2015 ANCC National Magnet Conference®
Section C710, 11:30 am
October 7, 2015

Understanding Nurses' Roles in Accountable Care Organizations

Trish O'Keefe, PhD, MSN, RN, NE-BC
President
Morristown Medical Center
Morristown, NJ

Atlantic Health System

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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

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Morristown Medical Center,
Morristown, NJ
MAGNET RECOGNIZED
BEACON AWARD FOR EXCELLENCE
BEST HOSPITALS
U.S.News
NATIONAL
2014-15
NJBIZ
ALL BUSINESS • ALL NEW JERSEY
Horizon
LEADER
LGBT HEALTHCARE EQUALITY
2014
HEALTHCARE EQUALITY INDEX
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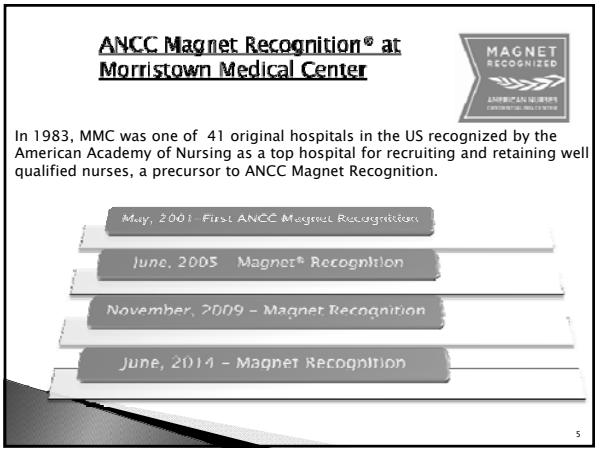
ANCC Magnet Recognition® at Morristown Medical Center
MAGNET RECOGNIZED
In 1983, MMC was one of 41 original hospitals in the US recognized by the American Academy of Nursing as a top hospital for recruiting and retaining well qualified nurses, a precursor to ANCC Magnet Recognition.
May, 2001 - First ANCC Magnet Recognition
June, 2005 - Magnet® Recognition
November, 2009 – Magnet Recognition
June, 2014 – Magnet Recognition
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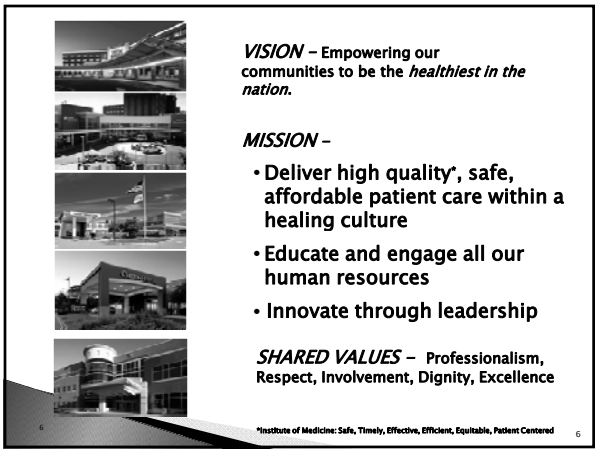
VISION – Empowering our communities to be the healthiest in the nation.
MISSION –
• Deliver high quality*, safe, affordable patient care within a healing culture
• Educate and engage all our human resources
• Innovate through leadership
SHARED VALUES – Professionalism, Respect, Involvement, Dignity, Excellence
*Institute of Medicine: Safe, Timely, Effective, Efficient, Equitable, Patient Centered
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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

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Why the change in healthcare?

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

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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)

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What is an Accountable Care Organization?

- 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.

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Waste WasteWaste Waste Waste Waste *Unnecessary Procedures Unnecessary Procedures Unnecessary Procedures* **$540 Billion** *Unnecessary Procedures Unnecessary Procedures Unnecessary Procedures Unnecessary Procedures. Unnecessary Procedures Unnecessary Procedures Procedures Unnecessary Procedures* Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Duplication Errors Errors Errors Err ors Errors Errors Errors Errors Errors Errors Errors Errors Error Errors Errors Errors Errors Errors Errors Errors Err ors Errors Errors Errors Errors Errors Errors Errors Errors Errors Errors Errors Errors Errors Errors Errors Errors Err ors Errors Errors Errors Errors Errors Errors Errors Error

JAMA, April 11, 2012

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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.

