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Creating a new healthcare landscape

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The scene may appear disruptive, but switching from fee-for-service to value-based care will benefit America's tired health system.

Healthcare reform is creating a transformation across all segments of the health delivery system and to how care will be delivered over a patient's lifespan. Much of the driving impetus of change for hospitals, providers, insurance payers, and patients is the recent U.S. legislation enacted by Congress in 2010. As a result, organizations and clinicians are seeking ways to shift from a model focused on illness to a paradigm of wellness. Continuing the present fee-for-service care delivery model as a way to fix the system has been deemed unsustainable to avoid bankrupting the healthcare system. Providing value-based services and population health initiatives are the new national priorities. The transition in concept seems simple; however, the grassroots path isn't as intuitive. Within each of the cost-saving models, providers are united in asking the deployment question, "How?"

The changing landscape has also created an advent of new abbreviations for models of care such as the Patient Centered Medical Home (PCMH), Accountable Care Organization (ACO), Value-Based Purchasing (VBP), and Patient Protection and Affordable Care Act (PPACA). With the myriad abbreviations, knowing which direction to guide staff members' attention can quickly become a blur. Rather than segmenting the different aspects of healthcare reform, an examination of the emerging intersections among key stakeholders provides a unique vantage point. A requisite for nurse leaders today is having the ability to effectively articulate how the legislative and new patient delivery concepts translate to staff members rendering patient care. Focusing on the intersection between the hospital, provider (inclusive of nurses), and patient can be an effective roadmap of the important elements that are necessary for frontline staff during a time of disruptive innovation.

Mountains and molehills

Healthcare reform is increasingly focused on clinical outcomes and patient experience perceptions that have a direct impact on a hospital's bottom line. Within the hospital interior, a wealth of data exists about the patients being served and the care they receive. Historically, the question has been whether processes were improving. The PPACA of 2010 legislatively changed the question leaders need to ask with the enactment of two programs that

should be on every nurse leader's radar: the Hospital Readmissions Reduction Program (RRP) and VBP.

The RRP targets hospital readmission rates within the first 30 days after a patient's discharge to home for designated disease conditions. Hospitals are evaluated against the national average for the comparison reference point. Penalties for excessive readmissions under the program were capped at 1% in 2013, 2% in 2014, and increase to a maximum penalty cap of 3% in 2015. Hospitals incur an all-or-nothing penalty under the RRP where the maximum cap percent is applied to hospitals rather than a partial amount of a range. The designated disease conditions for 2013 under the RRP include acute myocardial infarction, congestive heart failure, and pneumonia. In 2014, additional disease conditions have been added: acute exacerbation of chronic obstructive pulmonary disease, cardiac artery bypass graft, percutaneous transluminal coronary angioplasty, and other vascular procedures.[1]

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VBP targets clinical process of care outcomes and patient experience scores. Organizations are evaluated on either their achievement level (hospital standing in relation to its peers) or improvement level (magnitude of improvement over time), with the better score of the two evaluation factors used in the analysis calculation during a given year. The percentage of a hospital's Medicare patient reimbursement started at 1% in 2011, and increases by one-quarter of 1% over a 4-year duration until a maximum penalty cap of 2% is reached in 2015.[1] Hospitals may receive an incentive return (a greater return than the initial amount withheld by the Centers for Medicare and Medicaid Services [CMS]) by achieving or improving performance at a level higher than the comparison peer benchmark), a partial return of the withhold, or a full withhold retained by the CMS (up to the maximum penalty cap for the given year).

With the PPACA enactment of the VBP program, patient experience "top box" scores (patients that rate a facility at either a 9 or 10 on a 10-point scale) are accelerating upward.[2] If the volume of patients reporting top-box scores shifts upward, the benchmark comparison used as a determinant for a hospital's positioning in relation to its peers shifts upward as well. Hospitals and providers who are unable to deliver care from the vantage point of value through the patient's eyes, in addition to the requisite technical expertise, will subsequently encounter lower scores in relation to other hospitals. A disconnect between patients and providers now reduces a hospital's revenue stream within a shifting delivery system paradigm of how hospitals are evaluated due to the PPACA legislation.

