‘The beautiful thing about an institutional special needs plan is that it allows you to redesign the Medicare benefits to meet the needs of the residents.’

Nurse Practitioners GIVEN HANDS-ON ROLE

Meg LaPorte

New managed care plans thrive in some facilities.

Fifteen years ago when Tom Coble stumbled into the nursing facility business, having made a major career change, he had no idea how serendipitous that move would be. He knew he wanted to go into business for himself, he says, but he "never, ever would have guessed" that this work would be so fulfilling. "I love the nursing home business," he says. "This has become a passion for me."

Coble is passionate not only about running his six nursing facilities and one assisted living residence in rural Oklahoma, but also about HealthCare Management of Oklahoma (HMC)—a company that helps Medicare managed care plans facilitate the clinical management of enrollees that reside in nursing facilities.

More specifically, HMC is a company that "partners with health plans to help them manage and operate a specific kind of Medicare managed care plan known as an institutional special needs plan (SNP)," explains Coble. "We manage the day-to-day care of the enrollees within the facilities."

Innovative Approach

Coble is especially fervent about HMC's innovative approach to managing the care of nursing facility patients, which he calls "preventive care for nursing facilities." That is, HMC-employed nurse practitioners are assigned to oversee all of the health care needs of an enrollee as well as to monitor their general well-being. "They'll even help coordinate doctor appointments and arrange for transportation to hospitals and clinics when necessary," Coble says.

In contrast to a more traditional model of nurse practitioner utilization, in which an attending physician employs a nurse practitioner to supplement visits to facility patients, HMC-employed nurse practitioners are not restricted in the nature or number of visits they can make to patients, either by regulation or by reimbursement.

Coble created the model in the mid-1990s, after seeing too many patients go to the hospital "who could have been treated more appropriately in the facility." His aim was to reduce unnecessary hospitalizations and emergency room visits, improve the quality of patient care, and maybe save

some money for the facility at the same time.

"I wanted to find out how to put a plan of care together that would allow us to get our residents the care they need."

The results, says Coble, were striking. "It really improved family satisfaction, helped facilities with cash flow, and stabilized and increased census," he says, adding that "we've also seen improved surveys."

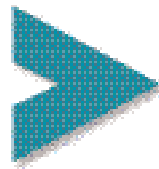
Why It Worked

The secret to his success? "This model was put together from the eyes of a nursing facility operator and closely follows the survey process," says Coble. "Since the insurance company is in the business of taking risk and paying claims, when it comes to doing case management and managing care, they don't do that well historically. So that's where we come in. I always say we're the interpreters."

Needless to say, Coble, who recently served three terms as president of the Oklahoma Health Care Association, has come a long way in his second career. This year alone, he has received four invitations to present his model for institutional SNPs at national conferences.

Innovative nurse practitioner models like HMC's are gaining ground in long term care and are most likely attributable to the rise in institutional SNP plans. Created by the Medicare Advantage (MA) program under the Medicare Modernization Act of 2003, SNP programs were intended to foster such innovation.

One element of the SNP model lends itself to this goal: SNPs are able to restrict enrollment to three groups of Medicare beneficiaries—institutionalized, dual-eligible, or those with severe or disabling chronic conditions. Unlike the typical MA plan, all three SNP plan types are able to disproportionately enroll or limit enrollment to the designated population or subpopulation, which enables them to design



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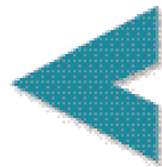

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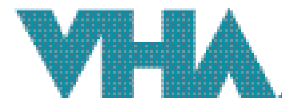

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programs based on the special care needs of their enrollees.

All SNPs must offer Medicare Parts A, B, and D benefits. Dual and institutional SNP beneficiaries can enroll in and disenroll from a SNP anytime throughout the year, while chronic-care SNP enrollees have a one-time special election period that is based on their qualifying diagnosis.

Working With SNFs

Institutional SNPs serve individuals who reside—or are expected to reside continuously for 90 days or longer—in a long term care facility. This is defined as a skilled nursing facility (SNF), a nursing facility (NF), a dually certified facility (SNF/NF), an intermediate care facility for persons with mental retardation, or an inpatient psychiatric facility.

