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Quality Transitions Boost Value-Based Services

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Streamlining transitions of care, along with reducing hospitalizations and re-hospitalizations, is a priority in any value-based payment model. Here is a look at 2 nursing-intensive initiatives that are leading the way.

As value-based care becomes more common, post-acute and long-term services and supports providers will need to become more adept at preventing hospital admissions and emergency department visits, and nurses appear to play a key role in the success of those organizations that have made this a priority.

"The RN is an incredibly important person in the nursing home, and we do not have enough of them," says Lori Popejoy, Ph.D., R.N., associate professor at the University of Missouri in Columbia and principal investigator on the Missouri Quality Initiative for Nursing Homes (MOQI).

The Centers for Medicare & Medicaid Services (CMS), concerned with unnecessary hospital admissions, developed the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents in 2012. Two programs achieved "consistently significant favorable effects," according to a study in *Health Affairs*: the MOQI and OPTIMISTIC (Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care).

Changing the System of Care

Advance practice registered nurses (APRNs) were integral in the success of the MOQI. The APRNs did not have collaborative agreements with physicians, so they could not diagnose and prescribe. However, they were able to change the system of care, improve quality, and increase staff members' clinical capacity so residents could be cared for in place.

"It was working with the staff, the administrators and providers to implement processes to elevate practice overall," Popejoy says. "We are identifying illness early enough to influence the outcome, so it does not result in an admission."

The APRNs work full-time in the 16 participating nursing homes, alongside the providers. They communicate with clarity and accuracy. They help staff complete nursing assessments and talk with patients and families about advance directives and goals of care. They often help gain families' trust that their loved ones can be cared for in place. They also analyze every hospital transition and share that data monthly with officials at the organization.

Additionally, the initiative encourages the participating nursing homes to have sufficient licensed nurse staffing and to collaborate about clinical decisions.

"If the RNs and LPNs work together, we [can] elevate everyone's skill set," Popejoy says.

The second phase of the demonstration project is now under way, with 40 nursing homes. It is testing new Medicare Part B payment codes, which will reimburse participating nursing homes an additional daily rate for caring for acutely ill residents with 6 common conditions: urinary tract infection, asthma, pneumonia, heart failure, dehydration, infected pressure ulcer, or cellulitis.

Looking forward, outside of the demonstration project, APRNs could see sick patients and bill for visits, which may help implement the model in other settings. However, if residents are kept at the nursing home when ill, the home will need additional funding to pay for the extra nurses, equipment, and lab or radiology services that might be needed, Popejoy says.

Embed RNs and NPs

"OPTIMISTIC is about developing a more comprehensive approach to the many drivers of rehospitalizations," says geriatrician Kathleen Unroe, M.D., principal investigator and program director of the OPTIMISTIC project at the Indiana University Center for Aging Research in Indianapolis.

The OPTIMISTIC model addressed many of those factors by embedding a geriatric- and palliative-care-trained registered nurse in each of the 19 participating nursing homes and nurse practitioners available for additional support. The nurse provides direct and indirect care, and watches for changes in condition.

"The nurse also serves as a lead trainer and mentor to the staff," Unroe explains.

The OPTIMISTIC nurse completes a detailed root cause analysis of why any resident is transferred to the hospital, and identifies opportunities for improvement in the transfer process. That information not only is used to benefit that resident, but when it is aggregated with other hospitalization data, the nurse can spot trends at the caregiving level, such as an increase in falls or pressure ulcer rates.

The OPTIMISTIC nurse practitioners do not replace primary care providers, but collaborate with them.

"They do a detailed transition visit when a resident returns to the facility," Unroe says. "They address polypharmacy and overall care planning."

Thorough nursing assessments of the resident when there is a change in condition are key. The nurses use a modified SBAR (Situation, Background, Assessment, Recommendation) communication tool to discuss the change with the provider.

"[Communities] with these enhanced care and supportive services were able to keep sick residents in place and reduce hospitalization rates," Unroe says.

Payers are creating incentives to manage appropriate residents in the less expensive setting of a nursing home. And, Unroe says, physicians also are facing pressure to avoid unnecessary hospitalizations or emergency department visits. They will feel more confident if the nursing home has the supports in place to care for the sicker patient.

"The question is, do [communities] have the clinical capabilities and processes in place to follow through," says Unroe, adding that the nursing home must dedicate a nurse or nurse practitioner to the program and provide staff members with what they need to support sick residents in place.

The nursing homes participating in the OPTIMISTIC demonstration project are also taking part in the second, payment phase.

Additionally, there are new payment codes for physicians, nurse practitioners, and physician assistants to promptly assess the acutely ill residents. The OPTIMISTIC nurse practitioner will follow up, as well as the primary care provider. The grant ends in 2020.

"We also continue to fine-tune the clinical model from phase one," Unroe says.

Unroe has founded a business, Care Revolutions, to consult and help spread the OPTIMISTIC model to other organizations.

Improve Weekend Staffing

Partnering with an accountable care organization, or convincing hospital discharge planners and case managers to make an organization a favored provider, requires data. Nursing Home Compare quality measures tell a story about patient outcomes and risk of unnecessary hospitalizations.

"Readmissions scores are tremendously lower in the best-performing facilities," says Chris Murphy, a partner and consultant at BKD in Tulsa, OK.

Staffing levels play a critical role, especially the difference between weekend and weekday levels, he reports. Most readmission and emergency department visits take place on weekends, when staffing lacks registered nurses.

"You do not want to be the facility with banker's hours," Murphy says. "We need our best clinicians on the weekend."

Additionally, having nurse practitioners in the buildings can backstop readmission risk, and they will pay for themselves, Murphy says.

"If you can prevent a readmission by having a nurse practitioner on-site, there is a return on investment," he reports. "That is revenue for your facility; it's another Medicare day for the midnight the patient is not in the hospital. And you set the stage for future admissions."

Under the CMS Patient Driven Payment Model (PDPM), organizations will track patient functions on admission and at discharge from subacute care. That data can tell a powerful story about the organization's ability to improve patients' function.

Communication, building relationships, and having the confidence of hospital case managers are also important.

"You want to be the first call and the right of first refusal," Murphy says. "Serving [...] to help them make a decision is a great role for post-acute care."

Editor's note: Right before we went to press with this article, an interesting study appeared in JAMA Internal Medicine. *It reported on a cohort study of more than 17 million hospitalizations, showing that patients released to home with home health services had a higher 30-day rate of readmission than those released to skilled nursing. See* JAMA Internal Medicine *for details.*

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