2015 ANCC National Magnet Conference®
Section G710, 11:30 am
October 7, 2015
Understanding Nurses’ Roles in Accountable Care Organizations

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Morristown Medical Center
Morristown, NJ

Atlantic Health System

Morristown Medical Center
Morristown, NJ

6,612 employees: 1800 nurses
1,588 physicians
198 medical residents
687 licensed beds
40,828 admissions
4,317 births
86,385 emergency visits
419,118 outpatient visits
In 1983, MMC was one of 41 original hospitals in the US recognized by the American Academy of Nursing as a top hospital for recruiting and retaining well-qualified nurses, a precursor to ANCC Magnet Recognition.

MISSION -
- Deliver high quality*, safe, affordable patient care within a healing culture
- Educate and engage all our human resources
- Innovate through leadership

VISION - Empowering our communities to be the healthiest in the nation.

SHARED VALUES - Professionalism, Respect, Involvement, Dignity, Excellence

*Institute of Medicine: Safe, Timely, Effective, Efficient, Equitable, Patient Centered
Today’s Objectives

- Overview of Healthcare Reform
- Understand the importance of “Accountable Care Organization (ACO)” as key to the changing healthcare environment at the national level.
- Share Atlantic/Valley’s ACO Journey
- Explore Creating and Evolving Nursing Roles
- Highlight Outcomes related to readmission and community programs

Why the change in healthcare?

- Increased aging population
- Cost of healthcare
- Readmission rates impacting reimbursement
- Fragmented healthcare

Defining an ACO

The Center for Medicare & Medicaid defines ACO’s as a group of physicians, hospitals & other healthcare providers, who come together voluntarily to give coordinated high quality care to their patients on Medicare.

(www.CMS.gov 6/29/15)
The goal is to provide coordinated care ensuring that Medicare beneficiaries (ie. Patients), especially those with chronic illness, get the right care at the right time, while avoiding unnecessary duplication of services and preventing maintaining safety.

An ACO is successful when it delivers high-quality care in a cost effective manner. This results in more efficient spending of health care dollars.

The ACO will share in the savings it achieves for the Medicare program with its members accordingly.

Why are ACO’s being established?

In response to the passage of The Patient Protection and Affordable Care Act (PPACA) of March, 2010, Accountable Care Organizations were formed to help fulfill the goals of this legislation in communities.

Focus of the ACO

- Improving healthcare outcomes for individuals & the population served
- Improving the delivery of health care services
- Reducing health care expenditures.
**Accountable Care Organization Terminology**

- ACO Member
  - Physician/Provider
- ACO Beneficiary
  - Patient(s)
- Attribution
- Affordable Care Act (ACA)
- CMS
  - Centers for Medicare and Medicaid Services
- Medicare Shared Savings Program
- Triple Aim
- 33 Outcome Measures

**How do ACO’s Function?**

- Focused on increasing cooperation and coordination among providers.
- Performance improvement programs and educating the consumer on how to improve their individual health.
- Physicians, nurses and other health care professionals & organizations who will work together to provide high-quality cost-effective service and care at the right time in the right setting.
- Held accountable by CMS (Medicare) and other payors by reporting on and being rewarded for improvements in quality outcomes and cost reductions.

**Three Types of ACO Programs**

- Medicare Shared Savings Program—a program that helps a Medicare fee-for-service program providers become an ACO.
  - January 1, 2012
- Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program.
  - 35 Rural and physician-based
- Pioneer ACO Model—a program designed for early adopters of coordinated care. No longer accepting applications.
  - May 4, 2015 evaluation report for first two years
  - 19 locations in USA
Shared Savings Program

- To improve beneficiary outcomes and increase value of care by providing:
  - Better care for individuals;
  - Better health for populations; and
  - Lowering growth in expenditures
- The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/about.html

- 404 programs in USA
- 7.3 million people served
- 49 States, plus Washington DC and Puerto Rico

