2016 American Nurses Association Annual Conference

Connecting **Quality**, **Safety** and **Staffing** to Improve Outcomes

Weaving Expanded Roles of the RN into Population Management

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MARCH 9-11, 2016 LAKE BUENA VISTA, FL www.nursingworld.org/ANAconference

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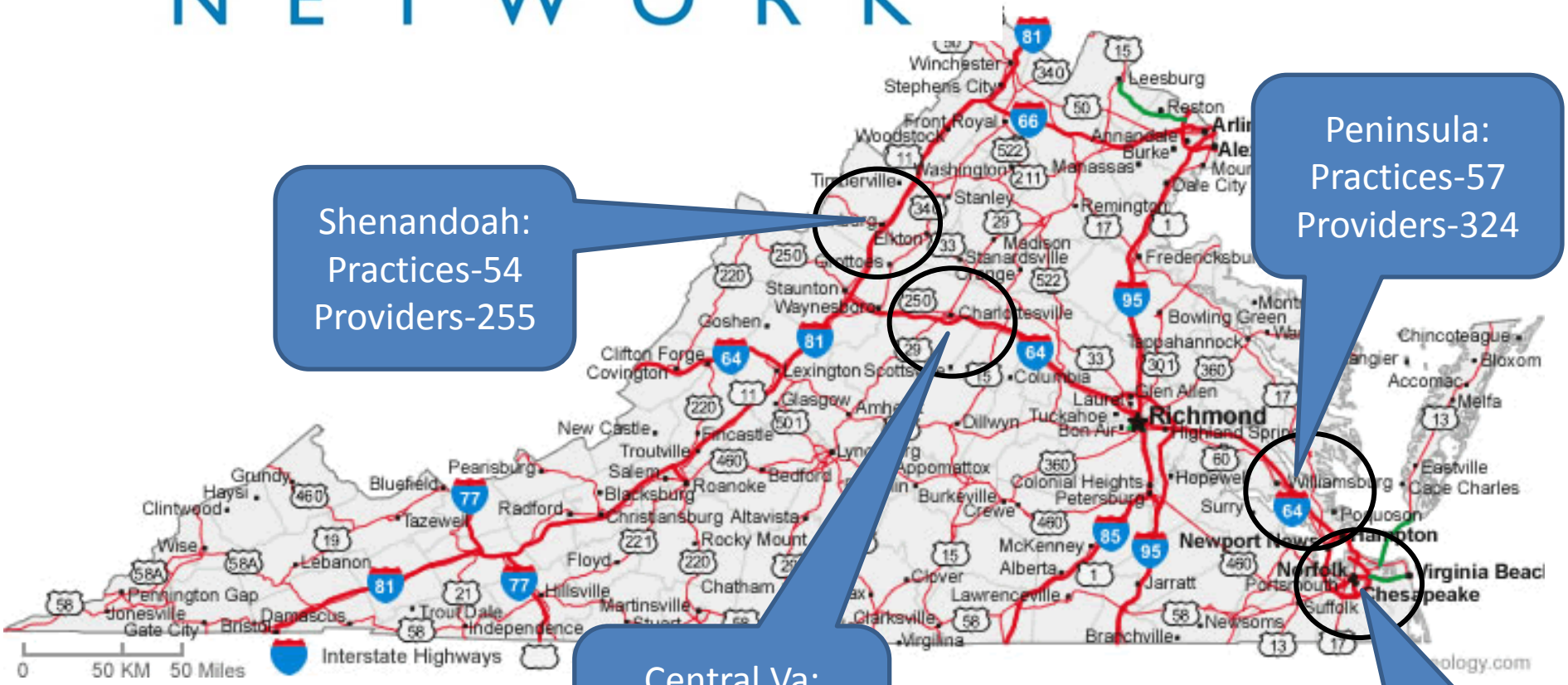
Objectives:

- Explore the evolution of healthcare leading to Quality Care and accountability for Populations
- Define “Clinically Integrated Network (CIN)” and “Population Health”
- Discuss the SQCN nursing model used for patient stratification & management
- Identify two roles of RNs in the SQCN model
- Discuss the competencies required for each role

Sentara Quality Care NETWORK



Clinically Integrated Network (CIN)

- Physician-led network
- Members selectively chosen
- Otherwise independent physicians & practices
- Improve the health of defined populations
- Reduce costs while assuring quality of healthcare
- “Safe harbor” from anti-trust laws
- Investment in an infrastructure

https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf

Clinically Integrated Network (CIN)

“a network of **otherwise independent** physicians who collectively commit to quality and cost improvement. To support these efforts, physicians in the CI network may—under a **"safe harbor" from antitrust law**—negotiate collectively for commercial payer contracts, with **joint contracting** seen as "reasonably necessary" to support investment (of both time and resources) in performance improvement and ensure cross-referrals among participating providers.”

https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2014/09/deciphering-the-reform-alphabet

