Nursing’s Call to Transform the Health Care Delivery System

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Spring Forum
March 14, 2012
VNSNY: Who We Are

- Founded in 1893 by Lillian D. Wald, VNSNY is the largest non-profit community-based health care agency in the U.S.
- Serves all five boroughs of NYC, plus Westchester and Nassau Counties
- Plans a statewide expansion
- Provides a range of services to an average daily census of 31,000 patients, from newborns to seniors
- 14,000 employees – most are field staff providing direct care
  - Nurses: 2,369 || Nurse Practitioners: 28
  - Nurses at Director-level and Above: 48
- Serve a socio-economically diverse population (36% speak a foreign language)
VNSNY Provides Care Across the Continuum of Needs

Continuum of Patients/Needs

VNSNY’s Continuum of Care

Independent

Independent with acute episode (short-term need)  B

Chronic condition(s), medically routine and/or complex (long-term need)  C

End of Life  D

A

Post-acute nursing, rehabilitation

Hospice and palliative care

Prevention

Health Promotion

Primary Care

Long-term Home Health Care Program

Health Plans
Transforming the Service Delivery System

- Community-Based Models of Care
- Health reform legislation from the Affordable Care Act
- Chance to transform system to improve care

Mechanisms for improvement:
- Quality
- Access
- Add value while slowing costs
Transforming the Service Delivery System

The Future System
- Quality care accessible to diverse populations
- Promotes wellness and disease prevention
- Reliably improves health outcomes
- Compassionate care across lifespan
- Diverse needs of the changing patient population

How?
- Primary care and prevention are central drivers
- Interprofessional collaboration and care coordination are norm
- Payment rewards value
- Quality care at affordable price
- Redesigning the care delivery system
The Evolving Role of Nurses

**PAST**
- Task-oriented
- Transactional
- Single professional
- Short-term relationship
- FFS payment

**FUTURE**
- Outcomes-oriented
- Episode of care
- Partner with physicians, hospitals
- Longer-term relationships
- Care management, ongoing support
- Risk-based, prospective payment
- Coordinator of interdisciplinary team
The Current Institute of Medicine (IOM) Report

The Future of Nursing: Leading Change, Advancing Health

- A partnership between the Robert Wood Johnson Foundation and the Institute of Medicine
- Report issued on October 5, 2010
- Improve how health care is delivered to meet the needs of all patients
- Process was led by Senior Adviser for Nursing at the Robert Wood Johnson Foundation
The Future of Nursing: Leading Change, Advancing Health

A blueprint to:

• Ensure that nurses can practice to full extent of their education and training

• Improve nursing education

• Provide opportunities for nurses to assume leadership positions and to serve as full partners in health care redesign and improvement efforts

• Improve data collection for workforce planning and policymaking
The Future of Nursing: Leading Change, Advancing Health

The Process

- Convened key researchers to validate evidence-based findings
- Convened public hearings on a range of areas:
  - Acute care
  - Care in the community
  - Education
Community-Based Models of Care

Embedded in the Affordable Care Act &
IOM Report on the Future of Nursing
Message One

#1) Nurses should be able to practice to full extent of their education and training

- Need to remove scope-of-practice restrictions for APRNs
- Need nurse residency program to better manage transition from school to practice and across practice settings
The Recommendations

• Practice to the full extent of practice
• Capitalize on nursing’s versatility and adaptive capacity
• LIFE Program (Living Independently for Elders)
• Riverside Proactive Health Management Program
• Ruth Lubic, Family Health & Birth Center
  – 195 centers started in NYC
• Lisa Ayers, BSN, RN – Public Health Nurse, Schenectady NY
Scope of Practice

Darlene Cadigan, RN
Mobile Outreach and Case Management to the deinstitutionalized mentally ill and homeless

- **Application:** Improved health and more effective community integration of at-risk populations. Mandatory training of boarding house operations.

- **Imperative:** Extend program throughout the state to reduce healthcare and societal costs associated with neglect of at-risk populations.
Scope of Practice

Housing-Based Care (Congregate Care)

• **Application:** Promote assets of people living in the community to promote a “community of health”

• **Imperative:** Provide reimbursement and organizational constructs that value the nurse’s role in primary prevention
Scope of Practice

Naturally Occurring Retirement Communities (NORCs)

- **Application:** Implement a health promotion focus in an area or housing structure (not designed or planned with seniors in mind) in which a significant proportion of older people reside.

