Penn Medicine

IS YOUR ORGANIZATION ACCOUNTABLE?

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Victoria L. Rich, PhD, RN, FAAN

Chief Nurse Executive, University of Pennsylvania Medical Center

Associate Executive Director, Hospital of the University of Pennsylvania

Associate Professor, Nursing Administration, University of Pennsylvania School of Nursing


BACK
TO THE FUTURE

The 40 Year Journey of Quality Improvement

" For more than 40 years it is unclear what the quality movement has accomplished… Instead of trying to fill gaps in knowledge about the epidemiology of quality, the focus should be on developing an epidemiology of *VALUE* which contains *both measurement* of *cost* and *quality*"

Robert H. Brook, MD, ScD
Rand Health (JAMA, Oct 27, 2010)

The Patient Protection and Affordable Care Act:

(PPACA) passed this year can be compared to the Social Security Act of 1935 and the Medicare Act of 1965.

Hence, The PPACA signifies REFORM!

IMPACT OF REFORM: NOW

- Insurance Reforms
  - Children can remain on their parent's policies until age 26.
  - Plans prohibited from placing lifetime limits on dollar value of coverage (but not other metrics, e.g. units of service).
  - Prohibits exclusion of children with pre-existing conditions.
- Medicare & Medicaid
  - $250 rebate for prescription drug coverage gap ("Donut hole") – eventually eliminates the gap entirely.
  - Reduce annual market basket updates for hospitals
  - Bans new physician-owned hospitals in Medicare
  - Expands coverage for children
- Quality
  - Supports comparative effectiveness research via "Patient-Centered Outcomes Research Institute."
- Tax changes
  - Imposes a tax of 10% on indoor tanning services (bigger changes are pushed off)