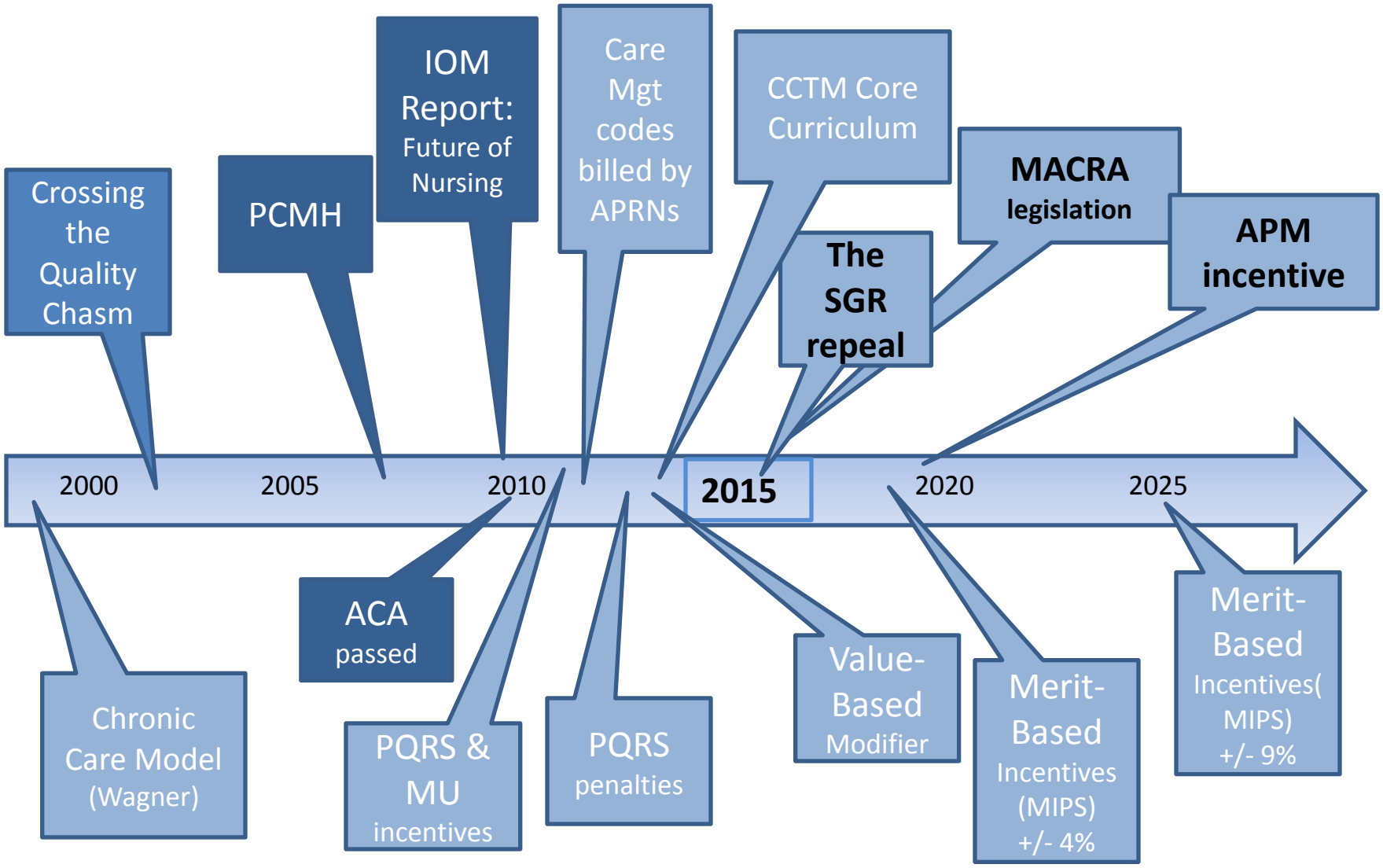
Clinically Integrated Network (CIN)

May include (FTC) :

- Establishing mechanisms to monitor & control utilization of health care services that are designed to control costs & assure quality of care
- Selectively choosing network physician who are likely to further these efficiency objectives
- The significant investment of capital, both monetary & human, in the necessary infrastructure & capability to realize the claimed efficiencies

https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf

Healthcare Evolution Timeline



Definitions

PCMH – **Patient-Centered Medical Home** – team-based approach to primary care, endorsed by 17 specialty organizations

PQRS – **Physician Quality Reporting System** [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html]

VBM - Value-Based Modifier – differential to physician payment under Medicare Fee For Service (FFS) [https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html#What is the Value-Based Payment Modifier (Value Modifier)]

SGR – **Sustainable growth rate** formula – formula designed to limit spending in fee-for-service medical care. Repealed in April 2015 & replaced with MIPS

MACRA – Medicare Access & CHIP Reauthorization Act of 2015 – ended SGR & established MIPS & APMs to stimulate movement toward goal of paying for quality & cutting unnecessary costs

MIPS – **Merit-Based Incentive Payment System** – combines previous programs (PQRS, VBM & MU) for one program & rewards physicians based on quality, cost containment & use of an electronic record [http://www.commonwealthfund.org/publications/blog/2015/apr/repealing-the-sgr]

APM – **Alternative Payment Model** – CIN, ACO, PCMH & Bundle payments

Care Coordination & Transition Management

Dimensions:

- Support Self-Management
- Education & Engagement
- Cross Setting Communication & Transition
- Coaching & Counseling of Patients & Families
- Nursing Process
- Teamwork & Collaboration
- Patient-Centered Planning
- **Population Health Management**
- Advocacy

Care Coordination and Transition Management Core Curriculum (2014). Haas, S.A., Swan, B.A., & Haynes, T.S. Ed. AAACN: Pitman, N.J.