Institutional SNPs may also serve individuals living in the community who require a level of care equivalent to that of individuals in one of the long term care facilities. In addition, SNP guidelines allow assisted living residences and continuing care retirement communities to serve as alternatives to facility-based care.

HMC nurse practitioner Ada Overton checks a patient's heart rate. Of the residents, she says, "They're like family to me."

Another noteworthy aspect of institutional SNP plans is that they also may own or operate long term care facilities. HMC is not the only company to venture into long term managed care territory—a segment of the health care system that has historically been shunned by managed care insurance plans.

NP Care, a Shelton, Conn.-based company that offers a nurse practitioner model similar to HMC's, was founded by a former nursing facility medical director and geriatrician who was frustrated by the Centers for Medicare & Medicaid Services' (CMS') vague guidelines for the use of nurse practi-

In-House Nurse Practitioner Raises Care Level

Pigeon Forge, Tenn., sits at the foothills of the Great Smoky Mountains and is home to the Dollywood Theme Park and an array of other tourist attractions, such as miniature golf courses, go-cart tracks, an Elvis Presley museum, and even an indoor skydiving simulator.

To the staff and residents of Pigeon Forge Health and Rehabilitation Center, however, the most valuable attraction is Alice Shook—an in-house nurse practitioner who coordinates care for the facility's residents in concert with the care team. They are very happy to have Shook—so happy, in fact, that Jon Bowers, the facility's administrator, believes it would be a travesty to lose her.

Shook's work has gained the enthusiastic endorsement of E. Joseph Steier, president of Home Quality Management (HQM), a multifacility provider based in Palm Beach Gardens, Fla., and owner of the Pigeon Forge care center. In the 18 months since HQM implemented a demonstration of Shook's "house staff practitioner" model in four of his facilities, he says he has saved thousands of dollars and improved quality of care at the same time.

New Utilization Model

Unlike the more traditional nursing facility model of nurse practitioner utilization, where a nurse practitioner supplements patient visits for attending physicians, Shook is part of a burgeoning model of care that places a nurse practitioner or physician assistant in a nursing facility full time (35 to 40 hours per week) for the sole purpose of overseeing the patients' care.

Although the relatively new Medicare Advantage managed care program known as special needs plans (SNPs) is proliferating, a nurse practitioner-as-care-coordinator model, Integritas Healthcare, the company that employs Shook and contracts with Pigeon Forge to provide her services, appears to be successfully operating its model outside the constraints of managed care.

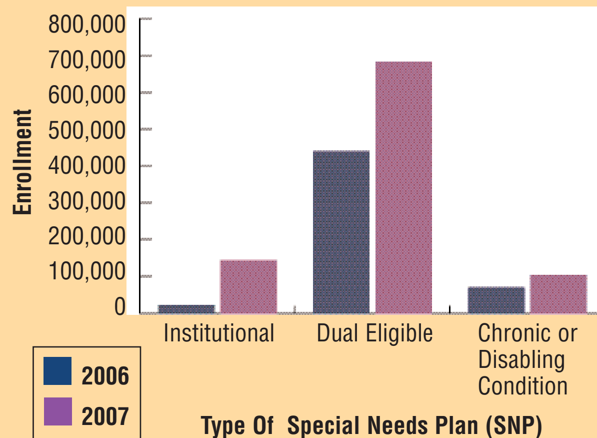
As a fledgling enterprise, Integritas has spent nearly two years honing its innovative—if not original—model through the HQM demonstration.

Shook loves her work so much ➤

tioners and the restrictions of working for a physician practice.

Although NP Care began working with Medicare fee-for-service plans (which make up the majority of Medicare beneficiaries receiving long term care services), thanks to CMS' clarification on the use of nurse practitioners in nursing facilities, the company now works with nearly any facility patient—be they covered by Medicare fee-for-service or an institutional SNP.

