

The Changing Face of Healthcare

10th Annual Nursing Leadership Conference

April 3, 2014

**Joan Cusack-McGuirk,
Sr. Vice President, Chief Nursing Officer
St. Luke's Cornwall Hospital**

Healthcare Care Delivery: *Is rapidly changing*

“High-tech, high- cost care
has shifted to low-tech care
at a lower cost unregulated
care, less overhead”

Times Union, January 7, 2014



Department of Health Council Passes Ambulatory Care Regulations



- An explosion of new models of care in recent years
- Flu shots in supermarkets!
- “More care is delivered outside the four walls of a hospital or clinic.” *Commissioner Dr. Shah.*
- Fragmented care has no place in a changing health care landscape where medical homes and ACOs are pushing the boundaries of coordinated care.

Healthcare Delivery has Changed:

The old way...



all healthcare services

The new way...



any time

The Environment in which we Operate



Shifting from Hospital-Centric care to Outpatient and Urgent Care Centers

Background



The Affordable Care Act (ACA)

- President Barack Obama signed the ACA into law in March of 2010.
- The ACA has been the catalyst for wide scale changes in healthcare delivery and payment in the United States.
- Uncertainties surround healthcare— **the only hard fact is that healthcare is changing quickly.**

The Undeniable Facts of Healthcare



- **Declining compensation** from all payer sources
- Enormous **pressure to reduce cost** of care
- **Improvement in quality** is non-negotiable
- The ACA has increased the number of insured patients
- The **patient is an informed consumer** and has ability to 'shop' for the best value and quality choices in healthcare

A Time of Healthcare Transformation



- Emphasizes the importance of wellness, population management & prevention
- Focus on transitions of care, safety and patient experience
- Importance of preventing readmissions, hospital acquired conditions, medical errors, and improving patient satisfaction

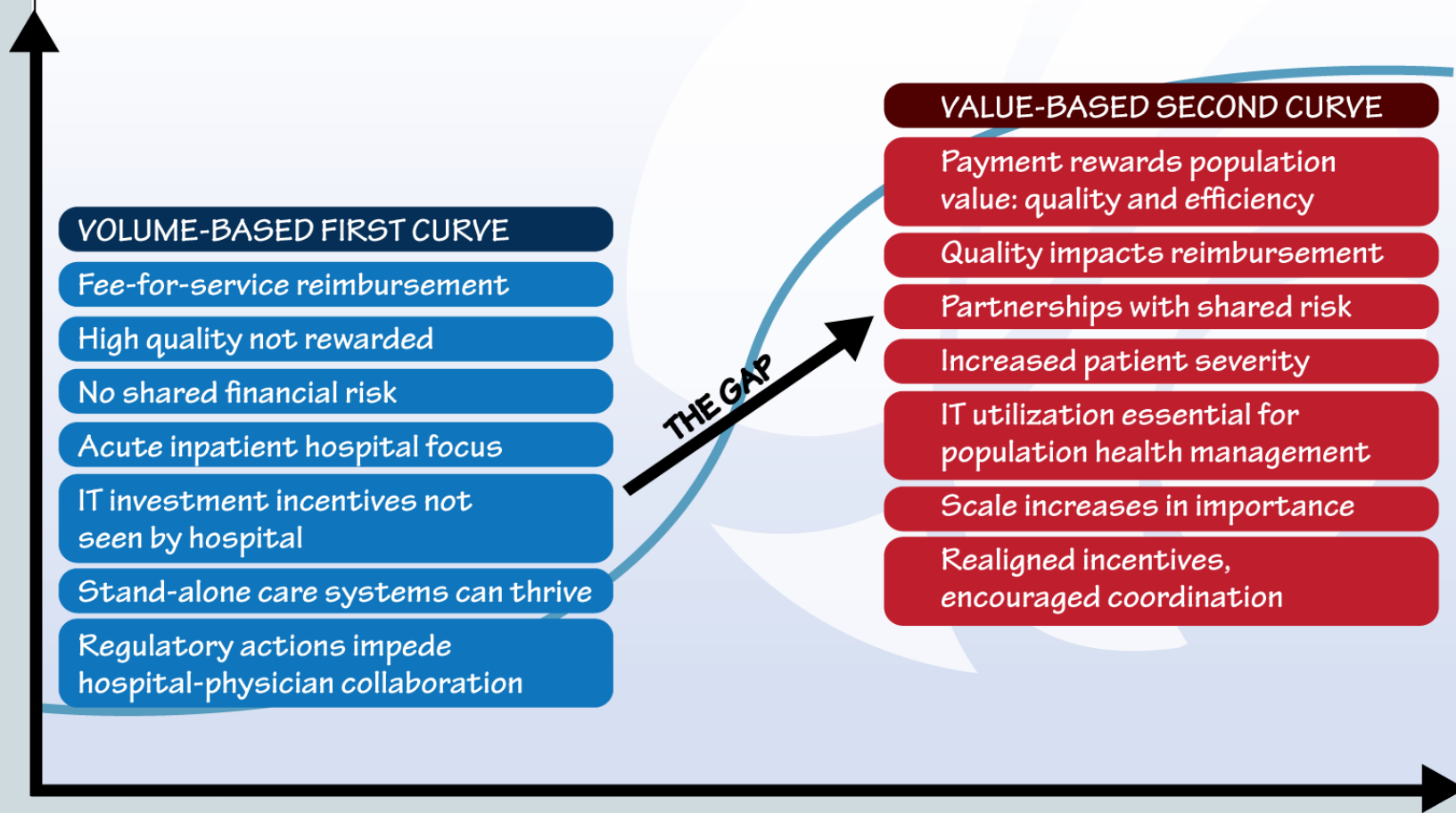
How?

The Undeniable Facts Value is Replacing Volume

- Reimbursement is driven by quality outcomes
 - No longer a fee for service arrangement
 - **Pay for Performance:** quality in clinical outcomes, costs and patient satisfaction
- Moving from episodic care to managing the health of a population (community)
- The risk is being shifted from **payer to provider**

Sanford, KD, Into the Next ERA, Nursing Administration Quarterly:
JULY-SEPTEMBER 2013, pgs 179-183

Shifting from Volume to Quality Based Performance



Reform

American Hospital Association Annual Meeting/Presentation,
2012; San Diego, California



So How Do We Do It?

