OPTIMISTIC

A Demonstration Project in the CMS Initiative to **Reduce Avoidable Hospitalizations** Among Nursing Facility Residents

Visit our website for supportive resources and FAQs

**Vision**
To revolutionize nursing home care.

**Mission**
To optimize the quality of life of nursing home residents by implementing evidence-based strategies to improve medical, transitional, and palliative care.

optimistic-care.org
• Please mute your line (*2) during the initial slides
• Unmute (*2 again) to speak
Fielding questions today …

Erin O’Kelly-Phillips, Analytics Team

Laura Holtz, Senior Research Manager & Payment Model Specialist
Billing Updates
Data and Analytics Team Updates
Rules about Insurance for Eligibility

• Residents must have Medicare Part B to be eligible
• Your weekly data must identify who has Part B on your roster
• If a resident does not have Part B, your facility cannot bill a change in condition for them
Insurance (con’t)

• Review insurance files to make sure Part B is identified
• Example of correct insurance info on template:

<table>
<thead>
<tr>
<th>MRN</th>
<th>Type</th>
<th>Plan Number</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>9997</td>
<td>Medicare A</td>
<td>11111111A</td>
<td>10/14/2016</td>
<td></td>
</tr>
<tr>
<td>9997</td>
<td>Medicare B</td>
<td>11111111A</td>
<td>10/14/2016</td>
<td></td>
</tr>
<tr>
<td>9997</td>
<td>Other</td>
<td>PXT1228</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Change in Condition

• The only conditions for billing and reporting are:
  – Pneumonia
  – Dehydration
  – Congestive Heart Failure
  – Urinary Tract Infection
  – Skin ulcers/cellulitis
  – COPD/Asthma

• Submit only conditions that have been certified by a provider
Change in Condition (con’t)

• All residents reported on this template should be OPTIMISTIC eligible

• Make sure the “End Reason” is given:
  – 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
  – Unknown
Other

- Ensure correct MRN for the resident on every row that they are listed - even if it is on multiple rows
- If you submit corrections to the Data Team, please make sure that you apply these corrections to all future submissions.
Quarter 1 Data

These percentages are estimated from your data, as reported to CMS on the first quarterly report.
Fielding questions today …

Erin O’Kelly-Phillips, Analytics Team

Laura Holtz, Senior Research Manager & Payment Model Specialist
Heart Failure
Prudence Twigg, NP
OPTIMISTIC Nurse Educator
Heart Failure

• Heart muscle is weakened and cannot pump enough blood to meet the body’s need for blood and oxygen (reduced cardiac output) AND the body fights back!
The Vicious Cycle of Congestive Heart Failure

LV Dysfunction causes
Decreased cardiac output

Decreased Blood Pressure and
Decreased Renal perfusion

Stimulates the Release
of renin, Which allows
conversion of
Angiotensin
to Angiotensin II.
Angiotensin II stimulates
Aldosterone secretion which
causes retention of
Na+ and Water,
increasing filling pressure
## Definition of Heart Failure

<table>
<thead>
<tr>
<th>Classification</th>
<th>Ejection Fraction</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Heart Failure with Reduced Ejection Fraction (HFrEF)</td>
<td>≤40%</td>
<td>Also referred to as systolic HF. Randomized clinical trials have mainly enrolled patients with HFrEF and it is only in these patients that efficacious therapies have been demonstrated to date.</td>
</tr>
<tr>
<td>II. Heart Failure with Preserved Ejection Fraction (HFpEF)</td>
<td>≥50%</td>
<td>Also referred to as diastolic HF. Several different criteria have been used to further define HFpEF. The diagnosis of HFpEF is challenging because it is largely one of excluding other potential noncardiac causes of symptoms suggestive of HF. To date, efficacious therapies have not been identified.</td>
</tr>
<tr>
<td>a. HFpEF, Borderline</td>
<td>41% to 49%</td>
<td>These patients fall into a borderline or intermediate group. Their characteristics, treatment patterns, and outcomes appear similar to those of patient with HFpEF.</td>
</tr>
<tr>
<td>b. HFpEF, Improved</td>
<td>&gt;40%</td>
<td>It has been recognized that a subset of patients with HFpEF previously had HFrEF. These patients with improvement or recovery in EF may be clinically distinct from those with persistently preserved or reduced EF. Further research is needed to better characterize these patients.</td>
</tr>
</tbody>
</table>
### Classification of Heart Failure

