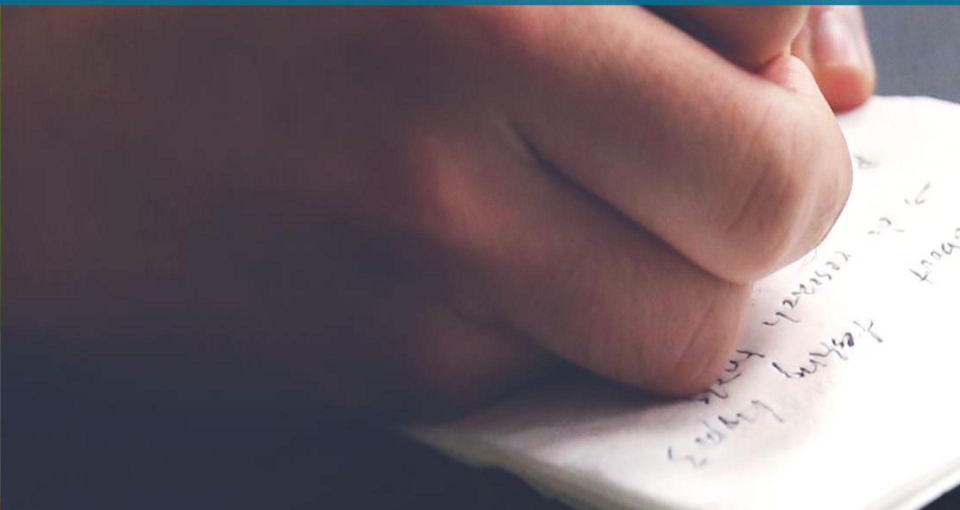
Lunch & Learn



Nurse Practitioner Home Based Primary Care

June 26, 2019

Tracey DeCastro, FNP-C, CFCS

Presented in partnership by:

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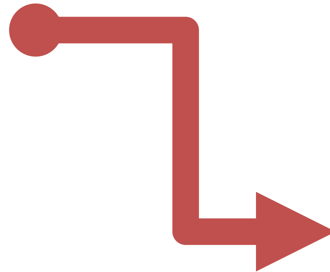

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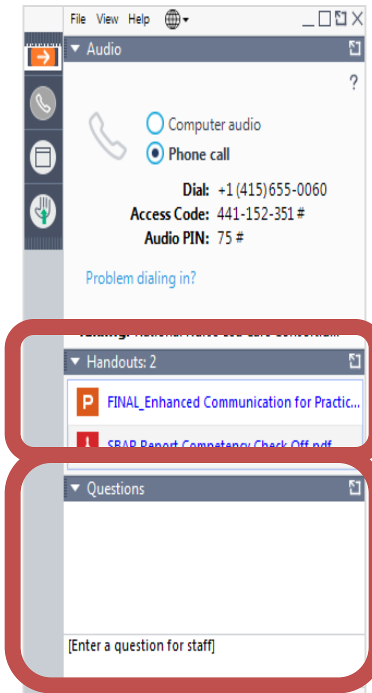

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- Participants who attend entire live presentation qualify for CE credit – 1.0 CE:
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  - **REQUIRED:** access & connect to presentation slide-deck
  - Phone-in-only participants **DO NOT** qualify
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- Participants who qualify will receive a detailed email on how to claim AANP CE credit:
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JNP Acknowledgment

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- Article source: https://www.npjournal.org/article/S1555-4155(18)30271-X/fulltext

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National Investment in Quality Improvement

- Changes to the health care system are here
- Nurse practitioners (NPs) will play a key role during the critical transition from Fee-for-Service to **Value-Based Reimbursement**
- **NNCC** and the **AANP** have partnered together to create the **Nurse Practitioner Support & Alignment Network (NP SAN)**:
  - Prepare NPs for the upcoming changes to the health care system
  - Provide free continuing education & professional development centered around value-based health care practices
  - Offer key training opportunities that ready practices for **Value-Based Reimbursement**

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Preparing NPs for Value-Based Reimbursement

What is the Quality Payment Program?

Began in 2017 as a result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and requires CMS by law to implement an incentive program referred to as the *Quality Payment Program*, that provides for <u>two</u> participation tracks:

MIPS

Merit-based Incentive Payment System (MIPS)

If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternative Payment Models (APMs)

If you decide to take pa… an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

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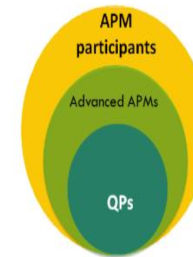
MIPS APMs

[MIPs vs. APMs Timeline]



- Designed for individuals & small practices
- Four (4) performance areas
- Replaces all current incentive programs
- Exempt if practice DOES NOT meet low volume threshold.

- Higher risk model
- Risk is shared throughout the APM
- Number of acceptable payment models is limited
- Rules to being considered a qualified provider (QP)

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Where Can I Go to Learn More?

1. **CMS QPP website** — www.qpp.cms.gov
2. **NPI Lookup for participation status** — https://qpp.cms.gov/participation-lookup
3. **AANP** — https://www.aanp.org/legislation-regulation/federal-legislation/macra-s-quality-payment-program

NURSE PRACTITIONER HOME-BASED PRIMARY CARE

Improved Outcomes with Improved Access

Tracey DeCastro, FNP-C, CFCS
Health@Home

Disclosures

- I am a current provider for PPC, Inc which is embedded with the health plan, Neighborhood Health Plan of Rhode Island.
- Health@Home is the nurse practitioner run program for high risk members for NHPRI.

Objectives

- Participants will learn the components of a successful home-based primary care program.
- Participants will learn how to identify, tracks and engage target populations for home-base primary care.
- Participants will be able to identify interventions to reduce hospitalization and emergency room usage using home-based primary care strategies.
- Participants will be able to identify the stratification process of the chronically ill population and how this interacts with resource allocation.
- Participants will gain an understanding of the evaluation and findings from 2015 & 2016 data cohorts of a home-based primary care program.

