The Future of Value Based Nursing Care

Nancy Carragee
April 15, 2016
Objectives today

• Align bedside nurse’s heart mission with today’s healthcare environment.
  – Value Based Purchasing message
  – WIIFM (nurses) message

• Understand nursing's role in creating value

• Discuss case studies from a value perspective, including financial impact of patient harm.
National Strategy for Quality Improvement

- Required by the Affordable Care Act (ACA) and released in March 2011, it set priorities and a strategic plan for the nation that includes three aims:

  - **Better Care**: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
  
  - **Healthy People/Healthy Communities**: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
  
  - **Affordable Care**: Reduce the cost of quality health care for individuals, families, employers, and government.

Source: http://www.healthcare.gov/center/reports/quality03212011a.html
# Medicare Value-Based Payment Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Fee-for-Service Payments</strong></td>
<td></td>
</tr>
<tr>
<td>85% tied to quality</td>
<td>2016</td>
</tr>
<tr>
<td>90% tied to quality</td>
<td>2018</td>
</tr>
<tr>
<td><strong>Alternative Payment Models</strong>*</td>
<td></td>
</tr>
<tr>
<td>30% tied to quality</td>
<td>2016</td>
</tr>
<tr>
<td>50% tied to quality</td>
<td>2018</td>
</tr>
</tbody>
</table>

*ACOs, bundled payments
Health Reform: Big Picture

Move to new, more coordinated, higher quality, more efficient, person/patient and population centered systems of care, aided by greater consumer information and the EHR, expanded access, new incentives for everyone, greater transparency and a strong emphasis on value.

In other words, fix everything that has been wrong for most of our careers.  _Peter Buerhaus, PhD, RN, FAAN_
Value Based Purchasing: Evolution toward Outcomes

- A percent of inpatient base operating payments are at risk based on quality and efficiency metric performance

<table>
<thead>
<tr>
<th>Year</th>
<th>1%</th>
<th>1.25%</th>
<th>1.5%</th>
<th>1.75%</th>
<th>2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2013</td>
<td>1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2014</td>
<td>1.25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2015</td>
<td>1.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2016</td>
<td>1.75%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2017</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FY 2017

- Clinical Process: 5%
- Outcome: 45%
- Patient Experience: 25%
- Efficiency: 25%
Legislative Forces Driving Healthcare Focus on Quality and Safety

- Value Based Purchasing
  - Evidence-Based Care
  - Patient Experience
  - Mortality
  - Hospital-Acquired Conditions
  - Efficiency

- Payment Penalties
  - Readmissions
  - Hospital-Acquired Conditions

- Inpatient Quality Reporting
Hospital Acquired Conditions (HACs)
(Medicare payment at risk: 1%)

• Began in 2015 with October 1, 2014 discharges
• CMS penalty program for hospitals in the lowest performing 25% with regard to HACs
• Measures include:
  – 8 Patient Safety Indicators (PSIs)
  – CLABSI
  – CAUTI
  – SSI (Colon surgeries and abdominal hysterectomies)
  – MRSA and C-Difficile
Readmission Reduction Program
(Medicare payment at risk: 1% in FY2013; 3% in FY2015)

• Began in 2013 with October 1, 2012 discharges
• CMS penalty program for hospitals with excess 30-day readmits for these conditions:
  – Acute MI (Heart Attack)
  – Heart Failure
  – Pneumonia
  – Total Hip/Knee Arthroplasty
  – COPD (chronic obstructive pulmonary disease)
## Triple threat

<table>
<thead>
<tr>
<th>Hospital-acquired conditions (HACs)</th>
<th>Not eligible higher payment (FY 08 ongoing)</th>
<th>IP VBP (FY 13 ongoing)</th>
<th>HAC Reduction Program (Starting FY 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter associated UTI</td>
<td>X</td>
<td>Finalized FY 16</td>
<td>Finalized FY 15</td>
</tr>
<tr>
<td>Surgical Site Infections</td>
<td>X*</td>
<td>Finalized FY 16</td>
<td>Finalized FY 16</td>
</tr>
<tr>
<td>Vascular cath-assoc. infections</td>
<td>X**</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90/ CLABSI</td>
</tr>
<tr>
<td>Foreign object retained after surgery</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Air embolism</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Blood incompatibility</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Pressure ulcer stages III or IV</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Falls and trauma</td>
<td>X***</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>DVT/PE after hip/knee replacement</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Manifestations of poor glycemic control</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Iatrogenic pneumothorax</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Ventilator associated events</td>
<td></td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Methicillin resistant Staph. aureus (MRSA)</td>
<td></td>
<td>Proposed FY 17</td>
<td>Finalized FY 17</td>
</tr>
<tr>
<td>Clostridium difficile (CDAD)</td>
<td></td>
<td>Proposed FY 17</td>
<td>Finalized FY 17</td>
</tr>
</tbody>
</table>

