Improving care for nursing home residents: CMS ups support of OPTIMISTIC to $30.3 million

With the announcement of an additional $16.9 million for a total of more than $30 million of Centers for Medicare and Medicaid Services funding since 2012, Indiana University’s OPTIMISTIC project commences the second phase of an innovative endeavor with a goal of improving the health and health care of long-term nursing home residents and ultimately reducing hospital admissions for this growing population.

In OPTIMISTIC’s four-year initial phase, focused on enhanced clinical care, nurses and nurse practitioners have been embedded in 19 central Indiana nursing homes to provide direct support to long-stay residents as well as education and training to facility staff. These specially trained professionals, who also lead care management reviews of long-stay patients to optimize chronic disease management, reduce unnecessary medications and clarify care goals, will remain in place during OPTIMISTIC’s second phase. The second four-year phase adds an additional layer of resources by introducing new Medicare payments to care for sick residents in the nursing home.

During the upcoming four years of OPTIMISTIC’s second phase, the 19 nursing homes that participated in the initial phase plus 25 additional nursing homes, who will be recruited from throughout Indiana, will implement a new CMS payment model which incentivizes nursing facilities, as well as their medical staffs, to provide higher levels of care on site rather than sending residents to the hospital.

“Under the current CMS payment system, nursing facilities do not receive additional reimbursement to provide the care needed by residents who become sicker, unless the nursing home sends them to the hospital and then readmits them to the nursing home under the Medicare post-acute care benefit,” said Project Director for OPTIMISTIC Phase 2, Kathleen Unroe, M.D., MHA. “There is no mechanism in place for CMS to pay nursing homes for ramping up nursing care and other care services needed when a resident becomes sicker. In phase two of OPTIMISTIC, CMS supports testing to see if unnecessary hospitalizations will decrease if they provide nursing homes incentives to provide care in place.”

The new payment mechanism will support short-term provision of on-site acute care to nursing home residents who have one or more of six conditions linked to approximately 80 percent medical staffs, to provide higher levels of care on site rather than sending residents to the hospital.
of potentially avoidable hospitalizations. These conditions include pneumonia (responsible for almost a third of potentially avoidable hospitalizations), urinary tract infections, congestive heart failure, COPD/asthma, skin infection, and dehydration.

All nursing homes participating in OPTIMISTIC will implement the new CMS payment mechanism. However, only the 19 facilities involved in the initial phase will have embedded OPTIMISTIC nurses and nurse practitioners, allowing the OPTIMISTIC project team to identify specific effects of the clinical innovations and the new payment method.

“CMS is investing in phase 2 for OPTIMISTIC and these other sites because early results from an independent evaluation of the phase I clinical program are already showing very positive results. We’re very excited to have this opportunity to demonstrate the full effect of OPTIMISTIC and see if we can further transform care with better aligning financial payments as well,” said project co-director Greg Sachs, M.D.

OPTIMISTIC is one of 6 sites nationwide participating in Phase 2 of this CMS Center for Innovations funded nursing home demonstration project.

Written by Cindy Fox Aisen. Full press release can be found at http://news.medicine.iu.edu/releases/2016/03/optimistic-nursing-homes-grant.shtml.

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**CMS Annual Report: 2014 Data**

In January 2016, CMS released their annual evaluation report for the *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents*, which funds OPTIMISTIC. This evaluation covers data for 2014, the first full year of the project. Below are the key summary findings for OPTIMISTIC. Consider that this data shows our performance relative to our comparison group, which is also improving on these measures. As CMS states, “early results are promising”!

*Full report can be accessed at https://innovation.cms.gov/Files/reports/irahnfr-finalyrthreereevalrpt.pdf*

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**Compared to our blinded control group, OPTIMISTIC:**

- Improved potentially avoidable hospitalizations by 29.3%.
- Reduced all-cause hospitalizations by 21.2%.
- Lowered per-resident expenditures on all-cause ED visits by 30.9% and on all-cause hospitalizations by 18.9%.
The ability to participate in decisions about one’s own medical care is an essential resident right. Unfortunately, residents may temporarily or permanently lose the ability to make medical decisions due to illness or other complications.