Medicare SNP Enrollment Growth 2006-2007



Source: The Centers for Medicare & Medicaid Services, Kaiser Family Foundation, and Mathematica Policy Research

And like HMC, NP Care, which employs 90 nurse practitioners in seven states, "embeds" nurse practitioners in nursing facilities. "Some people call us care management on steroids," says Brett Cohen, vice president of strategic development for Enhanced Care, NP Care's parent company.

Before nurse practitioners are embedded into a facility, however, they develop relationships with each of the facility's' attending physicians. "We integrate them into staff of the nursing home, where they work with the director of nursing and all of the aides," Cohen explains. "We bring in a full orientation and roll-out to make sure everybody is up to speed and knows how to utilize the nurse practitioner and knows when he or she is available."

NP Care also trains its nurse practitioners through a three-week orientation on the clinical management of geriatric patients, an in-depth review of the company's electronic medical record, and a comprehensive review of patient care in the nursing facility environment, Cohen says, noting that all of his nurse practitioners are also wound-care-trained.

Part Of Staff

Nurse practitioners employed by NP Care are typically assigned to one facility (sometimes two, depending on the number of patients). They become entrenched in the milieu of the facility's culture, much like a typical staff person would, says Jeanette Galvez-Piscioniere, NP Care's director of clinical operations. "They attend medical staff meetings in order to stay abreast of the facility's

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that the thought of going back to the physician private practice model gives her "the chills," she says. "When I think about going back, I just get in a cold sweat. I would never consider doing anything else."

When she worked with private practice attending physicians, Shook notes that her time was split among patients in four or five different facilities where she would see them only in the afternoons. "I would run through, check them real quick, get their assessments, sign their orders, and leave without any further contact with those residents until it's time to go back to recertify them," she says.

In contrast, Shook's current job with Pigeon Forge keeps her in one facility every day, Monday through Friday, "and when I'm not here, I'm on call," she says. In addition, Shook's previous work afforded her no contact with the administrative team at all. "Here, I attend the morning meeting where we discuss what has happened for the last 24 hours, and I make plans for the next 24 hours, looking at current issues in the facility."

> *'The thought of going back to the physician private practice model gives her the chills.'*

Shook, who also consults with the director of nursing, the medical director, and other clinical personnel as necessary to ensure the proper care of Pigeon Forge's patients, is considered an integral member of the care team, according to Bowers.

Demo Exceeds Expectations

"What we had in mind when we started with Integritas' model was can we find a way to go back to the industry and show them how to use a nurse practitioner or physician assistant and how it really impacts the building," says Steier.

According to Integritas' Chief Operating Officer Christine Gerace Johnson, who is a 25-year physician assistant with all but five of those years in long term care, the demonstration has proven its effectiveness in reducing hospitalizations, improving polypharmacy management, and increasing the cost savings for the facilities, she says.

When she put her model to the ➤

infection and wound rates, for example," she says.

Another benefit to the facility is that NP Care's nurse practitioner services are free of charge to the facility, Galvez-Piscioniere says. "NP Care contracts with the institutional SNP plan, which pays us on a per-member, per-month basis," so the service is also free to the patient.

Cohen claims that his company has seen profound improvements in quality of care, such as a significant decrease in avoidable hospitalizations, a decline in the number of medical deficiencies, and improved family and resident satisfaction.

"It also makes the building look really good," says Galvez-Piscioniere. "The administrators and the director of nursing love that, especially when they've previously had a shoddy image in the community." NP Care offers additional services to its facilities, such as specific f-tag programs aimed at helping the facility stay in compliance with federal regulations, Galvez-Piscioniere adds.

When she first began working for NP Care, Galvez-Piscioniere was assigned to a Connecticut nursing facility that had a 28 percent wound rate when she walked in the door.

"So, I said, you know what, maybe I can help them out with wounds. So I told them about our program, started doing more rounds in the facility with the infection control nurse, and instituted a wound care program. In a matter of three months, I was able to bring their wound rate down to the single digits," she says.

Evercare's Endurance

As the purported pioneer of the nurse practitioner-as-care-coordinator model, Minneapolis-based Evercare is the dominant force in institutional SNP plans today.

