CE 1.5 CONTACT HOURS

Remodeling a broken system through hospital-payer partnerships

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An outcome of the Patient Protection and Affordable Care Act (PPACA) is the creation of tighter alignments between hospital-payer partnerships through contractual agreements and incentivized programs. These relationships are being forged in response to the financial climate of a broken healthcare system and reimbursement shifting from a paradigm based on volumes to service value. Early adopters of these emerging contractual relationships are further aligning risk pools and shared savings for organizations, with a focus on population health by providers and wellness outreach to individuals before episodic treatment.

In addition to healthcare reform efforts to create health insurance exchanges (HIEs), regulate adoption of universal healthcare coverage, and improve access to healthcare services, the immense challenge of meeting the growing needs of an aging population looms. The anticipated burden this population will place on the healthcare system isn't without warranted angst. Recent projections about the future of care for older adults include two-thirds of senior citizens having one or more chronic conditions; 20% of individuals over the age of 65 presently seek treatment by 14 or more physicians.[1]

Although HIEs will expand coverage to Americans, a question remains about impact magnitude to the healthcare system when these individuals enter already strained clinician networks. The average number of patients seen per day by physicians in 2012 was 20.01.[2]

Revive the structure

To help meet these challenges, a renewed invigoration of population health management is underway. New structures are developing, such as the patient centered medical home, where a care team navigates the patient through what's been termed the "healthcare maze."[3] Accountable care organizations (ACOs) are also emerging, where alignments are created between physicians, hospitals, and other healthcare providers for coordinated service delivery to Medicare patients. The goal of ACOs is to ensure those with complex care needs and the chronically ill receive care when needed without unnecessary replication of services. ACOs also have a strong focus on diligently preventing medical errors.[4]

Under an ACO model, a population of Medicare beneficiary individuals within a catchment area is assigned to the ACO by the Centers for Medicare and Medicaid Services (CMS). Individuals retain freedom of choice so that they may seek services either within, or external to, the ACO network to which they've been assigned. However, providers get paid to keep patients well. Approximately 14% of individuals are already assigned to an ACO, with an anticipated program savings of $940 million within the first 4 years of implementation.[5]

Medicare Advantage bonus payments are an example of payment reform legislated as part of the PPACA. The Medicare Advantage program has a five-star rating system based on over 50 measures that are further classified into nine domains. Scoring is calculated according to specifications by the CMS, and the star ratings are transparent to consumers through the government website for viewing before enrollment. The PPACA authorized Medicare to pay bonuses to private insurance payers that received four or five stars (highest rating is five stars). Further, the CMS has initiated demonstration programs to increase the volume of payers receiving bonuses and promote ongoing improvements in star-level ratings.[6]

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The domains and corresponding measures are as follows:

- staying healthy (screenings, tests, and vaccines), 13 measures
- managing chronic conditions, 10 measures
- drug plan customer service, 7 measures
- ratings of health plan responsiveness and care, 6 measures
- health plan member complaints and appeals, 4 measures
- drug pricing and patient safety, 4 measures
- health plan telephone customer service, 3 measures
- drug plan member complaints, members who choose to leave, and Medicare audit findings, 3 measures
- member experience with drug plan, 3 measures.[6]

Payers are additionally partnering with clinicians who deliver care to Medicare Advantage individuals. For example, nurse case managers and data management systems have been provided by the payer to physicians who have a specified volume of Medicare Advantage patients to help support their care delivery. Clinical performance target scores are negotiated between the payer and the physician or advanced practice provider. Bonuses are paid if the target score is achieved.[7]

Quality improvement requirements, as part of the contractual arrangements, can contain items such as clinician and hospital metrics, acute care outcomes, and 30-day readmission rates. For example, a network may have a risk and distributive savings program with a payer. The system is evaluated against metrics, such as readmission rates, quality, safety, patient satisfaction, and efficiency. If the network fails to deliver on the metrics, payment reductions can result; similarly the payer can incur penalties if performance and cost data aren't delivered on time to the health system. To remain eligible for shared savings with the payer, the network is contractually required to improve

beyond the year one baseline, in years two and three.[8]

Patient engagement framework

Nurses, nurse managers, and NPs will need to embrace their full scope of practice as the older adult population continues to increase and as patient education rises in importance for encouraging self-management across care transitions and within the home setting. Nurses will be called on to fill a vacuum that's developing with the growing demand for healthcare services. Estimates of NP workforce growth are projected to increase from 128,000 in 2008 to 244,000 by 2025, a surge of 94%.[9] To fully optimize the emerging models that focus on an individual's wellness, the increased utilization of advanced practice personnel has become the crux of healthcare for delivery to effectively happen. Additionally, nurse leaders will need a simplistic framework for understanding risk propensity as it relates to aggregate population health management and their own roles and responsibilities.

When shifting from a fee-for-service to proactive wellness approach, a linear roadmap of steps can serve as a helpful guide to hospitals, clinicians, nurse leaders, and payers. Success isn't only aligning the key stakeholders of the medical team, but also building the capability to evaluate and monitor the health of an assigned population. The progression necessary to drive population health while mitigating risk includes the following steps: identifying high-risk populations, establishing a wellness program, creating action plans, repeating measures, and developing infrastructure sustainability.