Broad horizons

Another important piece of legislation separate from the PPACA, which becomes effective in 2015, targets hospital-acquired infection (HAI) rates. Organizations that score in the top quartile for HAIs, compared with the national average, will undergo an additional 1% reduction of all Medicare patient diagnostic related group reimbursements.[3] The penalty doesn't apply to only patients who acquired an HAI while under a hospital's care. The CMS posts publicly reported data on its website of health outcomes for many segments of the health continuum (such as hospital, home health, nursing home, and in-center hemodialysis). Consumers have the ability to review the CMS information when making educated decisions about where they should seek care. The magnitude of information available to consumers is increasing as the CMS expands the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to differing segments of the health delivery system. A correlation also exists between patient self-reported ratings of his or her physician and clinical outcomes.[4] Public reporting creates a perfect storm for hospitals ranking lower than their geographic peers to become at-risk for attrition of market share and negative brand perception.

Hospitals and clinicians will need to turn toward evidence-based practice (EBP) cited within literature and hospital protocols as a way to accelerate their patient improvement

curve. EBP allows organizations and providers the insight to know what works for improving patient outcomes before spending resources. With the payment models shifting from a fee-for-service to a value-based service (population health) model, organizations are faced with challenges in how they deliver care with dwindling reimbursement for inpatient setting care delivery. EBP will become not only the platform of what's recognized as best practice for healthcare medical claims reimbursement, but also the standard that clinicians are evaluated against if involved in litigation by patients.

What's the bottom line? Focusing on what matters to patients (in addition to administering the technical tasks) to set hospitals apart from the competition, or lead to organizational demise. Patients assume a clinician's skill mastery when care is rendered at the bedside; the differentiator will be clinical outcomes and patient experience to keep ahead of the competition curve.

Crossing oceans

Knowing the differences between vernacular and process is important to understand as best practices evolve. Terminology that was previously interchangeable within healthcare is becoming mutually exclusive at the process level. This creates the potential for confusion if leaders aren't current with industry evolutions of best practices over time and assume that similar terms reference the same practice. Examples are nurse hourly rounding (based on timeframe), nurse purposeful hourly rounding (use of structured questions), leadership rounding (the traditional c-suite engaged in rounding), leader rounding (a broader designation of rounders' inclusive of anyone with direct reports), and management by walking around (MBWA—encouraging leaders to visit the front line of processes they have little knowledge about [an outdated practice]).[5] Selection of two to three key initiatives for hardwiring sustainability is necessary to ensure success when examining priorities before shifting to the next initiative. Patients seek coordination of care among the clinical team that incorporates the most recent best practices.

Initiatives that include communication will become the metric of success for organizations—with the patient voice and level of family involvement as the barometer. Such initiatives may include rounding to obtain the real-time patient voice of his or her experience, teachback to ensure understanding and knowledge retention is adequate, and hospitalization postdischarge telephone calls to identify any communication gaps during the transition to home. A nurse's ability to communicate with patients and among the care team, as part of the HCAHPS survey, factors into the CMS withhold return calculation that determines the amount hospitals receive under the VBP program. Patients want to have the knowledge and skills for competent self-care upon arrival home. This process begins with the information and education delivered at the bedside by providers and is evaluated by patients through the experience survey, which now directly ties to a hospital's reimbursement with the enactment of the PPACA.

A provider's technical ability is assumed when patients visit the hospital. The areas for greatest hospital improvement are often the "softer skills," such as an interpersonal dialog with a patient at the bedside. However, these areas can be reduced to key behaviors that are needed for ensuring high-quality interactions and delivering care in a way that's meaningful to patients. The hospital top drivers of HCAHPS scores often involve a need for improved communication.[6] Taking the time to make eye contact with the patient, focusing on the patient without distraction, and listening to the patient before formulating the next response help to ensure a solid patient interaction. These techniques seem simple; however, within an environment that increasingly involves multitasking, time constraints, and reduced staffing, the basics can quickly become lost within the patient interaction.