Whether a resident has decision-making capacity is a clinical determination. It is a judgment about whether the resident can participate in making a specific medical decision at a specific time.

Generally, physicians are responsible for determining if a resident has the ability to make a specific medical decision. Nurses and other staff can help physicians by sharing observations about a resident to help figure out if the resident is able to participate in medical decisions. Psychologists are often asked to provide their opinion to the medical team.

The four criteria to consider in evaluating decisional capacity are:

1. Understanding relevant information about the decision (for example, potential risks and benefits);
2. Insight into how their choices will impact their (short and long-term) health;
3. An ability to reason rationally and make a decision; and
4. Making a stable and consistent choice.

Decisional capacity can be situationally specific. A resident may have capacity to make some decisions but not others. A resident may be able to decide what to eat for lunch but does not have the capacity to make some or all decisions about his or her medical care. For example, a resident may have the capacity to refuse a routine blood draw but not be able to make decisions about a complicated surgical procedure. It is also possible that a resident may lose decisional capacity when ill but regain it once he or she gets better.

Signs of possible impaired decision-capacity include difficulty with any of the following: paying attention, remembering relevant information, reasoning, or problem solving. Some examples of conditions that may impair a resident’s decision making ability include cognitive impairments that are present at birth, confusion from various illnesses and infections, side effects of medications, progressive dementias, brain injury from a stroke or accident, or acute mental illness.

Staff should contact the resident’s physician about a capacity evaluation if they see one or more of the following:

- The resident refuses a recommendation or treatment plan with low risk that would likely result in a good outcome.
- The resident does not demonstrate awareness of safety or consequences to statements and actions.
- The resident has recently had an acute infection/illness, change of condition, or altered mental status.

It is important to help support residents so that they are able to make their own medical decisions. Some ways to do this include:

- Ensuring the resident has his or her hearing aids and glasses.
- Using written information, drawing pictures, or using sign language.
- Displaying information on a computer, and using an interpreter when possible.
On March 9th, OPTIMISTIC's clinical staff attended a session on Healthcare disparities facilitated by our Medical/Transitions Core lead, Dr. Jennifer Carnahan. The following is adapted from Dr. Carnahan's presentation.

In a 2001 report on healthcare inequality, the Institute of Medicine identified 6 areas for improving the U.S. healthcare system to bridge the ‘quality chasm’ of care that exists in our country. One of these areas was to make healthcare equitable, meaning that care “does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.” Unfortunately in Indiana, quality gaps do exist based on these characteristics. For example, data has shown that:

- Indiana is in the 3rd Quartile for Overall Health System Performance for low-income populations (Commonwealth Fund, Sept. 2013)
- Indianapolis is in the Top 10 Metropolitan Statistical Areas (MSAs) for highest overall disparity between blacks and whites in access to high-quality nursing homes (Smith, 2007)
- Indianapolis is ranked the 3rd MSA in the nation for highest degree of segregation among black and white nursing home residents (Smith, 2007)
- In Indiana’s care settings, nursing homes scored below average on the majority of the Agency for Healthcare Research and Quality (AHRQ)'s quality measures (AHRQ, 2014)

We have also become increasingly aware of disparities that LGBTQ elders face in healthcare settings. This can be especially true in nursing homes where members of the community face potential discrimination combined with perceived decreased autonomy, which can cause many older adults to go back into the closet.

It is important to remember that just because someone has a certain personal characteristic, it does not necessarily mean that they face a particular disparity, or vice versa. For example, members of certain racial or ethnic minorities are often assumed to be in particular socioeconomic groups, which may or may not be the case. Although these statistics can be disheartening, healthcare professionals in our state can work towards lessening this quality gap by:

- Learning and using evidence-based medicine to treat all patients
- Learning and using evidence-based medicine related to healthcare disparities and social determinants of health
- Challenging ourselves regarding our own implicit biases
- Modelling health equity for our colleagues

Residents with decision-making capacity have the right to make decisions about their own medical care. These decisions should be honored, even when the choices seem unreasonable to others. The Health Care Representative or family cannot legally overrule the resident unless there is a reason to believe the resident's decision-making capacity is impaired.