Population Health

"A population health perspective encompasses the ability to assess the health needs of a **specific population**; implement and evaluate interventions to improve the health of that **population**; and provide care for individual patients in the context of the culture, health status, and health needs of the **populations** of which , that patient is a member" (Halpern & Boulter, 2000, p.1)."

Haas, SA; Swan, BA, Haynes, TS. (2014) Care Coordination and Transition management Core Curriculum. Pg. 113.

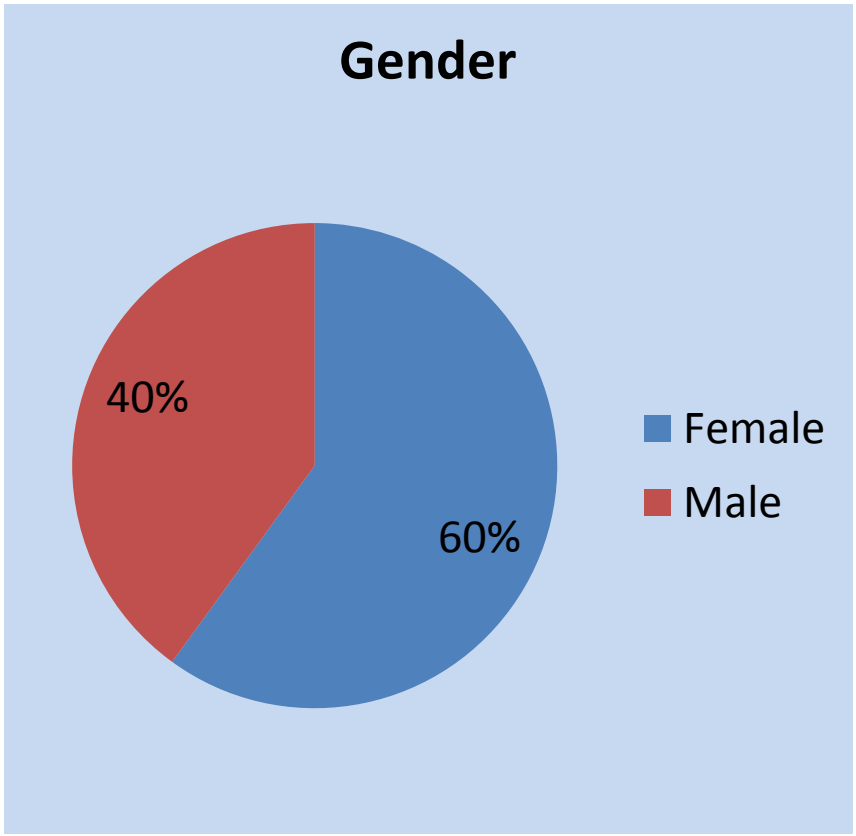
2014 SQCN Population

- **Healthcare System Employees = 21,437 lives**
- **Local Municipality Employees = 15,829 lives**
- **Medical School Employees = 821 lives**