<table>
<thead>
<tr>
<th>ACCF/AHA Stages of HF</th>
<th>NYHA Functional Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>A At high risk for HF but without structural heart disease or symptoms of HF.</td>
<td>None</td>
</tr>
<tr>
<td>B Structural heart disease but without signs or symptoms of HF.</td>
<td>I No limitation of physical activity. Ordinary physical activity does not cause symptoms of HF.</td>
</tr>
</tbody>
</table>
| C Structural heart disease with prior or current symptoms of HF. | I No limitation of physical activity. Ordinary physical activity does not cause symptoms of HF.  
II Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in symptoms of HF.  
III Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms of HF.  
IV Unable to carry on any physical activity without symptoms of HF, or symptoms of HF at rest. |
| D Refractory HF requiring specialized interventions. |
Diagnostic Tests in Heart Failure

• Echocardiogram (heart size, valves, EF)
• EKG (ischemia, heart block, atrial fib)
• BNP
• CXR (increased pulmonary vasculature, pleural effusions)
• Other labs: CBC, CMP, TSH/free T4, lipids
Causes of Heart Failure

- Disorder of coronary arteries
- High blood pressure
- Cardiomyopathy
- Abnormal heart rhythm
- Heart valve disorder
Symptoms

- Shortness of breath
- Swelling of feet & legs
- Chronic lack of energy
- Difficulty sleeping at night due to breathing problems
- Swollen or tender abdomen with loss of appetite
- Cough with frothy sputum
- Increased urination at night
- Confusion and/or impaired memory
Physical Exam Findings

- Edema (dependent, LE/sacrum)
- Ascites, hepatomegaly
- Tachycardic, weak pulses, S3 gallop
- Hyper or hypotensive
- Lung crackles or decreased BS (pleural effusions, decreased O2 sat)
- Jugular venous distension
Nursing Management of Heart Failure

GOALS

- Decrease symptoms of fatigue and dyspnea
- Decrease fluid volume overload
- Increase compliance with care/self care
- Increase activity tolerance
- Avoid complications and hospitalizations
Nursing Management: Monitoring

- VS, O2 sat
- Weights, daily or?
- Edema, lung sounds, dyspnea, DOE, JVD
- Constitutional symptoms: fatigue, sleep, appetite
Fatigue and Dyspnea Treatments

- Supplemental O2
- Deep breathing exercises
- Energy sparing techniques, rest periods
- Therapy for improved endurance
Fluid Volume Overload Treatments

- Diuretics
- Low Na diet
- Fluid restriction (sometimes)
- Frequent assessments
- ***DAILY WEIGHTS*** Early AM. Same scale.
Facility Considerations

- Access to timely labs/imaging
- Scales: working & available with procedures to accomplish, record, & communicate daily/weekly weights
- Oximeters, blood pressure cuffs: working and available
Qualifying Diagnosis of CHF

- CXR confirmation of new pulmonary congestion OR 2 of the following:
  - O2 sat <92%
  - New or worsening pulmonary rales
  - New or worsening edema
  - New or increased jugular venous distension
  - BNP >300
Facility/Provider Processes

- Need to communicate changes to provider
- Provider needs to certify
- Provider needs to communicate certification
- Nursing needs to implement care (new orders) and monitor (VS, O2 sat, weights, lung sounds, edema, JVD) and document.
OPTIMISTIC

A Demonstration Project in the CMS Initiative to **Reduce Avoidable Hospitalizations** Among Nursing Facility Residents

Visit our website for supportive resources and FAQs

optimistic-care.org