For nearly 20 years, the plan, which is owned by health insurance giant United Healthcare, has operated in the Medicare and Medicaid managed care environment.

Today, the company operates nearly 55 percent of the existing 84 institutional SNPs, with 21 percent of the enrollee market share.

Like HMC and NP Care, the genesis of Evercare is rooted in long term care. In 1987, two nurse practitioners—Jeannine Bayard and RuthAnn Jacobson—were inspired by their own experience as nurses in nursing facilities to create a care-delivery model that was more focused on primary medical care.

The two believed they could reduce the cost of acute medical care associated with hospitalization, while improving quality of care by coordinating

test with the help of Dennis Stone, MD, HQM's corporate medical director, the results were even better than they had expected. "The outcomes were astonishing," says Gerace Johnson, "resulting in an average of over $300,000 per year in financial improvement for each facility."

The demonstration measured three of the facility's economic outcomes: pharmacy management, including Medicare Part A pharmacy costs and polypharmacy rates among the residents; discharge management, that is, the cost of potentially necessary discharges such as acute infections, compared to unnecessary discharges, defined as those that could have been avoided if on-site medical care had been available; and intake management, such as admission reviews.

Under the demonstration, Integritas and HQM placed in each facility a full-time nurse practitioner who worked in collaboration with the facility's medical director. In addition, prior to the demo's launch, the nurse practitioners underwent extensive training and orientation, which encompassed disease management systems, clinical practice guidelines, geriatric procedures and protocols, and disease-specific assessment tools.

'Each facility also experienced an annual Part A pharmacy cost savings of $12,893.'

During the demonstration, Integritas also provided on-going training to each nurse practitioner, as well as to a variety of facility staff members such as the director of nursing, administrator, social worker, and the minimum data set coordinator.

The results show that compared with the national average rate of 62.7 percent polypharmacy the demo facilities were significantly below the national average. Each facility also experienced an annual Medicare Part A pharmacy cost savings of $12,893, says Gerace Johnson.

"I think we're at the point where the industry knows we have to have nurse practitioner programs, no matter how you structure them," says Steier, who is so happy with the demonstration that he is contemplating the expansion of it into each of HQM's 60 facilities.

NP Care takes its nurse practitioners through a three-week course on clinical geriatric care, in particular, in the nursing facility setting.

services to reduce duplication, fragmentation, and delays inherent in the existing approach.

Today, Evercare, which recently converted a majority of its Medicare Advantage plans to SNPs, claims that through its Ovations program it employs "the largest nurse practitioner workforce in the nation."

As proof of its achievements, the company points to an "independent federal study" of its program, which concludes that "Evercare reduced hospitalizations by 45 percent with no change in mortality; reduced emergency room visits by 50 percent; effectively reduced the number of medications taken by enrollees; and earned higher measures of quality for treating illnesses such as influenza, pneumonia, and depression."

The Evercare model diverges from the HMC and NP Care nurse practitioner models on some key elements, however.

To begin with, Evercare is its own institutional SNP plan, unlike HMC and NP Care, which are companies that contract with SNP plans. In addition, Evercare nurse practitioners see only Evercare enrollees in a facility, whereas NP Care nurse practitioners are rarely unable to see a patient in a facility no matter how they are covered. Finally, Evercare generally prohibits other nurse practitioners, such as those working for a third party, to oversee the care of its enrollees.

Evercare announced last year that it plans to expand its operations within the next five years to between 42 and 45 states and to continue growing at the rate of 20 percent to 25 percent annually.

Beyond Basic Services

"The beautiful thing about an institutional SNP is that it allows you to redesign the Medicare benefits to meet the needs of the residents, which in turn allows the nurse practitioners to basically become a full partner with the health plan and the delivery of care," Coble says.

According to Jeff Kelman, MD, chief medical officer for CMS' Center for Beneficiary Choices and a certified nursing facility medical director, institutional SNPs have the flexibility to provide services to their enrollees that go beyond the basic care that Medicare provides, which enables them to support their patients at the necessary level of care.