Through The Triple Aim



Reducing Cost

Reduce Cost Per Case
Reduce Redundancy
Improve Efficiency

Better Patient Care

Focus on quality care
Coordinate Care
High patient satisfaction

Better Health

Improving the health of the population

NYS Dept of Health: *New York's Pathway to Achieving the Triple Aim*, Reducing Avoidable Hospital Use through Delivery System Reform: New York's Medicaid Redesign Team Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan



- **Better Patient Care**
 - Focus on quality care
 - Coordinate Care
 - High patient satisfaction

The Future of Nursing Leading Change, Advancing Health



The nursing profession has the potential capacity to implement wide-reaching changes in the health care system.

With more than 3 million members, we are the largest segment of the U.S. health care workforce.

(HRSA, 2010; U.S. Census Bureau, 2009.)

IOM (Institute of Medicine). 2011. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press, pg. 23.

The Future of Nursing Leading Change, Advancing Health



“By virtue of their regular, close proximity to patients and their scientific understanding of care processes across the continuum of care, nurses have a considerable opportunity to act as full partners with other health professionals and to lead in the improvement and redesign of the health care system and its practice environment.”

IOM (Institute of Medicine). 2011. *The Future of Nursing: Leading Change, Advancing Health*.
Washington, DC: The National Academies Press, pg. 23.



- Better
- Health

- Improving the health of the population

Improving Population Health



- A profound philosophical shift in the health care delivery system.
- Coordinated care systems strive toward keeping a population healthy rather than just reacting when people become ill.
- Systems will be incentivized to manage patients outside of hospitals and minimize in- hospital stays.

Population Health



- Primary care will take an unprecedented role in lowering costs and improving quality
- The health care industry will increasingly accept shared risk
- Evidence-based practice will drive healthcare
- Variations in care must be reduced
 - Care Maps
 - Core Measures

Impact of Population Health

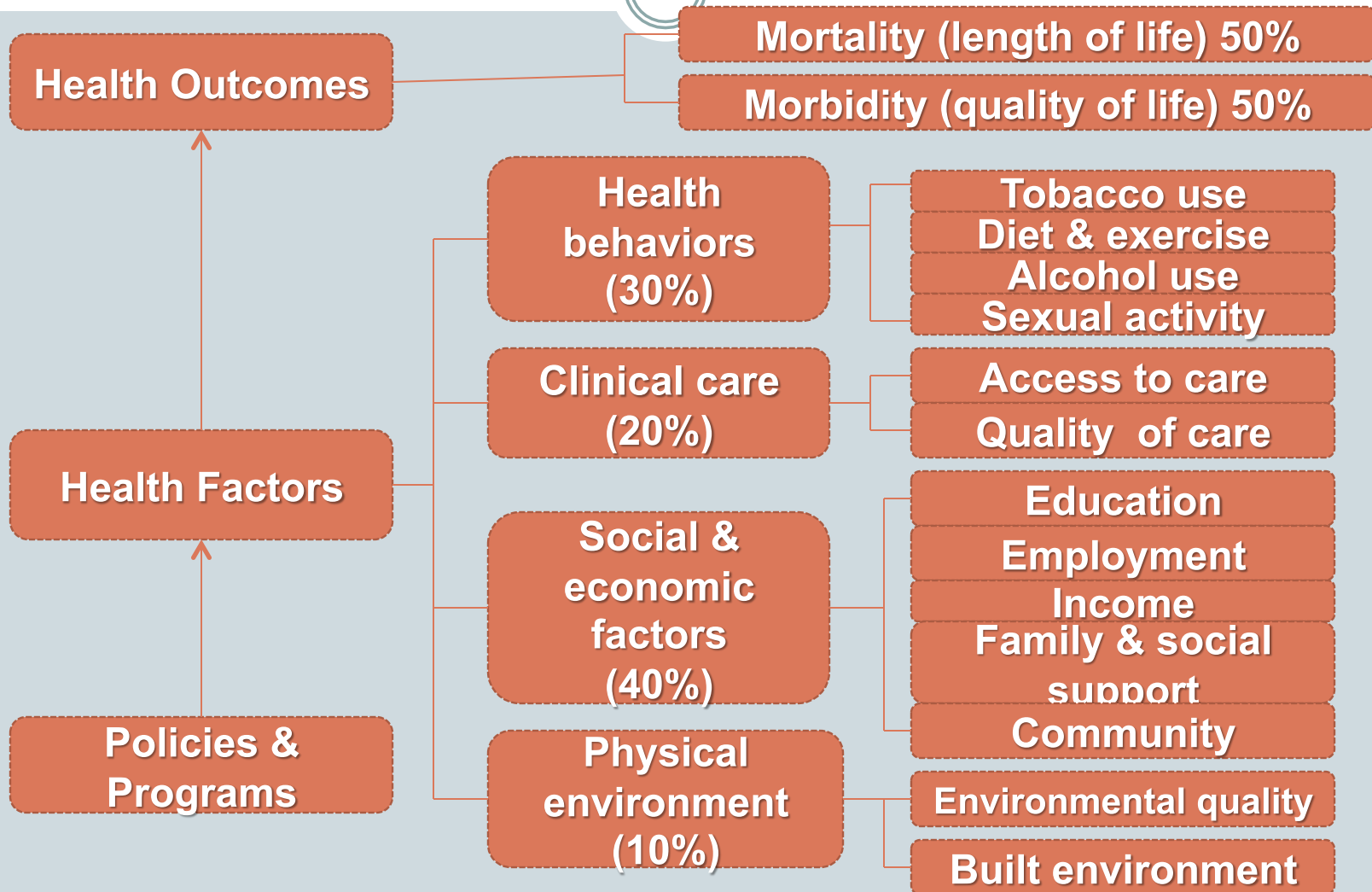


- Healthcare providers will soon share the financial responsibility for an entire population segment
- The focus must be to influence the other factors, not just the clinical care, that play a major role in health outcomes
- Nursing will become more involved to change the environment of their communities

May, E L, Population Health Management – Defining the Provider’s Role,
Healthcare Executive JULY/AUG: 2013, pgs. 20-29.