Nurses choose to work within healthcare to make a difference, and patients want to feel that they weren't just another body in the hospital queue. There's tangible relationship equity built between providers and patients during processes such as rounding and discharge calls. Having standardized patient touch points to confirm that a provider is adequately and accurately listening creates value that's often reflected in patient experience scores. The basics that patients seek in their care typically remain the same as healthcare goes through a period of disruptive change and innovation: a humanistic interaction, handholding when they're afraid, an explanation during times of uncertainty, and the opportunity to provide input about their own care. To the patient, it's personal.

Consistent delivery of the basics, 100% of the time, impacts the patient experience, patient safety, and shines a light on unknown blind spots within the direct patient care setting. If providers consistently deliver on what patients' say they want and improve processes accordingly, experience score evaluations, by default, will

increase. Ensuring delivery of the basics increases the power of an organization's brand, strengthens how units perform within an organization as a team, and provides the value that patients seek as a part of their care.

Through the woods

Traditionally, "healthcare as a business" wasn't a nurse's mindset or a nursing program focus of indoctrination for entering the profession. As a result, many providers need education about key business concepts and the knowledge necessary to pragmatically link the delivery of high-quality care with efficiency rather than "doing the same thing faster." This latter approach results in speeding up what's already broken and can result in further process deterioration. Understanding the financial stream and how it relates to patients is needed across the hospital, provider, and patient domains. For example, a hospital's potentially preventable readmissions can impact the organization's financial bottom line, is partially related to the preparation a patient receives before discharge, and corresponds directly with an individual's ability to successfully self-manage his or her condition at home.

Similarly, disparate systems can result from how a hospital prioritizes infrastructure initiatives or a lack of knowledge about available funding programs such as Meaningful Use.[7] For example, multiple software systems that are unable to interface creates duplicate entries by providers with added workarounds, increases the time required for care delivery, and expands the potential for errors. Lack of technology, or not using the full spectrum of point-of-care technology available today, can lengthen the period of time when information becomes available to specialists or primary providers outside of the hospital setting. Additionally, poor documentation within a system, technological complexity, or a failure to be geared toward the way a provider practices can result in hospital coding errors through down-coding services that were actually provided. These items impact a hospital's bottom line, communication between providers, and, ultimately, the care that patients receive.

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Over the fields

Fee-for-service models encourage patient testing and interventions that can be billed for revenue. Hospitals and providers make revenue through insurance reimbursement, which is based on procedural coding and the level of care needed by a patient. A value-based-services model more similarly resembles the capitation models that emerged in the 1990s. Keeping patients out of hospitals and the preventive health of populations is in opposition to a fee-for-service model. When wellness becomes a priority, rather than the billable revenue stream of an illness, it drives a need for patients to become knowledgeable about different care options. A value-based-services model shifts treatment to the most efficient and economical setting while ensuring that the level of care effectively addresses patient needs. It requires a mind shift in how care delivery is conceptualized for hospitals and providers.

The value-based-services model also shifts health education and wellness programs, patient engagement in lifestyle changes, and environmental triggers of preventable disease conditions to an equal importance of focus as the interventions that providers deliver. ACOs are required to have wellness programs as a participation requirement; hospitals are subject to incentives and penalties for specific disease conditions under the PPACA; providers are changing their affiliation and practice agreements to align with PCMHs and ACOs and modifying contractual payer agreements; and patients need providers who are savvy about community resources to help meet their complex chronic condition care. Under a value-based-services model, chronic disease management is a proactive approach rather than a reactive response through the hospital at the point of care. Among Medicare enrollees, 83% have at least one chronic disease condition, of which 23% of Medicare patients have five or more chronic conditions.[8] For cost containment of multiple comorbidities, hospitals, providers, and community-based services will

need to strongly unite for a comprehensive approach to patient care and lifestyle modification.