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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

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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.

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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

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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/

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Shared Savings Program

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

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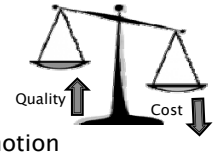
ACO Expected Outcomes

- Improved access for care
- Enhanced care delivery
- Improved individual care
- Health education and promotion
- Better population health
- Reduce cost
- Physician alignment
- Payment reform implementation



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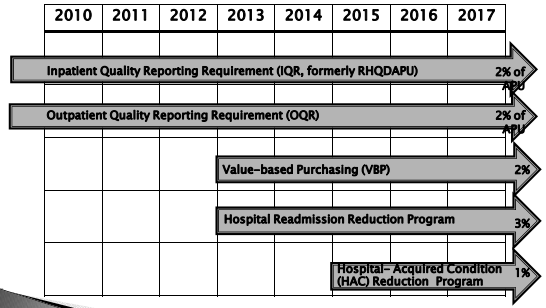
Medicare Payment at Risk Under CMS Quality-based Payment Reform Initiatives



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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

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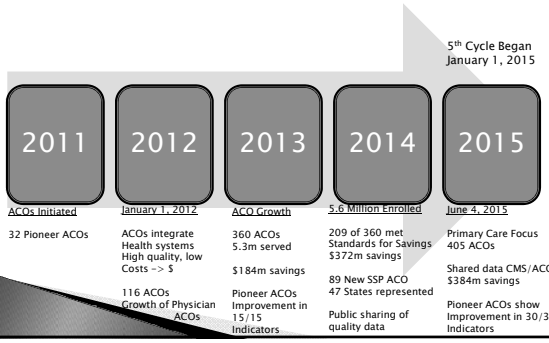
Summary of ACOs Over Time



Atlantic Health / Valley's ACO Journey

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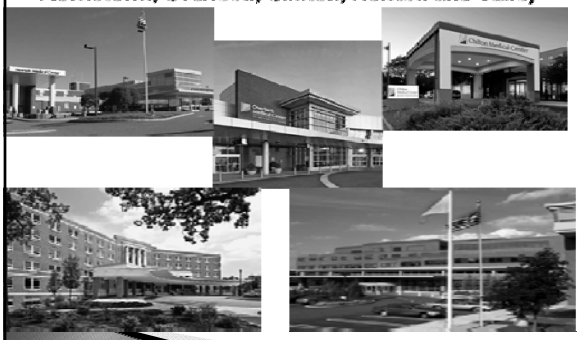
Atlantic ACO

Morristown, Overlook, Chilton, Newton and Valley



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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

BEST HOSPITALS U.S.News NATIONAL 2014-15

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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

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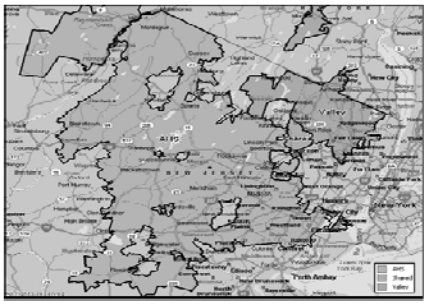
Atlantic ACO Service Area



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It's all about the Data!