Institutional SNPs are different from other SNPs in terms of why they might be attractive to insurance plans and what benefits they might provide, according to James Verdier, principal investigator with Washington, D.C.-based Mathematica Policy Research. "If a SNP is responsible for both the nursing facility and the hospital care for their beneficiaries, they can do things for them in a nursing home that will reduce the beneficiary's likelihood of having to go to a hospital if their conditions got worse, like an adverse drug reaction, for example," he says, "whereas, under traditional fee-for-service Medicare they would have to go to the hospital."

Such coordination of care, according to Kelman, may include additional physician and nurse practitioner visits, more rehabilitation therapy, better payment for intravenous (IV) medications, and different levels of occupational and speech therapy.

Verdier, who's organization recently conducted a congressionally mandated evaluation of the SNP program for CMS, further explains that if a managed care plan was at risk for both the hospital and nursing facility care they could take some savings they might achieve by keeping people out of the hospital and make additional payments to the nursing facility to provide additional preventative care—like nurse practitioner services—and maybe some of the more-intense services that might otherwise be provided by a hospital.

"So it would be possible for an institutional SNP to use some savings to make additional payments to nursing facilities," he suggests.

HMC takes advantage of this flexibility by allowing physicians to make visits to their nursing facility patients as the need arises, a stark contrast to the rigid Medicare regulatory visit requirements.

"If they need to come to the facility to see a patient, we pay for it; we don't have the restrictions around visits," says Coble, noting that his program also pays physicians more than the typical Medicare rate. HMC also provides its patients with some durable medical equipment that traditionally has not

been available to them in this setting, says Coble.

Working With Physicians

HMC nurse practitioner, Ada Overton, drives a 25-mile stretch of road that runs between Comanche and Ryan, Okla., just off of U.S. 81, at least three times a week to visit her patients, who reside in three nursing facilities. The most challenging part of Overton's job thus far is not the driving, she says, but getting physician buy-in.

When Overton began working for HMC last October there was one doctor who was already familiar with the setup, but another doctor took a little while longer to warm up to her.

"I don't think he had worked with a nurse practitioner before, so I had to assure him that I was not trying to overstep my boundaries," she says. "It took him maybe four to five months, but now he is very comfortable with me. I think he just needed to know that I wasn't just going to write prescriptions for the sake of writing prescriptions."

Apart from that minor challenge, Overton is nothing but positive about her job. The biggest attraction for her is the patients themselves. "They're like family members to me," she says. "I tell all of my patients and their families that they can talk to me any time—even when I'm not on-call. They can give my name to the on-call nurse practitioner, and she will contact me if they need to talk."

The feeling is apparently mutual. "Our families absolutely love having the nurse practitioners in the facilities. They look for them and they trust them," says Coble, adding that facility staff are pretty happy with the nurse practitioners in the building.

"We've seen improved communication with the attending physicians, whom they are seeing at their facilities more often."

All things considered, Coble is more than content with the SNP program and the benefits it has brought to his nursing facility partners. "We've developed a plan of care and benefit package so that the residents receive their care in their home, which is the facility," he says. "So, it takes worry and stress off of the family as far as trying to take off work or making sure the grandkids are taken care of, so they can go be with their loved one."

The best part of the program for Coble, however, is that "it really brings peace of mind to the families. I just can't describe how terrific it is."

Integritas Health Care employs nurse practitioner Alice Shook to work full time at Pigeon Forge Health and Rehab.

Usage On The Rise

Today, more than 840,000 beneficiaries in 41 states are enrolled in SNP plans, with sponsors that include state Medicaid managed care plans; commercial, multi-state publicly traded health plans; some physician networks; and disease management entities.

In the relatively short lifespan of the program, institutional SNPs in particular have grown considerably and at the same time drawn the attention of those in both the managed care and nursing facility industries.

According to Avalere Health, a consulting and research firm in Washington, D.C., while there has been significant growth in SNP enrollment across all three plan types, institutional SNPs have experienced the most precipitous growth, with a 255 percent jump in enrollment between September 2006 and March 2007 alone (from 39,325 to close to 140,000 enrollees).

