

SNP Alliance

Best Practices



October 2013

Family Choice: Best Practices in Care for Nursing Home Residents

Overview of Family Choice of New York I-SNP

Independent Health's Medicare Advantage Family Choice of New York (FCNY) is an Institutional Special Needs Plan (I-SNP) operating in Erie and Niagara counties in Western New York. FCNY enrolls Medicare beneficiaries who reside permanently in a nursing facility as well as those who participate in the New York State Assisted Living Program and meet the state criteria for institutional level care. Our Model of Care/Care Management Program is specifically designed for these individuals.

Family Choice began in 2005 as a specialized care management program for about 450 Independent Health Medicare Advantage members living in nursing facilities. In 2007, FCNY became a special needs plan. Since then, our membership has averaged approximately 1,400 members per year.

Description of the Target Population

The Family Choice of New York MOC for institutionalized members is based on the principle that appropriate medical care, treatment settings, outcomes and utilization of Medicare services for the frail institutionalized elderly is significantly different than those of more robust and functional Medicare beneficiaries residing in the community. This is true for a number of reasons, including:

- Anatomical and physiological changes that occur naturally as part of the aging process require specialized assessment, diagnostic techniques, and interventions sometimes unused in younger populations.
- The diseases of aging are chronic and degenerative in nature and institutionalized elders are older on average than elders living in the community. As a result, targeted outcomes for this group must emphasize assessment, early intervention, comfort, chronic disease management, and dignity rather than cure and restoration.
- The care of institutionalized and institutional equivalent elders is a multidisciplinary process; therefore, Family Choice of New York QI program includes the measurement of indicators that have a multidisciplinary focus.
- More than one-half of institutionalized elderly are cognitively impaired, which underscores the need for specialized care management for this population.

Demographics of the Nursing Home Population

Almost half of all people who live in nursing homes are 85 years or older. Relatively few residents are younger than 65 years. Most are women (72%), many of whom are without a spouse (60% widowed) and with only a small group of family members and friends for support.

- Some type of disability or impairment with activities of daily living (ADLs) is the most common reason that older people live in nursing homes.
- Not surprisingly, people living in nursing homes generally have more disability than people living at home.
- About one-fourth (25%) of nursing-home residents need help with one or two ADLs (e.g., walking and bathing). Three-fourths (75%) need help with three or more ADLs.
- More than one-half of residents are incontinent (either bowel or bladder).
- More than one-third have difficulty with hearing or vision.
- Dementia is the most common mental problem — and affects the majority of residents.
- More than three-fourths of nursing home residents have difficulty making daily decisions, and two-thirds have problems with memory or knowing where they are.

Demographics of Assisted Living Residents

- The majority of residents living in residential care facilities are non-Hispanic white and female. More than one-half of all residents are aged 85 and over.
- Nearly two-in-10 residents are Medicaid beneficiaries, and almost six-in-10 residents under age 65 have Medicaid.
- Almost four-in-10 residents receive assistance with three or more activities of daily living, of which bathing and dressing is the most common.
- More than three-fourths of residents have had at least two of the 10 most common chronic conditions; high blood pressure and Alzheimer's disease and other dementias are the most prevalent.

Overview of the Family Choice Model of Care and Care Management Program

People who reside in nursing homes or who live in the community but require an institutional level of care, are by their very nature frail, usually disabled, have multiple chronic conditions and are frequently in the last years of life. The Family Choice Model of Care is designed specifically around the needs of these members. It recognizes the need for increased hands-on primary care with emphasis on preventative care, frequent assessment, and early intervention to maintain the highest possible functional status, quality of life, dignity and comfort.

Family Choice understands that these goals cannot be achieved without addressing not only the individual member's medical condition, but also their psychosocial and functional needs. As a result, the model is based on: (1) an interdisciplinary approach; (2) use of a comprehensive individual plan of care; and (3) an electronic health record and continually updated clinical practice guidelines tailored to the target population.