Model of Health Improvement

Wisconsin County Health Rankings



Impact of Population Health



The consumption of high-cost healthcare is driven by the population's health status

- The sicker the population, the more that healthcare services and resources are expended for that group
- Conversely, a healthier population utilizes fewer healthcare resources

May, E L; Population Health Management – Defining the Provider's Role,
Healthcare Executive JULY/AUG: 2013, pgs. 20-29.



Reducing Cost

Reduce Cost Per Case
Reduce Redundancy
Improve Efficiency

Reducing Cost



- Current reimbursement is based on volume
- Projected reimbursement is based on value
- Payment based on outcomes

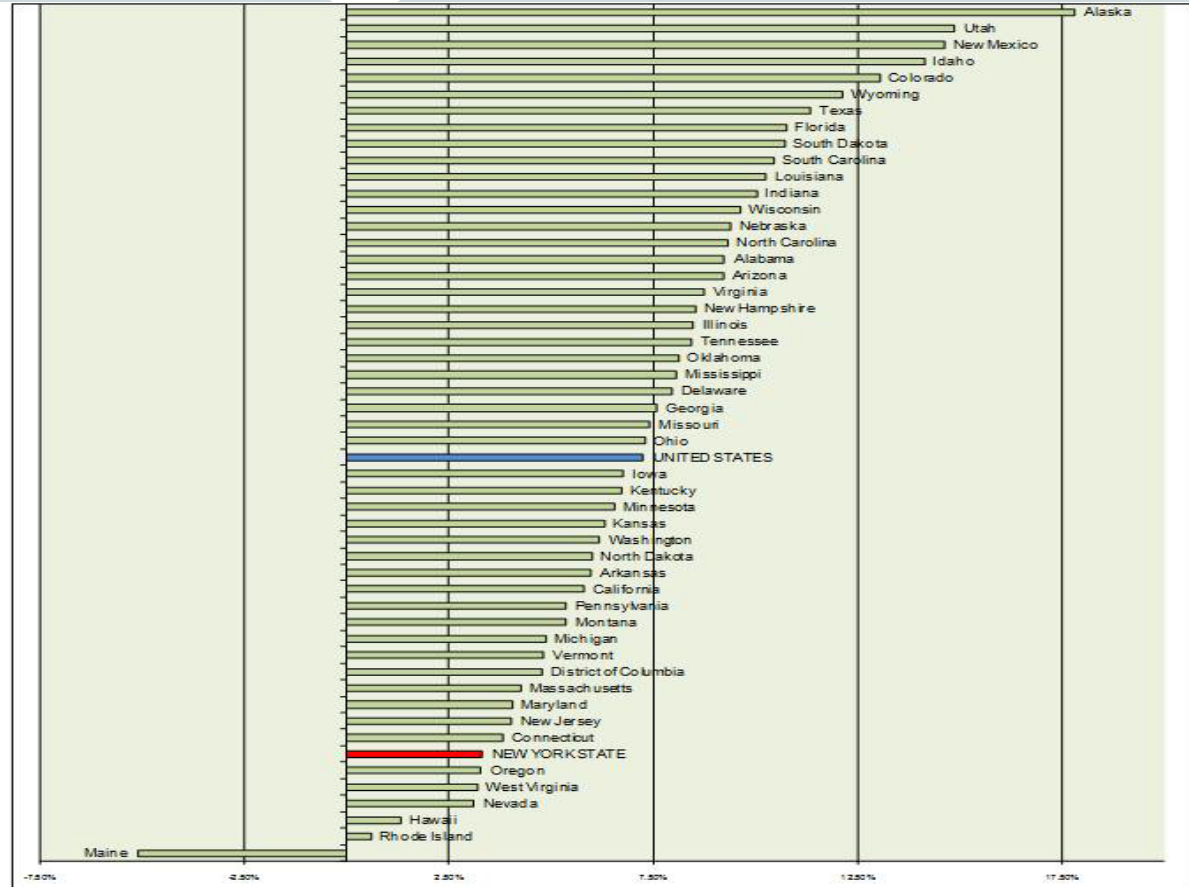
Where Are We?



Healthcare Association
of New York State

**New York
State's 2010
bottom line
margin is the
seventh worst
in the nation**

NEW YORK STATE	3.30%
New Jersey	4.04%
Massachusetts	4.25%
California	5.82%
UNITED STATES	7.24%
Florida	10.76%
Texas	11.33%



The Organization for Economic Co-Operation & Development (OECD)



The linked image cannot be displayed. The file may have been moved, renamed, or deleted. Verify that the link points to the correct file and location.

Gross Domestic Product (GDP)