Home-based Primary Care

- Aging population with multiple chronic illnesses.
- Complex medical, social, and behavioral conditions.
- Routine office-based care has not been effective.

Why Home Visits

- Study showed home visits for the elderly reduced cost of care, ED use and inpatient utilization[1].
- Home-based primary care reduced Medicare spending by 17% for frail elders by providing interdisciplinary care for individuals with multiple chronic conditions[2].

Why Rhode Island

- Improved overall state outcomes for Medicaid and Medicare-Medicaid populations where full-practice NPs are allowed[3].
- The utilization of full practice NPs is associated w/ decreased hospitalization rates and can positively impact quality and cost of care[3].

GOALS

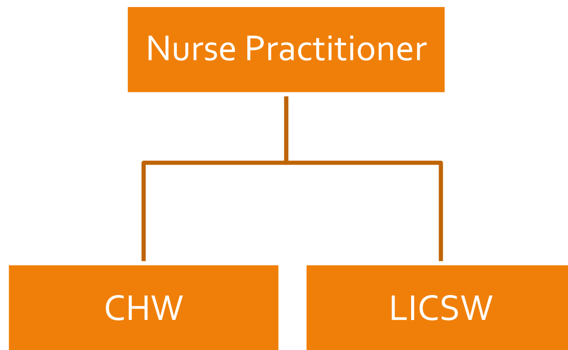
- Services provided are <u>in addition to</u> the PCP's treatment plan.
- Develop patient-centered goals
- Facilitate productive re-engagement with patient's PCP within one year.
- Decrease overall medical costs:
  - Reduce the need for ED visits and hospitalizations through intensive, high-touch/high-value interventions in the patient's home.

Barriers to Care

- Lack of education on chronic medical condition
- Co-Occurring behavioral health diags
- Transportation issues
- Language barriers
- Reactive/fragmented care