ACO Expected Outcomes

- Improved access for care
- Enhanced care delivery
- Improved individual care
- Health education and promotion
- Better population health
- Reduce cost
- Physician alignment
- Payment reform implementation
### Medicare Payment at Risk Under CMS Quality-based Payment Reform Initiatives

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### Changes…

- Moved from Fee for Service model to Value Based Purchasing model
- Provider reimbursement directly related to the quality of care and outcomes
  - Up to 30% Medicare payments for quality by 2016
- Increased utilization of health information exchange
- Plans to combine incentives with tools to increase quality

### Summary of ACOs Over Time

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>ACOs</td>
<td>32</td>
<td>116</td>
<td>360</td>
<td>806</td>
<td>528</td>
</tr>
<tr>
<td>Savings</td>
<td>$1.5M</td>
<td>$14M</td>
<td>$372M</td>
<td>$384M</td>
<td>$372M</td>
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<tr>
<td>States</td>
<td>15</td>
<td>15</td>
<td>15</td>
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- ACOs integrate health systems, high quality, low costs
- 5 ACOs shared data CMS-ACO
-公共 sharing of quality data
- 公共分享 of quality data
Atlantic Health / Valley’s ACO Journey

Atlantic ACO
Morristown, Overlook, Chilton, Newton and Valley

U.S. News & World Report
How U.S. News & World Report ranked Morristown Medical Center

NATIONALLY
* Cardiology & Heart Surgery
* Geriatrics
* Orthopedics
* Pulmonology

Regional high-performing adult specialties recognized:
* Gastroenterology & GI Surgery
* Gynecology
* Nephrology
* Neurology & Neurosurgery
* Urology
Our Atlantic ACO Today

- 5 Key Hospitals
  - Morristown Medical Center, Newton Medical Center,
  - Overlook Medical Center, Chilton Medical Center
  - and The Valley Hospital
- Serving four regions of northern New Jersey
- Primarily in Bergen, Morris, Passaic, Sussex,
  Union/Somerset counties
- 1,800+ Physicians
- 53,000 Medicare Beneficiaries
- $600M+/yr. Cost of Care

Atlantic ACO Service Area

It's all about the Data!

Wise person, 2013
Quality of Care Measurements

Five Domains

1. At Risk Population
   Frail Adult

2. Patient Experience

3. Care Coordination

4. Preventive Health

5. Patient Safety

Graham, 2011

Quality of Care Measurements

5 Domains

- Patient Experience
- Care Coordination
- Patient Safety
- Prevention Health
- At Risk Populations / Frail Adult

(Graham, 2011)

Quality Indicators

<table>
<thead>
<tr>
<th>Preventive Health-Adult</th>
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<tbody>
<tr>
<td>1. Nicotine</td>
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<tr>
<td>2. Preventative practice</td>
</tr>
<tr>
<td>3. Waist circumference</td>
</tr>
<tr>
<td>4. Tobacco screening and follow up</td>
</tr>
<tr>
<td>5. Depression screening</td>
</tr>
<tr>
<td>6. Colorectal Cancer screening</td>
</tr>
<tr>
<td>7. Mammographic screening</td>
</tr>
<tr>
<td>8. Blood pressure within norms</td>
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</tbody>
</table>
**Quality Indicators**

**At Risk Population: Tard Adult**

<table>
<thead>
<tr>
<th>Risk Populations</th>
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<tbody>
<tr>
<td>9. EOL - 6</td>
</tr>
<tr>
<td>10. DN - ICD-10</td>
</tr>
<tr>
<td>11. Hypertension + 100/100</td>
</tr>
<tr>
<td>12. Calcium 130</td>
</tr>
<tr>
<td>13. Infection</td>
</tr>
<tr>
<td>14. HCG = 5</td>
</tr>
<tr>
<td>15. Heart Failure Control</td>
</tr>
<tr>
<td>16. Severe Vasculitis Disease</td>
</tr>
<tr>
<td>17. 310 x 100</td>
</tr>
<tr>
<td>18. PCP in Another Location</td>
</tr>
<tr>
<td>19. Arthritis to Sphincter Dysfunction</td>
</tr>
<tr>
<td>20. Arthritis to Sphincter Dysfunction</td>
</tr>
<tr>
<td>21. Drug Therapy for CKD</td>
</tr>
<tr>
<td>22. Arthritis to Sphincter Dysfunction</td>
</tr>
</tbody>
</table>