In a recent analysis of the SNP marketplace conducted for the American Health Care Association, Avalere notes that enrollment in institutional SNPs is not evenly spread among plans or geographic regions. Of the 139,761 institutional SNP enrollees, one insurance company, United Healthcare (which owns Evercare SNP plans), has a 21 percent market share, or 29,585 lives, while the bulk of enrollment, approximately 105,823 (76 percent), is in special demonstration arrangements in the New York City metropolitan area and southern California, according to Avalere. Another 64 percent of institutional SNP enrollment is represented by SCAN Health Plan in southern California, Avalere says, and the remaining enrollment is spread among smaller local or regional plans with enrollment under 1,000 covered lives per plan.

Provider Benefits

According to CMS' Kelman, when he was still practicing in nursing facilities, "if a patient had a change of status, we

did a very nice job of providing extra care, extra services, the use of IVs, and round-the-clock extra nursing care to prevent hospitalizations," he says. "But the incentive was backwards for the facility because while it saved Medicare money on the hospital, it cost the institution money that was never compensated."

Kelman says that institutional SNPs have the potential to align all those incentives "so the extra services at that setting can be compensated appropriately, and patients can [avoid] unnecessary transfers, which is to everybody's advantage. It basically allows nursing homes the flexibility to provide services beyond what basic care Medicare services provide in order for them to support their patients at their level of care. And preventing unnecessary transfers always accrues to the benefit of the nursing home," he says.

For nursing facilities contemplating a relationship with an institutional SNP, Verdier advises that the model of utilizing a nurse practitioner to coordinate care works only if a facility considers having the nurse practitioner in the facility to be a benefit as well, "because SNPs can't just march into a facility and say 'you have to do business with us'; it has to be a mutually agreeable arrangement," he says.

Kelman underscores the importance of this advice by noting that nursing facilities do not have to agree to the SNP's requirements, "which gives them a certain leverage to give the extra services and extra benefits that they think are most appropriate with the SNP."

Teresa DeCaro, director of Drug Benefit Purchasing at CMS' Center for Beneficiary Choices, adds that "every SNP contracts for its provider services, so it must contract with nursing homes just like they would contract with physicians and pharmacies on the terms of their service delivery and financial arrangements."

DeCaro also advises that the two parties have an understanding of each other's responsibilities. "For example, there might be a beneficiary who is dehydrated, and instead of sending them to the hospital a nursing home might have a special infrastructure there so they can provide hydration through IV therapy at the facility," she says.

"Nursing homes should ask the SNP if it's the facility or is the health plan making the resources available even though they are all happening on that site, for example."

"I would never consider doing anything else," says Alice Shook of her work with residents of the Pigeon Forge center.

Looking Ahead

Although the SNP program is due to expire on Jan. 1, 2009, most observers of the program believe that Congress will reauthorize it. And while CMS officials were not able to speculate on that decision, DeCaro and Kelman expressed their belief that the program will thrive if Congress does reauthorize it.

Coble is certainly optimistic about the program's prospects. "I just think that institutional SNPs are the wave of the future," he says. "And in the right relationship and partnership it allows long term care providers to be able to seize control of their destiny, so to speak."

Assuming Congress reauthorizes the program, Verdier believes the growth in enrollment of institutional SNPs will be fairly gradual "because the SNP has to persuade the nursing home on a facility-by-facility basis that it is mutually beneficial for them." Verdier does note, however, that at some point the managed care arrangement might look so good to so many people that their families will want it for their loved ones and put pressure on the facilities. "But those are going to be slowly developing," he adds.

Not surprisingly, CMS officials also give SNPs a high mark. "I expect [institutional SNPs] to grow progressively as we go ahead," says Kelman, who stated in 2006 that the SNP program would have more of an impact on the future of nursing facilities than Medicare Part D.

"I'm encouraged by the interest of both providers and managed care plans—who seem to be committed to making this go forward."

Interest indeed; nursing facility owners have already begun courting Coble to get his SNP program into their facilities, he says.

And although HMC currently covers only 200 lives, he is working with insurance plans to expand into nearly 10 states. ■