Staffing Models Change Over Time

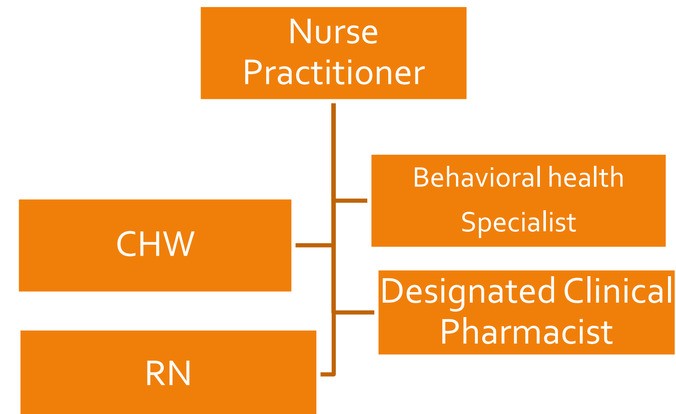
November 2014



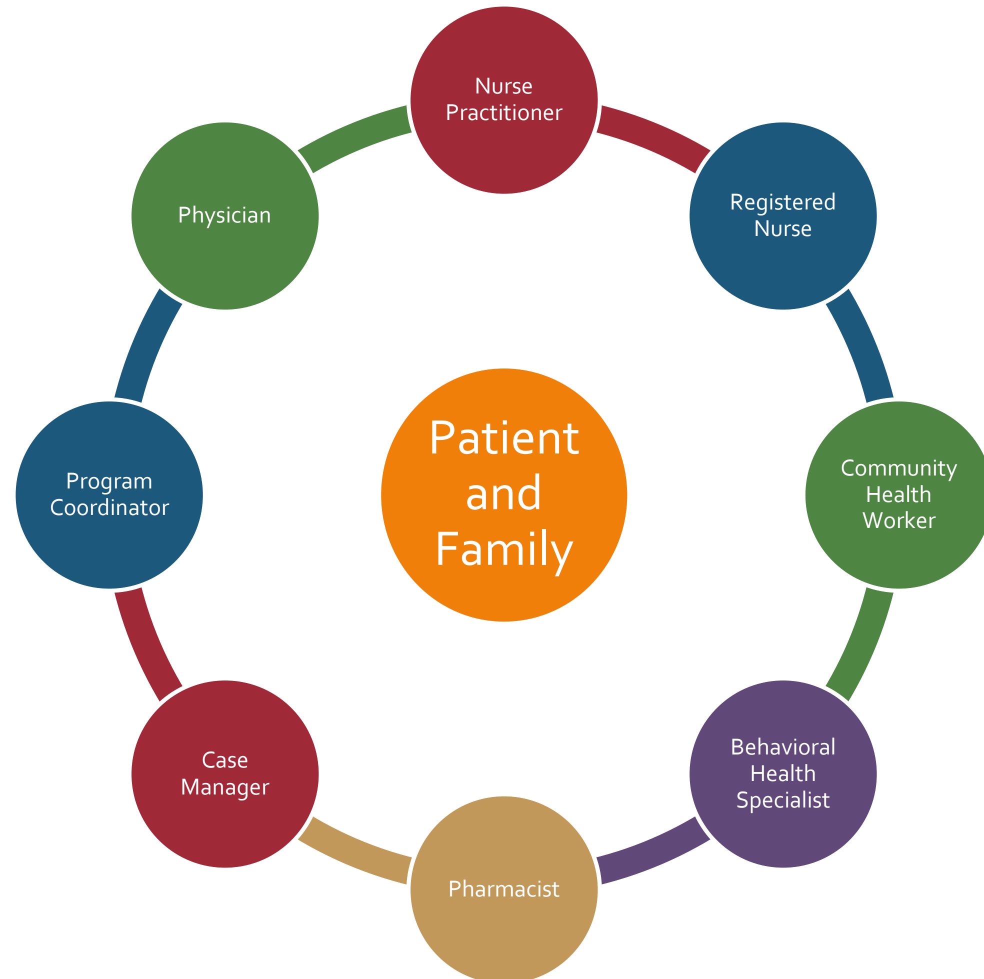
January 2019

Lead CHW

Lead NP



Team Members



Positions and Operations

- **Program Coordinator**
  - Practice Hub
- **Nurse Practitioner**
  - Clinical Assessment, diagnosis and treatment
- **Community Health Worker**
  - Outreach phone calls
  - Follow up vitals check and blood work
  - Primary contact, wrap around care management and social needs
- **Registered Nurse**
  - Targeted education, transitions of care, sick visit triage
- **Behavioral Health Specialist**
  - Provide consultative clinical BH support
  - BH assessment and therapeutic intervention

Identification of Target Population

- Utilize Neighborhood data and analytics, combined with medical director experience, to determine appropriateness for program
  - Adults
  - Prevalence of specific chronic conditions, with co-occurring BH
    - DM, COPD, CHF, HTN
  - High cost members
  - Inpatient/ER utilization

Patient Tracking

Health@Home Outreach Tracking

New | View | Reports | Admin | Info

Welcome

View Members

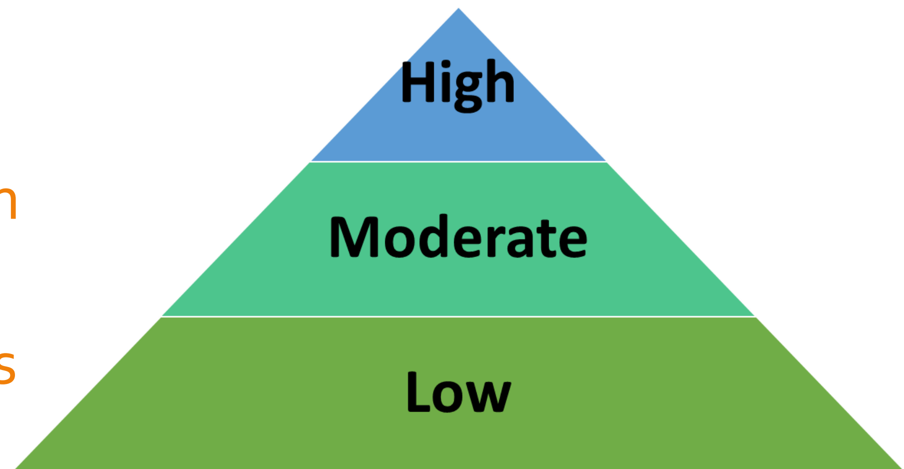
Export all pages | Export to Excel

Member ID	First Name	Last Name	Age	Language	Phone	Total Cost	Date Mailed	Call Count	Agreed To Program	Status / Staff
11076			60	English		$192,247.89	2/27/2017	2	TBD	
24210			50	English		$95,000.82		0	TBD	
60887			64	English		$102,215.31		0	TBD	
43921			51	English		$133,028.06		0	TBD	
11076			54	English		$106,840.39		0	TBD	
35785			65	English		$146,489.78		0	TBD	
97928			19	Spanish		$5,793.46		0	TBD	
35913			39	English		$33,666.88		0	TBD	
78082			33	English		$105,839.21		0	TBD	
30317			62	English		$97,250.98		0	TBD	
11007			56	English		$86,757.07		0	TBD	
67282			55	English		$91,520.16		0	TBD	
99307			56	English		$146,248.37		0	TBD	
47453			55	English		$219,471.87		0	TBD	
31747			63	English		$99,841.40		0	TBD	

1 2 3 4 ... Page: 1 of 6 Go Page size: 15 Change Item 1 to 15 of 79

Stratification Levels

- Patient risk stratification drives allocation of resources
- Dynamic, adjusted as needed, given changes in condition
- Frequency of follow-up is aligned w/ risk assessment



INTERVENTIONS

- **NP determines acuity/stratification level**
  - A person centered treatment plan is developed
- **Patient follow up**
  - Driven by patient stratification level
  - Dynamic process
  - Engagement typically for up to 1 year
- **Weekly rounding meetings**
  - Interdisciplinary team members
- **Weekly team Huddles**
  - Discuss patient progress/follow/up
  - Discharge planning
  - Confirm stratification level

INTERVENTIONS

- NP or other team member conducts high-touch, home-based visit.
- Frequency of f/u is aligned with risk assessment.
- Develop individualized care plan that encompasses self-directed goals and self-management, condition education and prevention.
- Sick visits within 24-48 hours to facilitate higher needs and avoid preventable ED visits and hospitalizations.
- Incorporate BH interventions into care plan.
- On Call

Transitional Care

- Visit w/in 48 hours of discharge from Hospital or SNF
- Collaboration between NP and RN
- Education and condition management
- Prevent Re-admission

Medications	Current Summary	Duplications	Dosing	Interactions	Abuse	Fill Gaps	Side Effects	Prevention/ Management	Cost	Conditions

MEDICATION FULFILLMENT TIMELINE

365 180 90 30

[+] Options Legend By: Classification PCP/Index: Timeline Details: Normal View

Ingredient	Strength	Daily Dose
Pain Medications		
acetaminophen	325MG	Varies
aspirin	81MG	81MG
gabapentin	400MG	2400MG
meloxicam	15MG	15MG
oxycodone	5MG	Varies
tramadol	Varies	Varies
BP Modifiers		
amlodipine	Varies	Varies
hydrochlorothiazide	Varies	Varies
lisinopril	40MG	Varies
metoprolol	100MG	Varies
Cardiac (other)		
atorvastatin	40MG	Varies
digoxin	Varies	Varies
rivaroxaban	20MG	20MG
warfarin	Varies	Varies
Diabetes		
canagliflozin	300MG	300MG
empagliflozin	25MG	25MG
glimepiride	4MG	Varies
insulin glargine	100UNT/ML	Varies
insulin lispro	100UNT/ML	Varies
metformin	500MG	Varies
pioglitazone	30MG	30MG
regular insulin, human	500UNT/ML	333UNT/ML
Psychotropics		
aripiprazole	5MG	Varies
bupropion	Varies	Varies
duloxetine	Varies	Varies
prochlorperazine	10MG	Varies
trazodone	100MG	100MG
venlafaxine	Varies	Varies