**Quality Indicators**

**Care Coordination**

- All Condition Readmissions
- COVID Admissions
- CIF Admissions
- PCP whose Qualifies for EMR Incentive
- Med Recs in office post patient discharge
- Full Screening Done

**Patient Safety**

**Quality Indicators**

**CANP: Patient Caregiver Experience**

- Timely Care: Appointments and Information
- Doctor Communication
- Patient's Rating of Doctor
- Access to Specialists
- Health Promotion and Education
- Shared Decision Making
- Health Status/Functional Status
**Population Health Needs**

<table>
<thead>
<tr>
<th>Setting</th>
<th>COE Transitions</th>
<th>ACO Patient Transitions *Office</th>
<th>Ancillary Providers</th>
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</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>Patient</td>
<td>Transition</td>
<td>Education</td>
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<tr>
<td>Acute</td>
<td>Inpatient</td>
<td>Coordination</td>
<td>Coordination</td>
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<tr>
<td>Chronic</td>
<td>Office</td>
<td></td>
<td>Complex Care Coordination</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>Highest risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative</td>
<td>5%</td>
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**ACO Centers of Excellence:**

Coordinated care and resources provided by expert clinicians and physicians who adhere to national standards in order to optimize health outcomes for the at-risk population.

Quality indicators are tracked and maintained

- Cardiac/Heart Failure
- Cardiac Valves
- Pulmonary
- Geriatrics
- Behavioral Health
- Oncology
- Musculoskeletal
- Diabetes

**ACO Website** ([www.atlanticaco.org](http://www.atlanticaco.org))
The Atlantic ACO Plan

- Deliver improved individual care
- Enhance population health
- Reduce the growth of healthcare expenditures

By:
- Competently Delivering & Coordinating Care
- Increasing Provider Engagement
- Implementing Performance Improvement Measures
- Effecting Clinical, Business & Consumer Change
- An Agent of Change

Nursing Leadership Role: Creating and Evolving Roles for Nurses

ACO’s Impact on Nursing

- Largest group of providers in the US
- Impacts more populations of patients than any other health care discipline
- Awareness of promoting safer transitions across all settings & levels of care
- Collaborates & communicates with team members across the continuum
- Enables interdisciplinary teams to provide high quality, evidenced-based care, by including nurses in all practice settings
Nursing Leadership needs to …
- Develop leadership and team effectiveness
- Build Care Coordination Skills
- Focus on Populations Based Health
- Strengthen Transitional Care Expertise
- Create Patient Navigators
- Utilize Performance Analytics/Tools

Evolving Role Opportunities for RN’s
- Patient Advocate
- Collaboration with interdisciplinary team
- Facilitate specific discharge plans and changes in level of service
- Performing comprehensive admission assessment
- Communicating findings to Care Managers so timely discharge plan can be developed

Care Coordinators
- Outpatient practices
  - Ensuring highest quality of care provided and CMS Metrics are tracked.

National Readmission Rates
- 150,000 fewer admissions annually since 2012
- 30-day readmission rate decreased
  - <19% to <18%

CMS– Transitional Care

- Eric Coleman's Community Care Transitions Program
- Project Boost
- Project Red
- Mary Naylor's Transitional Care Model

Care Transitions Program

- Care Transitions Coach

- 4 Pillars
  - Medication Self Management
  - Patient Centered Health Record
  - Follow up visits with PCP / Specialists
  - Red Flags

Care Transition Program

Care Transition Coach

- Medication Self-Management
- Patient Centered Health Record
- Follow up Visits with PCP Specialists
- Red Flags
**Project BOOST**

(Better Outcomes by Optimizing Safe Transitions)

