# The Value of Nurse Practitioners in a Team Based Care Approach for the Rural Elderly and Disabled Medicaid Population

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# Disclosures

I have no actual or potential conflicts of interest in relation to this presentation. This presentation does not reflect the views of my current employer.

# Presentation Objectives

- Define Medicaid Waiver Programs
- Discuss Home and Community Based Services for the Elderly and Disabled (E&D)Medicaid Waiver recipients
- Evaluate the use of nurse practitioners in the team-based approach of E&D Medicaid Waiver recipients
- Support the need for continued health policy that allows nurse practitioners to practice to their full scope when providing value-based care to vulnerable populations

# Medicaid Waiver Programs

What is a Medicaid Waiver?

- Medicaid pays for nursing home care for those with limited financial resources.
- For individuals who wish to live at home or in assisted living, sometimes Medicaid will pay for care in those locations if it can be obtained at a lower cost than in a nursing home.
- It does this through "Medicaid Waivers," which are also called Home and Community Based Services (HCBS) Waivers or Waiver Funded Services.

# Home and Community Based Services 1915(c)

- The Social Security Act of 1915 was amended in 1981 to allow states the ability to create Medicaid Home and Community-Based Services (HCBS) programs that would pay for home-based services for elderly and disabled individuals referred to as 19159(c)
- The HCBS in each state must be approved by CMS in a process known as a 1915(c) waiver
- The purpose for the "waiver" because a state has gotten CMS to waive certain requirements of the Medicaid program

# Rising Popularity of HCBS

- HCBS programs have become more and more popular as public opinion has become more critical of institutionalization.
- 1990 - Congress enacted the Americans With Disabilities Act to protect disabled individuals from discrimination
- 1999 - the U.S. Supreme Court decided the case of *Olmstead v. LC,* holding that unnecessarily segregating disabled individuals in institutions is illegal discrimination
- Medicaid HCBS programs are important tools that states can use to comply with the ADA and with the Olmstead ruling

# Taking a Closer Look at Olmstead

**The Supreme Court held that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions when the following three criteria met:**

1. **The person's treatment professionals determine that community supports are appropriate;**
2. **The person does not object to living in the community; and**
3. **The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.**

# Medicaid Waiver Programs Vary by State

https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/state-medicaid-policies.html

- **State Medicaid plans or state plan amendments often indicate what types of services are covered under Medicaid. You can** find more information about state Medicaid plans on Medicaid.gov.
- **You can also contact your state's Medicaid office and ask them about LTSS coverage. To find contact information for your state's Medicaid office,** visit the State Resources Map**, click on your state, and click the Medicaid agency link.**

*****They vary in structure and how they are administered*****

# Similarities in State-Based Medicaid Waiver Programs

- LTSS can be covered by waiver. Under a Medicaid waiver, a state can waive certain Medicaid program requirements, allowing the state to provide care for people who might not otherwise be eligible under Medicaid – such an elderly and disabled (E&D) waiver program
- Through certain waivers, states can target services to people who need LTSS. These waivers are called home- and community-based services (HCBS) 1915 waivers.
  - Are authorized under Section 1915 of the Social Security Act.
  - Are fee-for-service programs, meaning that the provider is paid for each service the patient receives (such as a test or procedure)
  - Require individuals to meet criteria that are set by the state and based on a person's level of need

# Similarities Cont'd

- **1915(c) HCBS Waivers**
  - Through the 1915(c) waiver program, a state can help people who need LTSS and are Medicaid-eligible by supporting and designing its HCBS services based on their needs. Waivers vary from state to state, and many states offer more than one type of 1915(c) waiver.
  - These waivers cannot be limited to a certain ethnic or racial group but can be limited in other ways:
  - May be statewide or geographically limited in coverage
  - May be limited to a certain medical diagnosis (e.g., mental health, developmental disability)

# Mississippi Structure of E&D Medicaid Waiver

- Administered and operated by the Medicaid’s Office of Long Term Care

  - Case Management services are provided by the Planning and Development Districts throughout the state.
  - The case management team is composed of a registered nurse and a licensed social worker who are responsible for identifying, screening and completing an assessment on individuals in need of at-home services.
  - If eligible, individuals will receive monthly visit from their assigned case management team.

# E&D Waiver Case Management Team per Administrative Code

- Two required individuals
  - Case Manager (must be a Registered Nurse)
  - Licensed Social Worker

- The case management (CM) team must
  - conduct face-to-face visits together using the comprehensive long-term services and support (LTSS) assessment instrument at the time of admission and recertification
  - Additionally, the RN and LSW must visit the person together on a quarterly basis (minimum)
  - Can visit more frequently if deemed necessary

# Case Managers (Registered Nurses)

Upon approval of the HCBS, the case managers can refer qualified individuals to the following services:

- adult day health care
- home-delivered meals
- personal care services
- institutional respite services
- in-home respite
- expanded home health visits
- community transition services
- physical therapy services
- speech therapy services

# Promoting Value: Where Nurse Practitioners (NPs) Fit In?

- Promote value by offering a level of advanced practice nursing to assist the current CM structure with:
  - Timely assessment and management of
    - Annual wellness examinations
    - acute conditions
    - Chronic conditions
    - Post hospital discharge transition of care
  - Improve patient outcomes and decrease cost
  - Encourages patient-centered care and shared decision making

- Beneficial for non-E&D Waiver participants, too
  - The same entity in MS also administers federal funding for the Area Agency on Aging
    - The Area Agency on Aging is a conglomerate of organizations that are networked across the United States and situated in various geographical locations in each state
    - Their goal is to provide assistance and access to resources for the senior population found in their localities.