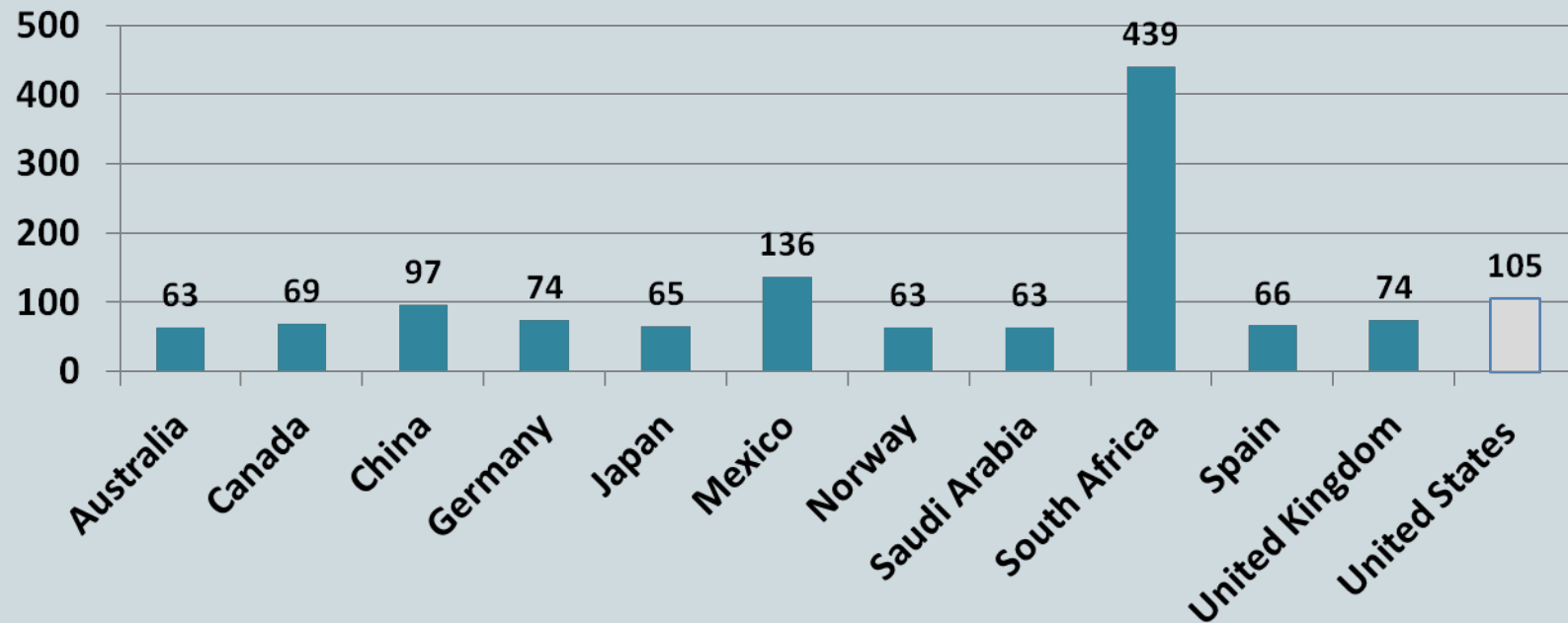


The linked image cannot be displayed. The file may have been moved, renamed, or deleted. Verify that the link points to the correct file and location.

World Health Organization- Adult Mortality Rates 2011 (selected countries)



Deaths between 15-60 Years



Data based on probability of death between
15-60 years of age, per 1000 population

Strategies for the *New Healthcare*



1. **Establish relationships** with defined pt populations
2. **Engage patients** in health and well-being behaviors
3. Redesign **primary care models**
4. Encourage early participation in healthcare systems-
participate in wellness– **not waiting for illness**
5. Move away from fee-for-service models of care
6. Create value through **population management**,
clinical outcomes and cost reduction
7. Decrease avoidable/ preventable ED visits,
hospitalizations and readmissions



St. Luke's Cornwall Hospital

Our Journey



Care Coordination



Care Transition Coalition




Care Transition Program



Care Coordination

Heart Failure (HF) Care Coordination

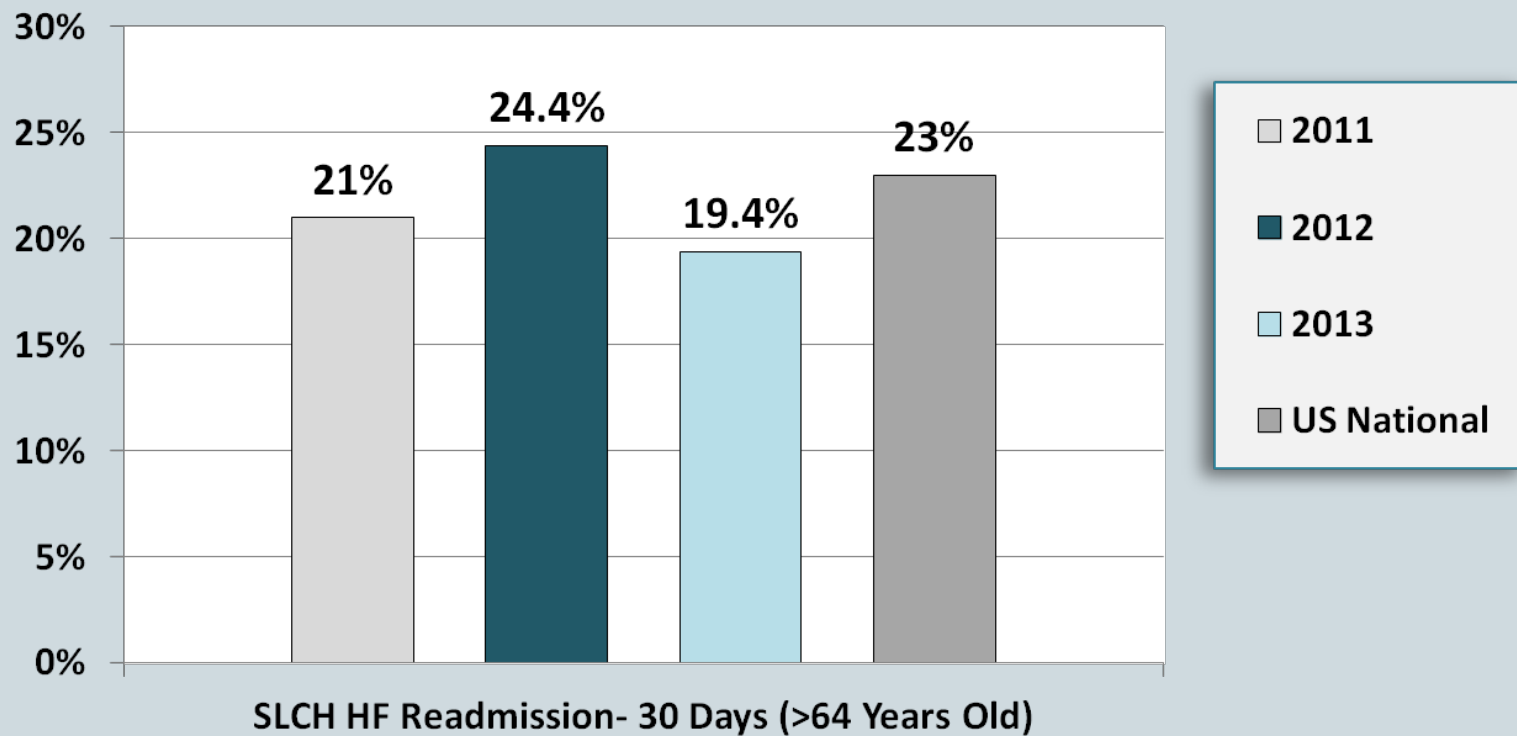


- **Care Transition Coordinators-** we deployed 2 critical care RNs to coordinate complex care for HF patients throughout hospitalization and post hospitalization
- Provided education in disease management and medications; interacted with physician to clarify/ revise care regimen; and home health agencies
- Care Management Program has demonstrated success in reducing HF readmissions