- **Imperative:** Create a permanent funding construct for “Aging in Place” Initiatives.
Scope of Practice

Nurse Family Partnership (NFP)

- **Application:** For every dollar spent on parental care, a return of $5.70 is realized by enhancing birth outcomes, improving parenting skills, and increasing employment.

- **Imperative:** Preserve funding within NFP for its expansion and continuance.
Scope of Practice

- **Recommendation:**
  - Provide equitable and adequate reimbursement for APNs

- **Evidence:**
  - Carolina Sandoval, MSN, PNP, RN – Advocate for California Latino Community
  - Difference in scope of practice regulations
  - 23% of NP in rural area and 46% in urban areas
Scope of Practice

Marion Norman, MSN, APN
School-Based Nurse Practitioner providing primary care services

• Application: Avert absenteeism and improve health education of children in school.

• Imperative: Require third party payers participating in fee-for-service payment arrangements to provide direct reimbursement to APNs who are providing care within scope of practice.
Scope of Practice

• Recommendation:
  ✓ APNs function within full scope of practice

• Evidence:
  ✓ $10 billion in the Affordable Care Act for expansion of FQHCs
  ✓ 2000 to 2006 patients seen by nation’s health centers grew by 38%
  ✓ APNs working in them grew by 64%
**Scope of Practice**

Pat Giordano, MSN, APN
Advanced Practice Nurse in Federally Qualified Health Center

- **Application:** Access to comprehensive primary care services for vulnerable population

- **Imperative:** Allow NP under Medicare program to authorize critical services for patients, such as home health, DME. Establish greater openness in credentialing process of commercial insurers
Scope of Practice

• **Recommendation:**
  - Remove reimbursement barriers to independent practice

• **Evidence: RN Midwives achieve positive pregnancy outcomes**
  - Shorter labor
  - Lower preterm rates
  - Lower rate of C-sections
  - Increase breast-feeding rates
Scope of Practice

Marina Burke, RN, ANP
Program Manager, Transitional Care
ESPRIT Medical Care, PC

- **Application:** Home-based primary care integrator with access to network of specialist providers, nurse practitioners, psychiatrists, licensed clinical social workers, nutritionists, and certified diabetes educators

- **Imperative:** Advocate for inclusion of incentive payments for home visits for interprofessional teams providing virtual PCMH
Message Two

#2) Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression

- More BSN-trained nurses
- ADN-to-BSN and ADN-to-MSN programs
- Increase student diversity to create workforce prepared to meet demands of increasingly diverse patient population
Higher Education

• **Recommendation: RNs should achieve higher level of education and training**
  - ✔ Strategies for seamless progression
    - Increase proportion of nurses with BSN degree to 80% by 2020
    - Double the number of nurses with a doctorate by 2020
    - Ensure that nurses engage in lifelong learning

• **Evidence:**
  - ✔ Nurse Faculty Shortage
  - ✔ In 2008:
    - 375,000 Masters (13%)
    - 28,000 Doctorate (1%)
Residency Programs

VNSNY RN Internship Program

- **Application:** Facilitate seamless transition of new graduates to community-based settings

- **Imperative:** Secure federal reimbursement for GME residency programs for nurses to transition to new roles and settings
RetentionPolicy

**Recommendation:**
- Enhance competency and improve the retention of nurses

**Evidence:**
- $200 million from 2012-2015 in Affordable Care Act
  - Hospitals will be paid for costs of clinical training to prepare APRNS
  - Nurses provided with skills necessary to provide primary and preventive care, transitional care, chronic care management, and other programs
- Every 1% increase in nursing turnover = $300,000 increase in annual budget (UHS/AACN Nurse Residency Program website – 2011)
Message Three

#3) Nurses should be full partners with physicians and others in redesigning U.S. health care

- Foster leadership skills and competencies
- Nurses must see policy as something they shape
Nurses as Full Partners

• Recommendation: “Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.”

• Evidence:
  ✓ Transitions of Care
    – Naylor APN Model
    – Coleman Health Coaching Model
Leadership for Health System Redesign

Interprofessional Team – Sharon Holden, MPA, BSN, RN, RDCS, Assistant VP Cardiopulmonary, ED, Critical Care and Renal Services; Judy Fancelli, BS, RN, VP of Business Development; Dr. Alan Tunkel, CMO

• Application: Enhanced patient satisfaction
  - 0.8% reduction in length of stay.
  - 51% reduction in ER recidivism.
  - Recognition by IHI as national best practice.

• Imperative:
  - Secure third-party payment for transitional care models.
  - Establish interprofessional teams as the foundational element for system redesign “that improves health outcomes and lowers costs”
Nurses as Full Partners

• Recommendations: “Nurses must see policy as something they shape.”