Timeline: 2016 (Se, Oct, Nov, Dec); 2017 (Jan, Feb, Mar, Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec); 2018 (Jan, Feb, Mar, Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec); 2019 (Jan)

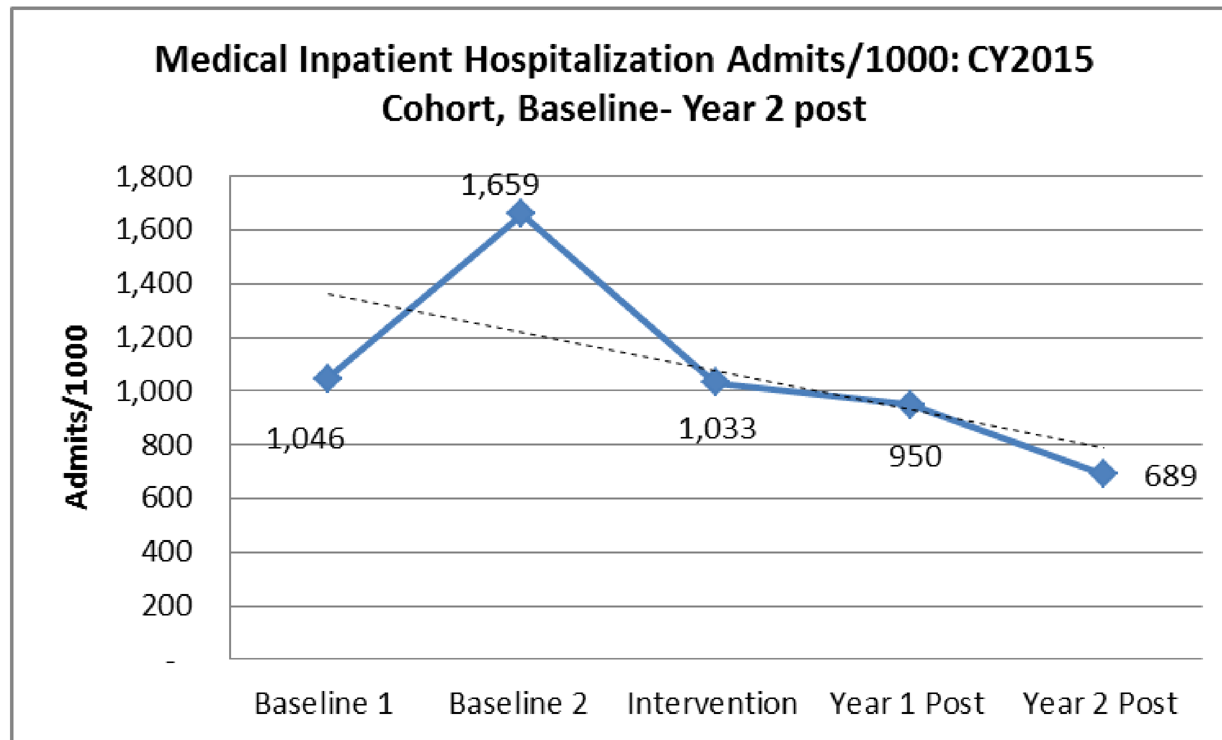
Metrics

- **Population demographics** (age, gender, primary care provider site, Race, line of business)
- **Utilization rates** (ER, hospital inpatient admits and days, Rx)
- **Costs** (total, per member per month)
- **Satisfaction**

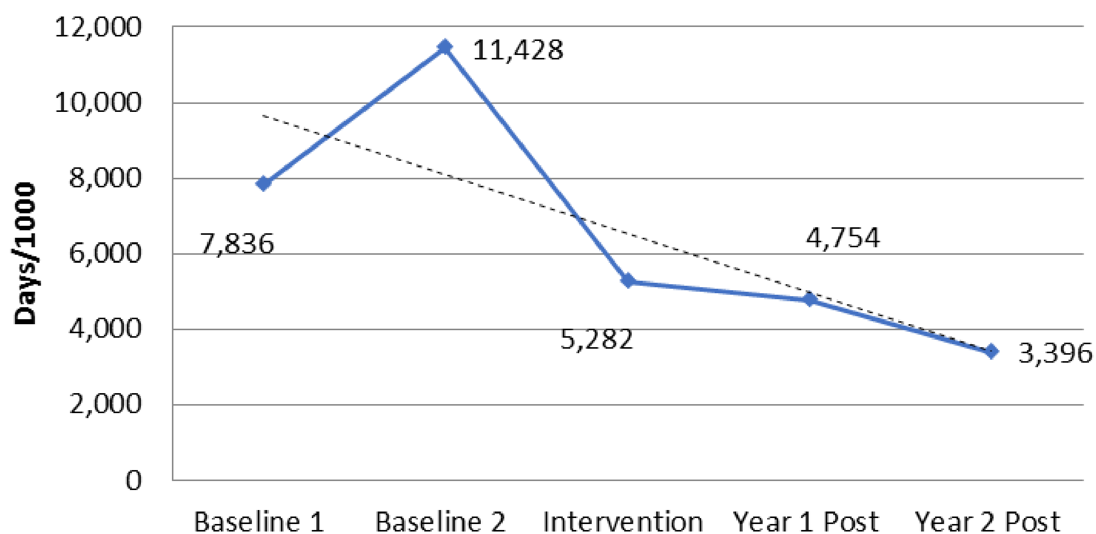
Evaluation Samples

- 2015 Cohort (CY2015)
  - Participants enrolled during 2015
  - N=471
- 2016 Cohort (CY2016)
  - Participants enrolled during 2016
  - N=408
  - Comparison group of 83 who met criteria but were determined unsafe or were failed outreach