Heart Failure Readmission Reduction



CMS Quality Metrics- Heart Failure Readmission

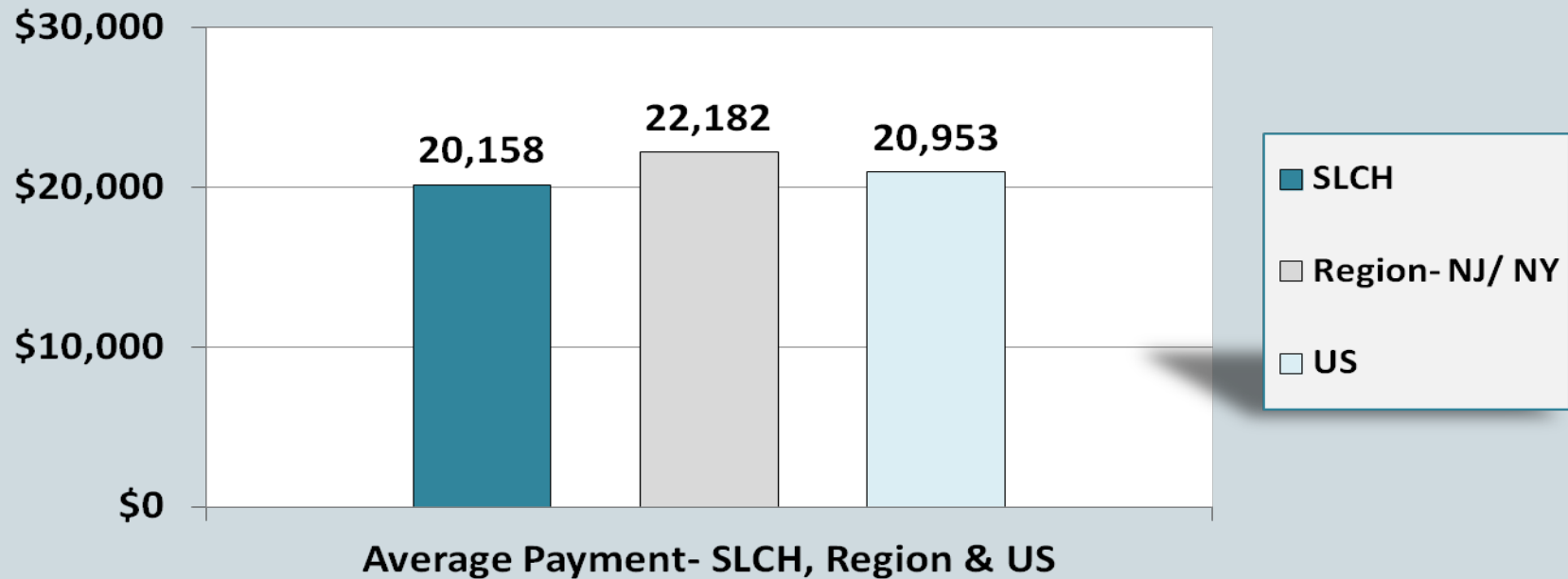


Population Health: Heart Failure



Low Cost Provider of Care

HANYS Bundled Payment Preview-2011: Hospitalization and 90 days



DRG 292 Heart Failure & Shock



Care Transition Coalition

Care Transitions Coalition



Launched in July 2012

- Eight healthcare agencies grew into sixteen
- The initial work targeted structure and process to:
 - Seamless transitions for post-hospital healthcare
 - Connections with needed community resources
 - Removing barriers to meeting the patient's needs

Care Transitions Coalition



Aligning With National Efforts To:

- improve outcomes
- integrate a sustainable healthcare delivery model

Focused on:

- enhanced communication
- education
- improved processes and
- cost containment

Care Transitions Coalition



The initial work targeted structure and process to:

- seamless transitions for post-hospital healthcare
- connections with needed community resources
- removing barriers to meeting the patient's needs

Care Transition Coalition



Improving Population Health through *Communication*

Improved conveyance of the patient's health care needs through different levels of care

- **Universal Transfer to SNF/ HHA:** a 'snapshot' of the patient's imminent needs
- **Nursing SBAR Handoff:** provides an in-depth overview of the hospitalization to the receiving facility

Care Transition Coalition



Improving Population Health *through* *Education*

Education provided to Community Providers' staff:

- Heart Failure Management
- Sepsis (identification/ treatment)
- Implanted Port Management

Care Transition Coalition



Improving Population Health through *Improved Processes*

- Inter facility review of acute care readmissions occurring within thirty (30) days of discharge
- Evaluate the readmission as a *'failed discharge'*
- Investigate processes and interventions that may prevent future episodes
- Participating in NYSPFP and GNYHA IMPACT Readmission Project

New York State Partnership for Patients (NYSPFP): Preventable Readmission Reduction Initiative



Three phase rapid cycle program focusing on:

- risk assessment
- preparing patient and caregiver for discharge during hospitalization
- providing timely communication to post-hospital providers

Improving Processes Across Care Transitions (IMPACT)



IMPACT

The Ultimate Goals

- to decrease preventable hospitalization
- to decrease preventable readmission and
- to avoid unnecessary ED utilization

Building Relationships with Community Partners

- **Skilled Nursing Facilities**

- * Campbell Hall
- * Elant, Inc.
- * Montgomery
- * Wingate

- **Home Health Agencies**

- * Good Samaritan
- * Willcare
- * Premier Home Health

- **Sub Acute Rehab**

- * Helen Hayes

* Original 8

- **Additional Stakeholders**

- Greater Hudson Valley Family Health Center
- Hospice of Orange and Sullivan Counties
- Independent Living
- Occupations, Inc.
- Orange County Commissioner of Mental Health / Mobile Mental Health
- Orange County Dept of Health
- Fresenius Dialysis
- Center for Wound Healing & Hyperbaric Medicine

- **Other Key Stakeholders**

- Physicians/Acute Healthcare Providers
- Crystal Run Healthcare
- Horizon Family Medical Group
- American Cancer Society
- American Diabetes Association
- American Heart Association
- Mobile Life Support Services
- Medical Groups
- Acute Healthcare Providers