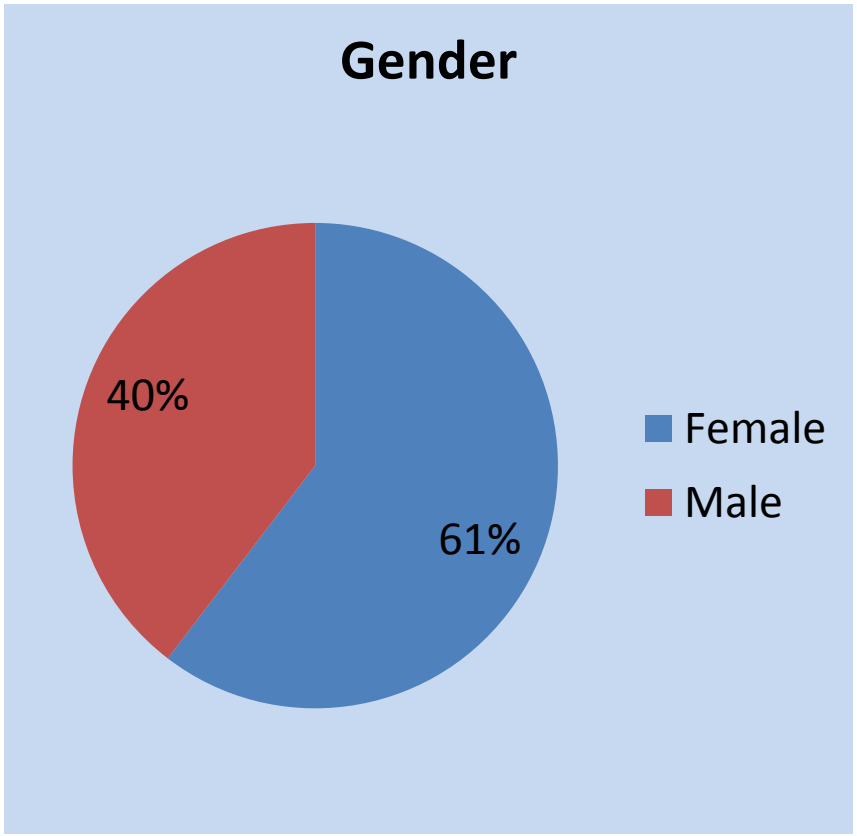
- **Total = 38,087 lives**

Population Characteristics

Municipality

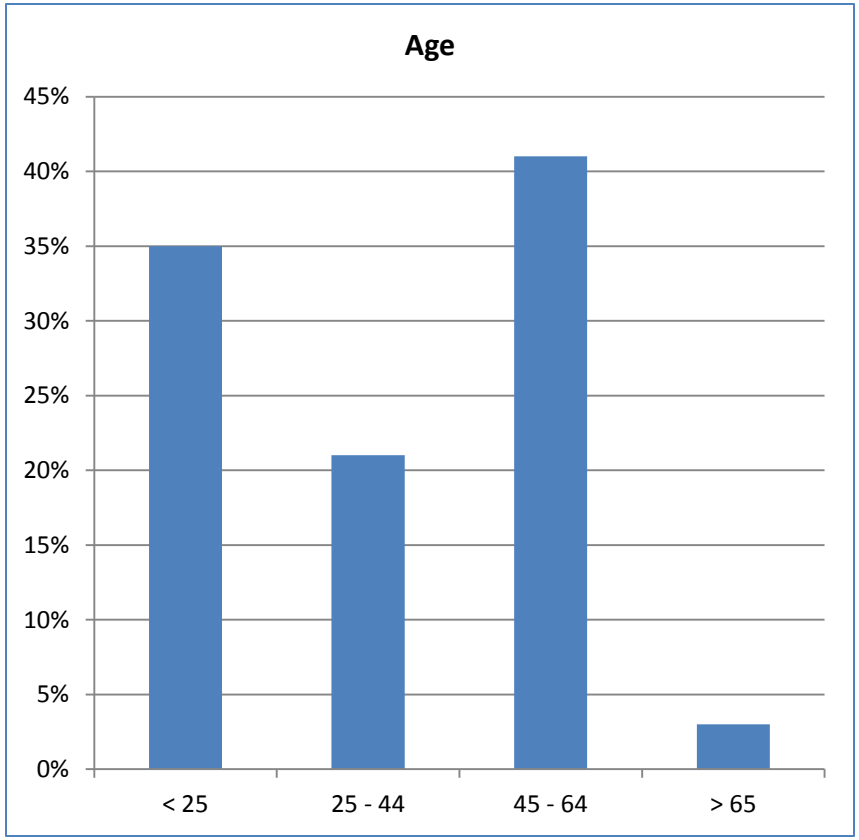


Healthcare System

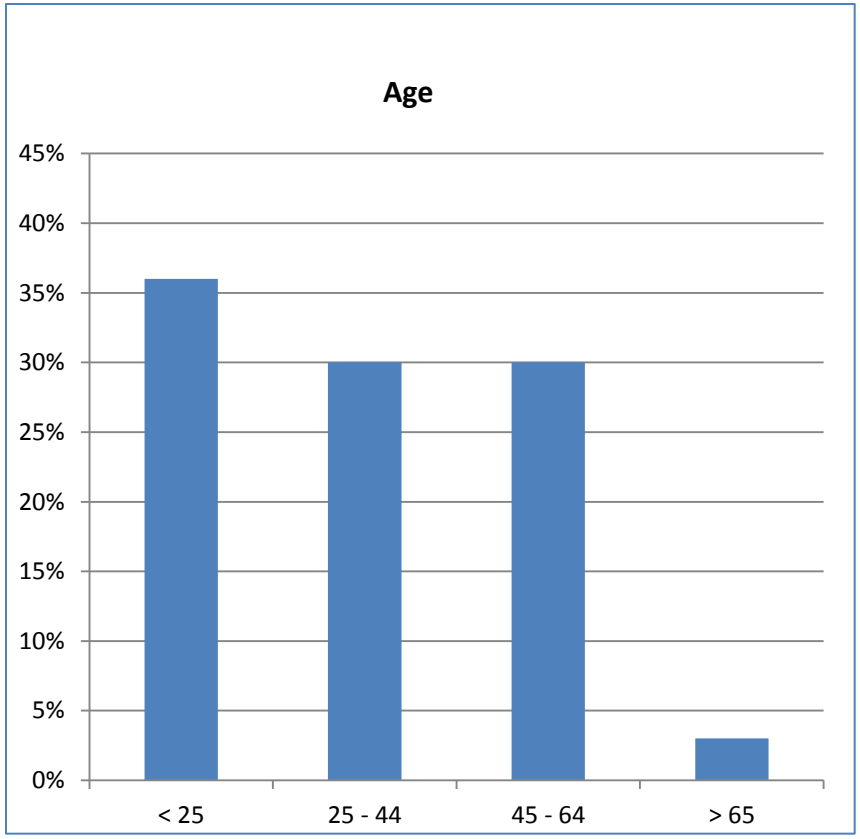


Population Characteristics

Municipality



Healthcare System



What were their health challenges?