- Society of critical care medicine
- Developed through $1.4M grant from John A. Hartford
- Based on *New England Journal of Medicine*, 1 in 5 Medicare beneficiaries were readmitted within 30 days

**Tools**

- Risk Stratification
- Risk Intervention Plan
- Universal Discharge Checklist
- General Assessment of Preparedness

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**Project RED**

(Re-Engineered Discharge)

- Research group at Boston Medical Center
  - Supported by AHRQ
- Develop & tests strategies to improve the hospital discharge process

**Tools**

- After hospital care plan
- Cultural competency to diverse populations
- Post discharge follow-up telephone calls

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**What is Transitional Care Nursing?**

- Dr. Mary Naylor’s Transitional Care Model
  - Transition Coach Visits patient in hospital prior to discharge
  - Performs home visit 24–72 hours post discharge
  - Three phone calls over the next month to review:
    - Progress towards goals
    - Encourage follow up appointments
    - Reinforce importance of when to call the provider
Transitional Care Model

Pros:
- Patient Centered Care is provided by the same APN across multiple settings.
- Patient satisfaction is enhanced.
- Quality of Care & Care Coordination are enhanced.
- Positive relationships are established.

Cons:
- Expensive since APN’s are the TCN’s

Beneficiary Role

- Active, engaged healthcare consumers
- Maintain active role in their healthcare
- Engage in patient education specific to their needs
- Maintain an accurate Personal Health Record
- Seek knowledge and skills necessary in order to maintain health and manage chronic illness
- Know where to go to obtain the right care, at the right time from the right providers/facilities in order to maintain highest level of functioning

Proof in Practice

- Lower Re-Admission Rates
- Heart Success iPad use
- Telehealth
- Pulmonary Navigator
Successful Outcomes

- Pulmonary Center of Excellence
  - Multidisciplinary approach
  - Nurse Navigator coordinates care
  - Works with MDs and APN
  - Includes three medical centers, 400 patients/year
  - Customized iPad program to report symptoms
  - 10% reduction in length of stay for COPD
  - 10.5% related admission rate

Nursing Home Collaboration

- Convenient location
- APN and Respiratory Therapist at MMC
- Discharge from MMC
- Follow-up by APN and Respiratory Therapist
- Aim to keep readmission rate low

Successful Transition Outcomes

- Matheny School for Developmentally Disabled Children Transition Nurse collaboration with MMC
  - Transition nurse from Matheny accompanies child upon admission
  - Complex medical needs explained, i.e. Cerebral Palsy
  - Provides staff with education specific to the child’s needs (e.g. orthopedic assist devices, feeding equipment)
  - Readmission rate lowered from 8.6% to 3.1%
Lessons Learned

- Be clear on Key Quality Indicators
- Value Data
- Monitor Outcomes
- Facilitate the professional growth and outreach of nurses
- Keep your eye on moving targets
- Communicate
- Leverage technology (EHR)

Going Forward ..... 

- Nursing will continue to play a key role to meet the changing needs of population health & disease management.
- Incorporate Nursing Informatics and use of Health Information Exchanges for data sharing health trends.
- As new roles and responsibilities continue to emerge, nurses will need to prepare our future nurses to meet the healthcare needs

Success

- Measuring efficiency and efficiently
  - Identify actionable trends
  - Analytic tools should align data
- Monitoring in real time
  - Improve both quality and patient satisfaction
- Communicating with patients, families, professionals
  - One centralized EMR system is ideal
Care Transitions Program

“Care transitions is a team sport, and yet all too often we don't know who our teammates are, or how they can help.”

~ Eric A. Coleman, MD, MPH~

Useful Links...

Atlantic ACO  www.atlanticaco.org
Centers for Medicare and Medicaid Services  www.cms.gov/aco
National Transitions of Care Coalition at  www.ntocc.org
Project Boost  www.hospitalmedicine.org/resourceroomredesign/RR_CareTransitions/CT_Home.cfm
Project Re-engineered Discharge  www.bu.edu/fammed/projectred/index.html

Presenter Information

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