Real Time Interventions

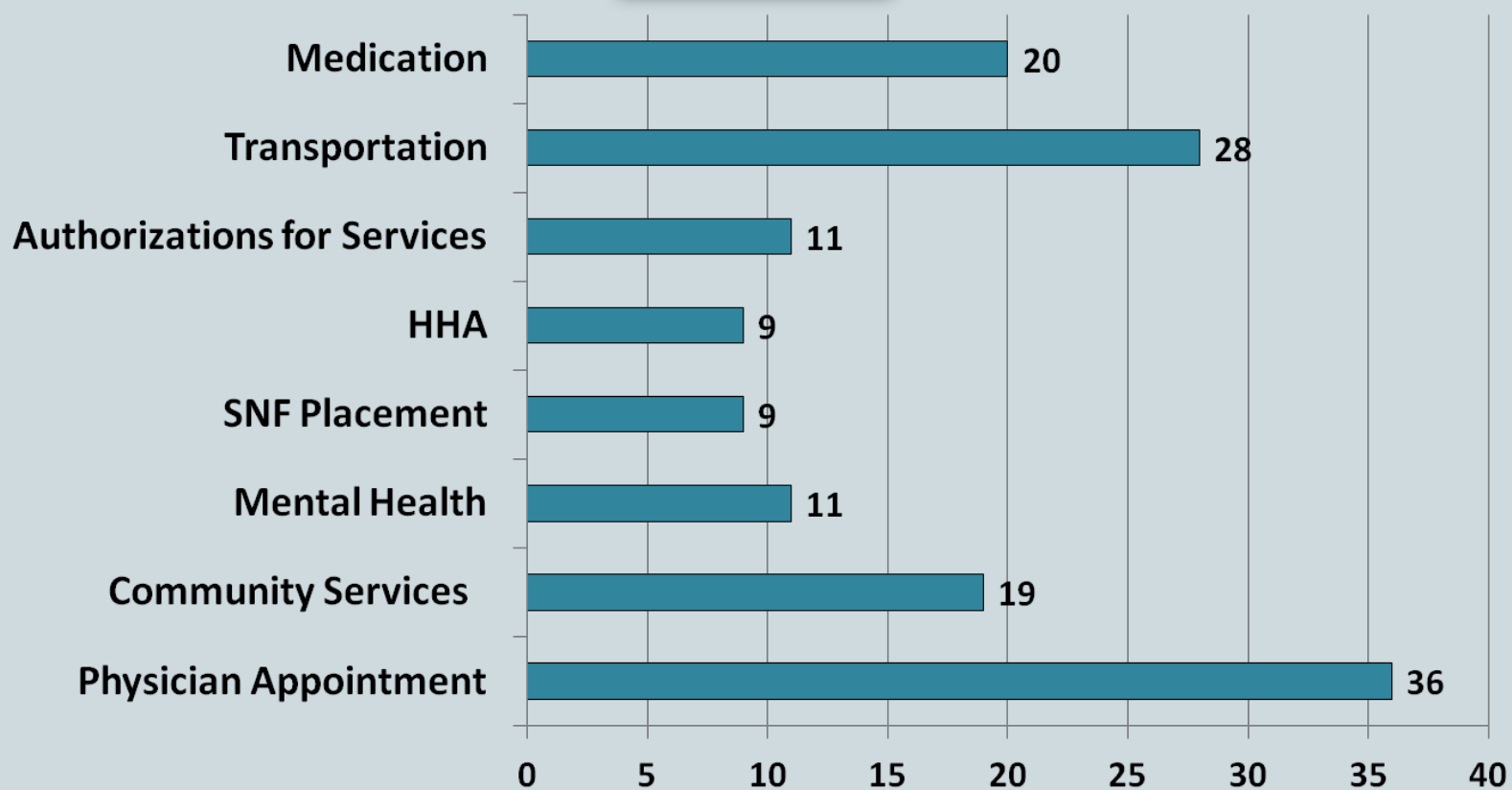


- Instituted a Case Management role within the ED 16 hours/day
- Enhanced care through communication with physicians, payers, skilled nursing facilities and transportation
- Decrease unnecessary hospitalizations by meeting the patient's needs at the initial point of encounter