One example of a successful transition is a payer with a diversified health and wellness program in addition to its offerings of health, dental, and vision care insurance. The high-risk populations for incurring claims within a 1-year timespan are prospectively identified through the use of validated question series, such as a frailty instrument, the Geriatric Depression Scale, and the Probability of Repeated Admission scale.

After the high-risk populations are identified, outreach and messaging is tailored to each individual in the cohort. Specifically targeted are opportunities that relate to lifestyle changes for better individual health management and programs based on health risk assessment results for conditions such as obesity, diabetes, or a need for smoking cessation. Individuals who engage in these programs can earn credits toward a reward program that furthers health and wellness for the member. Reward examples include fitness kits and travel first aid kits. The member also has the ability to track his or her member engagement in the program over time, health outcomes at an individual level, and any changes in his or her health risk assessment results.

Organizationally, the program is structured in a way that has hardwired its ability to make any necessary course corrections based on validated measurement data, and can subsequently modify its populations outreach when demographics shift for the sustainability of its wellness program.

Building trust through maturation

Nurse leaders need to understand the different distinctions of maturation for providing risk assessment and wellness programs, given their role in the healthcare of tomorrow and the importance of population health management. Nursing is the profession most often called on when populations are identified with a need for patient education and wellness coaching outreach. Knowing the level of maturation helps nurses understand the tactic that's being undertaken in targeting either an overall population under a chronic condition approach or a more tailored intervention to an individual.

A healthcare organization or payer's level of maturation can fall into one of four categories: population health awareness, a risk and propensity model, individualized health risk assessments and wellness programs, and member-specific health risk assessment and wellness programs. (See *Figure 1*.) The risk assessment and educational outreach activities an organization or payer conducts determines its quadrant placement. After the organization or payer's quadrant location is identified, a more robust program within the existing quadrant can be created or advancement can be achieved to a higher level of risk assessment, stratification, and outreach to consumers, patients, or members.

A basic *population health awareness* of a membership or population is the entry level for a wellness program. The upper left quadrant seeks to identify what's known about the population as a whole. The second level of maturation is adopting a *risk and propensity model*. The lower left quadrant begins to segregate the total population into subgroupings, such as risk according to chronic conditions. This category of wellness programs seeks to identify which members are engaging in preventive health, and messaging can be targeted to a specific population, such as individuals with diabetes. The third level of maturation is conducting *individualized health risk analysis* of members. The upper right

quadrant moves beyond categories of populations to the individualized member or patient level of analysis. The organization has shifted to a more advanced understanding of its population's health through the use of validated risk measurement tools.

After organizations or payers have migrated from an overall population view to an individualized member view for understanding an assigned population's health status, it becomes easy to shift to the fourth and highest level of wellness program maturation in the lower right quadrant. Stratification enables organizations to undertake individualized wellness program outreach to a manageable scale. *Member-specific wellness programs* go beyond the one-size-fits-all approach and tailor the wellness plan according to the knowledge of specific members. Individuals within a population have different health risks. Accordingly, the wellness plan has a program infrastructure that's adapted to the high-risk individuals at a per-person level of focus. With the deeper level of analysis, information, and outreach comes the greatest potential to produce a return on investment for an organization or payer. Working with assigned members on an individualized level allows for outcomes to be tracked over time, not only for the overall program, but also for each individual.

Location, location, location

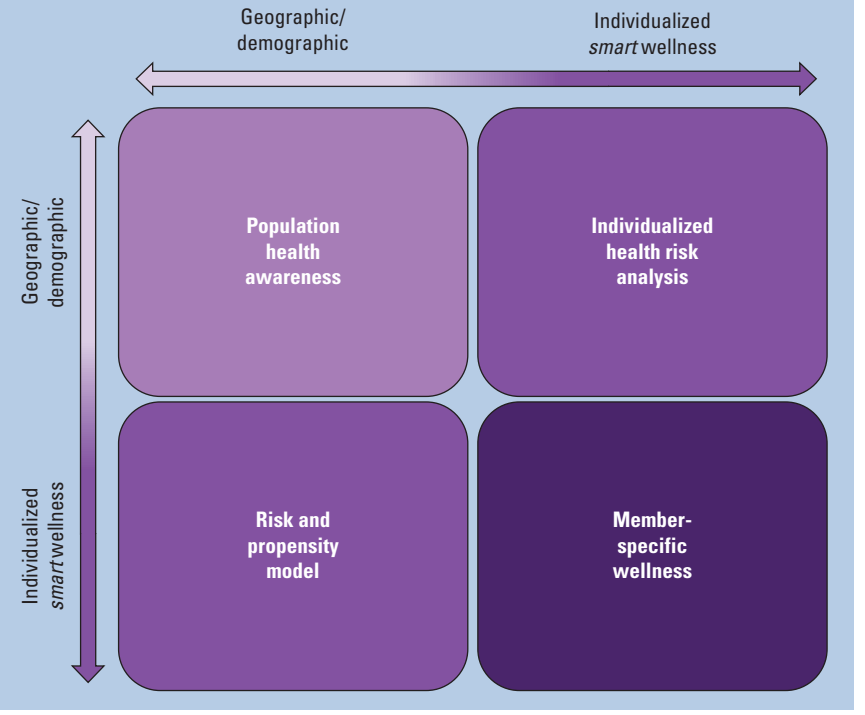
Although patients are often unaware of their assigned ACO, the location where an individual chooses to seek services impacts the hospital's bottom line. Under the emerging wellness models, keeping patients within their assigned catchment areas and establishing relationships are the keys to increased hospital profitability. Preventive health helps reduce insurance claim volumes, and the intersection between the patient relationship, care delivery, and health education is where the nurse leader can make a tangible difference.