Wise person, 2013

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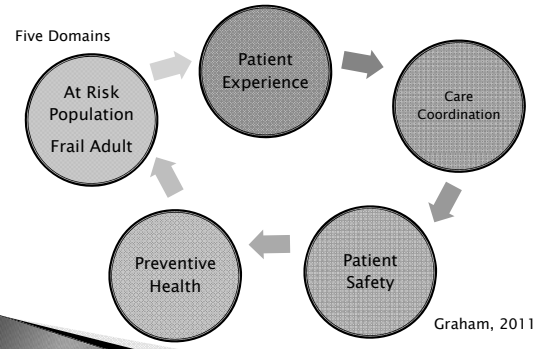
Quality of Care Measurements



Graham, 2011

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Quality of Care Measurements

5 Domains

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

(Graham, 2011)

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Quality Indicators

	Preventive Health-Adult
1	Flu Shot
2	Pneumococcal Vaccine
3	Weight Screening and Follow Up
4	Tobacco Use Assessment and Intervention
5	Depression Screening
6	Colorectal Cancer Screening
7	Mammography Screening
8	Blood Pressure within 2 years

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Quality Indicators

	At Risk Populations
	Diabetes
9	HGAIC < 8
10	LDL < 100
11	Blood Pressure < 140/90
12	Tobacco Non-Use
13	Aspirin Use
14	HGAIC > 9
	HTN
15	Blood Pressure Control
	Ischemic Vascular Disease
16	LDL < 100
17	ASA or Another Antithrombotic
	Heart Failure
18	B-Blocker for Systolic Dysfunction
	Coronary Artery Disease
19	Drug Therapy for LDL Lowering
20	ACE/ARB

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Quality Indicators

	Care Coordination/Patient Safety
21	All Condition Readmissions
22	COPD Admissions
23	CHF Admissions
24	PCPs who Qualify for EMR Incentive
25	Med Reconcile after Inpatient Discharge
26	Fall Screening Done

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Quality Indicators

	CAHPS: Patient/Caregiver Experience
27	Timely Care: Appointments and Information
28	Doctor Communication
29	Patient's Rating of Doctor
30	Access to Specialists
31	Health Promotion and Education
32	Shared Decision Making
33	Health Status/Functional Status

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Population Health Needs

Setting:	Physician Office*	Hospital	*Office	Physician Office
ACO Focus:	Patient Education	Transitions Coordination	COE	Ancillary Providers Complex Care Coordination
Tools:	Portal - education tools Patient EMR - Relay Health Community Health Events Screening			

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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	Behavioral Health
Cardiac Valves	Oncology
Pulmonary	Musculoskeletal
Geriatrics	Diabetes

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ACO Website (www.atlanticaco.org)

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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

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Nursing Leadership Role: Creating and Evolving Roles for Nurses

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ACO's Impact on Nursing

- Largest group of providers in the US
- Impacts more populations of patients than any other heath 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

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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

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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.

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National Readmission Rates

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

Blumenthal, M.P.P., Abrams, M., & Nuzum, R. (2015). The Affordable Care Act at 5 Years. New England Journal of Medicine. 372(25), 2451-2458.

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CMS– Transitional Care

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

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Care Transitions Program

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

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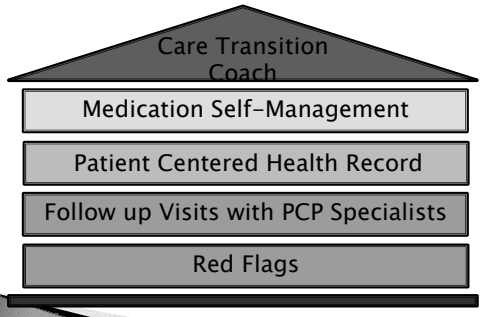
Care Transition Program



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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

Berenson, R.A., Paulus, R.A., & Kalman, N.S. (2012). Medicare's Readmissions-Reduction Program – A Positive Alternative. NEJM, 366(15),1364-1177.

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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

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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

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Beneficiary Role

- Active, engaged healthcare consumers
- Maintain active role in their healthcare
- Engage in patient education specific to the 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

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Proof in Practice

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

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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

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Nursing Home Collaboration

CareOne at Madison Avenue

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

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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%

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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)

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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

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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

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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~

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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

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Presenter Information

Trish O'Keefe, PhD, MSN, RN, NE-BC
President
Morristown Medical Center
Morristown, NJ, 07936 USA

Trish.O'Keefe@atlantichealth.org
973 971 5749

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