Composition /Roles and Responsibilities of the Interdisciplinary Care Team

TEAM MEMBER	ROLES / RESPONSIBILITIES
Family Choice Nurse Practitioner or Physician Assistant (for CM 1 and CMs)	<ul style="list-style-type: none"> • Coordinates care and services to the members assigned to them • Visits the member at least monthly or more often as their risk level requires • Makes unscheduled visits in response to changes in the member's condition • Conducts initial and annual health risk assessment • Communicates regularly with the PCP, member, family and other members of the team. • Oversees the member's Individual Plan of Care
Primary Care Physician	<ul style="list-style-type: none"> • Visits the member at least every 60 days and more often as needed • Responds to call from the Mid-Level Practitioner (MLP- A Nurse Practitioner or Physician Assistant) • Provides guidance and oversight of medical care provided to members
Family Choice Registered Nurse	Supports the MLP in visits to assisted living members The Transition RN supports members through the transition process
Family Choice Social Worker	<ul style="list-style-type: none"> • Assesses members' psychosocial needs on admission and annually • Makes regular visits to members who require psychosocial interventions • Assists members/responsible parties to document their health care wishes and advance directives • Works collaboratively with facility social service staff to identify members' needs
Care givers (Nursing Facility or Assisted Living Staff)	<ul style="list-style-type: none"> • Deliver care as ordered by the PCP and MLP • Notify the MLP of changes in the member's condition
Member/Family/Responsible Party (RP)	Provide input on preferences for health care delivery
Network professionals including specialty physicians; mental health professionals; pharmacists; physical, occupational and speech therapists; and others who may be asked to participate in the interdisciplinary care process based on the individual member needs identified by the Interdisciplinary Care Team.	

Individual Plan of Care and Electronic Health Record

The FCNY Individual Plan of Care is composed of the entire contents of the member's Family Choice of New York Electronic Health Record. The essential elements are: All MLP assessments; visit notes, and on-call MLP notes; communications with the member/RP and PCP; member demographic data and advance directives, social service assessments, and visit notes; and health risk assessment score and medication list. It is a living document that is continually updated as the member's needs and preferences change.

Clinical Practice Guidelines (CPGs)

Although many medical organizations have developed written and/or electronic clinical practice guidelines, none exclusively address the diseases and conditions, both chronic and acute, that are common to residents of long-term care facilities or those living in the community who require an institutional level of care. It is critical for FCNY to continually provide consistent, effective and efficient care management services that are tailored to our special member population. Our proprietary Clinical Practice Guidelines are designed specifically for the members we serve and form the basis for our Care Management Program.

The FCNY Chief Medical Officer, Medical Directors, Associate Medical Directors and a group of experienced geriatric physicians have developed the CPGs. They are updated annually and whenever FCNY physicians and physician members of the Quality Improvement Committee identify new clinical best practices in current literature.

FCNY Stakeholder Satisfaction Outcomes

Indicator	Threshold	2013 Jan-July Ave. FCNY Performance Outcomes
Satisfaction Outcomes		
Appeals	0	0
Grievances	0	0
Family Satisfaction	90% positive	97.5%
Member Satisfaction	90% positive	99%
PCP Satisfaction	90% positive	97%
NF Satisfaction	90% positive	97%

Examples of Innovative I-SNP Care Delivery Processes that Improve Member Outcomes and Resource Utilization

1. In an effort to eliminate needless hospital admissions, FCNY developed a “Treat-in-Place” program. When the member’s nurse practitioner/physician assistant and/or the facility staff identifies a change in the member’s condition that would otherwise result in a hospital transition, FCNY places the member on skilled level care in the nursing facility. Without changing locations or even beds, the member can receive services such as IV hydration or antibiotics, physical therapy or intensive wound care. FCNY reimburses the facility at a special Treat-in-Place rate. The result has been a significant reduction in hospital admissions and re-admissions and improved member outcomes due to the ability to treat the member in their own surroundings with clinicians especially sensitive to the needs of frail patients with complex conditions.
2. FCNY includes staff social workers on the interdisciplinary team. This has been very effective in responding to member’ psychosocial needs. For example, the social worker meets with the member and family and helps them understand their treatment options and document their preferences. As a result, over 90% of our members have documented health care directives.
3. To reduce hospital readmissions within 30 days of discharge, FCNY conducts an Acute Transition Analysis Report on every hospital admission to identify the causes of the transition and determine if it could have been avoided. When a readmission within 30 day occurs, the clinical team conducts a Frequent Admission Analysis to identify possible causes and interventions. As a result, FCNY’s readmission rate averages only 14%.