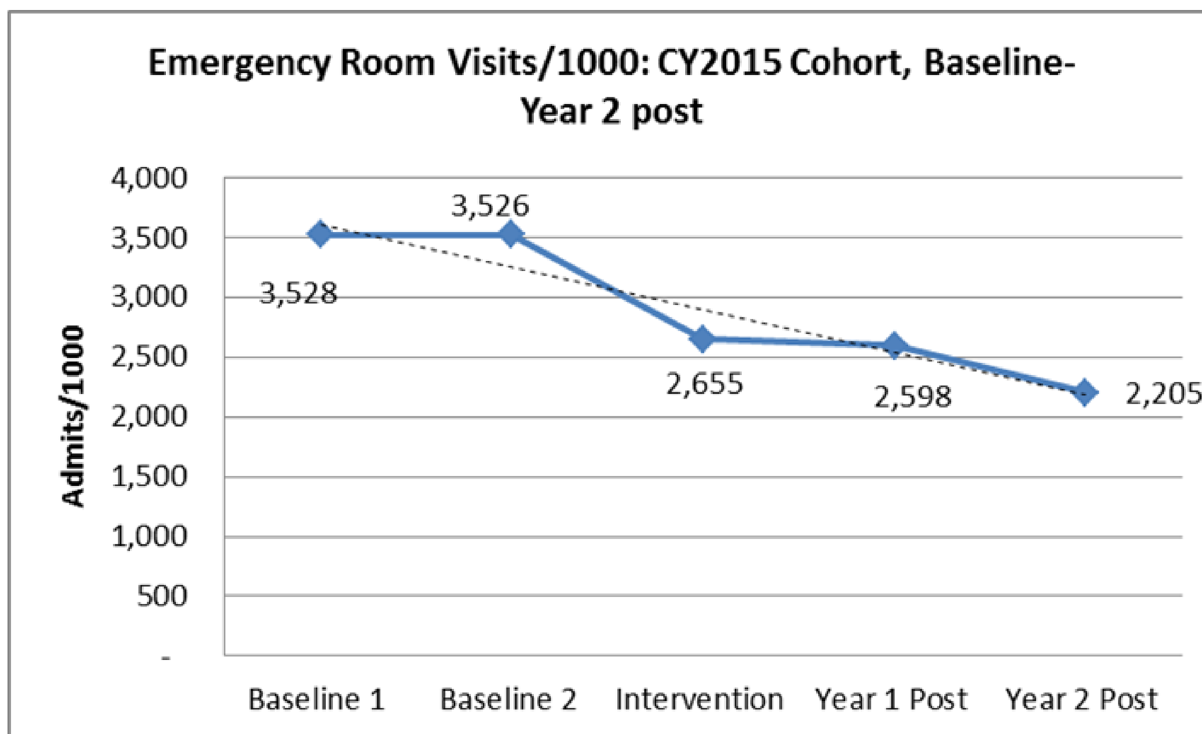
Evaluation Findings Cohort 1: Medical Inpatient Hospitalizations