Nurse leaders are positioned to effectively help individuals shift from the second level of risk and propensity models to the third level of individualized health risk analyses. Since the 1980s, organizations have been adopting service lines for high-revenue populations, such as cardiac care and neurology patients.[10] However, risk and propensity models take stratification a step further to those individuals most at risk for having health insurance claims and accessing the system.

Transitioning to an individualized focus is, by default, the definition of patient-centered care. Bedside education from nursing staff members lends well to individualized health risk assessments where risk factors are known through the duration of a stay, and education occurs before discharge. The effectiveness of this bedside education impacts how individuals view the care they receive, and also where they choose to access services.

A mutual goal between the payer, patient, and nurse leader is preventing 30-day posthospitalization readmissions. Identification of those most at risk for readmission during a stay and focused education conducted at an individual level can help close the gap on readmissions that occur from poor patient self-management on arrival at home. Approximately 20% of patients will opt not to visit the same facility when readmitted to a hospital for care. Although this may be due to myriad factors, such as dissatisfaction, fear of retribution, and seeking a second opinion about a complex

Figure 1: Levels of health risk assessment maturity



chronic condition, the occurrence of attaining services elsewhere limits visibility of the organization to the magnitude of the problem.

Additional consequences can be higher mortality when patients choose an alternate hospital for a readmission and compromised patient safety.[11] Further, individuals who choose a secondary hospital for treatment of a condition that falls under the CMS guidelines as a 30-day readmission may have more disadvantages of limited access to the primary admission medical records, delayed treatment, discontinuity of care, and increased exposure to healthcare-associated infections.[11]

Beginning in 2015, under Section 3008 of the PPACA, hospitals may have an additional 1% reduction in Medicare inpatient payments if they're within the top 25% of national risk-adjusted hospital-acquired conditions for all hospitals during the prior year.[12] Many of the 10 categories that fall under the Section 3008 provision can be mitigated to some degree through the nursing process or have an educational nursing component of signs and symptoms to proactively monitor post discharge by the patient.

The 10 categories include:

- foreign objects retained after surgery
- air embolism
- blood incompatibility
- stage III and IV pressure ulcers
- falls and trauma
- manifestations of poor glycemic control
- catheter-associated urinary tract infections
- vascular catheter-associated infections
- surgical site infections
- deep vein thrombosis/pulmonary embolism related to total knee or hip replacement.

Aligning the partnership

The role of nurses on the front lines of population health and public health nursing dates back to the 1860s with work done by Florence Nightingale.[13] In the future, nurses will be called on to take a significant role in health policy and planning. Research has documented a correlation between the quality of nursing care and rates of patient complications.[14-16] This relationship opens the door to nurse leaders taking an active role in population health management, documenting their contribution to the bottom line and their relationship in the hospital-payer mix. Legislation is already creating a stronger link between patient outcomes, care delivered at the bedside, and reimbursement. Nurse leaders have the opportunity to advance the profession through risk identification and stratification of patients, and working with different entities proactively, such as the payer industry, to build connections that will further population health and create alignments across the different settings where nurses provide care.

A starting point for nurse leaders should be staff members' awareness of their care delivery role and the various ways that reimbursement is being shaped through healthcare policy. Increased emphasis on an individualized approach and the therapeutic nurse-patient relationship during the care episode can help bridge gaps from patients seeking care in alternate—rather than the most appropriate—settings. A third element of awareness that's necessary includes understanding the different levels of maturation an organization can achieve with risk propensity and stratification as community-health provider relationships continue to transform over time.

Understanding the new health delivery models creates an alignment of hospital-payer relationships focused on the emerging population health approaches.

Hospital-payer relationships are changing and evolving as the United States undergoes payment model reform and increases attention on the health management of populations. Risk stratification is a successful method for understanding a population to mitigate claims and health expenditures while at the same time identifying individuals who require greater engagement in their health. Not only is consumer outreach and education becoming a necessity before patients need health services, but patient engagement also helps to ensure individuals will self-manage their care toward a goal of health promotion.

Understanding population health from the vantage point of the emerging health delivery models creates an alignment of hospital-payer relationships focused on the emerging population health approaches of tomorrow. As a nurse leader, you'll

continue to be at the forefront as the definition of at-risk populations, stratification of health condition segments, and improved patient outreach merge with the evolving types of wellness programs and population health management. You'll be the proactive leader in the paradigm shift from sickness to maintained wellness. NM

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