- **Large percentage of pediatric patients**
- **Most common disease - CVD**
- **Most costly disease - Diabetes**

2014 Quality Scorecard

Diabetes: Most expensive condition

1. % A1C Performed
2. % A1C < 8
3. % LDL Performed
4. % LDL < 100
5. % Nephropathy screen

CVD : Most common condition

6. % LDL testing and
   % < 100

Wellness/screening:

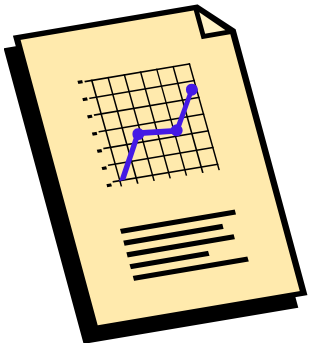
7. % Breast cancer screening
8. % Adolescent well visit
9. % Adolescent immunizations

Utilization:

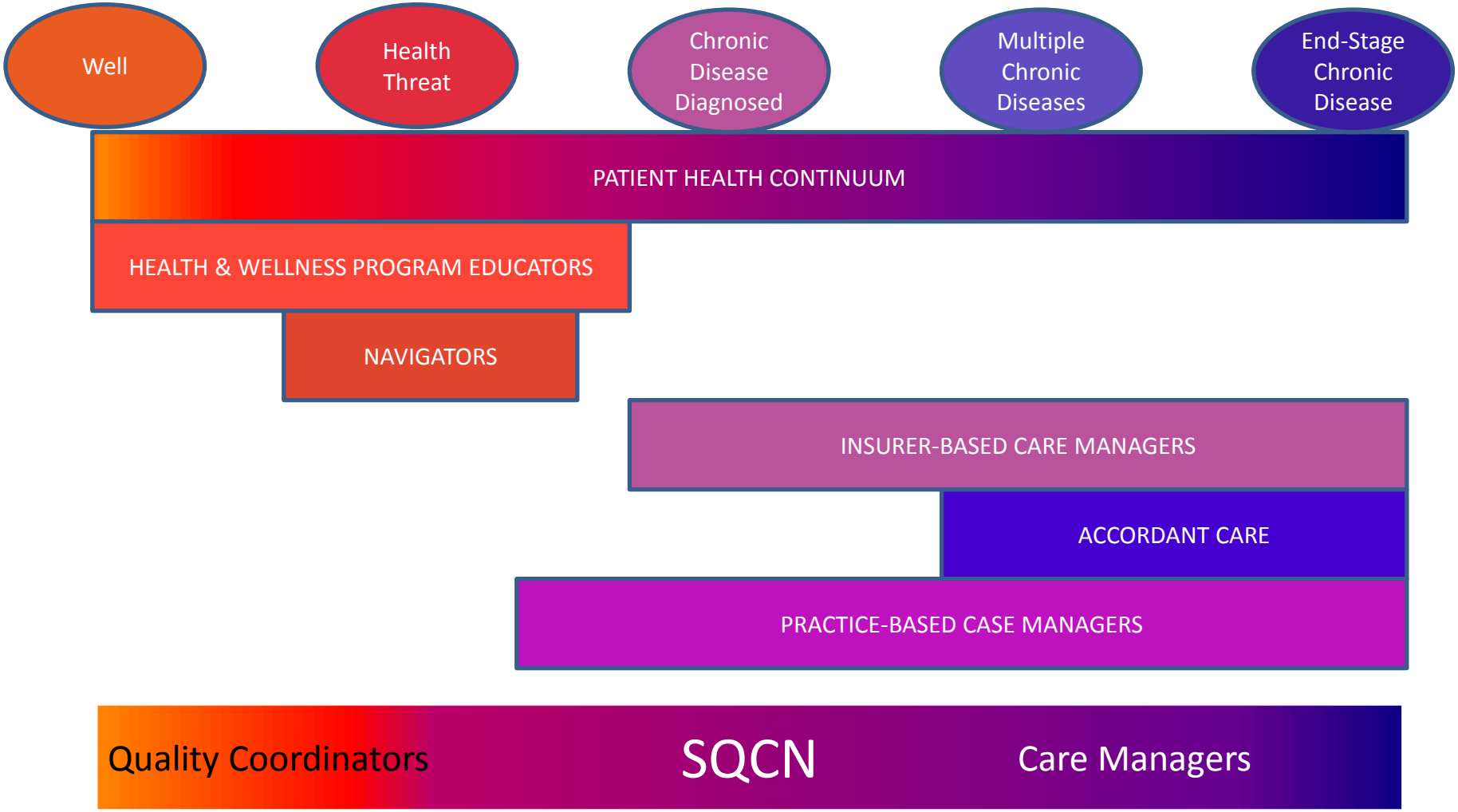
10. % Poorly controlled diabetics not on insulin