Evaluation Findings Cohort 1: Medical Inpatient Hospitalization



Evaluation Findings Cohort 1: Emergency Room Visits



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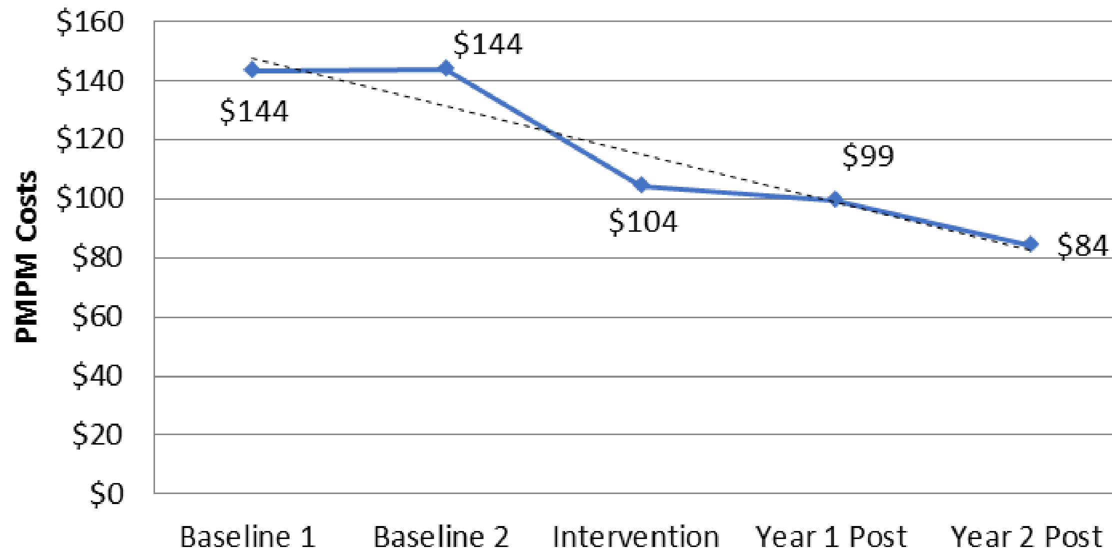
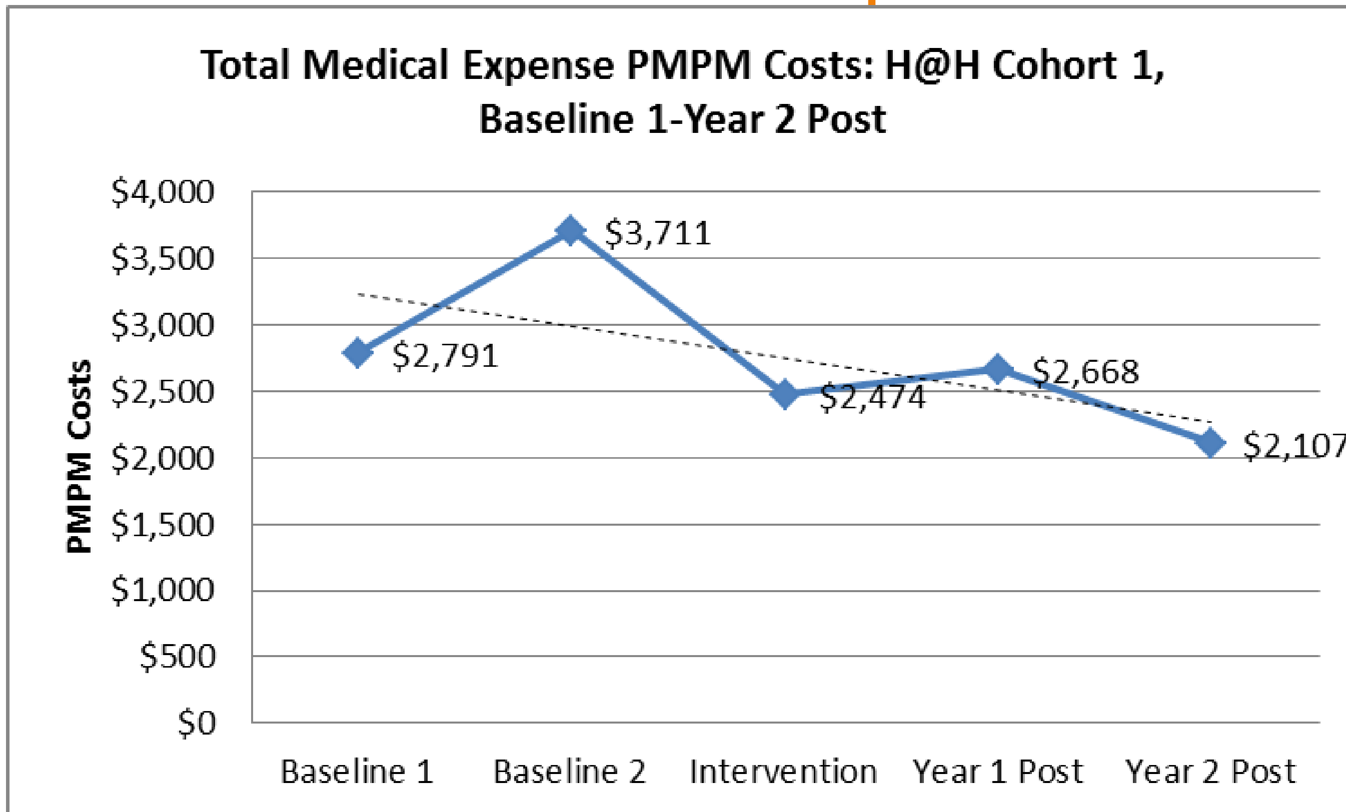
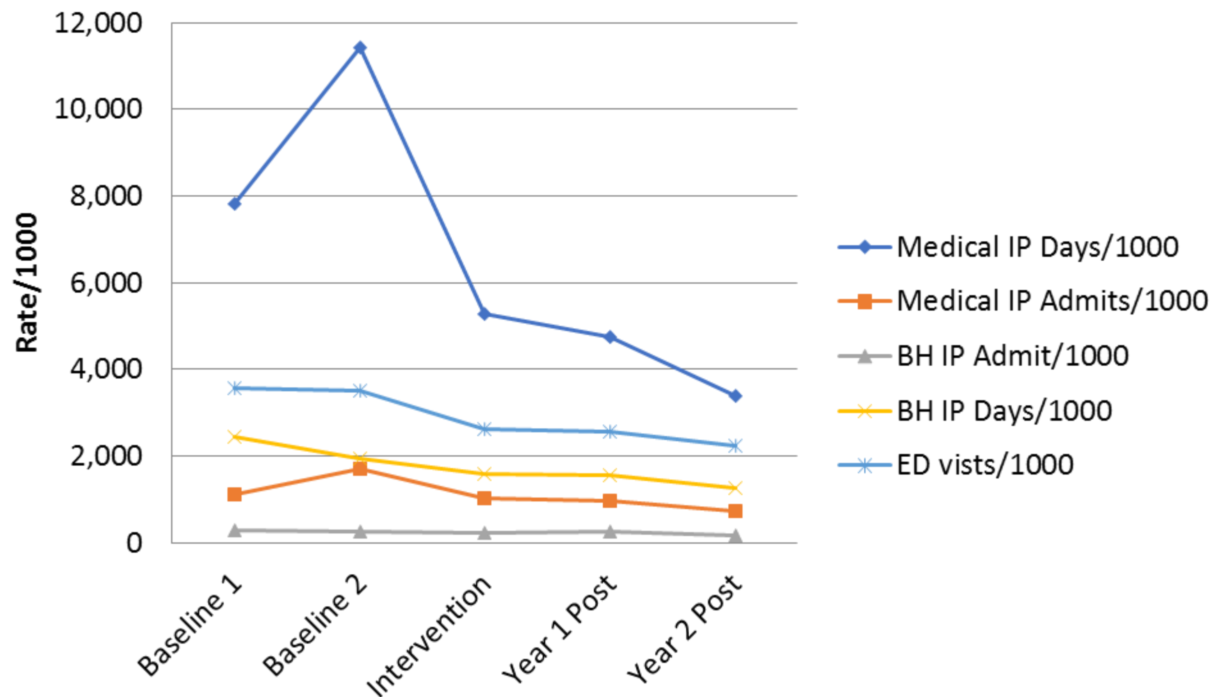