• Evidence: Nursing’s pivotal role in care coordination
  ✓ Guided Care Model
  ✓ Hopkins Hospital to Home
  ✓ Geisinger Health System Model
  ✓ Kaiser Permanente
Leadership for Health System Redesign & Expansion

CHOICE MLTC: Nurses as the care coordinators in an interdisciplinary team approach to chronic care management

- **Application:** Nurses provided high-touch care coordination to more than 10,000 at-risk seniors and high-cost chronically-ill dual eligibles
- **Imperative:** To ensure Medicaid Redesign Initiatives establish as a foundational element the care coordination role of nurses
Nurses as Full Partners

• **Recommendation:** “… Health care organizations should offer nurses the chance to lead and manage collaborative efforts with physicians and others”

• **Evidence:**
  - ✔ Transforming Care At Bedside (TCAB) Projects
  - ✔ Community Based Recidivism Initiatives
VNSNY Transitions of Care (TOC)

• **Application:** Provide transitions of care intervention for patients with Empire Blue Cross with positive cost and health outcomes

• **Imperative:** Establish TOC as the standard care with all public and private payers
Affordable Care Act

- The Federal Government is headed in several important directions:
  
  ✓ **Accountable Care Organizations (ACOs):** integrated delivery systems whereby a set of providers associated with a defined population of patients is accountable for the quality and cost of care delivered to that population
  
  ✓ **Patient-Centered Medical Home (PCMH):** integrated model of care which broadens access to primary care services, implements evidence-based medical approaches, and enhances relationships between patients, physicians, and nurse practitioners to improve clinical outcomes
  
  ✓ **Population-Based Care Coordination**
Leadership for Health System Redesign & Expansion

**VNSNY Hospice & Palliative Care:**
VNSNY Hospice Care is the largest provider in metro NYC, where hospice is underutilized

- **Application: SPARK -** Nurses with education and expertise in advanced pain symptom management provide a bridge to end-of-life care

- **Imperative: INCUBATE and pilot innovative models with payers for end-of-life reimbursement**

**Ann Campbell, RN-BC, MPH**
NP Student at Hunter-Bellevue School of Nursing
HAVEN - Hospice Specialty Care Unit, Bellevue Hospital
Health Home

VNSNY Designated as a Health Home in the Bronx

- **Application:** Nurses integrate the health and human services needs of fragile at-risk populations through grass roots coalition models

- **Imperative:** Nurses attain governance seats on emerging systems of care
Nurses as Full Partners

• **Recommendation:** “Nurses must take responsibility for personal and professional growth by continuing their education and seeking opportunities to develop and exercise leadership skills.”

✓ **Evidence:**
  ✓ RWJ Nurse Executive Leaders
  ✓ RNs in the Boardroom
  ✓ J&J, Wharton Nurse Executive Fellows Program
Leadership for Health System Redesign & Expansion

Joan M. Marren, RN, MA, Med
Chief Operating Office, VNSNY
President, VNSNY Home Care

Member of the NYS Home Health Care Reimbursement Workgroup

- **Application:** Influenced legislation, policy and organization strategy relative to the fullest expression of nursing practice and leadership

- **Imperative:** Nurses exercise their responsibility to obtain seats at the table that drive the architecture and delivery of health care
Message Four

#4) Effective workforce planning and policy-making require better data collection and an information infrastructure

- Need balance of skills and perspectives among physicians, nurses and others
- Need more specific workforce data collection both within and across professions
“We’ve got lots of information technology. We just don’t have any information.”
Better Data Collection & Information Infrastructure

- **Recommendation:** Build an infrastructure to collect and analyze health care workforce data

- **Evidence:**
  - US Department of Labor
  - When HIT fully implemented it will be a significant subset of care – 15-37%
Meaningful Use: Encourage EHRs to exchange information at the point of care

• Feb 2009: President Obama passed a $26 billion stimulus package, known as the American Recovery and Reinvestment Act (ARRA) for the development and adoption of Healthcare IT

  – ARRA spurs the adoptions of EHRs and the creation of a nationwide HIT infrastructure to increase connectivity and information exchange at the point of care
  
  – Establishes incentive payments through Medicare for eligible professionals and hospitals who demonstrate the “meaningful use” of “certified EHR technology”:

    • Improve quality, safety, efficiency, care coordination, population and public health; reduce health disparities; engage patients and their families; ensure adequate privacy and security protections for personal health information
Discussion