If you have any questions or would like to learn more about decision-making capacity, please reach out to your OPTIMISTIC Nurse.
The fourth annual RESPECT Center conference was held on March 4th, 2016 with 180 people in attendance. The program featured keynote speaker, Marie Bakitas, DNSc, NP-C, FAAN of the University of Alabama at Birmingham. “Let’s Talk Palliative Care: Continuity Across Settings”, focused on communication and practical skills for providers and caregivers, care across settings, and practical guidance for difficult cases. The day started with a new pre-conference workshop with presenter Lyle Fettig, MD, on the use of Social Media in Palliative Care and more than 150 tweets were shared that day. Dr. Kathleen Unroe, OPTIMISTIC project director, spoke on a panel about palliative care in the nursing home setting, which was moderated by Dr. Greg Sachs. Again this year, the OPTIMISTIC advance care planning intervention was featured at the poster session.

**Upcoming Event:**
Advisory Board Meeting
Tuesday, April 26th, 5:30 - 7:30pm
Eskenazi Conference Center 302 A&B

**Staff Spotlight: Becky Ridder, RN**

Becky Ridder has been an excellent representative of the OPTIMISTIC program as she brings experience in nursing care and management to her role as an OPTIMISTIC RN. Though not with the team from the very beginning, she required little time learning the role and integrating herself into her facility. She has been identified by her Executive Director and Director of Nursing as a key team member in the facility, working alongside staff in both a supportive and mentorship role. She spends much of her time in direct patient care yet is deliberate in using each encounter as a learning opportunity for staff. She has worked on several projects in the facility including one to improve the resident feeding process and another to assist with the CNA Education course. She is passionate about providing her residents and families with the opportunity to review their goals of care, providing support during and after the planning process. We are proud to have Becky as a member of our team and are pleased to recognize her for this award.

**Recent OPTIMISTIC Activities**

**Jan. 2016**
Advisory Board Meeting
OPTIMISTIC Leadership
Respecting Choices Training
Dr. Susan Hickman

**Mar. 2016**
RESPECT Center Conference
Laura Holtz
Health Disparities Education Session
Dr. Jennifer Carnahan
Facility Spotlight: Miller’s Merry Manor

Led by Keith Wilson, ED and Jennifer Bodary, DNS, Miller’s Merry Manor has steadily increased support of our OPTIMISTIC initiatives. MMM actively utilizes our OPTIMISTIC NP and RN for resident changes in condition, and this has led to decreased hospitalizations. A team approach between Miller’s and OPTIMISTIC has also led to increased staff education and ACP discussions. Miller’s quality nurse and Paula Bittelmeyer, OPTIMISTIC RN, collaborate on a monthly newsletter which educates staff on quality improvement topics such as SBAR, documentation, pain management, and comfort care. MMM administration recently organized a meeting with our OPTIMISTIC NP and RN and Miller’s physicians in order to promote collaborative efforts in the care of all Miller’s residents. We are pleased to recognize Miller’s Merry Manor for their support of OPTIMISTIC!

ECCP Spotlight: Nevada

OPTIMISTIC is one of seven programs in the nation supported by the CMS Innovation Center’s “Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents”. As part of our ongoing newsletters, we will spotlight the unique features and goals of each of the other six programs, known as ECCPs.

Health Insight of Nevada is implementing their intervention to reduce avoidable hospitalizations in 24 nursing facilities across their state. Called “ATOP” (Admissions and Transitions Optimization Program), the intervention uses ‘pods’ consisting of one Advanced Practice Registered Nurse (APRN) and two RNs to cover five nursing facilities each. These pods implement INTERACT tools, a resident risk assessment program, and a medication reconciliation program to identify and appropriately respond to residents’ changes in condition and reduce unnecessary hospitalizations.