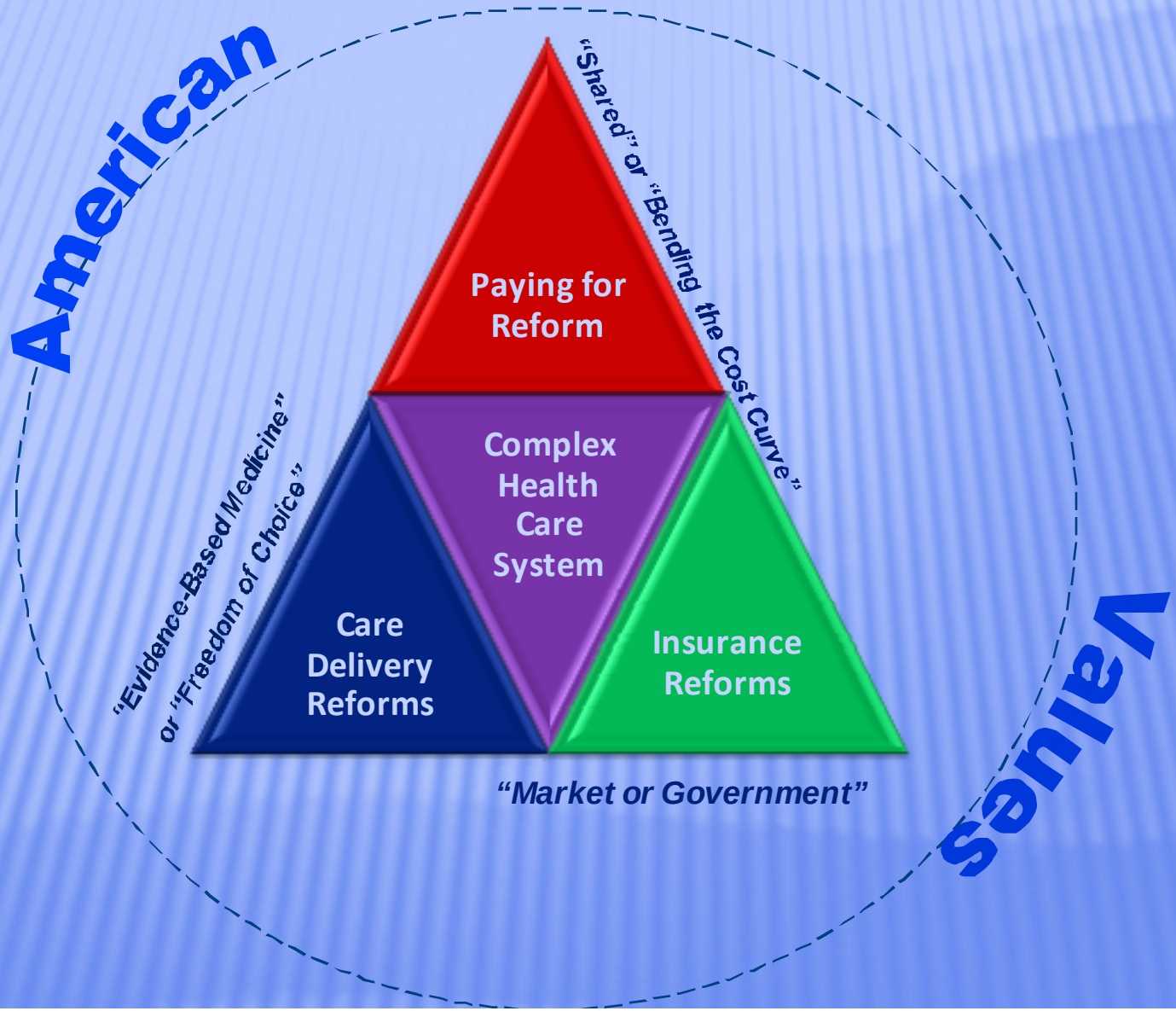
Expanding Health Care Coverage

- **The bill will cover an additional 32 M non-elderly people (leading to 94% of total nonelderly population with coverage) by:**
  - Expanding Medicaid to 133% of the federal poverty level (FPL)
  - Subsidizing new insurance exchanges
  - Providing tax credits to small employers
  - Enacting commercial insurance market reforms
- **However, Congressional Budget Office (CBO) estimates ~23 M non-elderly will remain uninsured in 2019 under the Senate proposal**
  - ~ 1/3 would be undocumented immigrants

Impact of Reform: 5 Years Out

- Individual and Employer Mandate
  - U.S. Citizens and legal residents required to have coverage (tax penalties if non-compliant)
  - Employers penalized for not offering coverage
- Insurance Reforms
  - Establish state-based "exchanges" through which businesses with <100 employees can --\\\\----purchase coverage.
- Medicare & Medicaid
  - Reduce hospital payments for hospital acquired conditions by 1%
  - Require Medicare Advantage Plans to use 85% of premiums for medical care
  - Reduce "disproportionate share" payments: initially by 75%, with subsequent increases.
- Quality
  - Require conflict of interest disclosures across stakeholders
  - Requires enhanced data collection
- Tax changes
  - Impose fees on health insurance sector
  - Impose excise tax on "Cadillac plans" (2018)

REFORM IS ABOUT MORE THAN HEALTHCARE



American Values In the Legislation

- "Market" — Use managed care

or

- "Government" — "Mandated Coverage" and Government "takeover" of health care

- "Evidence-Based Medicine" — "Accountable Care Organizations"

or

- "Freedom of Choice" — "Death panels"

- "Shared" — Tax wealthy to subsidize newly insured

or

- "Bending the Cost Curve" — 1) Lower payments to providers & device companies
  2) Tax "Cadillac" plans

Care Delivery Reform:
Accountable Care Organizations (ACO)