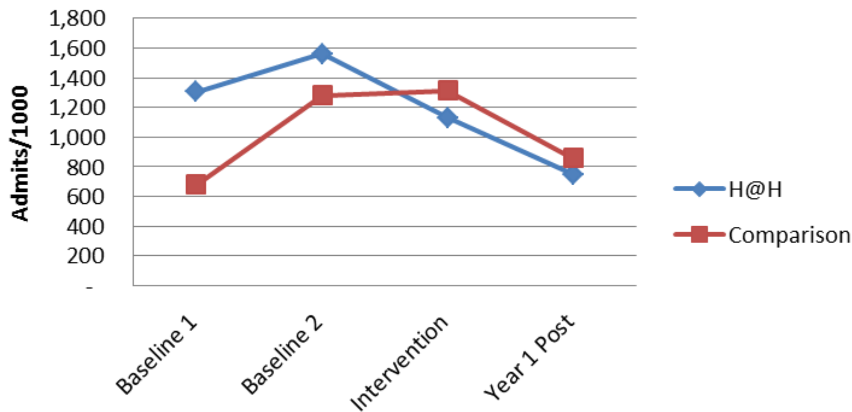
Evaluation Findings Cohort 1: Total Medical Expense

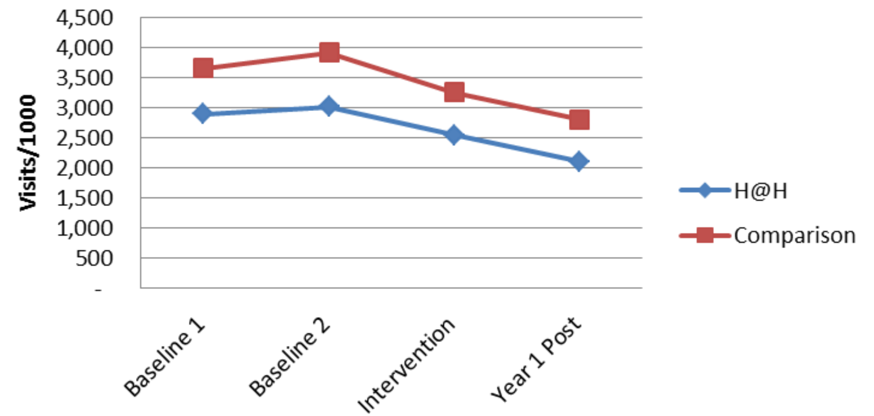


Evaluation Findings Cohort 1: Summary Utilization

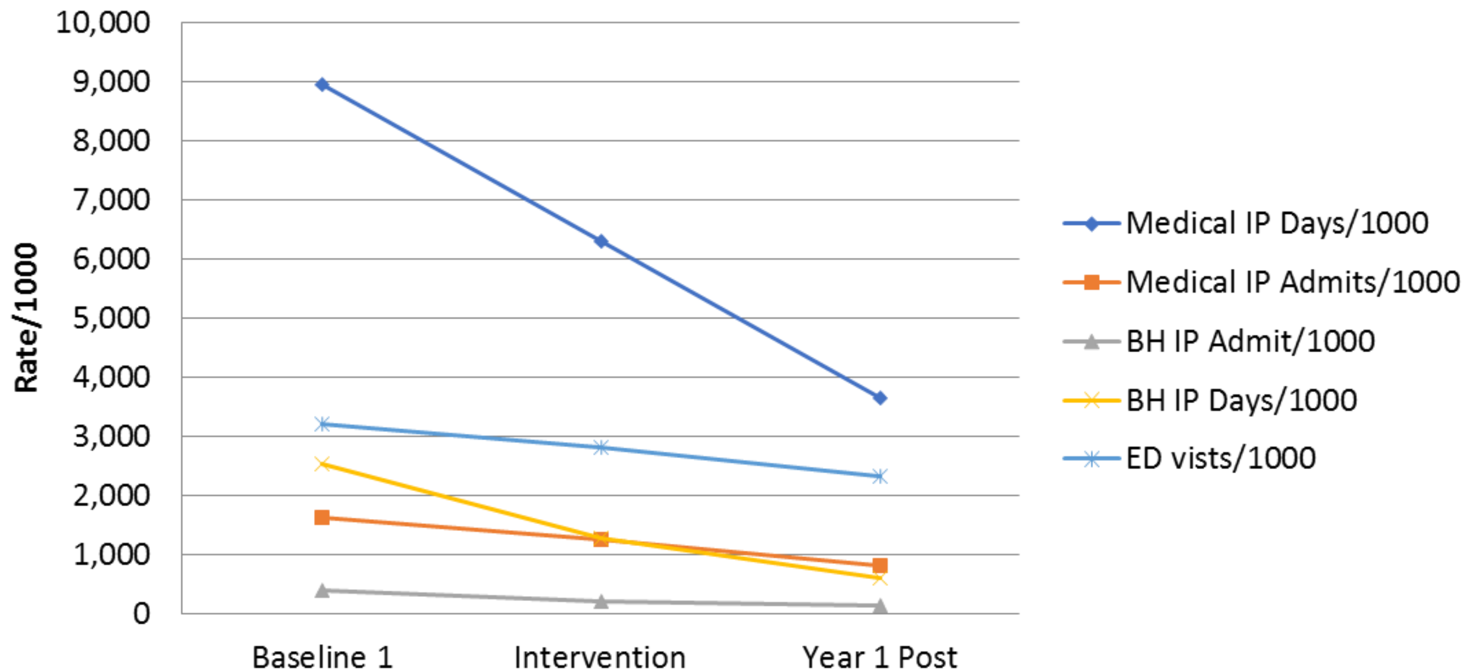


Evaluation Findings 2016 Cohort 2: Summary Utilization

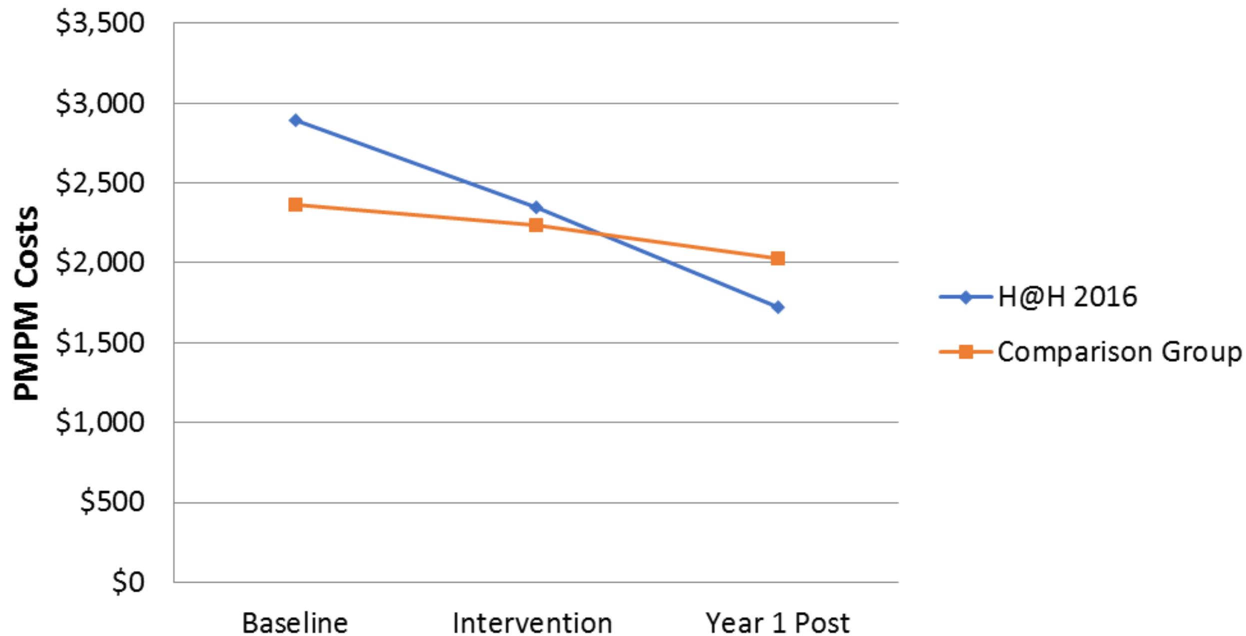




Evaluation Findings Cohort 2: Summary Utilization



Evaluation Findings Cohort 2: Total Medical Expense



Summary of Findings

- Evaluation found both immediate and long-term program effects on key measures of utilization, including inpatient and emergency department utilization.
- Participants of the home-based primary care program report overwhelming satisfaction.

Conclusion

- Value in full-practice NPs
- Population health approach is essential to enable program expansion without increasing expenses.
- Improved outcomes in vulnerable populations

References

[1]Melnick, G.A., Green, L., & Rich, J., (2016). House Calls: California Program for Homebound Patients Reduces Monthly Spending, Delivers Meaningful Care. *Health Affairs*, 35(1), 28-35. Doi:10.1377/hlthaff.2015.0253,