*SSTI includes different conditions. ** Vascular Catheter is broader than the CLABSI measure. *** Hip Fracture in PSI-90
**Current Reform Landscape**
Changes are Coming Fast

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.0%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>2.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **30-day Readmissions Caps**   | 1.0%    | 2.0%    | 3.0%    |         |         |         |         |         |         |         |

| **Hospital-acquired conditions** |         |         |         |         | 1.0%    |         |         |         |         |         |

| **Market basket reductions**   | 0.1%    | 0.1%    | 0.3%    | 0.2%    | 0.2%    | 0.75%   |         |         |         |         |

| **Multifactor Productivity Adjustment*** | 1.0%    | 0.7%    | 0.5%    | 0.5%    | 0.5%    | 0.6%    | 0.6%    | 0.7%    | 0.7%    |         |

| **Documentation and Coding Adjustment (DCA)** | 4.9%    | 1.9%    | 0.8%    | 1.6%    | 2.4%    | 3.6%    |         |         |         |         |

| **Sequestration ***** |         |         |         |         |         |         |         |         |         | 2.0%    |

| **Other Adjustments**       |         |         |         |         |         |         |         |         |         | 0.2%    |

| **TOTAL IMPACT**            | 6.0%    | 5.7%    | 7.1%    | 9.8%    | 10.9%   | 12.9%   | 9.4%    | 9.4%    | 8.7%    | 8.7%    |

FY refers to the federal fiscal year. For example, FY 2012 began Oct 1, 2011 and ended Sept 30, 2012.

*The Multifactor Productivity Adjustment is an estimate generated by the CMS Office of the Actuary.

**DCA, also known as the behavioral offset. Estimates FY 2015-FY 2017 impact of the American Taxpayer Relief Act of 2012.

*** Sequestration (across the board cuts to reduce the federal budget deficit) will stay in place unless otherwise reversed by Congress.
Process Measures – it’s all about the nurses

<table>
<thead>
<tr>
<th>Measures</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge instructions for heart failure (retired)</td>
<td>High</td>
</tr>
<tr>
<td>Surgery patients whose urinary catheters were removed on the first or second day after surgery</td>
<td>High</td>
</tr>
<tr>
<td>VTE Prophylaxis</td>
<td>Shared</td>
</tr>
<tr>
<td>Stroke patients receive written educational material about stroke care and prevention during stay</td>
<td>High</td>
</tr>
<tr>
<td>Early elective delivery</td>
<td>L&amp;D</td>
</tr>
<tr>
<td>Sepsis screening</td>
<td>High</td>
</tr>
</tbody>
</table>
## Patient Experience – Always

<table>
<thead>
<tr>
<th>Actual Question</th>
<th>Nurse Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did nurses explain things in a way that you could understand?</td>
<td>High</td>
</tr>
<tr>
<td>Patients reported they “always” received help as soon as they wanted. (call button)</td>
<td>High</td>
</tr>
<tr>
<td>How often did hospital staff do everything they could to help you with your pain? How often was it well controlled?</td>
<td>High</td>
</tr>
<tr>
<td>New medication: Staff tell you what is was for? Describe side effects in a way you could understand?</td>
<td>High</td>
</tr>
<tr>
<td>Overall rating 9-10</td>
<td>Shared</td>
</tr>
<tr>
<td>Staff took preferences and those of my family or caregiver into account in deciding what health needs would be when I left. (and clearly understood medications)</td>
<td>High</td>
</tr>
</tbody>
</table>
Practical Tips on Patient and Family Engagement

• A new culture requires intention. Encourage patients to engage.
• Don’t refer to patients in the third person
• Recognize that googling your own diagnosis is a sign of engagement
• Adopt the belief that better informed patients manage their care better
• Simplify messages – make it easy to remind patients.
• Welcome family interest in care.
• Let patients scour the earth for information and appreciate their efforts
• Let patients help with quality and safety – value their questions and reminders.

The patient engagement imperative; American Nurse Today; Issue Date: February 2014 Vol. 9 No. 2
Author: Rose O. Sherman, EdD, RN, NEA-BC, FAAN, and Nancy Hilton, MN, RN, NEA-BC
Who Succeeds and How?