Winding rivers

In the most restrictive and traditional sense, "provider" often referred to physicians. Over time, providers included physician assistants and nurse practitioners as the scope of practice expanded. Within the hospital setting, patients often perceive a provider as anyone dressed in scrubs. Although, undoubtedly, patients need to know the type and level of specialization of the individual caring for them, nurses need to view themselves within a broader framework of how a provider is defined today. Anyone that touches the patient is eligible for interpretation as a provider in a more generalized sense when a patient completes an experience survey.

Although a patient experience survey often delineates providers from nurses within a question set, the overall experience that impacts different time-points during their care and how questions are answered remain filtered through an overall feeling created by the entire health delivery team. A poor interaction can lead to a downward spiral of the patient experience, just as easily as a high-value interaction can change the perception of subsequent encounters. Hospital credentialing processes are independent of an individual's definition of provider. Today the opt-in of individuals considered a provider denoted on a patient experience survey is determined by the patient. Independent of individualized roles, a "gestalt effect" exists of which the nurse is a potential member that may be within a patient's frame of reference.

Organizations understand the importance of cultural diversity as often demonstrated through annual competencies, staff training, and human resources tracking. Increased focus has taken hold within the healthcare industry through senior leader affiliations with associations such as the American College of Healthcare Executives (ACHE). Having a heightened awareness and knowledge of diversity issues is mission-critical to organizations today. The ACHE has created Regent-at-Large positions based on attributes related to diversity and has developed a Statement on Diversity.[9] Some hospitals have developed patient advocacy councils that specifically represent the cultural and ethnic diversity aspect of the populations they serve.[10]

Providers will need a heightened awareness as more individuals enter the healthcare system for services given the aging population and diversification of the United States in general. Hospitals, nurses, and patients are positively impacted through meeting the unique needs of diverse groups of individuals. An organization's internal brand equity is strengthened, nurses learn cultural aspects from each other, and the patient voice is more accurately reflected through different practices and traditions being recognized within the healthcare setting.

A mesmerizing scene

To avoid potentially preventable readmissions, patients will need to understand their medical condition management, providers will be increasingly called on to share medical information and records with patients, and hospitals will be required to seek ways of integrating information between disparate technologic communication systems. Although 81% of specialists report sending information back to a primary care provider, only 62% of primary care providers report receiving information back after a patient is sent for consult.[11] Patient transparency with his or her health condition and medical record information can help bridge a void that presently exists between different health sector provider handoffs.

Healthcare will have an intersection to balance between patient privacy of information and the needs of an aging, complex, multiple chronic condition population with cognitive diseases such as dementia (where the supportive care often falls to a family member for coordinating communication). More than 5 million individuals have dementia in the United States, and the age of onset is starting to occur earlier. The 2013 estimates of Alzheimer disease costs in the United States were projected to be $203 billion. Further, in 2012, 15.4 million caregivers provided more than 17.5 billion hours of unpaid care, estimated at $216 billion.[12] As patients with dementia and multiple complex chronic conditions increasingly cross different sectors of the healthcare delivery system, it will require transparency of information to be reframed from a process element to being a patient safety priority.

Reform within healthcare is a time of dynamic and disruptive innovation. Increasingly, leaders will need to find solutions for financial viability. Although many providers and organizations are questioning how to deploy infrastructure, the essentials within each of the differing models for the front lines of healthcare will remain the same: delivery of high-quality patient outcomes and experience within a context that's based on value. Looking to the intersections between hospital, provider, and patient becomes important for understanding common elements of

messaging to create a greater alignment among all stakeholders within the reform era.

The healthcare of tomorrow is guaranteed to look different than the landscape of today to avoid bankrupting an already broken system. However, knowing the legislative changes as they relate to a hospital's data, questioning whether an organization is accelerating the improvement curve fast enough, seeking high-impact initiatives to support the bottom line, and keeping the human element intact as healthcare transforms to a population health focus will continue to remain the essentials. NM

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