Extra Credit: % Patients > 18 with

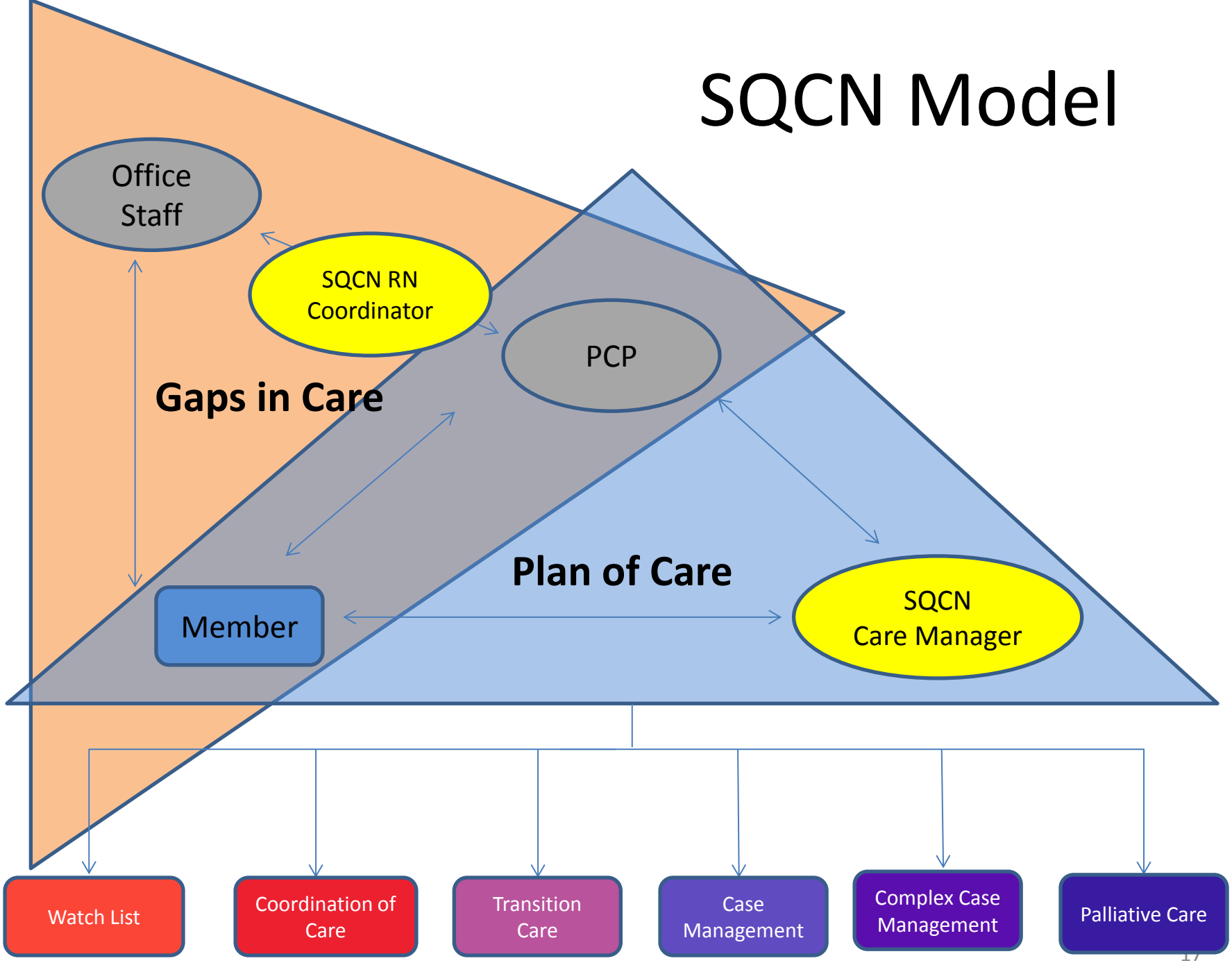
11. BP data
12. BMI data
13. Smoking status data



Health Continuum & SQCN Model



SQCN Model


Office Staff
SQCN RN Coordinator
PCP
Gaps in Care
Plan of Care
Member
SQCN Care Manager
Watch List
Coordination of Care
Transition Care
Case Management
Complex Case Management
Palliative Care