[2]De Jonge, K.E., Jamshed, N., Gilden, D., Kubisiak, J., Bruce, S.R., & Taler, G., (2014). Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders. *Journal of the American Geriatics Society*, 62, 1825-1831.

[3]Oliver, G.M., Pennington, L., Revelle, S., & Rantz, M., (2014) Impact of Nurse Practitioners on Health Outcomes of Medicare and Medicaid Patients. *Nursing Outlook*, 62(6), 1-8. http://dx.doi.org/10.1016/j.outlook.2014.07.004.

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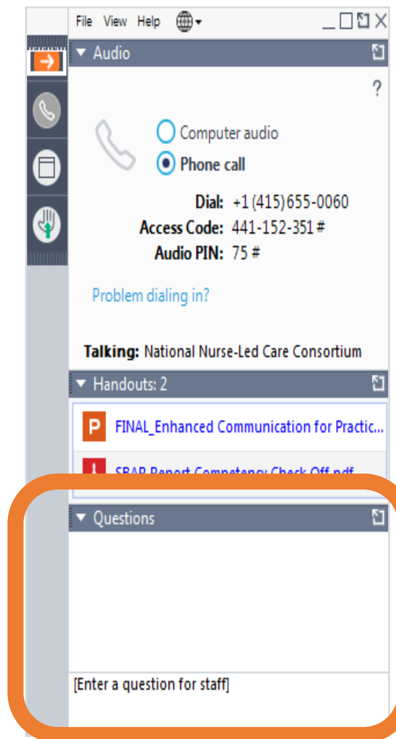

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Other QPP or NP SAN Questions?

For more information on the **QPP** or the **Nurse Practitioner Support and Alignment Network (NP SAN)**:

- Email **Joseph Reyes** at **jreyes@aanp.org**
- Email **Cheryl Fattibene** at **cfattibene@nncc.us**
- Visit us **online at https://www.aanp.org/practice/np-san**
- **Stay up to date** on the latest CE opportunities: **http://bit.ly/NPSAN_subscribe**

Coming Up

Bill analysis: How to read and analyze NP legislation

July 17,2019

1pmEST

Tay Kopanos, VP of State Government Affairs at AANP

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