and satisfaction of residents and their families
Two NPs Cross Paths in 1987

- Ruth Ann Jacobson, NP
  - VP Medical Delivery, Share Health Plan

- Jeannine Bayard, NP
  - VP Planning and Devt., Share Health Plan

Conditions in NHs in 1987 MN

- In 1987, physicians were paid to see nursing home residents only once monthly
- When an acute change of condition occurred, the resident was sent to the hospital
- Residents were bounced in and out of the hospital
- Costs
  - Financial
  - Emotional
  - Physical

A New Integrated Model of Care

- Bayard and Jacobson reactivated their NP credentials
- Attracted a geriatrician to sign on
- Were able to recruit academic physicians for support
- Created a new fee schedule with higher rates
- NPs provided direct care in contracted nursing homes in collaboration with PCPs

A New Managed Care Model

- With the blessing of Robert Ditmore, then president of UnitedHealth, EverCare was approved
- Approved by HCFA (now CMS) as a pilot program in 1987
- Expanded to other markets in 1994
- Awarded it Federal Medicare Demonstration Project status in 1995

“Institutional Special Needs Plan”

- Medicare Advantage Plan targeting a specific population
- Eligibility Criteria
  - Part A Medicare
  - Part B Medicare
  - Must be long term care nursing home resident
  - Disqualifying criteria: On ESRD Dialysis program at time of enrollment
- Nurse Practitioner is assigned to collaborate with PCP
- Comes with a Part D Prescription Drug Plan

What’s in it for the facility?

- Waive 3-day qualified stay for Part A SNF benefit
- Back-end incentives based on meeting quality measures such as admit rate, etc.
- Addition of an NP at no cost to the facility
Responsibilities of the Nurse Practitioner

- Initial evaluation—Usually taking 2-3 hours
- Monthly notes
- First call for any change of condition
- Must discuss any change in plan of care with the PCP
- Extensive advance care planning
- Monthly calls to family
- Becomes member of facility medical staff

The Studies

The Implementation of the EverCare Demonstration Project

Robert L. Kane, MD, and Stanley Black, MD

Evercare represents a unique approach to providing medical care for elderly persons who are frail and functionally limited, often residing in long-term care facilities. It offers a comprehensive package of multidisciplinary care provided by nurse practitioners. The project was developed in four pilot programs at four sites: Boston medical center, New York, and New Jersey. The program is in its fourth year, with a total of 2,370 patients at two sites, Boston Medical Center and New York Presbyterian Hospital. The study uses the same study design used in the original demonstration project, assessing outcomes of care in the pilot programs and comparing them with the original demonstration project.

The Effect of Evercare on Hospital Use


- Hospitalizations twice as high in control residents as in EverCare residents
- The difference corresponded to Evercare’s use of intensive service days
- Preventable hospitalizations lower in EverCare residents
- Use of NP saved $103,000/year in hospital costs per NP

“The Right Care in the Right Place”

“Comprehensive managed-care programs, such as Evercare and the Program of All-Inclusive Care for the Elderly, and provision of special care units have demonstrated that high-quality end-of-life care for patients with advanced dementia can be enhanced under managed-care programs that are not feasible under current fee-for-service payment mechanisms.”


Why does it work?

- Extensive training/orientation of NP/PAs
- Early detection and treatment of change of condition
- Treat-in-place philosophy
- Intensive advance care planning
- Effective palliative/end-of-life care
- Introduction of in-house interventions
- Inservicing nursing staff to increase skills
- Tight collaboration with PCPs and NH staff
- “QI” approach to hospital transfers
- Data collection and analysis
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Examples of Introduction of in-house/Outpatient Interventions

- Hypodermatoclysis (subcutaneous fluid administration)
- Bedside PICC placement (outside vendor)
- Outpatient transfusions coupled with strict evidence-based transfusion criteria
- PEG Change in Place

The Growth of the EverCare Model

- Grew to 1400+ Nursing Homes in the US
- Currently over 41,000 enrolled members in the US
- Since 2013, EverCare is now Optum CarePlus™
- Multiple competing Institutional Special Needs Plans across the country

The Growth of the EverCare Model: Variations on a Theme

- Capitation vs. Per Diem rates for Skilled Days
- Capitation vs. Fee-for-service for PCPs
- Contracted Model for Nurse Practitioners
- Shared Savings Models for Homes
- Aggregate Models for Multi-facility Ownership

CMS Proposed Rule: Reform of SNF Regs 7/6/2015

In this proposed rule, we propose to take a multifaceted approach to reducing unnecessary hospitalization which includes:

- Requiring that a facility notify the resident’s physician when there is a change in a resident’s status, including any pertinent information specified in §483.15(b)(2) - (§483.11(e)(7)(ii))
- Addressing communication through a robust interdisciplinary team, comprehensive person-centered care planning process and through training requirements (§483.21).
- Proposing a requirement for practitioner assessment prior to transfer to a hospital, except in an emergency situation (§483.30(e))
- Enhancing nursing care through a competency-based approach (§483.35).
- Strengthening the clinical record requirements to ensure adequate and appropriate information is available to evaluating practitioners (§483.70(i)).
- Ensuring ongoing evaluation of care process through implementation of a robust QAPI plan (§483.75)

Questions?