ACO Infrastructure

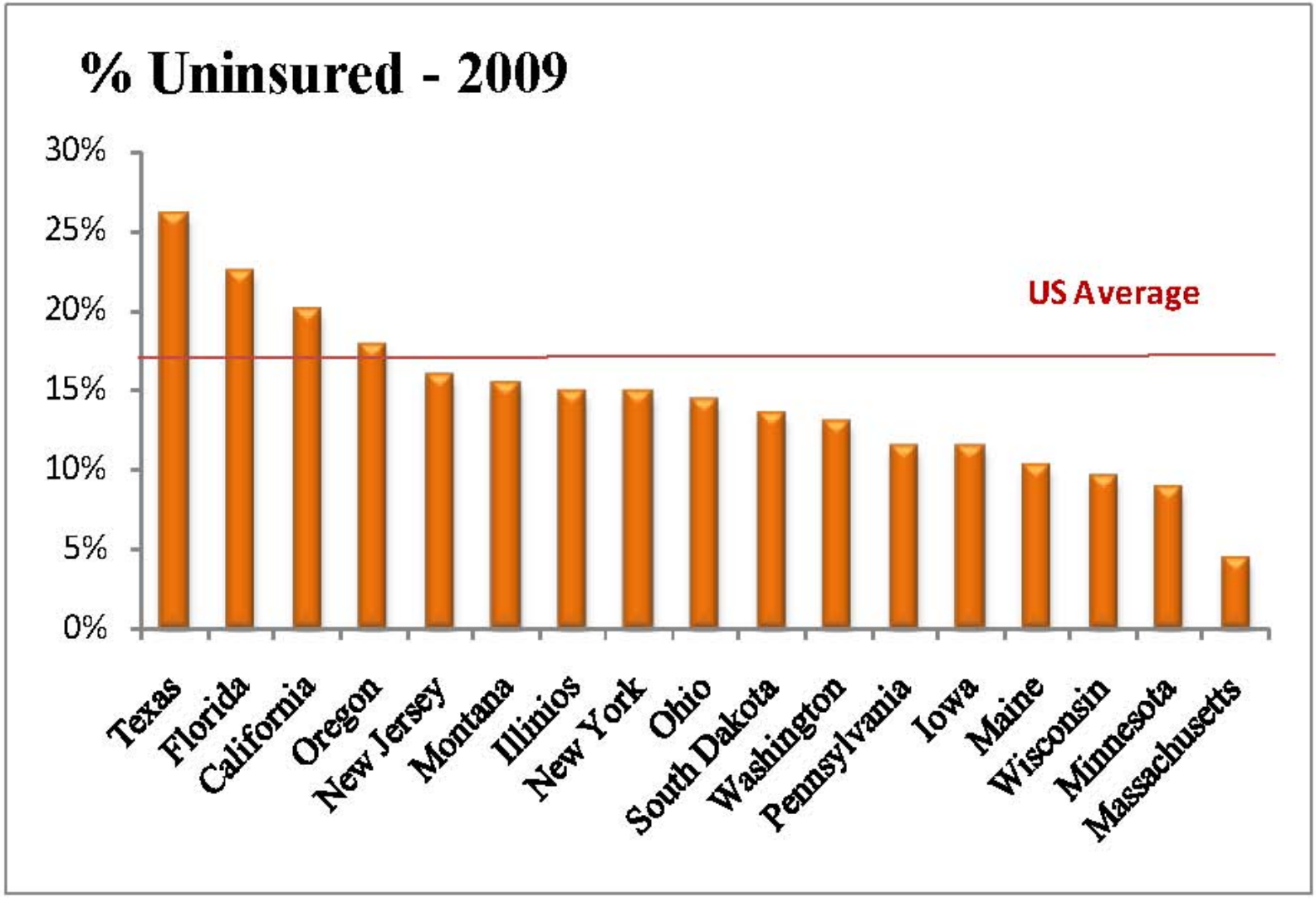
- Bundling of payment for services

- Creation of Medical Homes

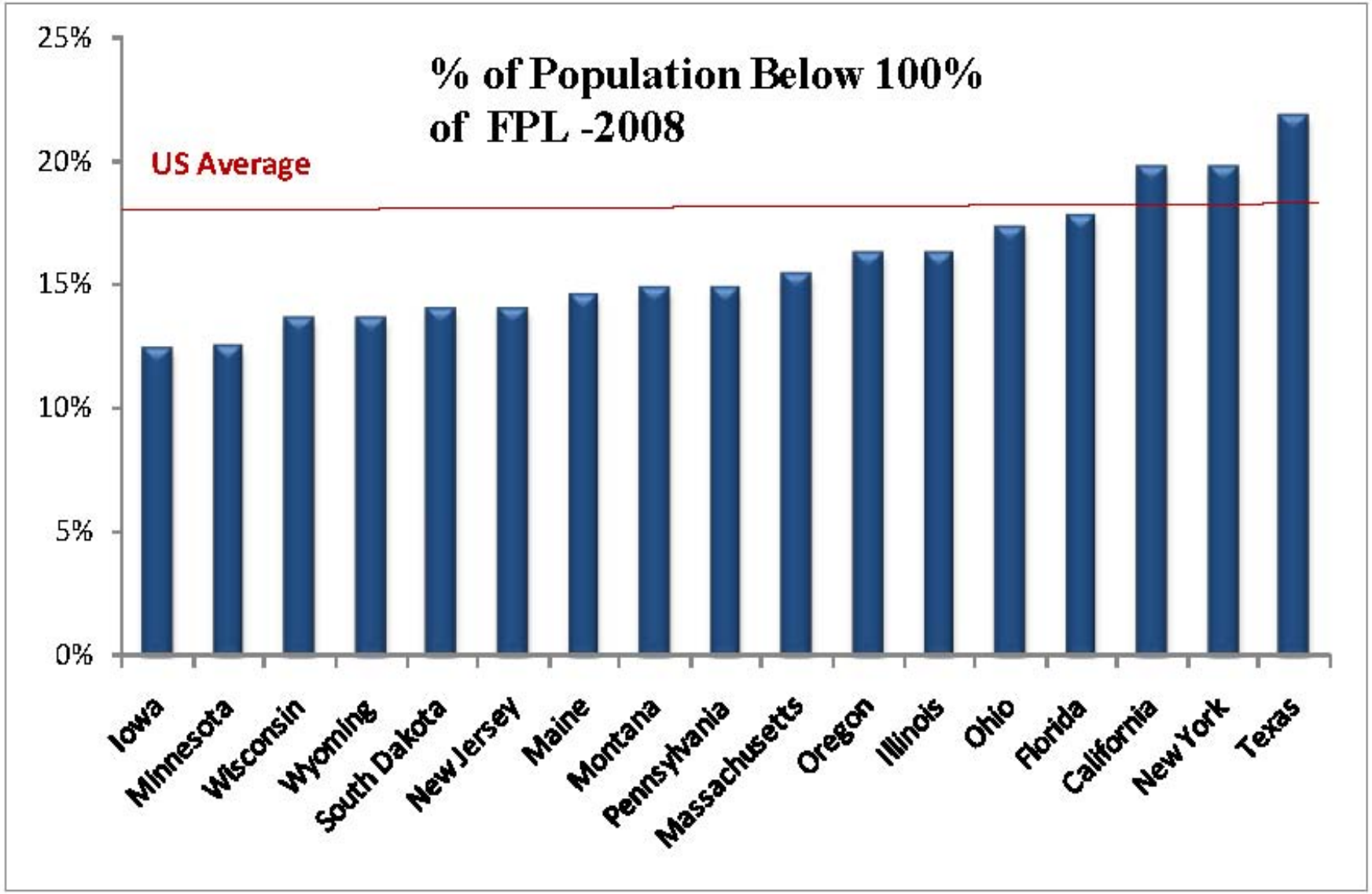
- Hospital value-based purchasing

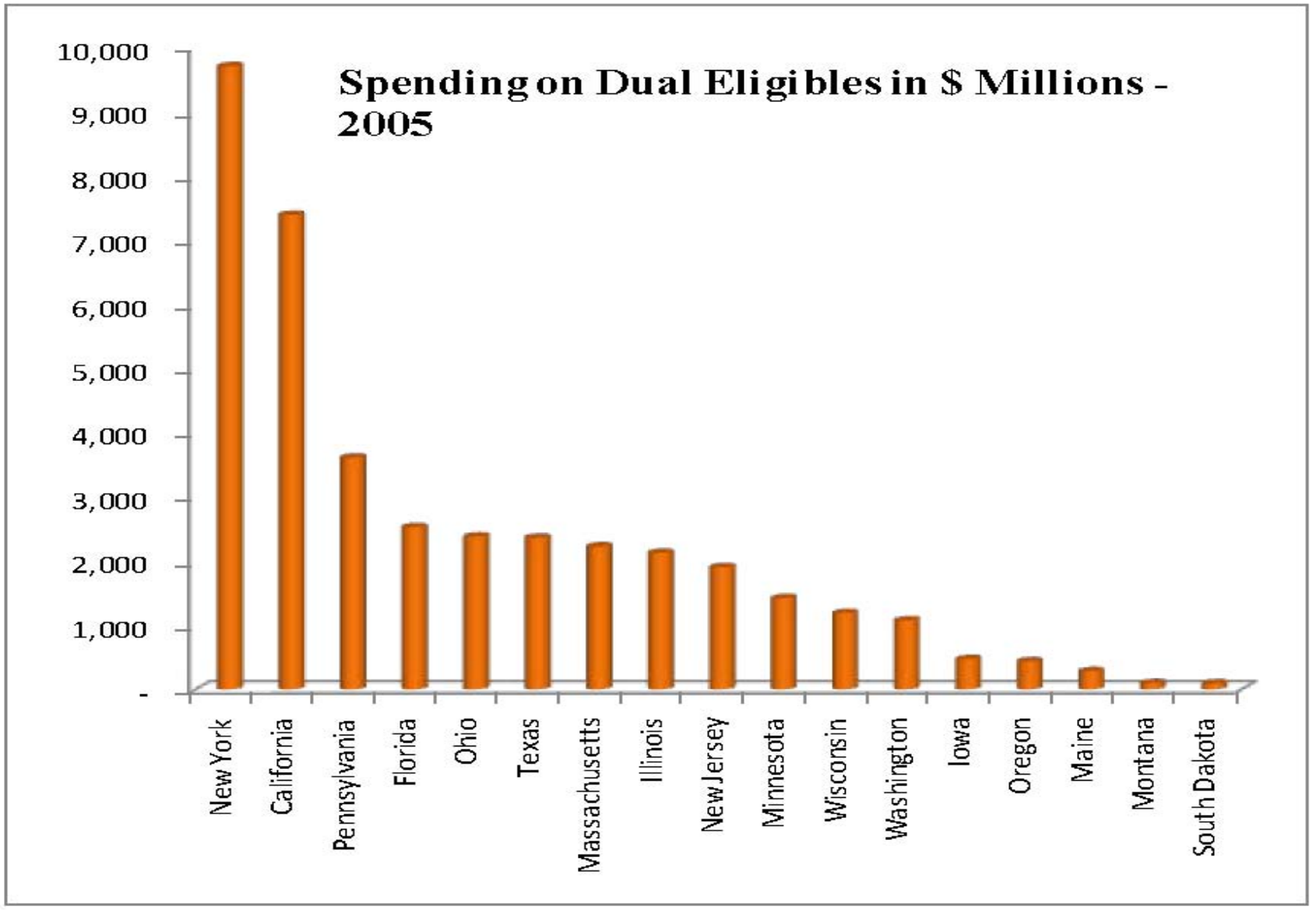
Bundling of Payment for Services

- 90% of adults over 65 years have at least one chronic illness
- Approximately 70% have 2 or more co-existing conditions. (National Bioethics Advisory Commission, 1999)
- By 2030 over 70 million Americans will be over 65 years
- Medicare spending variation exists among and within all areas of the USA



2009 Census Bureau Data


% of Population Below 100% of FPL -2008
US Average
25%
20%
15%
10%
5%
0%
Iowa
Minnesota
Wisconsin
Wyoming
South Dakota
New Jersey
Maine
Montana
Pennsylvania
Massachusetts
Oregon
Illinois
Ohio
Florida
California
New York
Texas



2005 Kaiser Family Foundation, State Health Facts

Creation of Medical Homes for Chronic Illness

Key Concepts for Providers:

- Adhere to evidence-based interdisciplinary care plans and protocols
- Use disease registries and multiple data sources to coordinate care
- Provide care in multiple arenas such as e-visits, e-learning and group visits
- Patient and Family have (1) clarity on provider responsible for care, (2) acknowledge care plan and actively engage and (3) have reasonable access to care information