Point of Entry Case Management



Jul- Dec 2013



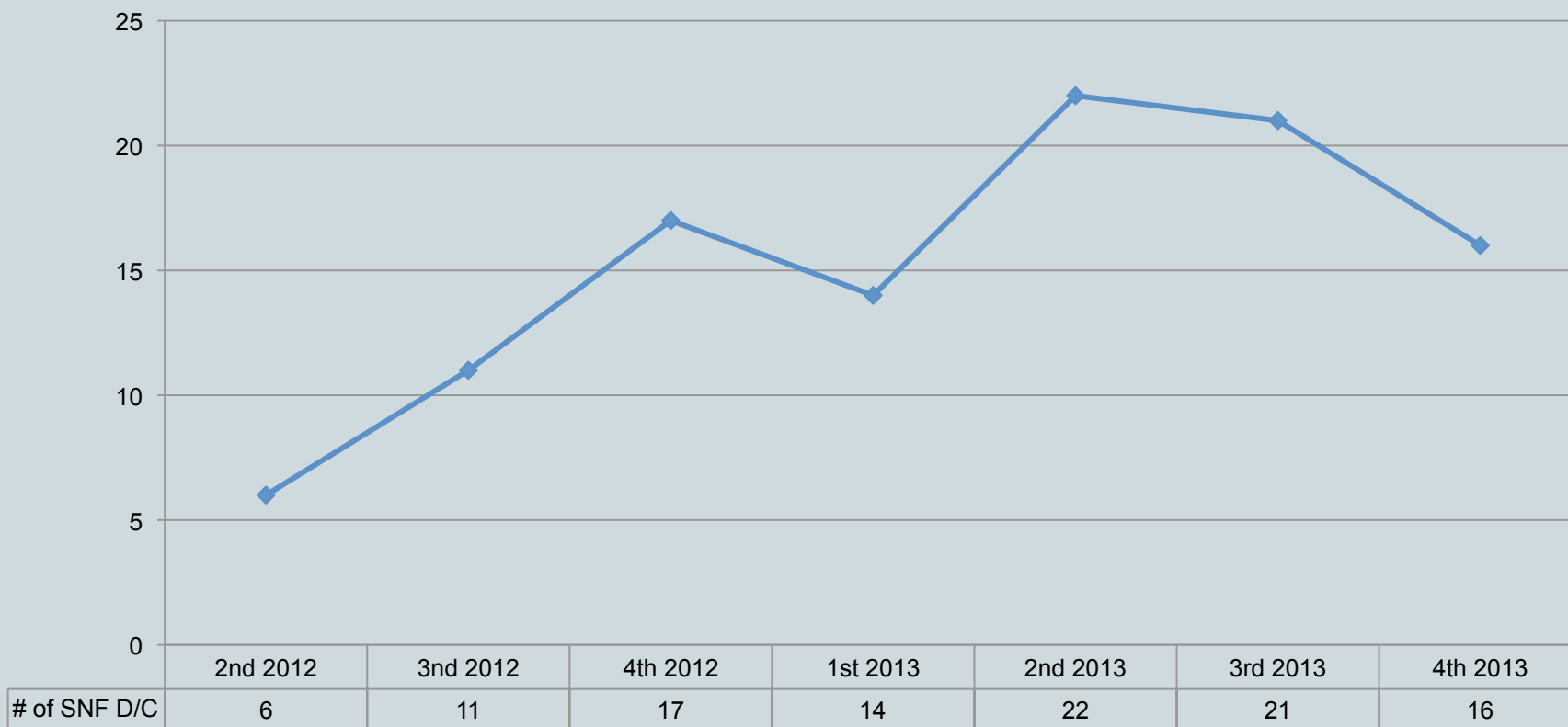
Increased Authorizations/Transfers



- Met with Managed Care Organizations to facilitate authorization approvals on weekends
- Staffing Model revised to accommodate weekend admissions



of SNF Weekend D/C by Quarter 2012-2013



Due to increased collaboration, education and partnership with the SNFs, there was an increase in discharges being accepted on weekends.

Community Health Innovations



- **Don't Go Home Alone Program:** designed to assist a pt and family with a safe discharge from the hospital, ED, ambulatory surgery, or interventional radiology procedures
- **Administration of a Patient Review Instrument (PRI):** pts that require nursing home placement can have this assessment done in their home and avoid unnecessary hospitalization

Community Health Innovations

Improved Access for Behavioral Health Patients

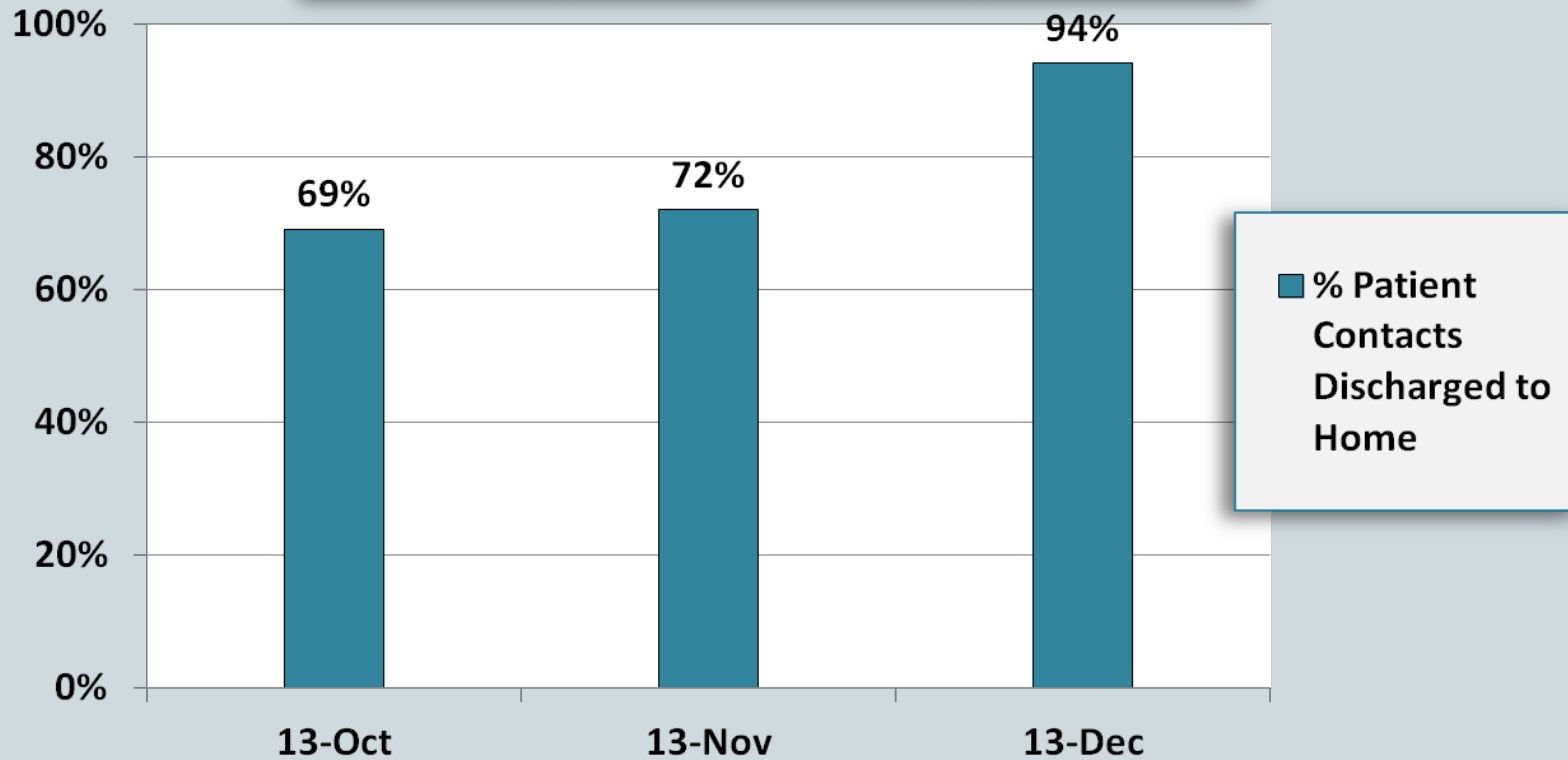


- Partnered with Orange County Commissioner of Mental Health and Occupations, Inc. to facilitate evaluations of patients presenting to the ED with behavioral health concerns
- Enhanced coordination of care by connecting patients with community mental health services

Mobile Mental Health



Pilot Program with Orange County



Only 2 of 74 patients returned to the ED within 30 days!