# Demographics of Each State

- Value of incorporating NPs is even greater in states with the following:
  - Healthcare provider shortage areas (HPSAs)
  - Rural and Medically Underserved Areas
  - Critical shortages of primary care providers
  - Large geographical areas that are considered rural
  - Recent closures of rural hospitals
  - Large rates of disability and chronic illnesses
  - Large percentages of E&D individuals with no transportation
  - Greater populations of individuals with low socioeconomic status

# Case Studies

- The following case studies are examples of a homebound rural elderly and disabled (RED) individuals serviced by a nurse practitioner home visiting program (NP-HVP):
  - Many of the individuals had multiple complex healthcare needs and had not been evaluated by a healthcare provider in an extended period of time, but continue to take prescription medications (such as coumadin)
  - When the NP-HVP was actively serving patients
    - 95 percent of referrals were through self-referral
    - the other percentages came from hospitals for transitional care services following discharge or primary care providers consulting the HP-HVP for their homebound RED patients.

# Case Study: Non-E&D Waiver Patient

91-year-old female patient walked into NP HVP office for additional information about the NP HVP. Patient had a local college student, who helped her run errands, bring her to the HVP office. She expressed difficulty getting to her healthcare provider's office due to advanced age, limited physical mobility, and transportation issues. The patient last saw her primary care provider 3 months ago. She has seen three different providers (to include specialist) over the last year for the same complaints of extreme fatigue, weakness, and fainting spells with no improvement, no relief of symptoms, and no further assessments or interventions.

- **NP Assessment:** During the NP's initial visit, patient reported weight loss over the last several months, extreme fatigue, weakness, and frequent fainting spells with a pulse of 42 beats per minute as she had been keeping a daily log of her pulse rate when symptoms occurred. Additional history showed her most recent fainting spell to be 3 weeks ago, which resulted in her calling 911, but did not feel like she needed to the hospital when EMS arrived. Patient has also been keeping a blood pressure (BP) log and upon review, the NP noted that the patient's BP had been running between 106-128/28-44, with a pulse rate in the 40s. The patient said this has been an ongoing issue for which she has seen three different providers over the last year.
- **NP Actions:** After the NP HVP assessment, a home-based EKG was performed which led to the patient seeing a Cardiology NP the next day. The cardiology nurse practitioner confirmed the suspicions of the HVP NP that there was a cardiac cause for the patient's ongoing symptoms.
- **Patient Outcome:** Patient had pacemaker placed the following day after seeing the cardiology NP. A follow-up phone call with the patient a week after she had her pacemaker placed revealed that she was "feeling the best she had felt in years." She was able to walk to her mailbox and up and down the street in her neighborhood without dizziness, shortness of breath, fatigue or fainting.

# Case Study: E&D Waiver Patient

71-year-old non-ambulatory male patient referred to the NP HVP by the local district Long-Term Care Medicaid Waiver Program due to poor living conditions, lack of transportation, limited mobility, and minimal assistance from family.

- **NP Assessment:** Patient is non-ambulatory and requires total assistance with transfers due to weakness and fatigue related to previous cardiovascular events, and limited vision due to having one eye. Patient estimated height is 5’11” and weight is 115 lbs. NP noticed that it had been over a year since patient was last evaluated by primary care provider for physical assessment and diagnostic blood chemistries.
- **NP Actions:** NP conducted a detailed health assessment and obtained blood chemistries for CBC/CMP to be sent to an outside lab.  Communication was initiated with the patient’s established primary care provider regarding the patient’s current status and lab results. Lab results showed patient was extremely anemic. Iron supplement was prescribed. Meals on wheels notified of patient’s nutritional needs.
- **Patient Outcome:** Since initial appointment, the patient’s primary care physician has requested additional labs be drawn and collaborates closely with the NP-HVP. Updated assessment findings are regularly sent to primary care provider to promote continuity of care. Continued follow up as needed in the patient’s residence.

# Where is the Value?

- Decrease health care costs for patients and insurance companies
  - Minimizes exacerbations
  - Improves coordination of care
  - Identifies areas of concern
  - Encourages healthier living
- Bridge the gap/divide among rural homebound E&D individuals and their established primary care provider and specialty provider
- Improves patient satisfaction and quality of life
- Meets the patient where they are

# Importance of Participation in Health Policy

- Engagement of stakeholders
  - Speak out
  - Share experiences
  - Encourage patients to vocalize their thoughts
- Familiarize yourself with the structure
  - Important to know what you are referring to and advocating for
- Bring together like minds
- Data is good,  but doesn’t always trump the life experience!
- Show up and be involved in various ways/venues