Hospital Value Based Purchasing (VBP)

1. Legislation requires that, effective October, 2012 (FY 2013), CMS withhold 1% of the base DRG payment to the hospital. Withhold increases by .25% each year until reaching 2% in 2015.

2. Hospital can "earn back" the payment, based on their Hospital Performance Score which is a weighted score compiling core measures (70%) and HCAHPS scores (30%)

3. Payment calculated based on the Hospital Performance Score achieved and recognition of the score improving when compared to baseline.

4. It is expected that CMS FY 2012 (October 2011) will serve as the baseline year for the scores.

5. Hospitals do not have much time to improve their Hospital Performance Score

Health Care Reform Requires "New" Core Competencies

Desired Core Competencies	Characteristics of the "Best Prepared"
Physician Integration (pg. 6)	A highly aligned medical staff characterized by outcome-based contractual arrangements, collaborative planning, and adequate representation in organizational governance.
Care Coordination (pg. 7)	Use of care coordination tools and processes by an empowered and integrated workforce to meet performance goals that are regularly measured and reported.
Cost Management (pg. 8)	A right-sized organization-wide cost structure highlighted by appropriate levels of staffing, capital spend and supply chain costs constantly reviewed based on comparative peer group studies and benchmarks.
Information Systems Sophistication (pg. 9)	An enterprise-wide IT platform that supports clinical and business decision making, information management and utilization, access by all stakeholders (physicians, patients, administration).
Balanced Service Distribution (pg. 10)	A rational service distribution system that has accessible primary care, easy access across the care continuum and is based on contemporary facilities and equipment; minimal clinical service duplication across the system.
Payor Relationships/ Contracts (pg. 11)	Maintaining strong relationships with payers and having the ability to negotiate support for "new-era" contract terms/mechanisms, as well as influence product design.
Financial/Capital Capacity (pg. 12)	Strong appeal to capital markets through sustained strength in operations, revenue growth, profitability, liquidity and balance sheet strength.
Scale/ Essentiality (pg. 13)	Sufficient scale in the market to attract competitive clinical and administrative talent, realize operating and capital economies, drive marketplace innovation and be an essential provider to health plans and patients; optimal portfolio of business units, service lines, and assets that permit the System to achieve its organizational goals and reflect the emerging model for the delivery of