- Hospitals with the BEST care
- Hospitals with evidence-based practice at the helm
- Hospitals with collaborative teams
- Hospitals with quality and safety focus
- Hospitals who liaison with their community care givers and resources
- Hospitals who measure, compare, implement change and re-measure
- Hospitals who involve patients and families
- Hospitals whose leadership promotes quality and safety first
- Hospitals with VERY SKILLED and KNOWLEDGEABLE NURSES!
This is one of your patients:

• Catheter placed in ED
• Day 4 – low grade fever, UTI suspected
• Culture positive
• CAUTI
## Care and Patient Impact

- Elderly
- Poor nutrition habits
- Poor hydration habits
- Discomfort
- Family unhappy
- Patient sicker
- Bladder control weakens during catheterization
- Patient becoming septic?; risk of mortality
- Creates a situation for understanding of appropriate discharge placement
Financial Impact

- Fixed DRG payment
  - $5,035 – Pneumonia
- Penalty for HAI – Refund Medicare 2%
- Penalty for IQR – Refund Medicare 1.5%
- Stays 3-4 days longer
  - Reimbursement - $5,035
- Patient is readmitted Day 14 for worsening symptoms, fever
  - Penalty for readmission
- Placed on broader spectrum antibiotic (more costly)
  - Reimbursement - $5,035
- Larger team involvement across continuum (NH, home health, etc)
  - Hospital now shares one payment with other providers

*Numbers are fictitious*
CAUTI Patient - Example

Pneumonia – no CAUTI

Cost of Care (3 day stay)
- $5,035 (x-ray, atb, room and board, etc)

DRG Reimbursement
- $5,285

Pneumonia with CAUTI

Cost of Care (6 day stay)
- $7,385 (expensive atb, analgesics, cultures, room and board, etc)

DRG Reimbursement
- $5,285 MINUS penalties

How much are you willing to refund to Medicare for that care you have provided?

Numbers are fictitious
# Estimated cost of HAI (Example)

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th>Average Cost</th>
<th>Projected Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>2</td>
<td>$48,814.00</td>
<td>$91,628.00</td>
</tr>
<tr>
<td>VAP</td>
<td>1</td>
<td>$40,144.00</td>
<td>$40,144.00</td>
</tr>
<tr>
<td>SSI</td>
<td>4</td>
<td>$20,785.00</td>
<td>$83,140.00</td>
</tr>
<tr>
<td>C-DIFF</td>
<td>6</td>
<td>$11,285.00</td>
<td>$67,710.00</td>
</tr>
<tr>
<td>CAUTI</td>
<td>3</td>
<td>$896.00</td>
<td>$2,688.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$285,310.00</td>
<td></td>
</tr>
</tbody>
</table>

Why Does That Matter to ME?

Tired of working short?

Travel budget for conferences cut?

What creates employee (specifically nurse satisfaction?)

- Ability to optimize conferences, online education offerings in our specialty
- Ability to network and share knowledge about patient care
- To fill our vacant FTEs

BEST care possible as if these patients were our family / friends
What Could be Done DIFFERENTLY?

**ED**

- Was catheter insertion medically necessary?
- Was insertion criteria used and followed?
- Was insertion technique audited?
- When was the last time the insertion clinician retrained on technique?

**Unit**

- Was diligence followed in bag positioning?
- Is catheter care training recurring or a “one time” event?
- Was catheter care diligently performed & performed correctly?
- Was there an opportunity to remove catheter prior to developing infection?
What is value?

• Value = Health outcomes achieved for patients relative to the cost of achieving the outcomes. (O/C)

• Which outcomes?
  – Important to your organization – find out!
  – Connected to nurses (defects, patient flow, variation in care)

• Which costs?
  – Unnecessary care, length of stay, avoidance of penalty and lost reimbursement
  – Any waste: excessive waits, supplies, staff time, rework
Understand value and create it

- Improve outcomes without changing the cost of improving the outcome (↑O)
- Decrease the cost of producing the outcome without changing the quantity or quality of the outcome. (↓$)
- Improve outcomes at the same time as decreasing costs) (↑O and ↓$)
Future nursing workforce will embrace value: be a part of and lead problem solving

• Reorganize your mind around value creation – become value conscious in all you do.
• Find out what outcomes are important to your employer – what to focus on, size and scope
• Be flexible, accept that creating value demands that choices be made
  – What can you give up? What can you do less of? What will you provide more of?
  – How can you apply your knowledge and experience to lower costs?

_Peter Buerhaus, PhD, RN, FAAN_
Finally, the new nursing workforce will embrace value ... be part of and lead in finding solutions

- Re-organize your mind around value creation... become value conscious in all you do
- Find out what outcomes are important to your employer .... They are trying to figure out their strategy ... What to focus on, what size and scope ... anticipate disruptions
- Be flexible, accept that creating and delivering value demands that choices be made
  - What can you give up? What are YOU not going to provide? What are YOU going to provide more of?
  - How can you apply your knowledge and experience to lower costs?
Questions?

“Price is what you pay. Value is what you get.”

Warren Buffet