Partnership with a Federally Qualified Health Center



- Place a care coordinator in the ED who will educate and link the patient to a more appropriate primary care setting.
- This program will enhance care through communication with physicians, payers, skilled nursing facilities as well as transportation.



Care Transition Program

Care Transition Program



- SLCH partnered with 2 insurance carriers to develop a care transition model.
- Emulated the HF program to other high risk populations: diabetes, COPD, ESRD.
- Based on the 4 pillars of Coleman's Conceptual Framework Model: medication management, patient centered health record, follow up with PCP, and red flags.

Care Transition Program



This is a program offered to members of our community being discharged from the hospital and is designed to help patients manage their transition from the hospital to home.

Participation in the program is expected to:

- provide patients with the necessary tools to better manage their health care.
- increase our patient's overall satisfaction with their transition from hospital to home.
- reduce avoidable hospital admissions/readmissions and emergency department visits.

Care Transition Team



- 3 RNs & 2 Health Coaches
 - Complex cases will be managed by the RN
 - Less clinical complex issues, more social issues managed by the health coach
 - Patients will be managed in the community and telephonically

Other Initiatives



- **Ventilator Weaning:** SLCH is working with community partners and our PCPs to develop weaning protocols that will allow for weaning of patients in a setting less costly than the hospital.
- **Peritoneal Dialysis:** to be performed in the SNF and eventually the home setting.
- **Wound Care:** to follow the patient through the continuum of care
- **Hospital → SNF → Home → Wound Care Center**
- **Pulmonary Rehab:** geared for the COPD population. Based on severity of illness, a referral will be generated to ease transition for evaluation into the program.

Other Initiatives



- **Medication Procurement:** potential solutions for off hour medication procurement especially in times of weather related issues.
- **Develop protocols, care maps:** for CHF, COPD, ESRD, DM
- **Improve process of receiving patients from SNFs:** for a more seamless transfer, a dedicated phone line to receive incoming calls for report.
- **Expanded Primary Care:** provide services after hours and on weekends to primary care patients with the goal of:
 - reduce unnecessary ED visits
 - improve patient service around non-traditional hours



We Need To Change!

Who We Are Today: *A Community Hospital*



Who We Need To Be Tomorrow: *A Community Health Center*



Medical Suites



Care Coordination Offices



Center for Telemedicine



Community Health Education Center

Delivery System Reform Incentive Payment (DSRIP)



- **Delivery System Reform Incentive Payment (DSRIP) - \$8 Billion**

- from Medicaid Redesign Team Federal waiver to reinvest in the transformation of the health system

- a 5 year waiver to fundamentally restructure the NYS healthcare delivery system

- **Two Goals:**

- decrease ED presentations by 25%

- decrease hospitalizations by 25%

Delivery System Reform Incentive Payment (DSRIP)



- **Three focus areas:**
 - #1 – Hospital Transition/Public Hospital Innovation/
Vital Access Provider (VAP)/Primary Care Expansion
 - #2 – Long Term Care Transformation
 - #3 – Public Health Innovation
- **Twenty-five program objectives**

In Closing



Einstein defines insanity as “doing the same thing over and over again and expecting a different outcome.”

“The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking.”

- Albert Einstein

Together, We're Better

**Creating Partnerships to Provide Better Care
to our Patients Across the Region**



Florence Nightingale



“Nightingale never held an official position in the government, yet she was able to bring about far-reaching reforms in the administration of her government and other governments for the betterment of society. She believed that everyone should be helped through education to develop his or her potential. She wanted this for soldiers, civilians, and nurses, rich or poor. Perhaps her mission was impossible to achieve, but in striving toward it she improved the human condition of her world.”

Notes on Nursing: What it is, and what it is not. Florence Nightingale, pg. 17.

References:



American College of Healthcare Executives, The Ethics of Access to Care and Care Disparities, August 7, 2013.

American Hospital Association Annual Meeting/Presentation, 2012; San Diego, California

Birk, S. Population Health Strategies That Deliver Value and Results, Healthcare Executive JULY/AUG: 2013, pgs. 10-18.

Coleman, EA., MD, MPH. © 2007 Care Transitions Program; Denver, Colorado.

County Health Rankings Model 2012 UWPHI, Healthcare Executive, JULY/AUG: 2013.

Crain's Health Pulse, January 8, 2014.

HANYS 2013 Budget Testimony, January 31, 2013.

HANYS Webinar, July 24, 2013.

References:



IOM (Institute of Medicine). 2011. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press, pg. 23.

J.B.Lippincott Company, Philadelphia. *Notes on Nursing: What it is, and what it is not*, Florence Nightingale, pg. 17.

May, E L, Population Health Management – Defining the Provider’s Role, Healthcare Executive JULY/AUG: 2013, pgs. 20-29.

Medicare Payment System Advisory Commission’s Report to Congress: Medicare Payment Policy.

NYS Dept of Health: *New York’s Pathway to Achieving the Triple Aim*, Reducing Avoidable Hospital Use through Delivery System Reform: New York’s Medicaid Redesign Team Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan

Nursing Administration Quarterly JULY/SEPTEMBER 2013

References:



OECD Health Data 2012. Accessed March 31, 2014 at <http://dx.doi.org/10.1787/888932315602>.

Sanford, KD, Into the Next ERA, Nursing Administration Quarterly: JULY-SEPTEMBER 2013, pgs. 179-183.

Times Union, Oversight sought for walk-in centers, January 7, 2014.

United Hospital Fund: 2013 Moving Toward Accountable Care in New York, pgs. 9-13.

World Health Organization (2013). Global Health Observatory Data Repository. *Mortality and global health estimates: Adult mortality data by country*. Accessed March 31, 2014 at <http://apps.who.int/gho/data/node.main.11>.