TRANSITIONS IN CARE — WHAT IS UPHS TRYING TO ACCOMPLISH?

The aim is to keep patients safe and stable and give them a safe medical "landing."

From the patient's perspective, **this means**:

- **Staying out of the hospital or the ED**
- **Connecting to a primary care physician**
- **Having the right pharmaceuticals**
- **Knowing what to do after discharge**

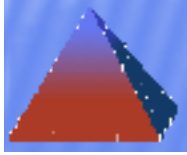
We're focused, for now, on the transitions in and out of the hospital.

WE'VE DEVELOPED A TRANSITIONS MODEL FOR UPHS — WITH SEVEN "LEVERS" THAT MAKE THE BIGGEST DIFFERENCE

UPHS Transitions Model — Seven "Levers"

- Screen for patients at greatest risk
- Real-time readmissions feedback to actively manage patients
- Interdis-ciplinary care planning
- Links to post-acute follow-up services
- Primary care follow up
- Med mgmt across the contin-uum
- Educa-tion & red flag mgmt

But ... It's the leadership "machinery" that makes the model work.



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TODAY'S STORY ABOUT LEADERSHIP MACHINERY HAS THREE PARTS

Core Competencies for Professional Nurses to become *VALUE DRIVERS* are defined in *"The Future of Nursing: Leading Change, Advancing Health."*

RWJ Foundation and IOM

Future of Nursing 2010

Some of Key Messages

- 80% of nurses in US receive a bachelor's degree by 2010
- Nurses should practice to the full extent of their education and expand roles to prescribing and diagnosing disease
- CMS and other agencies need to design payment policies that encourage up to date rules on nurse practice. Establish Nurse-run clinics.
- Nurses are full partners with physicians and others in re-designing healthcare.
- Double the number of nurses with doctorate degrees by 2020.
- Improved models of payment and care models that use nurses in expanded roles.

Nursing Profession's need to build an *Accountable Bridge* for Patient Centered Care as we walk on it…

Questions to be Answered
New Nursing Care Competencies

- Are we prepared to understand the context of suffering and chronicity?
- Are we aware of CMS core measures and nursing sensitive outcomes?
- Are we now willing to be accountable directly for patient outcomes?
- Are we developing peer evaluation skills that protect patient, family and others.
- Are we realizing the consequences and national profile and expectation our practice will have if we become a revenue center?

Questions to be Answered
New Nursing Care Competencies (con't)

- Are we comfortable being an equalitarian interdisciplinary team member?
- Are we willing to be accountable at all times- even when no one is looking?
- Are we willing to have our salaries based on direct outcomes of personal practice?
- Are we willing to recognize professional practice is not 36-40 hours/week?
- Are we experts in patient and family health teaching?

21st Century Vision of Global Healthcare

4 P's

- Prediction
- Personalization
- Prevention
- Participation

Lord Darcy (2010)

Summary

- An organization cannot be accountable
- Clinicians and Non-Clinician providers must be
- As nurses we can only control our own practice
- How will nurse practice accountability evolve?
- Only our profession can determine!
- It begins with each of us…

Thank You…

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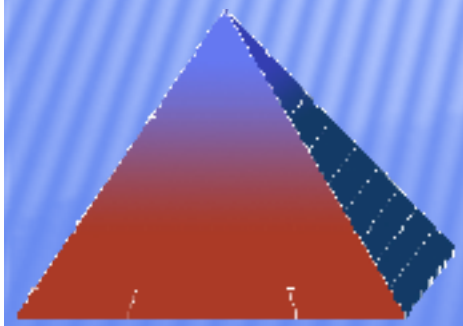

MAGNET RECOGNITION
AMERICAN NURSES CREDENTIALING CENTER