SQCN Quality Coordinator Competencies

Population Centered Care

Teamwork & Collaboration

Evidence-Based Practic

Quality Improvement

Safety

Informatics

SQCN Care Manager Competencies

Patient Centered Care

Teamwork & Collaboration

Evidence-Based Practic

Quality Improvement

Safety

Informatics

Role Competencies

Competency	RN Quality Coordinator	RN Care Manager
Patient/Population Centered Care	Population	Patient & Family
Teamwork & Collaboration	Providers & staff throughout network, insurer, IT & administration	Providers & staff in assigned practices, Care Managers from insurer and medical group(s)
Evidence-Based Practice	Locating evidence for best practices; Evaluating organizational environment Protocol development & dissemination	Knowledge of best evidence incorporated into Nursing Care Plans, Patient Interventions & Teaching
Quality Improvement	NCQA, HEDIS, & other quality measures; Network performance on quality dashboard; Practice workflow	Patient adherence & possession ratios; A1C levels in diabetic patients
Safety	Protecting patient PHI	Strategies to reduce risk of harm to self & clients.
Informatics	Assist members in adoption & use of registries & IT platform; collaborate with IT for reports & data maintenance	Effectively communicate across multiple platforms to inform all care team; Utilize decision-support tools to identify & prioritize patients

2014 Quality Scorecard: How did we do?

Diabetes: Most expensive condition

1. % A1C Performed
2. % A1C < 8
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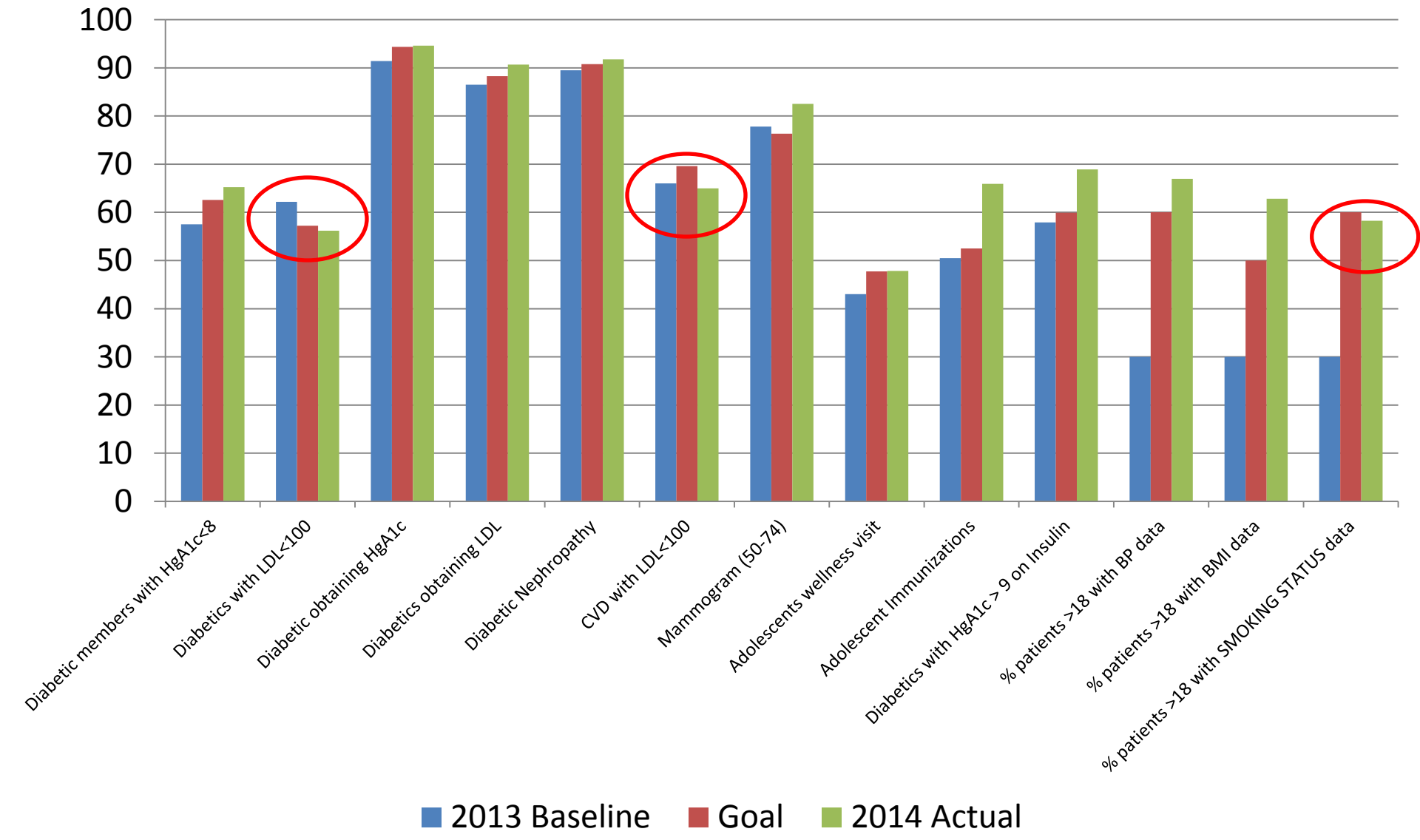
Goal Achievement: 2014



2015 Collaboration = Workgroups

Regional:

- Low Back Pain
- Headache
- Secure Messaging/Referrals

Cross-Regional:

- Diabetes
- Pharmacy
- Adolescent Physicals
- Women's Health

2015 Quality Scorecard

Diabetes:

1. % A1C Performed
2. % A1C < 8
3. % Nephropathy screen

Wellness/screening:

4. % Breast cancer screening
5. % Adolescent well visit
6. % Adolescent immunizations
7. Well child visit
8. Weight assessment age 3-17
9. % colon cancer screening

2015 Quality Scorecard

Transitions of care:

10. Hospital follow-up within 7 days for AMI, pneumonia, asthmas & COPD

11. ED follow-up within 7 days for headache, migraine, asthma & back pain

Protocols of care:

12. Use of imaging in LBP

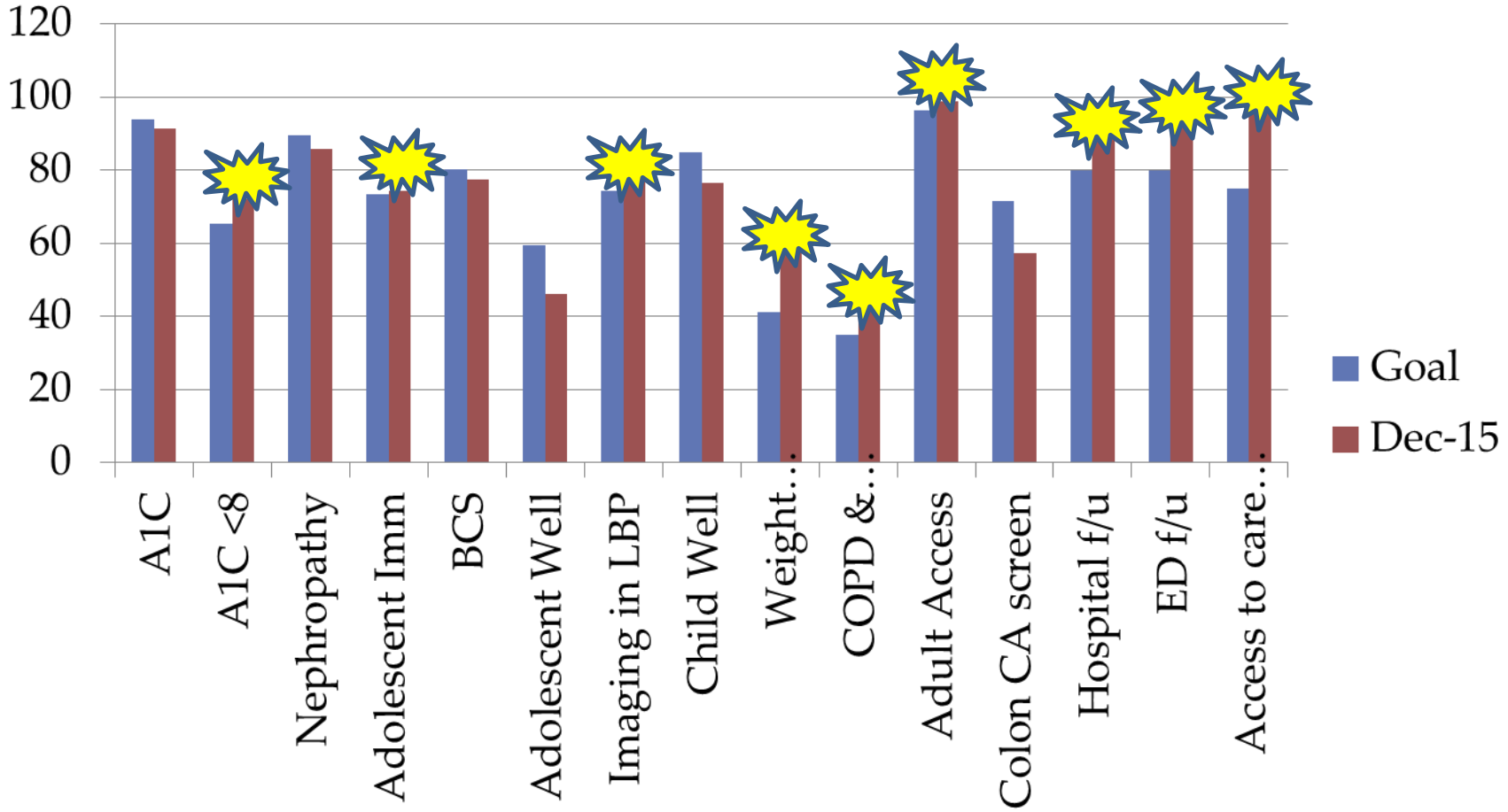
13. COPD & spirometry

Access:

14. Adult access to care

15. Access measurement survey

Goal Achievement 2015



Data as of 12/7/15, which was current at time of submission.

What's on the horizon?

- Additional Contracts 1/1/16
- Care Management Process Development
- New IT Platform
- Network Access
- Expanding workgroups
- Participant accountability

Questions?

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